

Michigan Department of Community Health
Medical Services Administration

**Prosthetics & Orthotics
Medicaid Provider Liaison Meeting**

Capitol Commons Center
Monday, November 19, 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

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 Prosthetics & Orthotics.

Affordable Care Act Provider Enrollment

Trish Darnell explained bulletin MSA 12-55 issued November 1, 2012. There are 12 provisions for enrollment, per Sections 6401 and 6501 of the Affordable Care Act (ACA). Effective dates on each provision vary depending on system change dates. The Centers for Medicare and Medicaid Services (CMS) requires that all providers be categorized according to level of risk. The Michigan Department of Community Health (MDCH) has adopted the Medicare Categorization for providers that are currently Medicaid enrolled and for providers that are not yet Medicaid enrolled. Newly enrolling Durable Medical Equipment/Prosthetics and Orthotics (DME/P&O) suppliers are considered high risk and additional screening activities will affect those providers. All enrolled providers are required to permit unannounced site visits both pre and post enrollment. Only moderate to high risk providers will have site visits. The high risk groups will have to submit to fingerprinting and background checks for newly enrolled providers. For new providers, there will be an enrollment fee. Federal regulations require all ordering and referring providers to be enrolled in the Medicaid Program, excluding those in a risk based managed care organization like the Medicaid Health Plans. Physician Assistants will be allowed to enroll in the near future. Additional provider enrollment information, including home address, date of birth, and Social Security number, will be required from providers and other disclosed individuals (e.g. owners, managing employees, agents, etc.). All providers will be required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDCH. A temporary moratoria, numerical caps, or other limits may be placed on the enrollment of new providers or provider types identified as having a significant potential or increased risk for fraud, waste, or abuse, as long as it would not adversely impact beneficiaries' access to medical assistance. There are no moratoria in place at this time. There are many additional reasons that MDCH may terminate or deny enrollment in the Michigan Medicaid program. The bulletin explains them in detail. MDCH may temporarily suspend payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program.

ICD-10

Michelle Miles from Provider Outreach explained that that ICD-10 Implementation is a national initiative. Handouts were provided for reference. The implementation date is set for October 1, 2014. MDCH continues to prepare by working on CHAMPS, policies, forms, etc. and will be ready for implementation on October 1, 2014. The coding set went from 13,000 ICD-9 codes to 70,000 ICD-10 codes. If providers have any questions regarding the transition, please visit the websites provided in the handouts.

National Correct Coding Initiative (NCCI)

Lisa Trumbell explained to the group that CMS has imposed new National Correct Coding Initiatives (NCCI) edits for Medicaid programs, which include Procedure-to-Procedure (PTP) editing and Medically Unlikely Edits (MUES). MUES limit the number of units that can be billed daily for a single procedure code. PTP edits do not allow specific procedure codes to be billed together during the same date of service. The new requirements are the result of Section 6507 of the ACA and will start for P&O providers in April 2013. Bulletin MSA 12-40 was provided to the group and all were encouraged to visit the NCCI website listed in the bulletin.

Provider Audits

Pamela Callum-Bragg provided information regarding provider audits. Handouts were provided for the group regarding Health Management Systems, Inc. (HMS). This is a fairly new CMS initiative that is approximately half way through implementation in the State of Michigan. The first part of the review process involves analysis and targeting of Medicaid data for potential vulnerabilities within the program, and scenarios are then developed for MDCH review. Once MDCH has approved the scenarios, providers are contacted by HMS, and any records or information that may be needed to review the claim are requested. Once the records are reviewed, MDCH is informed of improper payments made to the provider. At that time, providers are allowed to submit additional documentation if they feel something was missed during the audit. The Office of Inspector General (OIG) keeps providers informed on the process from beginning to end. After the reconsideration process, the provider is informed on the final decision and the justification of the decision. At that time, providers would be able to submit an official review. Once the notification occurs, the recovery process begins.

Automated Reviews and Complex Reviews are the two types of reviews done by OIG. HMS follows the current Michigan appeals process. There is a provider portal, which will allow providers to review their audits or change contact information.

Updates on MOPA/Workgroup Issues

Lisa explained that there was an internal audit done that slowed down the process. Lisa reviewed all the codes and compared them to Medicare rates as well as other payers. She hopes that by the end of next week she can submit a proposal to administration about the possibility of increasing fees for P&O providers. There are a handful of codes she researched that are over Medicare rates and will be decreasing by a small amount.

There are several codes that will have a diagnosis bypass that used to require Prior Authorization (PA).

Lisa asked the group if they had any items they would like to discuss regarding workgroup issues.

Are there any options for affordable helmets? Lisa is still awaiting response for this question.

A provider asked about the 4210 and 7510 and quantity limits. The reason they wanted to increase the limit was because of the PA process. Lisa says they did not work through this issue due to the internal audit, so it is not resolved.

Children's Special Health Care Services Transition

Kathy Stiffler provided an overview and background on the transition of children who have both Children's Special Health Care Services (CSHCS) and Medicaid into the Medicaid Health Plans (MHPs). Bulletin MSA 12-46 and L-letter L12-36 were summarized and handed out to the group. There are a total of 21,000 CSHCS/Medicaid beneficiaries that will be transitioned to MHPs. Transition will occur in phases. The first groups transitioned on November 1, 2012 were beneficiaries in the Upper Peninsula. The second group will be beneficiaries in Kent County, who received enrollment information on or around October 8, 2012. The last letters will go out to the remaining beneficiaries in mid-November. Those individuals will have until February 1, 2013 to select their MHP.

Benefits of transitioning this group into MHPs:

1. Organized system for primary care
2. Complex case management provided
3. Better access to primary care services – families choose their primary care physician
4. Better access to mental health and transportation services

All 13 MHPs completed a core competency review to determine their ability to serve this population. Twelve MHPs passed are accepting enrollments. Fee-for-Service PAs approved for a beneficiary before the transition will be honored by the MHP for 30 days after the beneficiary is enrolled in the MHP. After 30 days, providers and members must follow the MHP's PA and documentation requirements. The MHPs must allow members to continue to maintain established relationships with their primary care physician, specialty physicians, and hospital providers. Kathy informed the group that the MHPs are responsible for establishing their own network of providers. If access becomes a problem for the beneficiaries, the providers or beneficiaries should report it to MDCH.

Next Steps

MDCH staff asked if the group felt quarterly meetings were helpful to them or if they would prefer meetings to take place twice each year. Majority indicated that they preferred meetings twice each year as long as the workgroup keeps meeting quarterly so that providers see progression.