Michigan Department of Health and Human Services
Medical Services Administration

Durable Medical Equipment and Supplies
Medicaid Provider Liaison Meeting

Capitol Commons Center
Wednesday, March 13, 2019
1:00 p.m. – 3:00 p.m.

MINUTES

Welcome and Introductions

Lisa Trumbell opened the meeting with welcome and introductions.

Healthy Michigan Plan Updates

Kellie Green provided updates and distributed the Healthy Michigan Plan Progress Report. As required by Public Act 208, of 2018, there are new conditions of continued participation:

1. Effective January 1, 2020, Michigan Department of Health and Human Services (MDHHS) will require Healthy Michigan Plan beneficiaries to report at least 80 hours per month of work or other qualifying activities as a condition of continued eligibility for the Healthy Michigan Plan unless they are exempt from the requirement. Non-exempt beneficiaries exceeding 3 months (consecutive or intermittent) of non-compliance in a calendar year may lose their Healthy Michigan Plan health care coverage.

   Examples of exemptions from the work requirement include individuals who are medically frail, full-time students, caretakers for a child under the age of 6 years old (one person per household), and pregnant women.

2. Effective January 1, 2020, beneficiaries with incomes over 100% of the federal poverty level who have been enrolled in the program for 48 months or more may be required to contribute 5% of their income towards cost-sharing and engage in an annual healthy behavior as a condition of continued eligibility for the Healthy Michigan Plan unless they are exempt from the requirements.

   Individuals who are exempt from Medicaid cost sharing are exempt from paying the 5% contribution. In addition, individuals who are determined medically frail, pregnant women, and individuals who are not enrolled in a Medicaid health plan are exempt from both the 5% contribution requirement and the healthy behavior requirement.

The group was encouraged to visit the Healthy Michigan web page for more detail at: www.healthymichiganplan.org.

A participant inquired if providers would be able to view in CHAMPS if a beneficiary was non-compliant. Kellie was not sure if providers would have access to this information, but indicated that more information will be available soon.

U4 Modifier used with E0143 or E0240 versus use of NOC code E1399

The Program Review Division has seen an increase in prior authorization (PA) requests using Health Care Common Procedure Coding System (HCPCS) code E1399, primarily for pediatric walkers and other pediatric products that have an established HCPCS code (e.g. E0143). MDHHS utilizes the U4 modifier to distinguish pediatric items that meet specific HCPCS code definitions. Providers need to follow correct coding by matching the product to the HCPCS code definition and append the U4 modifier. MDHHS cannot automatically assign the U4 modifier on the PA request; the provider must include the U4 on the PA request. The PA process is less time consuming if the provider submits the original request with the correct HCPCS code and modifier (e.g. E0143 with U4). The MDHHS database reflects specific HCPCS codes that have been assigned the U4 modifier for pediatric products.

MDHHS has received requests for HCPCS code E0240 using the U4 modifier. MDHHS has not assigned the U4 modifier to this HCPCS code.

Participants requested clarification on the process when the primary insurance allows use of the E1399.

- Submit the PA to Medicaid using the appropriate HCPCS code (e.g., E0143 with U4 modifier).
- If the primary insurance made a predetermination using E1399, the provider must follow the primary payer rules. The provider should submit that documentation with the PA request so that it can be noted.
- If Medicaid approved PA and there was no predetermination from the primary insurance but they paid or denied using E1399, again the provider must follow the primary payer rules. Submit a clean claim to MDHHS (e.g., with no other billing or policy issues) including documentation of the primary insurance decision.
- If the claim was clean (no other billing or policy issues) and Medicaid denies the claim due to the E1399 code on the primary vs E0143 on the PA, contact the program review division or policy.

Policy Change Bone Growth Stimulator

The bone growth stimulator policy is changing payment rules from “rental-only,” to a capped rental item. PA is given in 3-month rental periods. Upon the 10th month of rental the stimulator becomes a purchased item. The proposed effective date for proposed policy 1852-DME – Payment Rule Changes to Osteogenesis Stimulator Policy will be May 1, 2019.

Program Review Division Staff Introductions:

Gretchen Backer introduced Adam Schlaufman, Departmental Analyst. Adam reviews PA requests for mobility items for beneficiaries under the age of 21. MDHHS hired another Analyst, Christine Wixtrom, who reviews mobility related requests for beneficiaries over 21

years of age and occupational therapy requests. The team is caught up on processing PA requests for mobility items within the required 15 business days.

Hospice/ Durable Medical Equipment (DME) Coordination of Services:

DME is included in the hospice rate when the medical need for the item is related to the hospice qualifying diagnosis. Recently, MDHHS has received inquiries from DME providers indicating confusion when DME items are included in the hospice rate versus separate payment to the DME provider. Lisa Trumbell inquired if participants were having any difficulties coordinating care with hospice organizations. A participant stated there is a helpful chart in the Hospice chapter of the Medicaid Provider Manual, but the chart needs more detail as many items are not listed (e.g., diabetic supplies, tracheostomy supplies, etc.). Lisa will share provider comments with the hospice policy specialist. A participant stated items included in their contracts that are covered by the hospice organizations are standard DME (e.g., hospital beds, standard manual wheelchairs) and not more complex DME (e.g., power wheelchairs). Non-standard items require hospice individual consideration and are typically denied, or the hospice will allow temporary short-term rental.

PA requests for DME when the beneficiary is receiving hospice services must include the qualifying diagnosis in the documentation for the requested equipment. MDHHS has had to return PA requests due to this information missing from the documentation. Providers must check the documentation before submitting the PA request to ensure the qualifying diagnosis is included in the documentation.

A provider recommended Medicaid carve complex rehab equipment from the hospice benefit because hospice organizations often deny these items. Lisa reminded the group that some of the DME items are included in the hospice prospective payment system (PPS) rate. The Centers for Medicare & Medicaid Services (CMS) sets the hospice PPS rate. Lisa is researching what specific equipment and supplies are factored into the PPS rate.

E2374 Joystick replacement for Group III Power Wheelchairs

In 2018, participants had stated that the rate for E2374 is not sustainable, especially when the replacement is on a Group III power wheelchair with multiple power functions. Lisa has researched this HCPCS code and will propose a fee increase to MDHHS Administration. The group was reminded that an 8% reduction (Public Act 131 of 2009) must be factored into the proposed fee. The proposal for a rate increase could be impacted by the results of the MDHHS Aggregate expenditure report due into CMS by March 31, 2019. This report is a requirement of the 21st Century CURES Act. The CURES act requires that Medicaid aggregate DME expenditures for calendar year 2018 must not exceed Medicare aggregate expenditures. If Medicaid payments exceed Medicare, the State must return the matching funds to CMS. Lisa will keep the group informed at the next DME Liaison meeting.

Commercial Insurance Denials for other than "not medically necessary"

Medicaid cannot make a payment following Medicare if Medicare denies a claim for "not medically necessary." This applies only to Medicare not to other primary insurances.

Providers have informed MDHHS of issues with Medicaid denying claims when the provider has obtained PA for item(s) but the primary insurance deemed the item(s) "not medically necessary."

Gretchen explained if the primary insurance rules were followed, the claim is clean (no other billing or policy issues) and MDHHS approved the PA, if the primary insurance (other than Medicare) denies for "not medically necessary," Medicaid will reimburse the claim. MDHHS needs TCN examples if CHAMPS is denying for other insurance deeming the equipment is "not medically necessary." Such examples should be sent to Gretchen and Lisa to work with claims on a resolution. Any TCN examples providers submit must be for active claims.

Other Issues

There has been an increase in emails coming through the MSAPolicy email box with basic policy and billing questions. Providers are reminded to review the Medicaid Provider Manual first if they have policy and billing questions. If they are unable to find answers in the provider manual, they should contact Provider Support. If Provider Support cannot answer the provider's questions, Provider Support will email Lisa directly for assistance.

Participants requested that MDHHS consider travel reimbursement for providers instead of paying for non-emergency transportation for the beneficiary to come to the DME location for repairs. Lisa indicated that Medicaid is required to provide NEMT services for beneficiaries. Travel is a service that is the nature of DME business and wouldn't be considered a separate payment to DME providers. Lisa is researching solutions when the DME provider must travel outside their service area to repair equipment when the original DME provider is no longer in business or refuses to repair the item.

A participant inquired if a verbal PA can be submitted for equipment repairs (e.g., power wheelchair in need of batteries and person has no other back up equipment). Gretchen indicated PRD has received some requests for verbal authorizations. Verbal authorizations are appropriate for situations when the repair is more of an emergent situation when the beneficiary does not have an alternative option for mobility while their equipment is being repaired (e.g., person does not own a transport wheelchair). If the beneficiary is still Medicaid eligible, and all policy criteria are met, the PA would be approved for the date the PA was submitted, not for the date the PA was approved. The provider must indicate on the PA request that they are requesting approval for the day the PA was submitted and provide an explanation. MDHHS will review policy regarding when verbal authorizations are appropriate and report back to the group at the next DME liaison meeting.

A participant requested that MDHHS allow verbal PA when a beneficiary is discharging from a hospital (e.g., child on a ventilator and needs a pediatric stroller). In these cases, the hospital wants to discharge patient with equipment but DME cannot as the item requires PA. A request was also made to allow temporary rental until the equipment has been received. There are items indicated in the Medical Supplier chapter of the Medicaid Provider Manual allowing a three month waiver from obtaining PA when the person is discharged from the hospital. MDHHS will discuss this request for future consideration.

A participant questioned if there was an option to "opt out," of receiving the hard copy PA determination letter. MDHHS is required to send a hard copy PA determination to the beneficiary; but will research this option for providers.

A question arose regarding whether providers can have access in CHAMPS eligibility to view when a beneficiary is going to be enrolled in a health plan. Providers will submit a PA mid-month, and 10 to 15 days later receive a return letter from PRD indicating the beneficiary will be in a health plan at the beginning of the next month. The participant requested that providers be granted the ability to see in CHAMPS that the person will be enrolled in a health plan in a few weeks, as MDHHS staff are currently able to view this information. To allow providers access to that information would prevent unnecessary submission of PAs to MDHHS. Lisa suggested the provider submit an email to provider support for follow-up with the Eligibility Division.

Next meeting: Wednesday, June 19, 2019

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.