Michigan Department of Health and Human Services
Medical Services Administration

Orthotics and Prosthetics
Medicaid Provider Liaison Meeting

Capitol Commons Center
Wednesday, October 9, 2019
1:00 p.m. – 3:00 p.m.

MINUTES

Welcome and Introductions

Lisa Trumbell opened the meeting and introductions were made.

Healthy Michigan Plan Updates

48-Month Cumulative Enrollment Changes

The Michigan Department of Health and Human Services (MDHHS) is delaying the implementation of the 48-month cumulative enrollment changes from January 1, 2020 to October 1, 2020. HMP beneficiaries who have incomes above 100% of the federal poverty level (FPL) and have been enrolled in the program for 48 cumulative months must engage in a healthy behavior and pay 5% of their income toward cost-sharing as a condition of continued enrollment in HMP.

Workforce Engagement Requirements

Beginning January 1, 2020, all HMP beneficiaries between 19 and 62 years of age who do not meet exemption criteria must report at least 80 hours per month of work or other qualifying activities as a condition of continued enrollment in HMP. MDHHS will accept a beneficiary's self-attestation to meeting an exemption or to completing work requirements, however, MDHHS will be conducting a compliance review afterwards on a sample of the population each month. Staff provided an overview of the work activities, exemptions and how these changes will be implemented.

MDHHS staff discussed the definition of medically frail and how a beneficiary could attest to being medically frail. Meeting attendees were encouraged to contact MDHHS at healthymichiganplan@michigan.gov with questions related to HMP and the work requirements.

In September 2019, MDHHS began mailing letters to beneficiaries who are identified as being subject to the workforce engagement requirements with information on reporting requirements and how to report an exemption, if applicable. MDHHS also began mailing letters to beneficiaries who had an exemption identified in the system. They received information related to work requirements, but were informed that they were exempt or excused from having to report.

MDHHS staff are continuing to conduct webinars to present information about the work requirements to stakeholders and will also hold in-person forums at various locations throughout the state. Additional information about the upcoming changes to the HMP program

are available on the MDHHS website at www.michigan.gov/healthymichiganplan >> Changes Coming in 2020.

Bulletin MSA 19-25 – Revised Standards of Coverage for Lower Extremity Orthotics

Meeting attendees were provided with copies of bulletin MSA 19-25, and the document was discussed. Lisa Trumbell shared that the policy was developed in response to questions from providers about the extent of MDHHS coverage parameters for lower extremity orthotics. The policy clarifies that MDHHS covers lower extremity orthotics (including night splints) regardless of diagnosis, for the manifestations listed in the bulletin. Meeting attendees were encouraged to share the policy with Medicaid Health Plans as questions about coverage arise.

Verbal Prior Authorization Requests

Meeting attendees were reminded that "verbal" prior authorization requests are accepted by MDHHS via either phone or fax. Verbal prior authorization requests must be submitted on the date of service, or the next business day if the service is provided after normal business hours, on a weekend, or a holiday.

Request to Set a Fee for L 1932

Ms. Trumbell shared that a request has been submitted to MDHHS leadership to set a fee for Healthcare Common Procedure Coding System (HCPCS) code L1932-Ankle-foot orthosis rigid anterior tibial section. The rate will be based on Medicare's rate per MDHHS methodology.

Prior Authorization Returns

MDHHS staff reported that many prior authorization requests have been returned to providers due to the following common issues:

- No brand, make and model number for an item are listed, or the provider did not indicate that an item was made "in house;"
- Missing documentation (e.g., physician's order);
- Failure to document functional limitations;
- Failure to list economic alternatives that have been tried; and
- Documentation was not submitted in a timely manner.

Meeting attendees were also reminded that when submitting prior authorization requests via the Community Health Automated Medicaid Processing System (CHAMPS), any supplemental information (e.g., brand, make and model number) should be entered in the "remarks" box. In addition, MDHHS staff shared that if providers receive an error message when entering certain diagnoses codes in electronic prior authorization request submissions, the "end date" field should be left blank.

Process for Submitting Provider Inquiries

Providers are reminded that for general policy questions, they should first consult the Medicaid Provider Manual and supplemental policy bulletins available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, or the Medicaid Code and Rate Reference tool available at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Medical Suppliers. If they are still unable to find an answer to their question, the provider may contact Provider Support at 800-292-2550 or ProviderSupport@michigan.gov. If Provider Support staff are unable to assist with a provider's question, they will then forward the inquiry directly to Lisa Trumbell.

National Correct Coding Initiative (NCCI)

In response to several denials of prior authorization requests due to Medically Unlikely Edits (MUEs) (i.e., two or more services that are unlikely to be needed on the same day, quantity limits, etc.), Ms. Trumbell indicated that these edits are set by the Centers for Medicare & Medicaid Services (CMS) contractor and must be followed. More information on the NCCI edits and corresponding Procedure-to-Procedure (PTP) edits is available in the Medicaid Code and Rate Reference tool or online at www.cms.gov >> Medicare >> National Correct Coding Initiative Edits. MDHHS staff and meeting attendees continued to discuss at length billing and coverage issues for specific codes.

Other Issues

MDHHS staff and meeting attendees also discussed the following issues:

- As a follow-up to a question at the previous Orthotics and Prosthetics provider liaison meeting, Ms. Trumbell indicated that Medicaid Health Plans may pay a lower rate than Medicaid Fee-for-Service for certain items if the Medicaid Health Plan has entered into a contract directly with a provider.

- A meeting attendee asked how recent changes to the law related to auto insurance coverage of health expenses impacts Medicaid's status as a "payer of last resort." In response, Ms. Trumbell indicated that Medicaid is required by federal law to be a "payer of last resort" with few exceptions, but that she would forward the question to staff in the Third Party Liability Division for clarification on how the auto insurance coverage changes impact this status.

- MDHHS staff and meeting attendees discussed possible changes to the schedule for provider liaison meetings and determined that the meetings will continue to be held twice per year. Attendees were encouraged to continue to provide topic suggestions in advance of each meeting. Additionally, Ms. Trumbell noted that providers should continue to reference the website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Medical Suppliers / Orthotists /

Prosthetists / DME Dealers for current information on upcoming provider liaison meetings and cancellations.

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.