Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

Durable Medical Equipment and Supplies
Medicaid Provider Liaison Meeting

Microsoft Teams Meeting
Wednesday, June 15, 2022

MINUTES

Welcome

Lisa Trumbell began the meeting with meeting protocols and introductions.

Program Updates - Policy Division Director

Meghan Vanderstelt stated that the Michigan Department of Health and Human Services (MDHHS) is awaiting notice of the end of the Public Health Emergency (PHE), potentially in October 2022. MDHHS is continuing with work to inform providers and beneficiaries. Individuals can refer to the website https://www.michigan.gov/mdhhs/end-phe for additional information; webinar information is available at https://www.michigan.gov/mdhhs/end-phe/events.

Children With Special Needs Fund

Marcia Franks, from Children's Special Health Care Services, gave a presentation of the Children with Special Needs (CSN) Fund. The PowerPoint presentation will be shared with the group. Program brochures are available at MDHHS Health Promotions (healthymichigan.com) >> click on Children's Health Care.

Contact Information
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Clarifications - Bath/Toilet Aids

- E0241 (BathTub Wall Rail)
- E0243 (Toilet Rail)
- E0244 (Toilet Seat Raised)
- E0245 (Tub Stool or Bench)

Effective January 1, 2022 (refer to bulletin HASA 22-03), prior authorization (PA) was removed from the items listed above (assuming the standards of coverage were met) and rates were added to each code. There has been confusion among durable medical equipment (DME) providers and MI Choice waiver regarding the billing process for these codes. Medicaid is typically the payer of last resort; however, when the person has MI Choice Waiver/Home and

Community Based Waiver coverage, fee-for-service (FFS) state plan services is primary. Items covered under the State Plan must be obtained through FFS first rather than through the MI Choice Waiver. If the item is not on the FFS Medical Supplier fee schedule or listed in the Medicaid Code Rate and Reference tool, it is not a covered item and could potentially be covered by the MI Choice Waiver program. Providers would then need to follow the coverage requirements of the MI Choice Waiver program.

Coordination with Medicare and other insurances: These four items are not covered by Medicare; they are currently statutorily excluded from coverage. Providers do not have to bill Medicare first for these items. Medicare must be identified on the claim; however, it is not necessary to bill Medicare first for these codes. Report the appropriate Claim Adjustment Reason Code (CARC) on the claim, in this case the appropriate CARC code is 96. For commercial insurances and employer group health plans, providers need to bill that insurance first and when providers submit the claim to MDHHS for co-insurance or deductible, they must report the CARC code that the primary payer put on the remittance advice. Providers must bill that insurance first; Medicaid is the payer of last resort.

COVID-19 DMEPOS Temporary Policies

- Prior authorization after the Public Health Emergency (PHE)

The PHE is still in effect as are the temporary DMEPOS policies. Providers will be notified when those policies end.

Due to the PHE, MDHHS lifted limits, PA, and additional documentation beyond the practitioner's order (a practitioner's order is still required, and that practitioner needs to justify on that order the medical necessity). MDHHS did not lift the standards of coverage for any items. The standards of coverage within policy are still, and will remain, in effect.

For PA, MDHHS had to file disaster relief waivers as well as 1135 waivers. PA is under the 1135 waiver. As it applies to the PHE, MDHHS cannot extend the lifting of PA after the PHE ends. That is a federal requirement.

Also, contingent upon the end of the PHE, MDHHS would like to provide as much notification ahead of time as possible and would like to utilize the typical promulgation period (a 35-day public comment period and then posting of the policy 30 days prior to its effective date = 65 days) for providers to prepare.

MDHHS has been in the planning process to reverse the five policies in stages, hoping to avoid overwhelming beneficiaries, providers and MDHHS staff/systems. There are federal requirements on many of the State Plan Amendments (SPAs), which involve notifying the Centers for Medicare & Medicaid Services (CMS), Tribal notifications and public notices. MDHHS will keep providers informed with as much advance notice as possible.

Blood Pressure Monitor Policy (HASA 22-16)

Policy bulletin HASA 22-16 (Changes to Blood Pressure Monitor Policy) became effective July 1, 2022. The blood pressure monitor policy was rather outdated and needed to be brought up-to-date with today's standards of coverage. MDHHS expanded the policy for all ages with hypertension and lifted (assuming standards of coverage have been met) PA for persons with renal disease as well as for women who are pregnant, during childbirth, or during the puerperium period with hypertensive disorders. The policy also provided clarification on frequency of the monitors.

CPAP Shortage

- Documentation timeframes (Extensions?)

In addition to the shortage of Continuous Positive Airway Pressure (CPAP) devices, CPAP supplies, DME and supplies, etc., there was a large CPAP/Bi-Level Positive Airway Pressure (Bi-PAP)/ventilator recall that occurred last year with a large manufacturer. MDHHS will not extend documentation timeframes. Note: During the PHE, MDHHS lifted additional documentation such as certificates of medical necessity (CMNs), sleep studies, and other medical documentation, so that is not needed during the PHE; however, a practitioner order is still required per state and federal rules regarding prescriptions/orders. It is suggested that if a provider is ordering supplies and an item is on back order, they should document in the beneficiary's file that it is on back order and include the response from the manufacturer (documentation) in the file as well. If the prescription appears close to expiring, contact the practitioner's office to get an updated order if still medically necessary.

For the CPAP recall (refer to numbered letter L 21-49 issued June 24, 2021), there are recommendations from the manufacturer and U.S. Food and Drug Administration (FDA) for mitigating the supply shortage and safe and effective measures to prolong the life of the item. The beneficiary should have discussions with the physician/practitioner as well as consult the manufacturer for safe and effective measures. (Reference www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Numbered Letters >> 2021 >> L 21-49)

Other Topics

Comment

A participant noted that authorization requests have been delayed for the time being and asked if there is any update on the 15 working day timeliness.

Response

Authorizations are taking longer due to staffing issues, which MDHHS is working to resolve. Currently, on average, authorizations are in the que for 10 days. If there are critical cases, reach out to Gretchen Backer to address (phone 800-622-0276; fax 517-335-0075).

Comment

A provider was contacted by a referral who is looking to save therapy time. They found in the policy manual that form MSA-1656 (Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices) only needs to be completed once unless there is a change in the beneficiary's medical or functional needs. If someone is presenting for a second wheelchair after five years and the primary reason is because of the condition of the chair and not a functional change, can they just do an addendum and submit form MSA-1653-B (Special Services Prior Approval – Request/Authorization) or does it create an issue? Does MSA-1656 need to be completed as well?

Response

The MSA-1656 is a baseline. If there is no change in medical or functional status relative to the device, the MSA-1656 is not required but it is strongly advised to indicate the situation on the cover sheet or in Direct Data Entry (DDE) so that MDHHS is not looking for the form – the cover sheet should clearly state that there is no medical or functional change. If MDHHS/Medicaid covered the original item within the last 10 years and only equipment changes are needed, we do not need the MSA-1656; if it was before 2010 or the wheelchair was not purchased by Medicaid or Children's Special Health Care Services (CSHCS), then MDHHS needs the MSA-1656. If the item was purchased by primary insurance, MDHHS does not require the MSA-1656; however, providers should submit a copy of documentation for the original purchase approval.

Comment

Medicare started covering procedure code E0467 – multi-function ventilator in 2019. Does Medicaid have any plans to cover?

Response

No, not at this time.

Next Meeting: Wednesday, September 14, 2022

An L-letter with additional details will be issued. Providers may also refer to www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/ Prosthetists/DME Dealers for meeting information. All meetings will be held from 1:00 - 2:30 p.m. via conference call and Microsoft Teams.

The meeting ended at 2:10 p.m.