Michigan Department of Health and Human Services
Medical Services Administration

Durable Medical Equipment and Supplies
Medicaid Provider Liaison Meeting

Microsoft Teams Meeting
Wednesday, October 6, 2021
1:00 p.m. – 2:30 p.m.

MINUTES

Welcome

Lisa Trumbell began the meeting with meeting protocols and introductions.

Program Policy Division Director

Cindy Linn shared that Jackie Prokop, Program Policy Division Director, retired from her position on September 24.

Coordination of Benefits

Margo Sharp reviewed information in the Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance section of the Coordination of Benefits chapter of the MDHHS Medicaid Provider Manual.

The review included general topics such as:

- Medicaid is the payer of last resort in most cases.
- Beneficiaries must use the highest level of benefits available under their primary insurance policy
- Medicaid is not liable for payment of services that are denied because coverage rules for primary insurance were not followed, (i.e., went out of network so primary insurance denied, the provider didn't obtain prior approval for the service).

Medicaid is liable for Medicaid-covered services that are not part of the primary health insurance coverage, (i.e., wheelchairs are not covered – Medicaid will cover within policy parameters and coverage rules). Medicaid requires providers to secure other insurance adjudication responses which must include claim adjustment reason codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service, (i.e., dental carrier never covers a vision service). If payments are made by another insurance carrier, the amount paid, whether it's paid to the provider or the beneficiary, must be reflected on the claim so that Medicaid can determine payment liability. The issuance of prior authorization does not override other insurance rules, correct coding, and Medicaid policy criteria.

"Lessor of" policy = how Medicaid determines what our payment liability would be for beneficiaries with other insurance. Medicaid payment would be the lesser of one of the following:

- The beneficiary's liability, including co-insurance, co-pays, or deductibles; or
- The provider's charge, minus contractual adjustments; or

- The maximum Medicaid fee screen minus the insurance payment.

The above determines Medicaid liability. This can result in a zero payment liability for Medicaid.

The Coordination of Benefits chapter has a table that explains when prior authorization is required when the beneficiary has primary insurance. A participant commented that it is difficult to determine if other insurance benefits will exhaust and to know when it is appropriate to file a prior authorization request with Medicaid. If the provider knows that the primary insurance benefit has been exhausted, it's going to exhaust, or it might exhaust, MDHHS recommends the provider submit a prior authorization request prior to providing the service. This should prevent service delays should the primary insurance determine the benefit plan has been exhausted.

Meeting participants raised questions and concerns regarding the difference between the billed amount and what the primary insurance will pay; changes to the Community Health Automated Medicaid Processing System (CHAMPS); billing and reimbursement issues with primary/secondary to Medicaid (including co-insurance and deductibles) and tertiary payments; pricing issues; issues with CARC codes (i.e., 1, 45); and fee schedules processing logic in CHAMPS. MDHHS Provider Support staff requested that providers provide them with examples, including TCN examples. Providers that indicated the referenced issues were instructed to e-mail Provider Support with examples: providersupport@michigan.gov

Philips Recall and CPAP/BIPAP Supply Limits

Recall L-Letter L 21-49

The letter was reviewed at the last meeting and is posted on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> click 2021 under "Numbered Letters." The intent of the letter was to clarify the importance that beneficiaries should stay in contact with their physician and DME provider to address treatment options and that the DME providers must keep documentation in the beneficiary's file. If the beneficiary is not using the CPAP machine or the BI-PAP, it is unnecessary and discouraged to send supplies for the machine.

For ventilator patients, Philips suggested a HEPA filter be used. Lisa asked the group if the previously reported issue of Philips requiring the DME to provide the HEPA filter was still occurring. A participant stated they are still providing microbial filters (nothing from Respironics) and the filters are purchased and provided as part of the patient's care at DME provider's expense. Lisa Trumbell questioned whether Medicare is not covering either, and participants responded that was correct. A participant confirmed it was incidental to rental of the ventilator device. Philips has started to replace machines.

CPAP/BIPAP Supply Limit Review

At the last meeting, there was an inquiry as to whether MDHHS would consider the same frequency of replacement supplies (i.e., filters, tubing, etc.) for CPAPs and BI-PAPs as Medicare. MDHHS reviewed Medicare and other payers frequency limits, manufacturers suggested replacement schedules, warranty periods and the U.S. Office of Inspector General report from 2013-14 against the current MDHHS frequency schedule. The overall suggestion by OIG was that Medicare make their frequency for the time period that you could replace these certain supplies more lengthy; this has not yet been done. Lisa Trumbell stated that, at this time, she will not suggest that there be a change to the supply limit, however, this can be revisited again. Lisa now needs to look at current overall policy for CPAPs

and Bi-PAPs as limits were lifted during the COVID emergency as long as the physician documented on the physician order the medical need for the quantity ordered.

E0561/E0562 During CPAP Rental Period

Recently, policy has received an increase in provider inquiries regarding if the humidifiers are included in the rental for CPAPs and BIPAPs. Humidifiers are a separately billable item as it is not an accessory integral to the operation of the CPAP/BIPAP. As long as the policy standards of coverage, prior authorization and documentation requirements are followed, it may be billed separately. During the public health emergency, prior authorization and documentation (physician order still required) are lifted. (Refer to policy bulletin MSA 20-14.)

Some participants stated they are receiving rejections from one of the health plans indicating the humidifiers are included in the rental payment of CPAPs/BIPAPs and wondered if there is information available in policy stating these codes are separately billed. Lisa indicated that the HCPCS codes are not included in policy and that she recently provided clarification to the health plan that humidifiers are a separately billed item. NOTE: If the CPAP/BIPAP is in a rental period, the humidifier should be billed as a rental as well. If providers are still having issues with this health plan, they may contact Provider Support who can contact the contract manager. Suppliers/providers should e-mail communication from the health plan to Lisa Trumbell at trumbelll@michigan.gov, with the subject line reading "Liaison Meeting", for assistance.

Billing Pneumatic Compression Pumps/Supplies

Lisa Trumbell has received questions regarding billing pneumatic compression pumps/supplies. In an attempt to clarify, Lisa shared a brief summary of coverages.

Pneumatic compression garment sleeves are included in the rental period. For purchase, if needed and medically necessary, they are separately billable and require PA. Lisa confirmed for a participant that if the pneumatic compressor never converts to a purchase, the sleeve would also not be purchased.

Full policy is in the MDHHS Medicaid Provider Manual, Medical Supplier chapter (Pneumatic Compressors and Appliances [Lymphedema Pump] subsection). The MDHHS Medicaid Provider Manual is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

A4606 (MSA 20-14)/Pay Cycle 36/37 Remittance Advice Issues

The A4606 (oxygen probe that goes with oximeter) and some RA issues with cycles 36 and 37 have been resolved. A4606 was unfortunately dropped from bulletin MSA 20-14 (Attachment A). The bulletin is a temporary COVID bulletin that removed quantity limits, PA, and documentation except for the physician's order, and there is still the need to justify the medical reason for the item and the quantity. The error was discovered in July, and corrections were made in CHAMPS. Notification was made through a ListServ message and Biller B Ware (which is now Medicaid Provider Alerts & Resources) and MDHHS reprocessed claims back to March 1, 2020. Regarding PC 36 and 37 RA issues: RAs were not showing all payment details – only denials – and this was corrected. The RAs were released in PC 38. Questions were raised as to why did it take so long into the day to post?

MDHHS recognizes and acknowledges the frustration. Unexpected errors can occur in Systems: MDHHS tries to address expediently, completing research before notification is issued.

If MDHHS missed an auto-correction on the A4606, which was on a paid line and is now past filing time limits, how do you correct? The provider should send an e-mail to Provider Support and give the TCN, indicate you were part of the liaison meeting and this code was discussed, and they can assist you on how to correct.

To reiterate, although MDHHS lifted the limits during the pandemic through Bulletin MSA 20-14, the physician order/practitioner order still needs to justify the medical need and the quantity. Information must be kept in the beneficiary's file.

NOTES:

- Provider alerts are posted on the MDHHS website at www.michigan.gov/medicaidproviders >> Provider Alerts.

- ListServ information and instructions are available at www.michigan.gov/medicaidproviders >> [under "Resources"] Listserv Instructions. (Lisa Trumbell recommends signing up for "Professional Providers" vs. "All Medicaid Information" which may be an overload of notices to providers.)

MSA 20-14 Medicaid Health Plan Compliance

Bulletin MSA 20-14 is a temporary COVID policy; at the beginning of the bulletin, it indicates lifting of limits and PA – this applies to MHPs as well. If an MHP is not compliant with that bulletin, then providers are strongly urged to share the bulletin with them. In addition, billing policy is in bulletin MSA 20-25 (supplemental billing bulletin) which states that MHPs must comply with MSA 20-14 (although their billing rules may be different). Providers need to check with MHPs as far as their billing procedures but they cannot be more restrictive than FFS. If you experience continuing problems with MHP compliance, e-mail Provider Support and they will contact the contract manager or Lisa Trumbell.

Lisa clarified that the temporary Medicaid COVID policies for DME/supplies is still in place. Although Governor Whitmer's Executive Orders ended for the Public Health Emergency (PHE), the federal PHE Is still in effect. (Refer to Bulletin MSA 20-36, issued May 20, 2020, regarding Notice to Terminate Policies and Processes relative to COVID.) MDHHS continues to monitor CMS guidance regarding the PHE and providers will be notified in advance of PHE changes.

Providers inquired if Medicaid is waiving the need for a certificate of medical necessity for oxygen like Medicare did. Lisa confirmed during the PHE, the CMN is not required. A physician/practitioner order remains required, and prescription/order timeframes remain as indicated in the policy manual.

Regarding the six-month re-certification and re-testing, it would benefit the practitioner to conduct another test but it is not required during the PHE. These requirements also apply to Medicaid managed care plans. Documentation requirements may be different, but MDHHS is not requiring the test. The start date was effective March 1, 2020. If providers are having problems with the MHPs complying with the temporary COVID policies, they should try to resolve the issues with the MHP first and then contact Provider Support who will have a contract manager intervene.

Automatic Refills/Expected Useful Lifetime

Repair vs. Replace Requests for Equipment Over 5 Years Old

Automatic refills for medical supplies are prohibited as it results in potential overutilization. Lisa provided a summary of the policy and stated that the beneficiary must confirm additional supplies are needed prior to the provider delivering the supply.

Lisa explained there have been complaints from beneficiaries and advocates regarding the DME providers calling to let them know that the five-year frequency limit is up, and that the beneficiary qualifies for a new piece of equipment. Lisa explained the differences between expected useful lifetime, reasonable useful lifetime, and that if a piece of equipment is still in good condition at the end of five years, it may only require repair. Providers must evaluate the need for repair versus replacements. Just because the five-year frequency limit is up does not mean the person automatically gets a replacement device.

Comments were made by meeting participants that evaluating an item for repair versus replacement is time-consuming and costly to the provider and requested that MDHHS pay separately for this service as Medicaid is the only payer that requires this. Lisa Trumbell responded it is part of the overall nature of DME business; however, MDHHS is willing to meet with providers to discuss the issue further. Participants interested in meeting with MDHHS may e-mail Lisa.

Gretchen Backer further commented that when the evaluation team determines a beneficiary's need for an item, part of the justification needs to address the cost of repairing the item verses replacing the item.. Parts or components that are not functioning is different than if the person has a disease that is progressing and therefore needs either the wheelchair to be updated with additional components or needs replacement altogether.

If providers want further discussion, Lisa can set something up. Lisa will talk to other states as well. E-mail Lisa at trumbelll@michigan.gov with your interest in group meeting participation.

Next Meeting: 2022 Meetings will be posted on-line in December

Since the PHE is still in effect, it is most likely that the first meeting in 2022, possibly all, will continue to be via Microsoft Teams or call-in. Go to www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/Prosthetists/DME Dealers for meeting schedules.