Durable Medical Equipment, Prosthetist, and Orthotist Supply (DMEPOS) Frequently Asked Questions

Question: Is there a resource that walks through the process for appealing a payment that was incorrect?

Answer: Providers are encouraged to contact Provider Support for an initial claim review. Before contacting Provider Support please review the Claim Review/Appeal Process. For additional details on the appeal process review the Michigan Medicaid Provider Manual, Chapter General Information for Providers, Section 17 Provider Appeal Process.

Question: How do I bill NOC codes?

Answer: Procedure codes that do not have an MDHHS established fee screen require manual pricing. Depending on the service, pricing is completed through the claims processing process which requires documentation with the claim. Other types of service require pricing to be completed through the Prior Authorization process. Please reference the General Information Section of the Michigan Medicaid Provider Manual, Section 9.2 D for detailed information on the process.

Question: How are prior authorization requirements determined? For example, L4387 versus L4361

Answer: Prior Authorization coverage determinations are based on the evaluation of the documentation received and all of the following:

- The beneficiary's benefit plan scope and coverages (e.g., Emergency Services Only);
- Food and Drug Administration (FDA) and manufacturer product intended usage(s);
- Healthcare Common Procedure Coding System (HCPCS) Level II code definitions as deemed by the American Medical Association; and
- The safety and effectiveness of the product for age-appropriate treatment as substantiated by current evidence-based national, state, and peer-review medical guidelines.

Reference the Medical Supplier Chapter of the Michigan Medicaid Provider Manual, Section 1.8. **Please note that the PA requirement for L4361 has been temporarily removed during the COVID-19 emergency; per MSA Bulletin 20-32.

Question: When Medicare is primary and denies a NOC code how is it billed to Medicaid?

Answer: When Medicare denies a code, and Medicaid is secondary it would be billed to Medicaid with the claim adjustment reason codes (CARC's) from the primary payors EOB. Prior Authorization is required for (NOC) codes. Reference the Coordination of Benefits Chapter of the Michigan Medicaid Provider Manual, Section 2.1.