MRCA

November 22, 2019

MSA Policy Bulletins

Proposed

MSA 1926- HMP Healthy Michigan Plan Updates

- New Work Requirements effective January 1, 2020 for beneficiaries ages 19-62 and do not meet exemption criteria have to complete and report 80 hours of work or other qualifying activities per month.
- Beneficiaries enrolled in HMP after January 1, 2020 will have to complete 80 hours of work or other qualifying activities for their second month
- Activities must be reported at the end of the month
    - Kiosk at MDHHS local office
    - Online through MI Bridges
    - Phone Reporting line
- Beneficiaries that are not compliant for three months in a calendar year may be disenrolled and subject to a one-month penalty of non-coverage

MSA 1936- Pharmacy Medicaid Health Plan Pharmacy Drug Coverage Transition

Outpatient prescription drugs will no longer be covered as a part of the Medicaid Health Plan (MHP) benefit. Effective December 1, 2019, all pharmacy drug coverage will be transitioned to Fee-for-Service Medicaid.

Final

MSA 18-50 Claims for Medicaid Beneficiaries Eligible for Medicare

Effective for dates of service January 1, 2019 and after MDHHS will begin to reimburse claims when a beneficiary is eligible for Medicare Part A or B but not enrolled.

- Previous system defect causing claims to deny with CARC 22 “This care may be covered by another payer”. MDHHS was routinely identifying and resurrecting claims until October 4, 2019 when the system was corrected.
- Current issue when beneficiary is enrolled in a Medicare Advantage plan and it is reported as Commercial or HMO claims are denying with CARC 22. Projected fix date December 13,2019
    - MDHHS is working to identify and reprocess these claims. If you do not see a new claim within 30 days contact provider support

MSA 19-13 Co-payment increase for OPH Visits

Beginning with July 1, 2019 dates of service and after the co-pay for outpatient hospital visit will increase to $2

- Medicaid FFS MA
- HMP with income levels under 100% of the FPL

MSA 19-15 Manual Provider Manual Update

Beginning for dates of service on and after April 1, 2019 MDHHS will add J1322 (Vimizim) to the MHP carve-out list and coverage will require a PA.

MSA 19-19 Enrollment of Portable X-ray suppliers and Independent Testing Facilities

Effective September 1, 2019 MDHHS allows the enrollment and reimbursement of PXRS and IDTF suppliers.

- Providers must be enrolled with Medicare before applying for enrollment with MDHHS.
- Providers already enrolled with Medicare must enroll in CHAMPS with the correct specialty or subspecialty type within 6 months of the effective date of this policy.

MSA 19-20 Enrollment Requirements for Prescribers

Effective October 1, 2019 providers who prescribe drugs to beneficiaries must be enrolled in CHAMPS.

- If the prescribing physician is not enrolled claims will be denied
- Since July 1, 2018 pharmacies were given an informational edit if the pharmacist was not enrolled, this was switched to deny effective October 1, 2019

NCPDP Code 889: PRESCRIBER NOT ENROLLED IN STATE MEDICAID PROGRAM

System Updates

- Newborn Reporting- December 13, 2019
  - If a newborn is transferred on the DOB will be able to report appropriate admit type (IE: Urgent, Emergency, or Elective)
  - PACERS may now be required for newborn transfers
- Trauma- December 13, 2019
  - Allow Trauma admit type 5 for ESO beneficiaries
- Quarterly APC Updates- October will be updated 12/13/2019
- APR DRG Version 37- loaded into CHAMPS 12/13/2019
- *Cash Reports- going away January 1 2020
- *FD622- no longer mailed online in FS system only in CVS files effective January 1, 2020

Predictive Modeling

Initial Process

- Claim enters CHAMPS and goes through the initial claims editing (IE: OI, eligibility)
- Claim then goes through Claims Sure the PM system. PM letter is generated
- Provider has 45 days to submit records- claim will continue to suspend
- If applicable a DMP message may be sent requesting additional documents within 10 days
- Depending on if the records support the service PM editing is either forced or denied

If the claim is forced then the claim goes back through CHAMPS editing again before it is released.

Second Review Process

If a claim is denied for PM and the provider can identify the missing records within the upload then we can send the claim for a 2nd review. If it is determined the claim was denied in error the claim is resurrected by MDHHS. If the denial is upheld the provider can rebill the claim and submit all the appropriate records

Reminders:

PACER Required -CARC 197

- Emergency Transfer requires a PACER
  - The initial admission does not require PACER if it is an emergency

15 Day Readmit- CARC 133 RARC N47

- You can use the claim limit list to identify the previously paid/suspended claim

Three Day Window- CARC 96 RARC M2

- Outpatient services within 72 hours of an inpatient hospital stay billed by providers under the same EIN must be combined into the IPH claim.
  - The admit date should be the actual/true admit date
  - The from date should be the first day of the outpatient services
- If the claims are not related the appropriate condition code must be appended to the claim
- Critical access hospitals are only exempt if Medicare is primary

CARC 16 RARC N48- Invalid copay amount reported

- When CARC 3 Reported other than whole dollar won't accept