ATTENTION: DME Providers

MAY 2019 PROVIDER BULLETIN

853 West Washington Street | Marquette, MI 49855 | (906) 225-7500 | 1-800-835-2556 | www.uphp.com

Effective May 1, 2019

Upper Peninsula Health Plan (UPHP) will require durable medical equipment (DME) providers to submit the acquired cost pricing for all manually priced codes on our new DME Manually Priced Code Form. The form is located on our website under the "Providers" tab at:
- https://www.uphp.com/providers/forms-links/

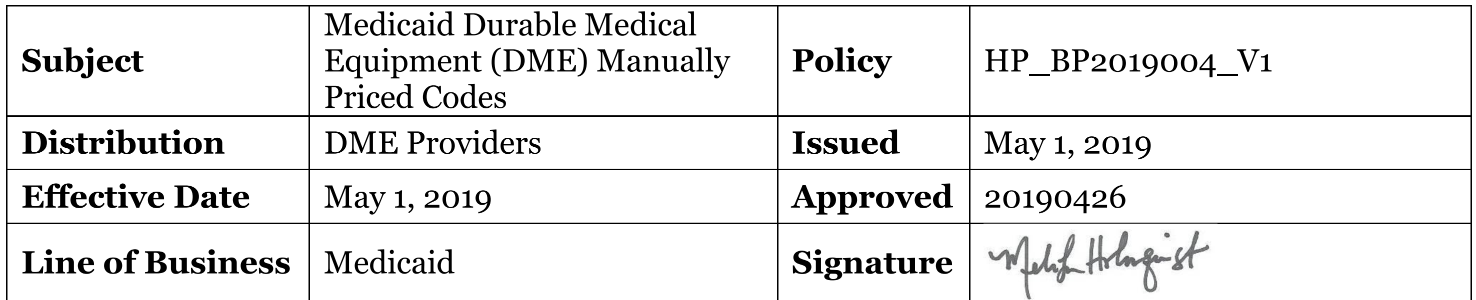
DME items may require authorization; please refer to the grid located on our website at:
- https://www.uphp.com/providers/authorization-process/

Please see the attached UPHP Billing Policies regarding manually priced codes and lift chairs.

Please fax completed forms to the UPHP claims processing fax at (906) 225-8770.

Questions? Contact the UPHP Claims Department at (906) 225-7746.

Billing Policy



Subject	Medicaid Durable Medical Equipment (DME) Manually Priced Codes	Policy	HP_BP2019004_V1
Distribution	DME Providers	Issued	May 1, 2019
Effective Date	May 1, 2019	Approved	20190426
Line of Business	Medicaid	Signature	

Disclaimer

This policy does not address all issues related to reimbursement for services provided to enrollees. All items and services are subject to review for medical necessity, member eligibility, member plan benefits, and provider eligibility for payment at the time of service.

Policy

Upper Peninsula Health Plan (UPHP) will reimburse Medicaid Durable Medical Equipment (DME) manually priced codes at 17% above acquisition cost.

Manufacturer quotes or dealer list prices are not accepted as documentation of cost. Modified manufacturer invoices will not be accepted.

Reimbursement Guidelines

If the manually priced code requires prior authorization (PA), a PA form must be submitted to the UPHP Utilization Management (UM) Department. A listing of items requiring PA is provided on the UPHP website at https://www.uphp.com/providers/authorization-process/.

If the manually priced code does not require PA, the DME Manually Priced Code form must be submitted to the UPHP Claims Department fax at (906) 225-8770.

- This form can be submitted prior to the submission of the claim or at the time of claim submission and found at https://www.uphp.com/providers/forms-links/ under DME authorizations.
- Acquisition cost must be included.
- If UPHP does not receive the acquisition cost, it will reimburse at the penny fee until the invoice is completed correctly and received within the one-year timely filing period.

If the DME provider manufactures the item, detailed wholesale cost/price must be included.

Attachments

UPHP DME Manually Priced Code form

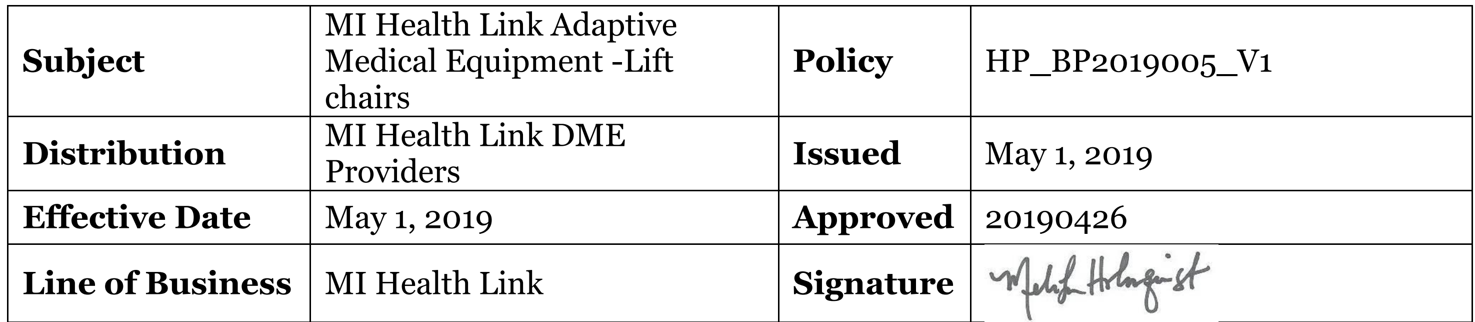
MSA 11-17

Resources
https://www.uphp.com/providers/authorization-process/ https://www.uphp.com/providers/forms-links/

History

Review Date	Action Taken
20190425	Initial policy submitted for final review.

Billing Policy



Subject	MI Health Link Adaptive Medical Equipment -Lift chairs	Policy	HP_BP2019005_V1
Distribution	MI Health Link DME Providers	Issued	May 1, 2019
Effective Date	May 1, 2019	Approved	20190426
Line of Business	MI Health Link	Signature	

Disclaimer

This policy does not address all issues related to reimbursement for services provided to enrollees. All items and services are subject to review for medical necessity, member eligibility, member plan benefits, and provider eligibility for payment at the time of service.

Policy

Upper Peninsula Health Plan (UPHP) MI Health Link covers adaptive medical equipment and supplies per the Minimum Operating Standards for MI Health Link Program and MI Health Link Home and Community-Based (HCBS) Waiver. Covered Healthcare Common Procedure Coding System (HCPCS) codes are either reimbursed per the established Michigan Department of Health and Human Services (MDHHS) fee schedule rate or are manually priced. Manually priced codes are determined per the Manually Priced Billing Policy that can be accessed at https://www.uphp.com/providers/provider-resources/ and will require use of the Manually Priced Code Billing Form that can be accessed at https://www.uphp.com/providers/forms-links/ under DME authorizations.

UPHP MI Health Link covers lift chairs. To bill for the chair, UPHP requires durable medical equipment (DME) providers to bill S5199, personal care item, NOS. This code requires prior authorization (PA).

Reimbursement Guidelines

- PA is required on S5199, personal care item, NOS for the chair and must include Certificate of Medical Necessity (CMS- 849).
- Centers for Medicare and Medicaid Services (CMS) requires all NOC codes to be billed with a description. Please include this in loop 2400 and segment SV101-7 on an electronic claim or field 19 on a paper claim form.
- Delivery and shipping costs can be billed on a separate S5199 line. Costs must be supported and will be reimbursed at 100%.
- A Manually Priced Code Billing Form must be filled out and included with an invoice denoting acquired cost of the lift chair.
- UPHP will reimburse the chair at 17% above acquisition cost.
- Chair must be a basic model, no upgrades will be allowed.
- E6027 – seat lift mechanism incorporated into a combination lift chair mechanism reimburses from the fee schedule.

Completed Manually Priced Code Billing Form and invoice should be faxed to the UPHP Claims Department at 906-225-8770 for processing.
Attachments
https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms849.pdf Manually Priced Code Billing Form
Resources
UPHP Manually Priced Billing Policy HP_BP20190004_V1

History

Review Date	Action Taken
20190425	Initial policy submitted for final review.

DME Manually Priced Code Form

- *This form is **NOT** for miscellaneous codes or prior authorization (please see DME Supply Request Form).*
- *Invoice with **ACQUIRED** cost is required in order to process (retail cost is not accepted).*

Section 1: Member & Provider Information				
☐ UPHP Medicaid	☐ UPHP HMP	☐ UPHP CSHCS	☐ UPHP MI Health Link	☐ UPHP Medicare Advantage
Member Name:		Member ID Number:		
Provider Office/DME Provider:				
Provider NPI:		Contact Name:		
Provider Phone Number:		Provider Fax Number:		

Section 2: Manually Priced Item Information	
If there is a claim on file that reimbursed for $0.01, it will be reprocessed when this form is received and approved. *Invoice must be received within the 365-day timely filing limitation of service date.*	
HCPCS Code:	Quantity:
Product Description:	
Acquired Cost:	

****UPHP OFFICE USE****

☐ Approved Price $____________________________

☐ Acquired Cost Invoice Needed (NOT RETAIL PRICE)

☐ Request Denied (SEE NOTES BELOW)

NOTES: ____

____

____

PROCESSED BY: ____ DATE: ______________________

Please call the UPHP Claim Services department with any questions at (906) 225-7746.

Fax completed form to: UPHP Claims Processing at (906) 225-8770.

Last Revised: 04/25/2019

msa MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-17

Distribution: Hospitals, Physicians, Durable Medical Equipment, Prosthetics, Orthotics, and Suppliers, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers

Issued: May 10, 2011

Subject: Change in Acquisition Cost Definition

Effective: As Indicated

Programs Affected: Medicaid and Children's Special Health Care Services (CSHCS)

Effective for prior authorization (PA) requests received on and after May 15, 2011, the Michigan Department of Community Health (MDCH) will apply the definition of acquisition cost to include only primary discounts for manually priced Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). This policy eliminates the requirement to include secondary and tertiary discounts with the request.

The following items must continue to be included on the PA:

- Manufacturer's actual invoice along with primary discount;
- If the manufacturer's actual invoice is not included, medical review staff will assign a penny screen to the code until the invoice is received;
- If requesting reimbursement for labor, the specific time must be stated on the request form; and
- Any required documentation listed in the Standards of Coverage in the Medical Supplier Chapter of the Medicaid Provider Manual.

NOTE: In order to be eligible for consideration of only the primary discount, quotes and/or dealer list prices will no longer be accepted on and after May 15, 2011. Modified invoices will not be accepted.

Billing Requirements

Services indicated as requiring prior authorization cannot be billed to MDCH until prior authorization has been approved and services have been rendered. The prior authorization number must be reported on the claim.

Reimbursement

For DMEPOS items that do not have established fee screens or are custom fabricated the reimbursement continues to be acquisition plus 17% over cost.

Public Comment

The public comment portion of the policy promulgation process is being conducted concurrently with the implementation of the change noted in this bulletin. Any interested party wishing to comment on the change may do so by submitting comments in writing to:

Attn: Lisa Trumbell
MDCH/MSA
PO Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: trumbelll@michigan.gov

If responding by e-mail, please include "Acquisition Cost Policy" in the subject line.

Comments received will be considered for revisions to the change implemented by this bulletin.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Form Approved OMB
No. 0938-0679
Expires 02/2020

DME 07.03A

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID ______________________		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #________________
PLACE OF SERVICE ______________	Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	______________ ______________ ______________ ______________	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #________________

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 *(99=LIFETIME)* DIAGNOSIS CODES: ______ ______ ______ ______

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Check Y for Yes, N for No, or D for Does Not Apply)
❑ Y ❑ N ❑ D	1. Does the patient have severe arthritis of the hip or knee?
❑ Y ❑ N ❑ D	2. Does the patient have a severe neuromuscular disease?
❑ Y ❑ N ❑ D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
❑ Y ❑ N ❑ D	4. Once standing, does the patient have the ability to ambulate?
❑ Y ❑ N ❑ D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: ____ TITLE: ___________________________ EMPLOYER:________________________________

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR SEAT LIFT MECHANISMS (CMS-849)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/ DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the PHYSICIAN'S name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.