MEDICAID MINUTES
November 9, RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Mr. Solomon Williams
Ms. Jan Sticka
Ms. Jerri Jackson
Ms. Cindy Crockett

FACILITATORS PRESENT:
Ms. Jane Knight
Ms. Karen Northcutt

MS. KNIGHT: Solomon Williams from the Medicaid Agency is here with us. And he is going to introduce his team and lead off.

MR. WILLIAMS: Good afternoon, everybody. I'm Solomon Williams with the Medicaid Agency. I have Jan Sticka and Jerri Jackson with the Medicaid Agency, and Cindy Crockett from HP.

1. Alabama Medicaid is putting an inaccurate value for the contractual adjustment on some denied claims in the 835 file. A value equal to that of the contractual adjustment is being placed in value of the CO-96 code in the CAS segment as a negative amount. This falsely inflates the balance on every account where this value is provided. The only time this value would be accurate would be if there was a takeback, but these are denied claims. Example ICN's are: 2015194027981, 2015195028708, and 2015198028037.

   <u>Response</u>: All three of these claim examples posted an EOB code of 9919 which set to Claim Adjustment Reason Code (CARC) 96 which, subsequently, was one of the EOB codes identified as needing to be changed back to CARC 45 to correctly reflect a write-off. The issue was resolved 07/25/2015 and any claims processed after that date should return a CARC 45.

   <u>Discussion at meeting</u>

   AUDIENCE MEMBER: Yes. That part about the 96 to the 45, yes, we did get that provider alert back in late July. That's not as much of what this question was about. This is more about the dollar value assigned to the CO45 or CO96. Regardless of which one you chose, you would still put that negative amount there. Let's say the claim was for $24,000 in total charges, and the negative amount would then be the negative 20,000 on that denied claim, which would be, in the current setup, a negative 20,000 on 835 file, which would process through most of patient accommodating systems -- excuse me -- as a debit adjustment of $20,000, which would kind of throw it off in all except the manually we looked at, so we're not falsely inflating the accounts.

   MS. CROCKETT: So is it still doing that right now?

AUDIENCE MEMBER: Yes.

MS. CROCKETT: Okay. Are these three examples that you have since 7/25?

AUDIENCE MEMBER: No. These were priors. But I can provide new ones to the group if you need me to.

MS. CROCKETT: Please do. That will give us something new to research. We probably answered the question the way we did because the examples were date of service or were processed before July 25th.

AUDIENCE MEMBER: I can provide examples. That's fine.

MS. CROCKETT: Thank you.

MS. KNIGHT: Any other questions?

(No response)

2. How should we report the adjustment of gastric lap band via subcutaneous port using fluoroscopic guidance? There is no CPT code to describe this procedure, only a HCPCS S-code, S2083.

   <u>Response</u>: The adjustment of the band is included in the 90 day global surgical period and is normally done in the physician's office during a follow-up visit. In the event that the recipient is seen in the ED, the appropriate E&M code should be billed and the adjustment is included.

   <u>Discussion at meeting</u>

   MR. WILLIAMS: Are there any questions? Because when we first saw this, we were unsure about the setting.

   AUDIENCE MEMBER: What about cases where it's over 90 days and you're out of your global?

   MS. NORTHCUTT: On that too, I think Solomon and I have talked about this question in general. And I think when you talked about the 90-day global, it's not really a hospital thing, but it's a physician thing. But because we're not held to the 90-day, the question still remains as to why they're doing it in the hospital. I think that's probably the biggest question that was raised of having that adjustment performed in the hospital instead of the physician office, where they would be held to the 90-day. And I think for hospital outpatient clinics, if you will,

if there was a bariatric doc that had a hospital-based clinic department, I don't know if that happens very often. But I guess in that event, if they showed up and it would be a clinic, it would be included in the clinic visit, I think is where we got to, just like the last one like using the unlisted codes.

3. Is there a list available of chemotherapy drugs and/or other highly complex drugs/biologic agents that when given in their subcutaneous form should be billed using the drug administration CPT code 96372 (THER/PROPH/DIAG INJ SC/IM) and not the chemotherapy administration codes 96401-96549? For example, Cahaba posted a list of some of these drugs on their website on March 26, 2015 (http://www.cahabagba.com/news/drugs-administration-coding/).

   Response: Not at this time; however, this has been forwarded to program area for further review and consideration.

4. a) We have heard that Medicaid will now cover screening digital breast tomosynthesis (CPT 77063). Is this correct and are there any restrictions, such as place of service, providers, etc.? Is this service covered in a hospital setting?

   b) Does Medicaid cover diagnostic tomosynthesis (CPT 77061 and 77062) in a hospital setting? If not, are there any plans to consider covering this service in the near future?

   Response: A request has been submitted to cover CPT 77061, 77062 and 77063 in a hospital setting with an effective date of January 1, 2015. CPT 77063 will be limited to 1 every 12 months for women ages 50 through 64.

Discussion at meeting

MR. WILLIAMS: As of today, the system has not been updated, but as soon as it is updated then it should reflect an effective date of January 1st on all three codes.

MS. NORTHCUTT: I've got just a reminder too on this. Not specifically on Medicaid for this, but there's some national restrictions from FDA that really in this coding, how this goes, you'd need to perform a 2D and 3D, not just 3Ds. So you can have 3D that you revert back to the 2D or you can have 2D that you have a new software that actually does 3D. Because there has been some interpretations that, oh, I only do 3D. Well, I only do 3D is not a real good answer, even though we have that code as a digital for the diagnostics. So I think it's to come. But it should be secondary or an add on to 2D for films. So just a side note.

AUDIENCE MEMBER: And tomosynthesis. It says January 1 of 2015, so we can retroactively rebill those?

MR. WILLIAMS: Yes.

AUDIENCE MEMBER: Okay.

MR. WILLIAMS: Yes. Once our system is updated. And I'm sorry, I don't have a date as to when that might be completed. So you may just want to check with us before submitting those.

AUDIENCE MEMBER: Will we be held to a timely filing limit, if you update it prior to over a year out on the effective date?

MS. CROCKETT: No. It won't be a year out. Medicaid has sent a request over to Hewlett-Packard Enterprise (HP) last week for it to add it to the system. Jan said it will probably be updated within the next couple of weeks. So what I recommend you might want to do is call the provider assistance center before you get ready to bill the claims and see if they're covered or you can try to bill one -- don't bill an entire batch -- and see if it will go through. So you can use one of the couple of different ways to see when it's updated in our system.

5. Do we need to carve out the outpatient observation hours during actively monitored procedures if all guidelines are followed to be an outpatient observation stay?

   Response: No. Unlike Medicare, Medicaid has no such requirements.

6. We have noticed denials for Medicaid patients for no authorization and there is an authorization in the system. When we have called on this we are being told that the Medicaid system is randomly producing duplicate ID numbers for patients and the authorization could be tied to the patient's other ID number. Unfortunately we have not yet determined a way to tell online which patient ID number the authorization is tied. We are being asked to try to rebill the claim under the patient's other ID number to determine if this resolves the denial. What is causing the random assignment of duplicate numbers and when might this be corrected?

   Response: The Agency is in the process of moving to a new Eligibility and Enrollment system that will ultimately replace its aged mainframe system. This transition has presented some challenges. Due to both systems operating simultaneously, random duplication of recipient ID numbers is one of those challenges. This happens primarily when a recipient reapplies for Medicaid after his or her number (usually a 500 number) has become inactive for various reasons and a new number (usually a 530 number) is assigned upon reenrollment.

Discussion at meeting

MR. WILLIAMS: And sometimes when you have a prior authorization (PA) out there, it could be linked to an incorrect number, therefore, causing your claim to deny. We know it's an issue. We're working on it. We apologize for it. But we really don't have a date as to when that issue might be resolved, but I would suggest that you continue calling our customer provider assistance center, if you're trying to verify PA. I just don't have a time that I can tell you that that will be fixed.

7. a) If a hospital utilizes a company in the ED that supplies splints and braces/crutches and DME supplies that dispenses in the ED can the company bill for the supply or does the hospital bill?

   Response: ED supplies such are splints, braces and crutches are inclusive in the facility fee based on the level of the E&M code and cannot be billed separately by the hospital. A DME supplier can bill separately for medically necessary items that are considered a DME item such as a wheelchair. Please refer to the DME fee schedule and Appendix P of the provider manual.

   b) If burn garments are dispensed in an outpatient hospital clinic are these considered DME? Should the hospital send the patient to the DME for these items or can the hospital bill for these items?

   Response: A hospital's OP clinic can dispense and bill for burn garments if prior authorized by Medicaid.

8. If a hospital based reference lab receives a specimen from a physician office does the hospital bill for the lab or can the hospital bill the physician office and the physician office bill on their visit bill?

   Response: Specimens and blood samples sent to the hospital for lab work are classified as "non-patient" since the patient does not directly receive services from the hospital and should be billed as bill type 14X. If a physician sends a blood specimen to an outside lab for processing, only the venipuncture code with a "90" modifier should be billed and not the 80000 lab code.

9. If diagnostic tests are ordered per protocol (EKG for chest pain protocol, for example) at triage in the ED *prior to the patient being medically screened* by a physician or non-physician practitioner and the patient leaves the ED prior to being medically screened, can the hospital bill for the diagnostic test?

Response: **Yes. The hospital cannot bill a facility fee; however, it can bill for ancillary services associated with the visit.**

10. Medicaid has indicated to our facility that they do not cover the HCPCS codes specific to placement of drug-eluting stents – C9600-C9608. Are hospitals supposed to use the corresponding CPT codes that do not differentiate between drug-eluting and non-drug eluting stents, such as CPT 92928 instead of C9600 when a drug-eluting stent is placed?

    Response: **Yes. Medicaid does not cover C codes so use the appropriate CPT code.**

11. Please expand and report/present something on one of these current topics from your website (or another current topic of your choice):
    - RCO development: http://medicaid.alabama.gov/news_detail.aspx?ID=9361
    - CORE certification (pg 5): http://medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.7_Provider_News/2.3.7_15_April.pdf

    Response: **Jerri Jackson will give an update on RCO development.**

MS. JACKSON: I'm Jerri Jackson and I work in the managed care division at Medicaid. I was in the hospital program before. So a lot of you in here already know me. But our primary focus right now in managed care is the implementation of the regional care organizations - RCOs. That has been one big project that we've been working on. A lot of things are going on at the same time while we're trying to do the implementation.

The first thing that's going on that you probably have heard about is our 1115 waiver which is going to provide the funding for the program. We've been in contact weekly for the past three months with CMS to discuss the transition pool and the funding structure of the RCO. Another meeting that we've been having separately with our managed care team and CMS is in preparation for our readiness review. We've been meeting with CMS every two weeks on readiness review and how our team will be getting ready to and prepare to do this readiness review to make sure that the RCOs will be ready and up and running October 1, 2016.

There are five regions in the state. Right now we have 11 probationary RCOs. There are three RCOs in region A, and there are two in all the other regions. And if I had a map I would show it to you, but there is one on our website. We've got the northern region, west (which is Tuscaloosa), central, Birmingham, and Mobile. We've got the five regions of the state covered with those 11 probationary RCOs.

And remember as I talk about them, those are the probationary RCOs. They haven't reached their full certification. They won't reach the full certification until after the readiness review.

Right now Medicaid has been really working with PCPs to discuss the physicians and

special physician groups. We're going to have a meeting this week with them to discuss their concerns. A lot of their concerns are surrounding their payment and their panels. They want to make sure if the Patient First program as it is today, will be functioning the same as we move into the RCOs. And we're going to be seeing a different Medicaid when we move into the RCO. Because right now, if a provider has an issue or a problem, they come straight to our Patient First program if it has to do with the Patient First doctors or the panel or assignments or patient assignment.

When we move into the RCO, the providers will be contacting the RCOs. And those RCOs may see things a little differently. And it just depends on how they structure their program as to how physicians will be billing or hospitals will be billing. They do have to use what we pay now, minimum, to any provider as the base of what they'll have to use in their payment structure.

Also, as we're moving in tandem in everything, we are working right now -- we've released an RFP for the enrollment broker. That enrollment broker is going to be responsible for signing up recipients into an RCO. And remember right now, we're going to have three in the northern regions and two in all the other regions. So everything has to be done in a fair and an equitable way, although our recipients do have a choice. They will have a choice of providers, and they will have a choice of RCOs depending on where they live.

The other thing that is moving right along is our Health Home program. Our Health Home program began in 2012 in four areas of the state. It is now effective. April 1 of this year, 2015, we did go statewide with the Health Home programs. The primary purpose of the Health Home program was to provide care coordination to our high-risk and moderate risk recipients in those regions so that they could have the best care available and to utilize their visits in the way they need to be utilized.

As we move into the RCO program, Care Coordination is going to be a huge part of regional care organizations that it will be divided out into the three areas, general care coordination, maternity care coordination, and our health home care coordination. So Health Home will not go away. It will continue as we move into the RCOs.

Maternity right now as it moves into the RCO, the same thing. Right now the care coordination is in the maternity program and it will continue as we move forward. So the RCOs will be providing a lot of care coordination.

Also, while we're looking at all of our changes, in Medicaid, we're going to have changes across the board in our managed care division as well as in the finance division and our quality analytics division.

Right now the way we handle the Patient First program is we've got program managers in that area. We've got the maternity program people that work in the maternity. We've got Health Home people that work in the Health Home program area. All of our jobs in the managed care are going to change. We've been working with personnel, and we are in the process of recruiting for the five RCO manager positions. That RCO manager position will be responsible for filtering Medicaid information back and forth from Medicaid to the RCO, and that's one of the primary functions. And they'll be responsible for an entire region since there is going to be five of those.

We are also looking at hiring financial staff as well as quality analytics staff. So all of

those areas will have to have those key positions to get started.

The maternity program right now has several nurses in those in different positions. And so their primary duties will change. Our administrative positions will also change. Because we're going to one of monitoring, of reviewing, instead of policy-making and looking into claims. We may look into any counter-data claims, but there will just be a different way of looking at things and a different way of functioning.

Right now, October 1 of this year, we had two reports that were essential that came in from the probationary RCOs, and we're in the process of reviewing those reports. One of them was for financial solvency because, as you know, Medicaid has to review each probationary RCO to make sure that they each stand alone and be financially solvent.

The other report that we have received is our service and delivery network. Each RCO and each region is responsible for providing a network in those regions of physicians, cardiologists, pediatricians, and PCPs as they are today. Hospital facilities, inpatient psych facilities. There is a key list of those key providers that are being looked at very closely on our website.

And if you would like to know more about our RCO program, on our website, we do have a triangle and it says RCO. And you can look on there, we're trying to keep it updated as quickly as possible. And we do go out and speak to different groups if you ever need us to talk to you. Our communication division handles that.

Discussion at meeting

AUDIENCE MEMBER: When we move to the RCOs, will the criteria change then for Medicaid patients as far as the medical necessity criteria? Will there be a different expectation?

MS. JACKSON: In our contract, there is a utilization management section. Right now, to me, it will be the same right now. Because we're still going to have fee for services recipients, and those recipients that will be in the RCO. So that hasn't changed right now.

AUDIENCE MEMBER: Just to follow up on her question, will the RCOs be allowed to, in their contracts with specific providers, delineate the medical necessity criteria. So Medicare Advantage contractors, they have different medical necessity than fee for service Medicare? Are you going to allow that in your contracts with them?

MS. JACKSON: In our medical necessity criteria in the contract, it's the same for all RCOs, medical necessity. But you're talking about inpatient review?

AUDIENCE MEMBER: Any medical necessity criteria. Are they going to be able to do it? Because you're not going to narrow the network, right?

MS. CROCKETT: Can the RCO kind of change the way things are now?

MS. JACKSON: No. They can't change the way the rules are today.

MS. CROCKETT: For inpatient admissions. They can't make it any more stringent.

MS. JACKSON: Right.

MS. CROCKETT: It has to remain like it is today.

AUDIENCE MEMBER: And they can't narrow the network?

MS. JACKSON: What do you mean by narrowing the network?

AUDIENCE MEMBER: They can't exclude providers.

MS. JACKSON: Right. If you're willing, they have to accept you.

AUDIENCE MEMBER: Thank you.

Additional discussion at meeting

AUDIENCE MEMBER: On question eight, with regards to the reference lab, if the reference lab happens to be a lab from our facilities, I mean, we have physicians' offices and the lab specimen goes to our hospital lab. Is that still applicable in this situation where you say we need to bill it for the 90 modifier just for the venipuncture in the physician office? Our hospital lab is acting as a reference lab for the physician office.

MS. CROCKETT: So the physician office may actually be a suite in your hospital, but they are not affiliated with the hospital.

AUDIENCE MEMBER: They are. They are Baptist employed physician offices, and our main hospital lab is performing those lab tests.

MS. CROCKETT: But they have their NPI number and they get paid by us by submitting their claims directly from the physician's office?

AUDIENCE MEMBER: Yes.

MS. CROCKETT: And they would bill as outlined here with the venipuncture 36415 with the modifier 90, and you would bill for the lab.

AUDIENCE MEMBER: Okay. Thank you.

MS. CROCKETT: Yeah. Sometimes that's easy for the providers to get that confused because they are part of your network and they may be in a suite in your hospital, but your lab

is different from their physician's office. It's still considered a send-out lab.

AUDIENCE MEMBER: Even in regard to the hospital side. They don't collect the specimen, our hospital is who collects the specimen and we conduct the tests.

MS. CROCKETT: So it's not like the nurse in the physician's office drawing labs and sending it? You have a phlebotomist there that's drawing the specimen and then taking it back to the lab?

AUDIENCE MEMBER: Yes.

MS. CROCKETT: We better go back and research that.

AUDIENCE MEMBER: Thank you.

MR. WILLIAMS: Have you submitted a claim with that example?

AUDIENCE MEMBER: I can look into that and can send an example through Peggy.

MR. WILLIAMS: Or you can send it directly to me, solomon.williams@medicaid.alabama.gov.

MS. KNIGHT: Okay. Are there any other questions?

(No response)

MS. KNIGHT: Well, thank you very much for joining us and giving us the update on the RCO through this challenging time.