MEDICAID MINUTES
July 13, 2015 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Mr. Solomon Williams
Ms. Jan Sticka
Ms. Aleetra Adair

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: Everyone, we'll go ahead and get started with Medicaid. I'd like to welcome Solomon Williams, Jan Sticka, and Aleetra Adair.

1. Follow up to Question #3 from March 2, 2015 RIC/RAC meeting. You clarified that if a patient gets Hydromorphone 2mg injection from single dose vial at 0800 and a separate administration of 2 mg from another single dose vial at 2000 (on the same day) that this should be billed as one unit of J1170 which has a description of "up to 4mg". Since there are two separate drug administrations (one in the morning and one in the evening), can the hospital bill two administrations for that date of service, one for each administration of the drug given?

   Response: **In the above scenario, bill 2 units of the J code. CPT Administration codes are not billable in the ED. In other outpatient settings the applicable CPT Administration code can be billed in conjunction with the medication.**

   Discussion at meeting

   MR. WILLIAMS: Good afternoon, everyone. Our answer is yes. In the above scenario, bill two units of the J code. And just keep in mind that in an emergency room setting that administration cannot be billed separately; but in other outpatient settings, applicable CPT administration code can be billed in conjunction with the medication.

2. Follow up to Question #4 from March 2, 2015 RIC/RAC meeting. Patient came to hospital for outpatient laparoscopy surgery. The surgery was converted to open. The admit order was not written until the day after surgery. The order did not say "inpatient". Do you bill inpatient from the beginning? Does Medicaid require the word "inpatient"?

   Response: **The admission order should clearly state what type of admission is ordered. If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services.**

Discussion at meeting

MR. WILLIAMS: In this case, we have a planned laparoscopic surgery and things go wrong -- for whatever reason, it turns to an open surgery. You can bill from day one as far as the doctor's order. You have up until 30 days to change those orders. So you can bill everything rolled all into one claim, one inpatient claim if you would like. That's perfectly fine.

3. Although the question regarding RT or LT procedures was answered in March (Question #1), it prompted another question: What's the progress on correcting the CPT list currently requiring RT or LT on procedures that do not require RT or LT? Examples: 47100 (liver bx) and 49652 (hernia repair, abdomen).

   Response: Providers should email codes in question to Jan Sticka at jan.sticka@medicaid.alabma.gov to research and request removal of modifier requirement as indicated.

   Discussion at meeting

   MR. WILLIAMS: Some of these we've fixed. There's some that are still out there that still needs to be addressed. Jan Sticka will be your contact person if you encounter any of those. Just e-mail her, and she'll be happy to research those for you and hopefully fix that issue that you're having.

4. An order is written and a prior-authorization is obtained for CT of the head with and without contrast (CPT 70470). The "without" contrast exam is performed and the radiologist determines that the "with" contrast exam is not necessary. The ordering physician has to be contacted to revise the order to CT of the head without contrast and the hospital has to obtain another prior-authorization for CT of the head without contrast (CPT 70450). This is a very time-consuming and burdensome process for the outpatient hospital. The other situation is when one exam is ordered, prior-authorized and performed and the radiologist determines that an additional exam is indicated which necessitates an additional order and prior-authorization which is time-consuming and results in delays for the patient and facility. Would you consider changing the prior-authorization process to cover a "family" of codes and not a specific CPT code? For example, the CT of the Head/Brain "family" of codes would include CPT 70450 (CT head without contrast), CPT 70460 (CT head with contrast), and CPT 70470 (CT head with and without contrast).

   Response: Medicaid understands that this is a challenge and is currently reviewing its process. At this time, please continue as you have.

   Discussion at meeting

   MR. WILLIAMS: Hopefully, sometime in the future, we will have a solution for you.

But in the meantime, if you have a problem that really needs to be addressed immediately, Russell Green would be the contact person for you.

5. Currently Medicaid doesn't cover the codes listed below. We would like to request that the codes be considered for coverage: The billing instructions were released in CR 5438 [pages 12 & 13 of MLN Matters Number: MM5438 were attached]

   99291 - Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

   99292 -Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

   G0390 -Trauma response team associated with hospital critical care service

- **Code 99291** is used to report the first 30-74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the individual is not continuous on that date. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code.
- **Code 99292** is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes. (See the following table.)
- The following examples illustrate the correct reporting of critical care services:
- Total Duration of Critical Care Codes less than 30 minutes appropriate E/M codes
  - 30-74 minutes 99291 X 1 (30 minutes - 1 hr. 14 min.)
  - 75-104 minutes 99291 X 1 AND 99292 X 1 (1 hr. 15 min. - 1 hr. 44 min.)
  - 105-134 minutes 99291 X 1 AND 99292 X 2 (1 hr. 45 min. - 2 hr. 14 min.)
  - 135 - 164 minutes 99291 X 1 AND 99292 X 3 (2 hr. 15 min. - 2 hr. 44 min.)
  - 165 - 194 minutes 99291 X 1 AND 99292 X 4 (2 hr. 45 min. - 3 hr. 14 min.)
  - 195 minutes or longer 99291 and 99292 as (3 hr. 15 min. - etc.)appropriate (see illustrated reporting examples above)

Response: **Critical Care in the emergency room is covered with procedure code 99285. That is the only procedure code at this time that we recognize. Medicaid will not cover the codes listed above.**

6. The Medicaid Hospital Manual says Cardiac Rehab is a covered service. CPT code 93797 (physician services for outpatient cardiac rehabilitation; **without** continuous ECG monitoring, per session) is on the Outpatient Hospital Fee Schedule, but CPT code 93798

(physician services for outpatient cardiac rehabilitation; **with** continuous ECG monitoring, per session) is not. Could you please explain why CPT 93798 is not covered?

Response: **In 2013 coverage in the OP setting was ended in error. Coverage for 93797 and 93798 has been reinstated with effective date of January 1, 2015.**

Discussion at meeting

AUDIENCE MEMBER: So if you have claims that were denied, you can send them back and have them reprocessed?

MR. WILLIAMS: Yes. After January 1st, effective then.

MS. STICKA: The changes in the system now show effective 1/1/15. So if you have any claims 1/1/15 forward, reprocess them.

AUDIENCE MEMBER: Because we have several. Okay. Thank you.

7. In the April Medicaid Provider Insider, Alabama Medicaid said they are accepting the Medicare radiation therapy codes and provided a crosswalk which included a number of codes that Medicare does not allow for hospital billing (the G codes). (Medicare requires these G codes for physician billing). Are hospitals to use these G codes for billing Medicaid?

   Response: **No. Medicaid is in the process of updating all appropriate radiology codes for OP hospital claims processing and anticipate completion during the month of July.**

   Discussion at meeting

   MR. WILLIAMS: So if you have any outstanding claims, you should be able to reprocess those.

   AUDIENCE MEMBER: And you'll publish when the effective date is that they've been corrected or send out an alert?

   MR. WILLIAMS: Sure. I can, or I can call you directly.

   AUDIENCE MEMBER: Okay. Thank you.

   MR. WILLIAMS: There again, Russell Green is the contact person. If you have any immediate issues that you need resolved, Russell can help you with those.

8. Is genicular neurotomy a covered service? It is uncertain if this procedure would be coded as CPT 64640 or 64999, but regardless of the code selection, is genicular neurotomy covered by Medicaid? If it is a covered service, what is the correct CPT code to use?

   Response: **Medicaid does not cover this procedure as it is considered experimental and investigational.**

9. When will all the new CPT / HCPCS codes for 2015 be reflected on your fee schedules? New codes are rejecting as "not covered" since they have not been added to the fee schedules and the deleted 2014 codes are rejecting as "procedure code no longer valid." For example, 2014 CPT 77418 for IMRT is "no longer valid", but new IMRT CPT codes 77385 and 77386 are rejecting as not covered. How should hospitals bill for services described by the new codes in the interim?

   Response: **Medicaid is currently finalizing the fee schedule review process and anticipate completion during the month of July.**

Discussion at meeting

MR. WILLIAMS: And there, again, Russell Green is the contact person. If you have any questions, please e-mail Russell. Feel free to give Russell my name if you have to.

AUDIENCE MEMBER: So the 15 codes began January 1. And now this is seven months later. So come January of '16, we can anticipate the 16 codes not happening until July.

MS. STICKA: Hopefully not.

AUDIENCE MEMBER: Why? Why is this happening? It starts January 1.

MR. WILLIAMS: I don't want to drop Russell's name again, but Russell would be a better person to ask because that's a totally separate area and I couldn't begin to explain what's happening in this area or what has happened.

AUDIENCE MEMBER: When the new codes are in place, are you going to allow us to refile claims back to January 1 with these new codes? Are the new codes going to be effective the time you place them in the system, in your system?

MR. WILLIAMS: I would say I think you would be able to refile and reprocess those claims. That's normally how it works.

AUDIENCE MEMBER: Can you bring Russell to the next meeting?

MR. WILLIAMS: I really wanted to bring him to this meeting, but he wouldn't come with me.

MS. STICKA: If there's a 7XXXX CPT code, we will.

MR. WILLIAMS: And if you send enough questions that pertain to his area, yes, I will try to bring him, yes. Russell is radiology.

10. If a Nurse Practitioner (NP) treats a patient in the emergency room, can the NP certify that visit as an emergency? If not, what is the protocol?

    Response: **Not at this time. Medicaid has reviewed its current policy which limits this to physicians only and will be implementing a change to allow NP/PAs to certify ED visits as soon as a State Plan amendment can be completed.**

    Discussion at meeting

    MR. WILLIAMS: Not at this time. Any visits can only be certified by a licensed physician. But we are in the process or we have reviewed our policy and we're looking to make changes to that policy. But before we can do that, we would have to submit a state plan amendment to be further approved by CMS. And I cannot give you a time frame, but hopefully soon.

11. If a patient receives outpatient services and remains at the hospital until the next day when he or she is admitted, are the outpatient services from the day prior to the admission date billed separately on a 131 bill type? The manual states that outpatient services should be bundled into the inpatient stay if the patient is admitted before midnight on the same day but does not address if the patient received services the day before the admission.

    Response: **If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services.**

    Discussion at meeting

    MR. WILLIAMS: And here, again, we realize our policy is not exactly clear in regards to this. You can bill up to one outpatient claim, if you so choose, or you can roll everything into an inpatient service, as long as you've got an admission order that is signed off by the doctor and the patient met SI's criteria for filing that. So you can submit everything for inpatient services, or you can separate one outpatient claim and then bill the remainder on an inpatient claim. Did that confuse anybody with that answer?

AUDIENCE MEMBER: I was really hoping Ann Benning would be here. Because this is truly not my question, but I have done some research on it. So I will give this all to you to

take back with an example showing this is what the issue is: You have a patient. Let's just say the patient comes in for an outpatient surgery, has a procedure performed, then later is admitted. Okay? The next day he's admitted. So your from and through date is one thing. Your outpatient surgery date was something totally different. You cannot get it to get through your edits.

Okay. Now, if you have the same scenario with a Medicare account, Medicare allows you, for a procedure date, to report the procedure date up the 72 hours before the admission. The problem is the edits in your software do not allow that to happen. So anytime we have a patient, an inpatient, that has a procedure prior to admission, all of the facilities in this room have difficulty trying to get that claim to process through the system.

MR. WILLIAMS: And for clarification, you're talking submitting two claims for the same date of service?

AUDIENCE MEMBER: No.

MR. WILLIAMS: They're separate dates of service?

MS. NORTHCUTT: Date prior to the admissions.

AUDIENCE MEMBER: They're combined. Because according to the administrative law manual, you're supposed to combine them. Okay?

MS. NORTHCUTT: If it's before midnight.

AUDIENCE MEMBER: So you're combining them. Okay? But then the edits that are in place, if you have a surgery, or the patient is there and they had surgery and then the next day, they're admitted. So it's all wrong, then. The way we do it, it's all wrong.

MS. NORTHCUTT: Well, see, the way I understand their manual is that if the admission occurred before midnight of that same day you would have to combine but if they have surgery on the 1st and they were not admitted till the 2nd, then they're saying that you would bill services for the first as an outpatient on a 131. And then the admission that next day would be an inpatient.

AUDIENCE MEMBER: We can do that? I don't think any of us have been doing that.

MS. NORTHCUTT: Yes. Because Medicare requires anything bundled within three days.

AUDIENCE MEMBER: I think that if we had patients that came in and had a procedure and then something happened and then you ultimately end up admitting them, that's all one thing. But your admit date, your from and through date is still going to be different than the date of the procedure.

MS. NORTHCUTT: If you bill it on the 1st and they're not formally admitted until the 2nd, then you do not have to bundle.

AUDIENCE MEMBER: Then you'll end up splitting the bill.

MS. NORTHCUTT: Right.

AUDIENCE MEMBER: There's no bundling happening. It's the same encounter.

MS. NORTHCUTT: That's where the administrative code probably needs to be looked at.

AUDIENCE MEMBER: Yes. The dates need to be expanded.

MS. NORTHCUTT: But it is not anything to Medicaid. Their bundling rule is one day, that same day, not three days prior in your care.

AUDIENCE MEMBER: If you want to do an outpatient, we'll split it and we'll do an outpatient and an inpatient. I don't know how we're going to do it, but we'll try it.

MR. WILLIAMS: Well, I will say this. I realize there's some confusion, and we do have plans to look at our policy. Hopefully, we can become a little clearer as to what we really want to allow. But we will be going to APR DRG's in hopefully a year, year and a half from now. So our policy probably will mirror Medicare's policy. But over the next month or so, we can take a look at our policies and make it look clearer for you.

MS. NORTHCUTT: Because you're going to be cheating yourself too, because the from date is always going to lose that first day and your whole per diem is gone. Unless you can be able to roll it back to when they came in the hospital is when they should have been an inpatient.

AUDIENCE MEMBER: But you can't do that because the physician's order is for the next day.

MS. NORTHCUTT: Right. But you can clarify an order in 30 days and make the inpatient admission date back to when the patient originally came in.

12. Please expand and report on Medicaid's January 7, 2015 Alert regarding Regional Care Organizations (RCO) development.

<u>Response:</u> Medicaid is close to receiving approval from CMS of the 1115 waiver that will fund the transformation to RCOs. At this time, the RCO effective date is set for

October 1, 2016. Current updates and information on RCO developments can be found at:
www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx

Discussion at meeting

MR. WILLIAMS: The only thing I really want to address real briefly about RCO is that we are close to getting approval for our 1115 waiver, which actually will give us funding to expand Medicaid with RCOs. We still have got some things to work through with CMS. And if you would like to be current on the information that's out, you can go to our website. We have a link that we update quite often with any developments for RCOs. So we would invite you to go out to our website and take a look at our web page.

Additional discussion at meeting

AUDIENCE MEMBER: During our March meeting, we were instructed to use the CMS inpatient only list regarding the procedures, trying to make a determination if it should be inpatient or out. And so we started that, but we're actually getting some denials because of cases that weren't on CMS's inpatient only list. And so we billed it as outpatient, but we're getting a denial saying that it should have been billed as inpatient.

MR. WILLIAMS: Now, if you have claim specifics, you can send those to us and we'll be happy to take a look at those.

AUDIENCE MEMBER: Do you follow Medicare's inpatient-only list?

MR. WILLIAMS: We try to in most cases, yes.

MS. STICKA: If there's something on their list as inpatient-only when we're reviewing HCPCS codes, they're not included in outpatient coverage. So are you talking outpatient billing?

AUDIENCE MEMBER: The patient was billed as outpatient. And it should have been outpatient. It's not on CMS's inpatient-only list. They denied because according to the Medicaid, it should have been done the same day.

MS. STICKA: I don't know any other instances that might affect that. Could you e-mail that to me?

AUDIENCE MEMBER: Okay. Thank you.

MR. ASHMORE: Anything else from anyone?

(No response)

MR. WILLIAMS: And just one final thing. I do want to say if you have questions, feel free to e-mail us at any time with questions. You don't necessarily have to wait to see us to ask questions. I mean, we're there every week and will be more than happy to answer questions for you. So feel free at any time to fire off a question.

AUDIENCE MEMBER: What's the e-mail address that would be best to use?

MR. WILLIAMS: You can use my e-mail address. I'll forward it to the appropriate person. It's solomon.williams@medicaid.alabama.gov. And I know there will be some questions pertaining to ICD-10 as of right now, pending CMS. And it will go forward with ICD, and we do have a link out on our website that you can review that will give you additional information on ICD-10 and those changes.

AUDIENCE MEMBER: Jan, what's your e-mail?

MS. STICKA: My e-mail is Jan.Sticka@medicaid.alabama.gov.

AUDIENCE MEMBER: What was Russell's one more time?

MS. STICKA: Russell.green@medicaid.alabama.gov.

MR. WILLIAMS: And you can start out by saying Solomon referred me to you, if you would like. He'd only do the same for me.

MR. ASHMORE: Okay. Do we have anything else?

(No response)

MR. ASHMORE: Thank you all for coming today.

MR. WILLIAMS: Thank you very much.