MEDICAID MINUTES
July 18, 2016 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Mr. Solomon Williams
Mr. Flake Oakley
Ms. Jan Sticka
Ms. Cindy Crockett

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Debbie Rubio

MR. ASHMORE: With us today from Medicaid, we have Solomon Williams, Flake Oakley, Jan Sticka, and Cindy Crockett.

1. Follow-up question from March 7, 2016 RIC/RAC meeting. In regards to L codes for outpatient hospital billing, do you have an updated fee schedule available?

   <u>Response:</u> **A change has been made to Chapter 19 of the provider manual that lists covered L codes in the OP hospital setting and is reflected in the July 2016 update.**

   <u>Discussion at meeting</u>
   MR. WILLIAMS: Good afternoon, everybody. And thanks for your patience on this one.

2. Effective January 2016, the MUE value for CPT code 94640 (Airway Inhalation Treatment) was changed from ten to two units. The past instruction for reporting units of 94640 from the CMS NCCI panel stated:

   *"Your inquiry requests clarification about the units of service that may be reported for this CPT code **94640** on a single date of service. A provider may report only one (1) unit of service (UOS) for a professionals (e.g., respiratory therapist) visit to provide services reported as CPT code **94640** even if those services require more than one inhalation treatment (e.g., multiple medications) at that encounter. The professional does not have to provide continuous face-to-face service during the entire treatment time but may initiate the inhalation treatment and return to continue or complete it. **If the professional completes the inhalation service(s) and terminates the patient encounter but returns later that day to initiate additional inhalation treatment(s) reportable as CPT code 94640 an additional UOS of CPT code 94640 may be reported for this subsequent patient encounter."***

   With the update to only 2 MUE units, do we continue to use modifier -76 for each additional treatment?

   <u>Response:</u> **No. The current MUE units for 94640 are two per date of service. Billing for more than one inhalation treatment during a single patient encounter by using 94640 with modifier-76 is not appropriate. If this procedure code is billed with modifier-76 appended, it will deny as a duplicate if provided by the same provider on the same date of service.**

Further clarification - Per the 2016 Medicaid NCCI Manual Chapter IX-26: "CPT code 94640 should only be reported once during a single patient encounter regardless of the number of separate inhalation treatments that are administered." A provider may report only one unit of 94640 even if those services require more than one inhalation treatment. For example, if the inhalation therapy treatment is ordered as "aerosol times 3", the order can be considered as a single encounter and all three treatments would be billed once. However, if the physician orders an initial treatment and then subsequent treatments, the additional treatments can be considered separate encounters and billable.

3. Medicaid benefits for pregnant women now include prenatal care through pregnancy, labor, and delivery, and for 60 days postpartum as well as other pregnancy-related care. Due to this expansion in Medicaid benefits, claims for non-citizen births are resulting in a denial indicating no certified emergency indicator selected on the claim. The patients present to the emergency department but are transported directly to labor and delivery, which does not prompt a certified emergency selection on the claim. Additionally, there will be no documentation in the patient's medical record specifically addressing a certified emergency. Because care will never be rendered in the emergency department for pregnant patients, the certified emergency field on the claim will remain blank, which will result in a denial of all aforementioned claims. What is the course of action for hospitals to receive payment for these accounts? Can an OB-GYN physician certify? [example was provided]

<u>Response:</u> **Please refer to the March 2, 2016 Alert - Changes in Covered Services for Pregnant Women which states in the section titled Emergency Services for Non-citizens: "These claims will require the certified emergency indicator in order to be considered for payment including deliveries." When billing through the web portal put a service authorization of "3" for emergency. On UBO4 claim, enter an "E" in field 73. If the emergency indicator is not entered on the claim it will deny.**

<u>Discussion at meeting</u>

AUDIENCE: I think the concern our facility had is some of these patients, when they come in through the ER, are sent directly to labor and delivery. So they don't necessarily meet the certified emergency requirement because they don't happen to meet a physician or another provider. They're in for a labor check, they're seen briefly, and then they're sent home. So in those instances, the additional coverage that's being provided can't really be utilized because we can't document a certified emergency on the claim.

MR. WILLIAMS: And that's fine. It's a noncitizen claim. You can use the emergency indicator for noncitizen. You will be fine.

AUDIENCE: Okay. So they don't have to actually see the physician in that instance?

MR. WILLIAMS: No.

AUDIENCE: Okay. Thank you.

4. Please provide information on the budget and what that means for providers, recipients, and services.

__Response:__ **Flake Oakley will do a presentation on the budget.**

MR. OAKLEY: Thank you, Wesley. I'm Flake Oakley. I'm the chief financial officer with Medicaid. And I think you asked a very pertinent question. It seems like we have a lot of interest in what our budget is. And I'd like to take a few minutes to go through that just to give you an overview.

(PowerPoint presentation)

MR. FLAKE: So that's the budget. And I'll be glad to try to answer questions.

AUDIENCE: I see where you're without adequate funding. Your plan is to shift the cost burden to hospitals for dialysis?

MR. FLAKE: Well, we're not shifting anything. We're just having to reduce, if we do. And again, that's an option. I'm not sure that one could be chosen.

AUDIENCE: Well, there are a lot of hospitals that don't have dialysis at all.

MR. FLAKE: Okay.

AUDIENCE: There are communities where they have outpatient dialysis centers, the hospitals don't have dialysis. And then that's just going to be a tremendous burden on the hospitals' EDs.

MR. FLAKE: Yes.

AUDIENCE: I mean, it's going to be overwhelming, quite frankly, to have every one of those outpatient patients coming in through the ED trying to get their dialysis every three days. I just don't see how that could even begin to be viable.

MR. WILLIAMS: Well, still, with that, most dialysis patients are still going to be Medicare eligible. So the centers will not refuse treatment. They will still be receiving treatment.

But I understand your point, what you're thinking. They're all Medicare eligible. That's a qualifier. Does that help a little?

AUDIENCE: A little bit, yeah.

MR. FLAKE: We're definitely weighing all of the ramifications of each one of these. And hopefully these dollars add up to more than the 85 million. So we don't intend to put lives at risk any more than what's absolutely necessary. At some point, the funding is not there, we have to cut to what we have to work with.

AUDIENCE: Does Medicaid still plan to go to APR-DRG in October?

MR. FLAKE: No. The RCO implementation has been delayed at this point. It's not been determined at what point it would be implemented. It all depends upon the funding and the timing of the resolution of the funding issues. And the APR-DRG implementation is delayed to coincide with the RCO at this point.

MR. WILLIAMS: And to add to that, there is an alert that went out a couple of weeks ago. And if you still have questions, you still can send your questions to the RCO data at medicaidalabama.gov, and your questions will still be answered.

AUDIENCE: And I'd just like to state, though, some of the proposed cuts are just going to cycle the money around. Because if you cut, say, the medication, you're just going to increase the re-admissions. The admission criteria is so relaxed as it is. I wonder sometimes if Medicaid has just looked at that. I mean, there's no rigid criteria for putting them in, so that could reduce costs. Because it's easy just to be placed based on the criteria now. Is that because you don't have a lot of post-acute benefits?

MR. FLAKE: We totally understand that.

MR. ASHMORE: Okay. Do we have any more questions for Medicaid?

(No response)

MR. ASHMORE: Okay. Well, I would like to thank Solomon, Flake, Jan, and Cindy for coming today.

MR. WILLIAMS: Thank you.