MEDICAID MINUTES
July 21, 2014 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Ms. Jerri Jackson
Mr. Solomon Williams
Ms. Betty Payne
Ms. Aleetra Adair

FACILITATORS PRESENT:
Ms. Margaret Whatley
Ms. Karen Northcutt

MS. WHATLEY: We welcome Jerri Jackson and the Medicaid group this morning. We'll get right to the questions.

1. **Can a hospital ED MD write observation services ordered, additional orders and manage these patients (keep in mind they may not have admitting privileges) as observation patients while in a distinct unit within the ED? Or would the care have to be turned over to another physician for patient management when observation services are ordered?**

   Response: Please refer to Chapter 19, page 29 of the Medicaid's provider manual for the following Outpatient observation policy:

   Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

   Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

   Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

   An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient.

   The following guidelines apply:
   - Patient must be admitted through the emergency room.
   - A physician's order is required for admission and discharge from the observation unit.
   - A physician must have personal contact with the patient at least once during the observation stay.

- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours but no more than 23 hours.

Discussion at meeting

MS. JACKSON: What Solomon and I are doing in our answer to this question is directing you back to our chapter. Because that's what we have to go on. And particularly, if you will pay attention to the second and third bullets. A physician order is required for admission and discharge from the observation unit. So we know that the physician's order is required. And a physician must have personal contact with the patient at least once during the observation stay.

And I believe some of what a hospital would have to think about really, is it would be between the hospital and the physician if it's not in our chapter.

Does that clarify it?

MS. NORTHCUTT: Yes. But it just says a physician. So if they're the one that wrote the order, would it have to be that same physician that sees them during that op stay?

MS. JACKSON: I would think that it would be the same physician. But, again, if they had to leave and another physician had to take over, that would be how the hospital runs its business.

2. **Per CMS Transmittal 581 Dated October 28, 2009, the "From" date on an Inpatient account can be prior to the admission date.**

   For Medicaid Inpatient accounts, the "From" date must match the "Admit" date.

   This issue was addressed at our March 2013 meeting and is still unresolved. It was my understanding that an update to the edit would have to be made in the HP system. Has a date been established that this edit would be completed?

   Example: The patient enters through the emergency department on the 17th and is not admitted until the 18th. The "From" date has to be edited to match the "Admission" date in order for the claim to pass Medicaid edits in the HP system. Currently this requires manual intervention from the billing staff.

   Response: The Alabama Medicaid Agency will set EOB code 0519 to "pay" for crossover claims. However, since Medicaid does not follow Medicare's guidelines, Medicaid claims will continue to deny for services billed prior to the admission date.

Discussion at meeting

MS. JACKSON: I do have to say that right now we have a list of change orders that the agency reviews on a monthly basis. And even though it's been written to cover what we said our answer is, that it sometimes takes time. And I can't give you a specific date of when it will be in. But the Alabama Medicaid Agency will set the EOB Code 0519 to pay for the crossover claims. But since Medicaid does not always follow Medicare guidelines - we try to mirror them as closely as possible - then Medicaid claims will continue to deny for the services billed prior to the admission date.

MS. NORTHCUTT: That's clear.

THE SPEAKER: Karen, can I ask if this is an NUBC requirement that changed the “from” date? Do they have to follow NUBC standard transaction code set?

MS. NORTHCUTT: I don't know .

MS. JACKSON: Well, for our Medicare claims, we will set it for the Medicare claims that come in. But for the Medicaid claims, it will continue to do as it does today.

THE SPEAKER: So you don't have to follow NUBC rules?

MS. NORTHCUTT: NUBC, National Uniform Billing Committee. Basically, they come up with every form locator on a bill and tell you when you can use it and how you can use it.

MS. JACKSON: They can use this with this one. I don't know that we follow every single NUBC guideline for transaction sets.

THE SPEAKER: It might be something that you will have to do something about.

MS. PAYNE: With Alabama Medicaid, we say that the date of admission must be on or prior to the "from" date of service. We do not allow the date of admission to be after the "from" date of service.

MS. NORTHCUTT: So if that was the NUBC, you don't necessarily have to follow that, if that's their guideline. Right?

MS. JACKSON: Well, we do for Medicare.

MS. NORTHCUTT: For Medicare crossovers?

MS. JACKSON: Yes. For the crossover, we would have to.

MS. NORTHCUTT: Okay. It's just a lot of manual intervention.

3. **Why will Medicaid not accept revenue code 110 (Room & Board-private) on an LTAC claim (provider #LTC2006H)? Crossover claims from Medicare are denied with Remarks code M50: missing/incomplete/invalid revenue code(s) and Internal Medicaid code 4520: BILL PROV ALL PT/PS RESTRICTIONS. Melissa Gill advised system issue. Is there a possible completion date? Our claims have been denying since October 2013.**

   Response: A system change was made by the Alabama Medicaid Agency on 5/27/14 to allow LTAC providers to bill room and board revenue codes. Please resubmit your denied claims.

   Please contact Solomon.williams@medicaid.alabama.gov if you have any more problems.

   Discussion at meeting

   MS. JACKSON: Okay. We did put in a change to allow this revenue code to be paid on LTAC claims. So those claims will need to be resubmitted when it's put in. And, again, this change was made on 5/27/14. So you should be able to bill now.

   THE SPEAKER: Well, we're thinking they might deny since they are past timely filing. And I talked to Solomon about it. Maybe they need to go through that administrative review for approval.

   MS. JACKSON: Did you say October 2013? How far past the filing limit would you be? Because you do have a year to file the claims from the date of service.

   THE SPEAKER: We'll check that. If the date of service is over a year, should we send those to administrative review with that form?

   MS. JACKSON: Yes.

   THE SPEAKER: Thank you.

4. **Why is there a discrepancy between electronic remit codes and paper remit codes? For example: for a CCI denial the adjustment code CO45 is shown on the electronic 835 remittance vs. on paper remits the code is 5920 or 5921.**

   Response: As a result of a HIPAA complaint filed against Alabama Medicaid to CMS, the Agency discovered EOB code 3323, PROCEDURE RESTRICTION - MODIFIER REQUIRED, was no longer mapped to a valid claim adjustment reason code (CARC) in its system. To avoid reporting invalid HIPAA CARC codes on the 835, Medicaid's financial system returned a default CARC code of 45.

   To correct the issue, Alabama Medicaid has re-mapped its internal EOB code 3323 to HIPAA CARC code 4, "The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service

Payment Information REF), if present". The CARC code 4 will now be returned on all future 835 remittance advice records.

When it was discovered that Alabama Medicaid was using HIPAA CARC 57, the Agency then reviewed all EOB codes that were mapped to HIPAA CARC 57. Medicaid EOB codes 5900, 5920, 5921, and several others were corrected on May 20, 2014; therefore, you should not be seeing CO 45 for these denials.

Alabama Medicaid has finished reviewing all Medicaid EOB code mappings to the HIPPA claim adjustment reason codes/remittance advice remark codes to ensure they are all mapped correctly and Medicaid is making updates as needed.

Alabama Medicaid returns both a paper remittance advice (RA) available in PDF format and a HIPAA compliant X12 electronic remittance advice (835) to its provider community.

Alabama Medicaid's proprietary Explanation of Benefit (EOB) codes are mapped to HIPAA claim adjustment reason codes and remittance advice remark codes. The proprietary EOB codes are used on the paper version Remittance Advice available in PDF format for download from Alabama Medicaid's website. Alabama Medicaid's proprietary paper version of the RA does not have to be HIPAA compliant; therefore, Alabama Medicaid can use its proprietary EOB codes which are more specific than the HIPAA codes. The proprietary paper RA is furnished as an additional resource for the provider. Many providers will use the RA to see the specific Medicaid denial reason to help resolve the denial.

The HIPAA codes are used on the HIPAA required on the X12 835 electronic Remittance Advice. Only the X12 electronic Remittance Advice (835) must be HIPAA compliant.

If you are aware of a situation like this in the future, please call Betty N. Payne at 334-353-5148.

Discussion at meeting

MS. JACKSON: The explanation of Medicaid's response has been written out. Basically, Medicaid has worked to correct the issue. And I know that Betty Payne's area has been discussing this with the group that asked the question. So if there are any further questions or further discussion, please talk to Betty about it.

Additional discussion at meeting

THE SPEAKER: Are you going to APR DRGs in 2015?

MS. JACKSON: Internally, we're looking at it. I can't say for sure right now. But we are going through a process. And whenever we get ready to implement, everybody should be ready and HP should be ready when or if we go. So right now we're on a timeline, and I believe October 2015 is our goal. We'll be releasing some information on that shortly.

MS. NORTHCUTT: And for those that don't really know what APR DRGs are, they're basically a different set of DRGs from MS-DRGs, which are your Medicare severity adjusted DRGs. And the APR DRGs really deal a lot more with pediatric population, women and children. So it's a different system and something different to actually learn. But just in case you haven't had the pleasure of looking at APR DRGs, it's a new do. You'll have to give your coders a break when it starts.

MS. JACKSON: It's very interesting to us too, because it will no longer be a per diem rate, a daily rate. It will be weighted on something different, and it will be based on each hospital.

MS. NORTHCUTT: It will be on age and four different severities. So it is interesting. And I think Solomon's going to be the go-to question person.

MR. WILLIAMS: Yes, I will be the contact.

THE SPEAKER: Jerri, do you have any updates that you can give us or anything that Medicare has got up and coming?

MS. JACKSON: Well, you know we're working on the RCO implementation. And all I can say about that is we're slowly working with CMS to work out some things with the 1115 waiver, and right now we're in the process of looking at contracts. So it's just a daily work in progress on our level.

THE SPEAKER: Do you expect a change in your medical necessity criteria to go along with the APR DRG change?

MS. JACKSON: Well, I've posed that question, but that answer has not come back to us yet. But to me, it seems like it would be a good time to do it. But we haven't gotten an answer to that yet.

THE SPEAKER: Along that same line, any projected change to the EPSDT screening process for hospitals?

MS. JACKSON: I don't think so right now with the EPSDT. Because that would be one of the concerns with the DRG, right? Can you send me that question so that I can make sure that Solomon gets it? Because Solomon is leading up our APR DRG work.

THE SPEAKER: Thank you.

THE SPEAKER: I have a question concerning the patient first referrals, the PCP and the NPI. We're receiving a lot of denials.

MS. JACKSON: Are you the specialist? Are you billing on behalf of a specialist, or are you the PMP?

THE SPEAKER: PMP. And we're receiving a lot of denials, as I stated. And one of the issues is we used to bill the claims with whatever PCP you had in your system, we would bill that NPI number.

Now, with the clinics, we're having a hard time trying to get an NPI from those clinics because they're saying they never saw the patient. The doctor will not let us use their NPI because they said they never saw the patient. So what do we do?

MS. JACKSON: Well, who did see the patient?

THE SPEAKER: When we call the clinic, they don't know. We don't have that information on the billing side, if I'm calling from the hospital billing office.

MS. JACKSON: You know we're in the beginning phase of this. We implemented it at the first of June. And there will be some hiccups with this, because what we're trying to do is get the PMP to be accountable for their patient load. So if they are the ones that refer the patient, then they need to be the one to send you that NPI and the referral.

THE SPEAKER: Okay.

MS. JACKSON: What we're not allowing anymore is for someone to bill with that group number. Because we want to make sure everything is tied back to that PMP.

THE SPEAKER: Exactly. So what do we do, though, when we call them to try to get a referral and they say I'm sorry?

MS. JACKSON: That they did not refer the patient?

THE SPEAKER: They didn't refer, the patient hasn't been seen there. They don't have any information. So would the patient actually be registered in your system, you have that group name. But they do not have any information.

MS. JACKSON: Call Latonda Cunningham. She is over the Patient First program. And she'll be able to help you, as well as HP will also be able to help you.

THE SPEAKER: They require that a patient have a patient first referral before they treat that patient?

MS. JACKSON: Technically, that is true, and that's what we're trying to get to.

MS. PAYNE: And that's what we're trying to do now is to make sure that you got your patient first referral before you treat that patient.

THE SPEAKER: Now, I'm having one with a clinic or group that was able to provide that referral form, and that did work out. But we have a major hospital in our city that will not budge at all. So where do you get the referral? I mean, there's no information. Am I the only one having the problem?

MS. JACKSON: You're not the only one having the problem. We're trying to work these out. Have you talked to HP?

THE SPEAKER: Yes.

MS. JACKSON: We're partnering with HP to work out each group's problems. So if you wouldn't mind getting back with us about this.

THE SPEAKER: No, I don't mind.

THE SPEAKER: Who is HP?

MS. JACKSON: HP is Hewlett Packard. They're our fiscal intermediary. And they handle all of our billing and any systems issues that providers may have. They will actually go out to your office to help you with your systems billing.

THE SPEAKER: Well, HP has been very helpful, but we're still not getting anywhere. We're still getting denials.

MS. JACKSON: Again, the goal is to work with the PMPs to make sure they're accountable to the patients that are on their panel. Some of them may say that they might not know the patient or they didn't know that patient was on their panel. Is that what you're getting?

THE SPEAKER: Yes.

MS. JACKSON: That kind of information? Then you need to get that information back to HP or to the program area so that we can look at that.

THE SPEAKER: Okay.

MS. WHATLEY: Well, if that's all, thank you to the Medicaid folks for coming out here to help. We appreciate it.

MS. JACKSON: Thank you.