MEDICAID MINUTES
March 19, 2018 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Mr. Solomon Williams
Ms. Susan Watkins
Ms. Cindy Crockett

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Becky Miller

MS. NORTHCUTT: Good morning, Solomon. I'm going to let you make the introductions for Medicaid.

MR. WILLIAMS: Good morning. My name is Solomon Williams. I'm with the Alabama Medicaid Agency, and to my left I have Susan Watkins and Cindy Crockett.

1. We are receiving denials for CPT code 90715 (TDAP vaccine 7 yrs or older) stating the procedure/revenue code is inconsistent with the patient's age. The patients are all over 7 years old, ranging from 10 to 59 years. Is this a true issue with the procedure code or is the TDAP not covered when given during an ED visit even if the reason for the visit is an injury where the patient requires a tetanus shot?

   Response: **CPT 90715 for TDAP is covered only for children ages 7-18 under the Vaccines for Children Program (VFC) when administered by a VFC provider.**

   Discussion at meeting
   MR. WILLIAMS: For this particular question, I inquired and asked for some examples and reviewed probably three claims where I think there were three different facilities. And all the recipients were between ages seven and 18 I think. And the claims that are denied, the examples that I received, were that providers were not VFC providers. If you have any questions, please feel free to follow up.

MS. NORTHCUTT: And you know to enroll as a VFC provider, you go through the Department of Public Health. And then once they get all the information they need, then they send the information to DXC and we update our provider file.

AUDIENCE: So that requirement wouldn't be waived for an emergency visit?

MR. WILLIAMS: Not for recipients ages seven through 18. Now, if they only need a tetanus shot, you may want to give them a tetanus specific shot.

2. Please provide guidance on the most appropriate CPT code for subcutaneous infusion of deferoxamine mesylate (Desferal) via CADD pump. For example: A patient presented to our outpatient facility for initiation of a subcutaneous infusion of J0895- deferoxamine mesylate (Desferal) via CADD pump. The infusion was started at the facility and ordered to continue at home over 96 hours. The needle became dislodged at home so the patient discontinued the infusion after 76 hours. What CPT code(s) would be used for the initiation of the subsequent infusion via CADD? Would any subsequent visits for the same drug by CADD be reported using CPT 96521?

   Response: In the scenario above, Medicaid will cover the subsequent infusion and subsequent visits for the same drug. Please refer to the CPT manual for specific guidance on the most appropriate codes to use.

   Discussion at meeting

MS. NORTHCUTT: Solomon and I talked about this. And because the infusion was discontinued and had to be restarted and because that infusion is going to be a go back home and be a long-term infusion, then you would use the CPT code for long-term infusion code. So you would start that over and have another initial because it is initial start again of that drug. And if they had to come back just for programing of that pump, then you would use the programing code for the pump.

3. Alabama Medicaid Fee Schedule that was updated summer of 2017 to include new CPT codes that were effective Jan. 1, 2017 includes and allows coverage for new CPT codes 36901, 36902, 36903, 36904, 36905 and 36906 when performed in an ASC; however, only CPT codes 36904, 36905 and 36906 were added to the Outpatient Facility Fee Schedule. Please verify if this is an oversight or if these procedures represented by CPT codes 36901, 36902 and 36903 have been designated as allowed only in setting of an ASC.

   Response: Effective March 5, 2018, Medicaid added CPT 36901, 36902, and 36903 to the outpatient fee schedule.

   Discussion at meeting

MR. WILLIAMS: This is an oversight on our part. Effective March 5th they have been added to the outpatient fee schedule. So it's currently posting on our website at this point.

AUDIENCE: For dates of service prior to the March 2018 implementation date of those codes, are you going to retroactively cover these services?

MR. WILLIAMS: Yes. The codes were covered. They were just not on the outpatient fee schedules.

4. Can you please cover EEG monitoring 16 channel (CPT 95953)?

Response: Yes. Effective February 1, 2018, Medicaid covers CPT 95953.

Discussion at meeting

MR. WILLIAMS: We submitted an update, I think it was a week ago. As of today, it has not been approved or finalized. So I would anticipate in the next week or so you should be able to process claims or submit claims with that CPT code.

MS. MILLER: Will that be retro?

MR. WILLIAMS: To February 1st.

MS. CROCKETT: But probably give us another week to get the file updated it sounds like. It can take us up to ten business days from the time we receive the request to get our files updated.

MR. WILLIAMS: Yes, a few more days.

MS. NORTHCUTT: That's general in the hospital setting that EEG is normally performed. So you will have some usage if you want to go back to the department and let them know. There was, I think, an 8 channel in the past. And so don't use that anymore. So that's why the recommendation was for the 16 channel.

Additional discussion at meeting

AUDIENCE: When a baby has its own Medicaid number but mother does not and the baby is delivered in the hospital, can we not get payment on the baby's?

MR. WILLIAMS: Not if it's a well baby, no. Everything is submitted under the baby's.

AUDIENCE: It's a well baby. Baby has coverage. Mother doesn't. No coverage.

MR. WILLIAMS: It's all included in that per diem rate for the mother at this point.

One thing I forgot to let you know, Susan Watkins has come over from the lab and radiology program. She now reports to me. I'm still in the process of hiring a nurse to replace Janice. So if you do have lab and radiology questions as well as cardiology, please forward those to me or Susan as well and we can take care of those, too. Okay.

AUDIENCE: So when reviewing Medicaid claims for babies and they have a sick and well rev code listed on the claim because the baby may have been sick one day and then well another and then may have went back to sick and then well again, why would the claim be denied because it was a sick and well claim, well rev code on the claim?

MR. WILLIAMS: Well, for the hospital per diem rate, it would be considered a well baby's claim. Now, there are exceptions to that rule, and those exceptions can be found in our hospital chapter. I

don't know the list of all the reasons you can submit a claim separately for the baby. But if the baby is sick and the baby has those conditions, then it can be submitted separately for the baby.

AUDIENCE: Just for clarification, if it is like she was saying, one day sick and one day well, then are you saying that you bill just the sick days separately?

MR. WILLIAMS: No. I'm saying basically if the baby is well and doesn't meet any of the conditions that are outlined in our chapter, then everything goes on the mom's claim.

AUDIENCE: Even if it's a situation when it's going back and forth?

MR. WILLIAMS: Well, the conditions that are listed or outlined in our chapter, they're a little more severe and I don't think it would be one day sick and the next day not sick.

AUDIENCE: Okay.

MS. NORTHCUTT: I think in the chapter, you'll have revenue codes that distinguish what level of service it is. And if you have a revenue code 170 or 171, you know, they can be a little jaundiced but not that sick. So those would be considered well baby until you get into the revenue codes 172, 173 and 174 that require active monitoring I think would be the case where they're that sick.

MR. WILLIAMS: Thank you. Any other questions? Okay. Well, thank you for your time. I hope you have a safe trip back home. We'll see you next time.