MEDICAID MINUTES
March 10, 2014 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Ms. Jerri Jackson, Director Managed Care
Ms. Jan Sticka, Institutional Services Program

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: Let's welcome Medicaid today as we get started. Do you have anything you want to say beforehand?

MS. JACKSON: Well, I wanted to say I'm back over institutional services. My name is Jerri Jackson. And I'm director over the managed care area now. Institutional services is part of that, which includes the hospitals. Jan Sticka works in institutional services. And we have a new associate director that's not here with us today, but, hopefully, he will be here with us at the meeting in July, and his name is Solomon Williams.

1. **For Medicaid patients, should qualitative immunohistochemistry (IHC) staining procedures be coded with the CPT codes 88342/88343 or the CMS codes G0461/G0462?**

   Response: Please use 88342/88343 for Medicaid.

   Discussion at Meeting

   MS. JACKSON: Typically, Medicaid does not cover those G-codes. We cover those G-codes mostly for crossover only. And so use the 8-codes.

   MS. NORTHCUTT: And just an FYI on that. Just the code crosswalk between the two are completely different. So it's going to be necessary for your lab to apply these codes for Medicaid and other payers and the G-codes for Medicare. So just making that clear to everybody. They're not a genuine crosswalk.

2. **The Procedure/Modifier Combination Requirements - October 22, 2013 Alert states new EOB code 3323 is a "procedure restriction - required modifier not present - A procedure code was submitted without the required modifier." In general, to specify laterality with a modifier, this has in the past, primarily been identified through billing if the procedure was a BILATERAL procedure only, using LT and RT as instructed in the 2014 Medicaid Hospital Manual, 19-24.**

   a. **Can you explain this new Alert requirement to add the left or right modifier for procedures when only performed unilaterally?**

   Response: The application of a Lt or Rt modifier would depend on the definition of the CPT code. For example, the definition of 69436 (tympanostomy, requiring insertion of ventilating tube, general anesthesia) does not indicate one or both ears so the

appropriate anatomical modifier would need to be appended. On the other hand, if the procedure code specifies in the definition one or both…, the code would only be billed once and no modifier needed.

b. Would you consider rescinding this requirement for the hospitals?

Response: Medicaid will not rescind this requirement for the hospitals.

c. If not, would you give us a list of the procedure CPT codes that you have in your system that require the LT or RT modifier? This would help us to be able to meet this new requirement. We anticipate a tremendous amount of work and time to create additional new charges, each with the LT or RT modifier for every potential procedure code in our billing systems to be able to comply. With a concise list from Medicaid, the additional work to comply could be much more manageable.

Response: There is no list available. Please consult with your certified coder.

Discussion at Meeting

MS. NORTHCUTT: Another difference we have between Medicare/Medicaid coding as well is, for Medicare, we use a bilateral modifier, which is called a 50 modifier, on one line; whereas, for Medicaid, a right modifier and a left, if you do bilateral, have to be billed on separate line items.

And this goes further to say and I think one of the questions were, if it's only one ear or it represents a unilateral procedure. It was looking as if it was looking for a right or left modifier when, in fact, you would not have to modify that in general because it was one ear. So just as a side note.

THE SPEAKER: But we're getting requests. I brought some of the examples, like of a collar bone or a wrist, arm, leg. And the claim was stopped because we needed a left or a right, when we're just doing one side. And the problem is that's going to take an awful lot of work to rework the charge master to set up different, separate charges. We're just going to have to basically duplicate everything. And that would be bad enough except we got a request when there was a midline hernia repair, and the claim would not be accepted by Medicaid unless we put right or left. And a midline is a midline. It's not either right or left.

MS. JACKSON: Well, if you get that one procedure code you need to let us know so that we can take that audit off of that one.

THE SPEAKER: Okay. We'll do that. But are you saying that anytime there's bilateral parts of the body, that we're going to have to identify with right or left? Not when it's done bilaterally. But only if it's done on the one, we're still going to have to identify with the right or left?

MS. JACKSON: Yes.

MS. NORTHCUTT: Is that surgeries?

MS. JACKSON: Surgeries.

THE SPEAKER: Surgeries only?

MS. JACKSON: Surgeries. Yes.

THE SPEAKER: Because all of ours were x-rays. The other ones were x-rays. All radiology. That's what I'm talking about.

MS. JACKSON: Oh. Yours were radiology codes?

THE SPEAKER: Right. That's where I'm saying it's going to cause a major problem for the charge master on the radiology side.

MS. NORTHCUTT: Yeah. Now, that would be a problem.

THE SPEAKER: And that's what we've got mainly. Our billers are having to do a lot of work.

MS. JACKSON: Well, we'll have to go back and look at that.

MS. NORTHCUTT: Yeah. Because I was looking at the example of a surgical procedure.

MS. JACKSON: And that's how we took it to mean.

THE SPEAKER: Now, on surgery, our coders can put in the modifier. But anything that's hard-coded, we're going to have to build in the CDM it just would be hard.

MS. JACKSON: We'll review it again with our systems people and see.

THE SPEAKER: Okay.

MS. JACKSON: And what hospital are you with?

THE SPEAKER: South Alabama.

MS. JACKSON: We'll have to do some further follow-up on this one.

Follow-up received from Medicaid 5/14/14:

The modifier requirement for PC that are denying. Examples given were: laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric (49652) stated as midline hernia repair

in the MR; several radiology codes (73000, 73130, 73090, 73560, and 73110) and a bone marrow aspiration code (38220) all of which have denied with EOB 3323. These codes all have the requirement of LT and/or RT modifier in IC. Did the requirement for the application of the LT/RT modifier come from a Federal Mandate?

This Medicaid requirement was put into place by the Agency, there was no federal mandate. The codes identified by hospitals that Medicaid reviewed and should not have been included in this audit have been removed. In the future, if a hospital identifies a procedure code that should not be in this audit, the hospital should notify Jan Sticka via e-mail at jan.sticka@medicaid.alabama.gov.

3. **Are lactation services covered and if so what codes are used to bill for this service?**

Response: No

Discussion at Meeting

MS. JACKSON: Lactation services are not covered by Medicaid. I will tell you that if you're asking about the pump, DME does not cover that breast pump. But the pump can be ordered through the WIC program through the Alabama Department of Public Health.

4. **a. Are clinic visits being reimbursed by Medicaid?**

Response: Yes, Hospital-Based clinics only.

b. If so, can you provide the appropriate definitions of a clinic E/M visit?

Response: Refer to the CPT manual E&M services guidelines section, which provides detailed definitions of each E/M visit level.

c. If paid, does Medicaid intend to have one level for clinic visits like Medicare?

Response: Yes, effective April 1, 2014 and thereafter, procedure code G0463 may be billed by hospitals for services provided in hospital based clinics.

Discussion at Meeting

MS. JACKSON: We ask you that you go to your E&M services guideline section which provides the definitions. But we have changed in that we are going to allow for the G-code, and there will only be one code that's necessary if you provide outpatient clinic visits. And it's the G-code. And it begins effective April 1.

MS. NORTHCUTT: I think one of the problems that we have with the E&M coding definitions, because we had a 1 through 5 level hospital visit before you changed to the G-code

that will happen April 1, and, therefore, we don't know the definition of that clinic visit. It's not a 1 through 5 anymore. So it looks as if the E&M guideline section really wouldn't apply.

MS. JACKSON: Right.

MS. NORTHCUTT: And what we have specifically for Medicare is because they would not give definitions, each hospital has their own definitions of what is considered an E&M to represent the facility. So in that regard, I think we were trying to see if we could follow that guideline, specifically since Medicare has actually gone to one level as well.

MS. JACKSON: And we are too.

MS. NORTHCUTT: Yeah.

MS. JACKSON: Which I think it would make it easier. But I do know that when provider review was doing reviews several years ago, we noticed a lot of up coding in the outpatient hospital department. This was on regular emergency room visit side. And some of the hospitals were saying that, well, every time we go in there, that that raises the level. So is that what you were trying to talk about you know, the hospitals have their own definitions?

MS. NORTHCUTT: Right. For both clinic visits and emergency department. So I think that that's where there's a basic disconnect between Medicare and Medicaid on that as well. Because, you know, a level 5, you have to be really admitted if you're Medicaid.

MS. JACKSON: And I think we do have them defined on the emergency room side. Because we actually go back in the hospital manual to those old Z-codes, and we try to show you what to pick out to bill for those levels of care.

MS. NORTHCUTT: And anybody not as old as me doesn't know what the old Z-codes are. A long time ago, there were three levels of Medicaid emergency department codes, and they were called Z, as in zebra, codes. And when Medicaid went to five levels in the emergency department, these Z-codes were crosswalked to the CPT code E&Ms.

And during that crosswalk, if you crosswalked to the highest Z-code, then it went to a high-level ED level that was recommended that the patient be an inpatient. So at that point, they had to be admitted.

So you can't really get more than a Level 4 in general before it had crosswalked to the Z-code. And then, of course, the critical care code is not recognized at all by Medicaid.

MS. JACKSON: Unless a patient transfers.

MS. NORTHCUTT: Right.

MS. JACKSON: Or passes away, then you can bill that one. That's what we would expect to see.

MS. NORTHCUTT: So it's completely different than Medicare and how we base our definitions. And to be honest and in general, most hospitals have to go by one coding direction, which is going to be basically the definitions of their own, that they have created within their facility because of the Medicaid/Medicare population.

So I guess with all of that being said, both have actually gone to one HCPCS code for the level. Now, hospitals still have the different levels, and they're now connected to a G-code for Medicare, and then it will turn around and be the same.

MS. JACKSON: That's for the hospital based. Now, are you saying that Medicare did come out with a G-code for the emergency room visits as well?

MS. NORTHCUTT: No. Not yet. No. Just for the clinic visits. We haven't gotten there yet. But they proposed it in November so now they proposed that they'll have two levels in the ED next year. So they left that alone. But no. Just in the E&M sector.

MS. JACKSON: Well, we'll definitely look into it if we're notified ahead of time that this code is coming. And we will look into it. Because it would make it easier for the hospitals to only bill one code for those emergency room visits also, and it would prevent any up-coding.

MS. NORTHCUTT: Yeah. Because, again, from the emergency department, they're not going to follow the E&M guidelines. And it's just too difficult to maintain two different definitions.

MS. JACKSON: It's hard.

MS. NORTHCUTT: To crosswalk two different emergency department definitions.

MS. JACKSON: Thank you.

5. **Do you cover Type B ED visits like Medicare (these are emergency departments that are not open 24/7)?**

   Response: No, we do not cover those.

6. **If the MD gives an inpatient status order as phone/verbal and is unable to sign off on that order prior to discharge, but his/her partner is available to sign off on this order prior to discharge, is this appropriate? The MD signing off isn't the MD that gave the order, so we want to make sure this isn't going to create an issue.**

   Response: According to CMS, the order must identify the qualified admitting practitioner and must be authenticated (countersigned) by the ordering practitioner

promptly and prior to discharge.

Discussion at Meeting

MS. NORTHCUTT: This is the follow-up to this, because I didn't see the answers till this morning. And someone had brought it to my attention as to why the question was asked. In general, from what I know is from the administrative code, where we had 30 days where we could actually sign an order if that admitting physician, even if there wasn't an order, we had 30 days post discharge.

MS. JACKSON: To change the order.

MS. NORTHCUTT: Okay. So it's 30 days

MS. JACKSON: You have 30 days to change the order. The reason why we allowed that 30 days was because sometimes the quality assurance nurses that review the records, they noticed that, oh, the patient should have been inpatient or the patient should have been outpatient. And there has to be an order in the record in order to bill Medicaid for those services. So that's why we allowed the 30 days. It wasn't because in this instance, this is not asking about the 30 days. This was asking about signing the orders. Right?

MS. NORTHCUTT: Exactly.

MS. JACKSON: Anybody?

THE SPEAKER: So if the physician say, then, authenticate the inpatient order, then does it automatically go back out like it would with Medicare? Right? I mean, for Medicare, the physician doesn't authenticate an inpatient order. Then it's considered outpatient because you don't have a valid inpatient order. So then in two weeks, if I can get that physician to write an order because it's under 30 days and he signs it at that point, is that then acceptable to bill that claim as inpatient?

THE SPEAKER: Because you're doing it within the 30 days.

THE SPEAKER: It's within 30 days.

MS. NORTHCUTT: If we have this scenario because we already have an inpatient order, and it was changed.

THE SPEAKER: You don't have a valid inpatient order.

MS. NORTHCUTT: Right. Right. So it's not valid. So in general, if there's not a valid inpatient order —— and I think this is being answered by Medicare again this time it would be as if the order never was written. So, therefore, it's an outpatient.

MS. JACKSON: I would say instead because, you know, this says promptly. I would say they need to rewrite the order.

THE SPEAKER: I'm sorry. If it's not a valid order but you have 30 days to obtain an order and it becomes valid at the time it's signed, then it seems to me like it would just be an invalid order. And as long as you got it signed within the 30 days, it would become valid at that point.

MS. JACKSON: It does. It's just that I'm concerned about saying anything different, because CMS guidelines say it has to be done promptly.

MS. NORTHCUTT: So can we pull out the administrative code? Does that overrule CMS?

MS. JACKSON: Well, I know the reason why we allow the 30 days wasn't to wait on the doctor to sign the order. It was to allow for a change.

THE SPEAKER: That's a different issue.

MS. JACKSON: Yes, this is a different issue.

THE SPEAKER: This issue is different because it's two different doctors. So when the doctor who signs the discharge does this mean he has to reference the admitting physician in his discharge? It says he must identify the qualified admitting practitioner. So does Dr. Jones, when he discharges the patient - Dr. Smith admitted the patient - does he have to say Dr. Jones discharging in accordance with Dr. Smith's admissions order?

MS. JACKSON: Actually, the question was addressing phone and verbal orders. So, yes, they would have to identify who the qualifying admitting practitioner was.

THE SPEAKER: The only orders that Medicare requires be signed prior to discharge are the inpatient order and the certification. So when you talk about orders to be signed promptly, most verbal orders, in a lot of cases, are signed after discharge.

So it goes back to the issue of, if you're going to allow the status order to occur 30 days after discharge, then that goes against really what Medicare is saying. And we don't want you to change it to what Medicare says, believe me. But I think that it ought to be allowable that it be signed if you can get it after discharge.

MS. JACKSON: And Medicare does not define "promptly," but before discharge.

THE SPEAKER: Right.

MS. JACKSON: Quickly as possible, I would say, prior to discharge. Promptly and prior to discharge.

MS. NORTHCUTT: I think Jerri and them are going to research further with their legal team. And just to be honest, it's a nightmare out there right now with Medicare. And whether you're an inpatient, outpatient, whether you should be there, if they sign, who admitted, it is a total nightmare, to the fact that there is a bill on the floor of the House and the Senate right now because of the misdirection and lack of clarification.

So just to give you a heads up, reading some of their stuff might not be helpful to you right now. So, I'm good with your administrative code. I'm trying to be nice. How diplomatic was that? But I think a lot of it is going to kind of be up in the air for at least another year, as best I can tell.

THE SPEAKER: But to clarify, though, what you said, so if we know it's in the 30 days, are you saying don't go back and get him to sign that order but to just write a new order?

MS. JACKSON: I would say to write a new order because that's showing you that it's done afterwards. And they would need to know.

THE SPEAKER: I think what she was saying was don't go back and get him to sign the initial order within 30 days. Just get a completely new order within 30 days. Because the initial order is invalid, so it will be an outpatient account. So you're just saying get a completely new inpatient order? Don't get him to sign?

MS. JACKSON: That's what I would do, because we're allowing you 30 days to change an order. But it was for billing purposes is why we allowed it, so that you could change it if everything in the chart went toward that way.

Follow-up received from Medicaid 5/14/14:

ICD-10: How should providers submit a PA request for a surgical or radiology code in September 2014 when that procedure will not be done until after 10/01/2014-by using the ICD-9 or ICD-10 code?

System changes were implemented in October 2013, to accept ICD-10 diagnosis codes. ICD-10's effective date of 10/01/2014 was based on dates of service (date of discharge for inpatient hospital claims). Therefore, the provider's PA request must use the ICD-10 code since the date of service is after the 10/01/2014 start date for ICD-10.

The April and Oct 2013 Provider Insider indicates for *claims* NOT to use the ICD-10 codes until 10/01/14 or instructed to do so as the claims will deny but how are PA's affected? Again, ICD-10 is based on date of service/date of discharge. In future Provider Insiders this will be clarified.

NOTE: As all hospitals should be aware, CMS has changed the implementation date for ICD-10 to October 1, 2015.