MEDICAID MINUTES
March 2, 2015 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Mr. Solomon Williams
Ms. Jan Sticka
Ms. Aleetra Adair
Mr. Stephen Mahan
Ms. Rita Brown
Ms. Betty Payne

FACILITATORS PRESENT:
Mr. Wesley Ashmore
Ms. Karen Northcutt

MR. ASHMORE: I'd like to welcome Solomon Williams, Betty Payne, Stephen Mahan, Rita Brown, Jan Sticka, and Aleetra Adair.

1. Follow up to Question #4 from November 3, 2014. Is there any further information on ever accepting modifier -50 for bilateral procedures as all other payers in lieu of the –LT and –RT exceeding the limit on MUE edit?

   Response: **No change at this time.**

2. In the past, patients had 16 inpatient days per year, which has been changed to unlimited days. Is a pre-certification now required, and what is the reimbursement policy for the additional days?

   Response: **No precertification is required. Reimbursement will be the established facility per diem rate.**

3. Please provide clarification of drug administration units versus coding units. Example: A patient gets Hydromorphone 2mg injection from single dose vial at 0800. Then in a separate administration at 2000 (on the same day) the patient gets 2mg more from another single dose vial. Since J1170 has billing units of "up to 4mg", should this be billed as 1 unit (because the total given was 4mg) or 2 units (because it was two separate administrations)?

   Response: **Bill one unit.**

Discussion at Meeting

MS. NORTHCUTT: I was going to say one thing on that particular one. That is a billing problem in the hospital setting. Because when the pharmacy dispenses is when you charge that drug. A dose is given by a nurse at 8 o'clock and then a nurse at 2 o'clock gives

another dose and pulls the drug out. Then you're always going to have billed two units on that claim.

So that is a problem as far as how that "up to" goes as far as billing a HCPCS code for that drug versus the actual dosage given. So that's the question, we're actually using two different vials in effect.

So if we have to just bill one unit because it's up to four, then you would have to look at a bill edit for certain HCPCS drug codes that are billed on outpatients that have up to xxx in your description. There's not a whole lot of them. I think there is Dilaudid and then of course we've got morphine up to 10.

So, again, just as a side note. But you would actually have to bill a bill edit not to get overpaid for that in the outpatient setting.

THE SPEAKER: My question was on that same question, the administration. Are you going to bill your push or your administration of that drug one time or do you get to bill your administration twice? And if you're billing your administration for AM and PM, then you're going to have associated med to bill as well.

MR. WILLIAMS: We can research a little further and provide an answer to you.

MR. ASHMORE: Any further questions on that one?
(No Response)

4. 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 IP then the OP services are rolled into the IP admission.**

   Discussion at Meeting

   THE SPEAKER: If the patient came in and had the outpatient procedure on the 1st and they rolled to inpatient on the 2nd, are we not required to convert that order back to inpatient effective the 1st?

   MR. WILLIAMS: I would think so. Betty, do you have any clarification?

   MS. PAYNE: What's your hospital policy?

   THE SPEAKER: To follow Medicaid's policy.

   MS. PAYNE: Karen, what's our policy?

MS. NORTHCUTT: From the Medicaid Manual, Chapter 19, it is when the order is written. But any outpatient services that are done prior to that inpatient would roll into that admission. But I think that we've always had problems from a billing standpoint when we have a from through date on the claim and it's an inpatient. And we'll have an ICD-9 procedure code on that inpatient claim that has a date of service. That is prior to the from through date on the bill.

I think that's where we've always had the problem from a billing standpoint with Medicaid. And it didn't really even matter because at that point they're not really looking at the I-9 procedure code, at that point they're going to pay a per diem.

So I don't know if that's still a billing issue. I just know it was in the past, that the from through and the procedure date were different. What you got, Shannon?

THE SPEAKER: Medicare does allow you to write an inpatient order after discharge. So one would assume, then, that you wouldn't have your inpatient start date on a date after discharge. It would have to go back to the beginning or the very first date of the encounter. And I think it does matter because if we are paid a per diem, if you wrote your inpatient order on the second day and you didn't start your inpatient admission until that second day, then you would also miss your per diem payment for the day that the patient had surgery, which was the outpatient.

THE SPEAKER: You have 30 days after discharge to change it.

MS. NORTHCUTT: In that case, then, the 30 days after discharge, then, of course, we don't have an order at all. So you would go back to the beginning because I would want to write the order the day they came in if that was truly the case. That might be something to look at in the manual to see if we could get that added to clarify that statement, and then we would kind of pull that together to say from the from date.

MR. WILLIAMS: I've taken notes. So we'll take a look at that for you. Thanks.

MR. ASHMORE: Is that all the questions we have?

(No response)

5. If a hospital employed NP treats a patient in the ED or hospital based clinic does the hospital bill the NP NPI on the UB04? If a NP orders diagnostic services in a hospital based clinic does the hospital bill the NP NPI on the UB04 as the attending physician when billing for these services?

   <u>Response:</u> Services provided by the NP should be billed on the UBO4 using the NP NPI#. The NP must be enrolled with the Alabama Medicaid Agency and have a valid NPI number. Refer to Appendix O of the providers manual for CRNP and PA services.

Discussion at Meeting

THE SPEAKER: Two questions here. If our NPs are employed by the hospital, do we still bill them on a UB and enroll them in Medicaid?

MR. WILLIAMS: Yes. If they're seeking payment, they would definitely have to be enrolled.

THE SPEAKER: The second question is, can the nurse practitioner who is employed by the hospital, working in the emergency department are they authorized to certify the visit as an ED visit or no? And I think that's kind of gone around before that they don't.

We have patients that the nurse practitioner sees them independently in the ED under the direction of the physician. The physician is not always actually seeing the patient to determine if that is a medical emergency.

MR. WILLIAMS: I do know clearly in our chapter it says physician. But I can look into that for you and maybe provide some clarity or guidance. But at this time, almost certain it is the physician. Physician has to be present.

THE SPEAKER: So the physician only?

MR. WILLIAMS: Yes.

MS. NORTHCUTT: Do you think that could be changed too while we're changing some things or actually looking at it?

MR. WILLIAMS: I'll take a look. I won't make any promises, but I'll certainly take a look for you.

MR. ASHMORE: Any other questions?

(No response)

6. In the future who is the contact at Medicaid to review potential additional diagnosis code additions to the LCDs?

   Response: Medicaid reviews LCD diagnosis changes during monthly Medicare Focus Reviews and makes needed updates at that time. Please contact Essie Duncan at Essie.Duncan@medicaid.alabama.gov with questions.

7. The Medicaid Agency issued a rule regarding having to list the per detail line breakdown of the primary insurance payments. The Medicaid Agency has reversed this decision and you can now submit the primary payment in the TPL section of the claim only. Will this reversal remain in affect or will this be required in the future?

Response: **Effective February 25, 2015, Alabama Medicaid has changed its reimbursement for outpatient claims that have Third Party Liability. Outpatient claims will capture TPL patient responsibility amounts at the header level or detail level. Providers should submit to Medicaid the "other payer" amount fields as processed by the other insurance payer at the header or detail level.**

Discussion at Meeting

MR. WILLIAMS: So basically, initially it was at the detail or the header level. We changed it to detail level. Now you can do both depending on how your other insurance payer pays.

8. Are you ready to accept the new subset modifiers for modifier 59?

   Response: **Yes.**

9. Please provide updates on Medicaid alerts, notifications and newsletters and provide any appropriate handouts. If possible, please make a PowerPoint presentation.

   Response: **These are available electronically on the AL Medicaid website and can be accessed at http://www.medicaid.alabama.gov/**

   Discussion at Meeting

   MR. WILLIAMS: We try and keep that information current on our website. So I'll just refer you to our website to find the latest alerts and updates.

Additional Discussion at Meeting

MS. NORTHCUTT: I was looking at the fee schedule and all the different fee schedules that are listed out there and noted that the dates have not changed since 2014. I didn't know if you had a routine time that you go out to the fee schedules and review those and update them, especially the hospital fee schedule. I know the pricing doesn't change a whole lot. But I didn't know if you actually go and review those at the beginning of every year.

MR. WILLIAMS: We actually do. I don't have a time frame. Betty, do you have one?

MS. PAYNE: It's on my to-do list.

MS. NORTHCUTT: I was just noting that. But a lot of times it will be new HCPCS or CPT codes for January. Just making sure that those are out there posted on the fee schedule. Thanks.

THE SPEAKER: Medicare has an inpatient only list, but Medicaid does not. Can you provide us an inpatient only procedure list? You have your outpatient.

THE SPEAKER: But not all hospitals are going out there and looking at that listing. And so you really wouldn't know until after you've received a rejection. So we were just wondering if you might possibly be able to provide an inpatient only list like Medicare does.

MR. WILLIAMS: Well, I can take a look at that.

MS. STICKA: You're talking about Medicare's list?

THE SPEAKER: Can you send us the Medicare only list?

THE SPEAKER: It's out there on Addendum E. So, Betty, we could use Medicare's list in the interim, maybe?

MS. PAYNE: I said that most cases Medicaid of Alabama tries to mirror Medicare. I realize we have children and Medicare does not. So there will be a little bit of difference. But most of the time we try to mirror Medicare. So look at your Medicare list.

MR. ASHMORE: Did we have any more questions?
(No response)

MR. ASHMORE: Well, that's it for Medicaid. Thank you for coming.

MR. WILLIAMS: Thank you for your time.