MEDICAID MINUTES
November 3, 2014 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Mr. Solomon Williams
Ms. Jan Sticka
Ms. Aleetra Adair

FACILITATORS PRESENT:
Ms. Margaret Whatley
Ms. Karen Northcutt

MS. WHATLEY: We are glad to have Solomon Williams and Jan Sticka from the Medicaid agency, and Aleetra Adair from HP. We appreciate your being here. We'll just jump right in.

1. With the new prior authorization for cardiology procedures with Care Core if the patient is self-pay and then retroactively receives Medicaid how do we get the prior authorization or will these be retroactively paid without PA?

   Medicaid's response: **If a patient is granted retroactive eligibility, a PA will not be required. Bill your claims directly to Medicaid and if they deny, notify Susan Watkins at susan.watkins@medicaid.alabama.gov.**

Discussion at meeting

MR. WILLIAMS: Good morning everyone. In regards to the authorization of cardiology procedures, a PA will not be required. If you have claims that you're having trouble processing, please notify Susan Watkins at the agency, and she should direct you on how to handle those.

2. Does Medicaid cover hypoglossal nerve stimulator system for treatment of obstructive sleep apnea? If so, as there is no specific CPT code should we use 64999 (unlisted).

   Medicaid's response: Medicaid does not cover the hypoglossal nerve stimulator system.

Discussion at meeting

THE SPEAKER: Even though you don't cover it, do you want them to bill it and get a rejection, or are you saying don't bill it at all?

MR. WILLIAMS: At this time, I don't have an answer for you.

THE SPEAKER: And I just thought about something, Solomon. In the hospital manual, it talks about any code that ends in 99, that medical records is supposed to code it to the closest that was performed with the modifier 22. That's what the rule says. So if you could go back and look at this and revisit it again.

MR. WILLIAMS: Sure. We'll table that question.

THE SPEAKER: Thank you very much.

MR. WILLIAMS: Thank you.

MS. NORTHCUTT: So the question is do we have to bill it or can we just bill the patient if we tell them?

MR. WILLIAMS: Well, I really don't know if you can bill the patient. I don't have a definite answer for you. So I really don't know at this point. I will get back to you.

3. CCI edits originally did not allow a modifier to by-pass edits between a CT of spine with intrathecal contrast and a myelogram. However, after input from the American College of Radiology that these tests provide different clinical information, CCI now allows a modifier. Therefore, can a hospital bill and modify with modifier 59 when a CT scan and myelogram are performed in the same session if there are separate orders, interpretations and medical necessity for each test?

   Medicaid's response: All providers, including hospitals, must comply with NCCI edits.

4. Do you plan on ever accepting modifier -50 for bilateral procedures as all other payers instead of requiring -LT and -RT?

   Medicaid's response: Medicaid has no plans to allow modifier-50 for bilateral procedures.

Discussion at meeting

MR. WILLIAMS: At this time, we have no plans. Not to say that things won't change in the future. But at this time, we do not.

THE SPEAKER: Does Medicaid follow Medicare's MUEs, the medically unlikely edits?

MR. WILLIAMS: Yes.

THE SPEAKER: There's going to be a problem because Medicare has recently clarified on those MUEs that there are surgical procedures that have an MUE of one. And if you perform those bilaterally, Medicare instructs you to add the 50 modifier and report a unit of one. If you try to use RT/LT modifiers and report on two separate lines, then you're going to exceed the MUE.

So just think about that and how you're going to deal with those. Because Medicare has run into that issue, and that's why their instructions came out to be sure to use the 50.

MR. WILLIAMS: Thank you, and we'll take that back with us.

5. How does Medicaid plan to process secondary payments related to the CMS 68% settlement?

   Medicaid's response: CMS is making a settlement offer directly to providers for claims that are in the appeals process. After reaching a settlement agreement, those claims will remain denied in CMS's system; therefore, Medicaid will not be reviewing those claims for payment.

Discussion at meeting

THE SPEAKER: I think the question was related to if there are any outstanding secondary payments for Medicaid, if you will move to recoup those payments once Medicare is paid the 68 percent.

MR. WILLIAMS: As far as Medicaid, those claims, they're denied with CMS. So, therefore, we don't have an obligation to do anything with those at this point.

Additional discussion at meeting

THE SPEAKER: I have a drug that we're giving outpatient, and we get denied for it because we have to do a procedure when we give the drug. I read through the manual, and the manual says outpatient surgery reimbursement rate is established for each covered surgical procedure on the outpatient surgical list. The rate includes everything, including drugs. Well, this drug has a medical necessity policy. So the drug has to have a procedure to administer that drug.

So why do we have a policy to pay for it when I'll never get paid for it because I have to go for the procedure? So what do you suggest that we do? We prefer to be paid for the drug. It's a very expensive drug.

MS. STICKA: Has it got a J code?

THE SPEAKER: Yes, it has a J code - it's JO585.

MR. WILLIAMS: With that question at this time, we don't have an answer.

MS. WHATLEY: Any more questions? Anyone else have any questions for the team from Medicaid?

MR. WILLIAMS: Thank you.

MS. WHATLEY: All right. Thank you. We really appreciate you coming out.