MEDICAID MINUTES
July 15, 2013 RIC/RAC Meeting

MEDICAID REPRESENTATIVES PRESENT:
Ms. Jerri Jackson, Institutional Services Program
Ms. Betty Payne, Policy and System Management
Ms. Jan Sticka
Ms. Shermeria Hardy-Harvest

FACILITATORS PRESENT:
Mr. Ingram Haley
Ms. Karen Northcutt

MR. HALEY: From Medicaid we've got Shermeria Hardy-Harvest, Jan Sticka, Jerri Jackson and Betty Payne with us today.

1. **Follow up to question #1 from the March 11, 2013 RIC/RAC meeting. Do you have any updates on reimbursement methodology for hospital OP clinic visit E&Ms?**

    - Medicaid does not have any updates on the reimbursement methodology for hospital OP clinic visits/E&M's, no policy revisions will be made at this time.

Discussion at Meeting:

MS. JACKSON: We're not going to make any revisions at this time. I do know that in the recent OP proposals that they're proposing bundling those rates. So we're looking forward to that when that time comes because the final rule hasn't come out yet.

MS. NORTHCUTT: Do you think you might go to one level, too?

MS. JACKSON: We would like to, that would be our recommendation. That has to be approved up our chain-of-command.

2. **Follow up to question #3 from the March 11, 2013 RIC/RAC meeting. What is the status on the change order to fix this: putting total charges in the contractual amount when it should be total charges less payment = contractual.**

    - A change order is still on our priority list from this request, it has not been forgotten. Currently we are working on federal changes and payment increases for the outpatient hospitals which will be effective October 6, 2013.

Discussion at Meeting:

MS. JACKSON: We've got a change order on the books for this change. Right now we're working on federal mandates. We've got a new hospital SPA coming out, and that will give us a 6 percent raise in our outpatient fee schedule. That's one of the things that we've had to move up on the change order

priority list. And any federal mandates, financial mandates come before these right here. But it is on the list.

MR. HALEY: Here's something somewhat tangential to this I want to mention to all of you. Two years ago Medicaid started allowing billing for days over 16. If you have a day over 16, it pays zero dollars, but it is allowed, it will run through the edits; whereas, before, they used to deny any day over 16.

Please, please, please bill those. Do not bill them as non-reimbursable or non-covered; just bill them as a covered day. We have some hospitals that we know are still doing that. And it's important to the Agency. It's important to the broader financing model for Medicaid to be able to pull those days in.

Even though it doesn't look like you're getting paid anything, it does impact reimbursement in the long term. So please, just as a reminder, if you have days over 16, do bill them as any other day.

MS. JACKSON: It really makes a lot of difference when those queries are being run for the Hospital Association to capture that data.

MR. HALEY: Because what happens - and I realize this kind of gets into the broader finance realm - you do eventually get paid for those days; it's just the timing of the payment is different. You're not getting any per diem payment, per se; you're getting your access payment later on in the year for that amount.

And having that charge, even though it's a zero pay, being able to collect that charge, we do calculate a cost. And you will get a reimbursement for it at some point if you do bill it.

3. A. Please provide education on 99495 and 99496 codes.

- Medicaid does not cover 99495 or 99496 as an outpatient hospital service.

B. We would like guidance on billing the new Transitional Care Management codes (99495 and 99496) for hospitals. The APC rate has been assigned but we would like guidance on what services should be provided to bill for TCM by the facility. Specific questions: 1) Will the physician fee be reduced if the hospital bills? 2) What services is the hospital receiving payment for? 3) Must the physician face to face portion occur in a hospital based department for the facility to bill TCM? 4) What services is the facility required to provide in order to bill TCM?

Discussion at Meeting:

MS. JACKSON: On this one, we do not cover those codes for the outpatients. So I'm not really sure what this question was all about because we don't cover targeted case management for an outpatient hospital.

MS. NORTHCUTT: Medicare started covering that last year. It's kind of a transitional care management so they're trying to keep the patients out of the hospital, so they're reimbursing physicians. And they also have a facility fee that they would pay under certain circumstances for the management of the patients.

MS. JACKSON: Okay. We know that it was on the physician fee schedule at one time, and it's been removed. It should not have been out there.

4. **Medicaid now has the following policy (from the January 2013 Provider Insider): Effective for dates of service on or after September 1, 2012, chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead.**

   Medicaid has indicated this policy is based in part on a coding alert in The Coding Institute from March 2004 that states "You shouldn't use 87491 (infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique) and 87591 (Neisseria gonorrhoeae, amplified probe technique) to report a single test that screens for both organisms."

   Many laboratories do not use a single test to screen for both organisms, but actually perform two separate and distinct tests, one for each organism. Therefore CPT code 87801 is not appropriate since the lab is not doing one test for multiple organisms. Would Medicaid consider revising the policy in light of this information?

   - Medicaid will review again for further consideration.

Discussion at Meeting:

MS. JACKSON: We will consider looking at it again. If we do decide to make a change, it won't be until next year.

5. **A. If a patient is an outpatient and/or observation but is in the hospital and has some rehab service (i.e. physical therapy), in order for the rehab service to be covered, we need a rehab diagnosis code. Can we pick up the code from the (physical) therapist's documentation? Does a treating physician have to countersign the therapist's documentation in order for us to pick up the code?**

   - The diagnosis is listed on the patient's 'Plan of Treatment' which must be signed by the physician.

   B. In the outpatient setting (OP rehab), can we use the rehab diagnosis/code documented by the therapist without a physician's signature?

   - Again, the physician's signature is a requirement on the 'Plan of Treatment'.

C. In the outpatient setting (OP rehab), can we code from the cert and/or therapist's evaluation prior to the MD signing the document?

- No, the 'Plan of treatment' is not valid, unless the physician has signed it.

Discussion at Meeting:
MS. JACKSON: You should be picking up your diagnosis from the 'Plan of Treatment'.

Additional Discussion at Meeting:
MR. HALEY: Do you have anything else you want to mention or add or talk about?

MS. JACKSON: No.

MR. HALEY: All right. Any questions?

SPEAKER: I don't know if you can answer this today, but one of our Medicaid billers asked me the question. They're starting to see failed claims coming back from Medicaid that says a diagnosis code isn't valid; it's an inpatient diagnosis, which, you know, we don't have a designation on diagnosis codes that wants an out or inpatient diagnosis. So I didn't know if there's something published somewhere.

MS. JACKSON: Was this maternity related, or do you know the details?

SPEAKER: No, it wasn't a maternity diagnosis.

MS. HARDY-HARVEST: What it is is the POA indicator. When we made the changes for the POA indicators, whichever one it is that says "exempt from reporting" is no longer valid.

SPEAKER: Well, these are outpatient claims that we're getting this on.

MS. HARDY-HARVEST: Okay. I thought you said they were inpatient claims.

SPEAKER: Well, these are outpatient claims that are saying that the diagnosis isn't valid for the claim because it's an inpatient diagnosis.

MS. HARDY-HARVEST: Okay. They need to call and speak with one of the provider reps at the provider assistance center and have them to look at the claim and see what the problem is.

SPEAKER: Okay.

MS. HARDY-HARVEST: Because without looking at the claim, I can't really tell you what the problem is. So just have them to call one of the reps or the provider assistance center, give them the ICN, and let somebody look at the claim and see why it is that the claim is actually denied.

SPEAKER: Do you follow the Medicare CMS inpatient only list for procedures?

MS. JACKSON: We don't.

SPEAKER: You don't. Okay.

MS. JACKSON: We had looked at it at one time, but we do not because of the way we pay.

MS. PAYNE: Are they talking about the MUEs for procedure codes on an outpatient or are we talking strictly diagnosis codes?

SPEAKER: Strictly diagnosis code.

MR. HALEY: Any other questions?

SPEAKER: Can you give me some advice on Photopheresis that's being done in an outpatient hospital? It's on your physician fee schedule but not on the hospital fee schedule.

MS. JACKSON: Is it being done outpatient, outpatient hospital?

SPEAKER: Yes.

MS. JACKSON: I think at one time we determined we do not cover that on an outpatient basis. But you can send me the information.

SPEAKER: Okay. So what would you need exactly?

MS. JACKSON: I would need to know the procedure code involved. Are you getting them denied?

SPEAKER: Yeah, they're denied. They're not on a fee schedule. They're denied.

MS. JACKSON: Okay. Well, you need to send me that information.

SPEAKER: Okay. Thank you.

MR. HALEY: Well, thank you for your time. We appreciate it.