

**Adverse Events, InterQual® and Alabama Medicaid Local Policy, and Billing
Questions and Answers
Revised June 18, 2010**

InterQual® and Alabama Medicaid Local Policy

- Q1. If my hospital has been using InterQual® and not the current Medicaid SI/IS criteria what should we do; switch to Medicaid's criteria?

The Alabama Medicaid Agency would like every hospital to continue billing as they did in 2007; this means that if you have been using InterQual for your chart reviews, then you should continue.

- Q2. How will hospitals review psychiatric and rehab charts?

Hospitals should continue to use Medicaid's SI/IS criteria for psychiatric and rehab chart reviews.

- Q3. When records are requested by AFMC, how does a hospital know AFMC has received them?

The Accellion® system is available for electronic submission, it is safe, HIPAA compliant and sends a read receipt when the document is opened. Alternatively, hospitals can utilize other means to verify receipt such as certified mail.

- Q4. Where can I find the Alabama Medicaid Local Policies?

The Alabama Medicaid Agency will send out an Alert prior to July 1, 2010 letting everyone know where to locate the Alabama Medicaid Local Policies for download. (Continue to check this section as the information will be posted as the answer for this question also).

- Q5. Will Alabama Medicaid implement the use of the CURP manual for Length of Stay (LOS) days for inpatient surgery?

The Alabama Medicaid Agency CURP manual will not be implemented at this time.

Adverse Events

- Q1. Will Medicaid reduce days for payment based on the presence of Adverse events?

No, it is the responsibility of each hospital to identify non-covered days based on the presence of Adverse Events, self report and reduce

the number of covered days accordingly. While hospitals are being asked to mirror BCBS's policy of self monitoring and reporting, if it is determined upon audit that Adverse Events were not identified and reported, the hospital may be subject to recoupment.

Q2. When should Adverse Events be reported? How should they be reported?

Adverse Events should be reported at the time of claim submission and they should be reported on the UB-04 claim form.

Q3. Can the hospital use documentation from a physician qualifying diagnosis as POA within 48 hours of admission?

The hospital may use documentation from a physician qualifying diagnosis to identify POA which must be documented within 72 hours of the occurrence.

Q4. How are the three serious preventable events (surgery on the wrong body part, surgery on the wrong patient, and wrong surgery on a patient) to be reported since they cannot be reported on the claim?

Adverse events that cannot be captured on the UB-04 claim form should be e-mailed to the Alabama Medicaid Agency at AdverseEvents@medicaid.alabama.gov. The document will need to be encrypted with a password assigned by the Alabama Medicaid Agency.

Q5. Will Medicaid require a hospital to submit a root cause analysis to Arkansas Foundation for Medical Care (AFMC) if an adverse event diagnosis was on the claim and there were no non covered days identified on the claim?

If AFMC identifies and determines that a hospital acquired infection or Adverse Event was billed for inappropriately, the hospital will need to send in documentation to support billing. Submission of a root cause analysis is not required by may be submitted as part of the documentation to support billing.

Billing

Q1. When will the encounter payment methodology for outpatient services begin?

The encounter payment methodology for outpatient services will begin when the State Plan Amendment has been approved by CMS.

- Q2. When reporting days on the claim that InterQual® would not have covered, should the hospital report past the 16 days that Medicaid will pay for? Will the system allow for this?

The system will allow hospitals to report this data. The Alabama Medicaid Agency would like hospitals to report this since this data will be crucial in determining payment methodologies after the two-year hospital assessment legislation is completed.

- Q3. Will 340B hospitals be required to provide the NDC code for all drugs?

340B hospitals will continue to be exempt from reporting NDC's on the claims.

- Q4. The physician may change patient status on an original order beginning with Date of Service July 1, 2010. What is the timeframe for this and who has to sign?

The order status change must occur within 30 days after the date of discharge. The physician or resident may sign the order.

- Q5. Are there still 16 inpatient hospital days and 3 outpatient days?

There are no anticipated changes to inpatient and/or outpatient days at this time.

- Q6. On an outpatient claim should a hospital span bill services?

If a hospital span billed services in 2007, Medicaid is asking the hospital to continue to span bill. If a hospital did not span bill in 2007; the hospital is asked to bill as they did in 2007.

- Q7. If a patient is a direct admit, but does not meet inpatient hospital criteria (SI/IS), can the hospital bill for outpatient observation?

The Alabama Medicaid Agency is not changing the current outpatient observation policy. In order for a hospital to bill outpatient observation, the recipient must present through the emergency department.

- Q8. If a patient comes through the ER and is admitted but doesn't meet criteria for inpatient or observation, can the hospital bill for observation?

No, if the patient does not meet observation or inpatient criteria, The Alabama Medicaid Agency should not be billed for observation or inpatient services.

Q9. When reporting span dates under the Occurrence Code, will Medicaid allow different span dates on the same claim form?

Yes, the Alabama Medicaid Agency will allow.

Q10. If a recipient still has hospital days left on the benefit limit; should an appeal be sent to Medicaid before denying the recipient?

No, the hospital should make its decision applying the proper criteria and notify the patient.