Ohio | Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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Providers Must Repay Medicaid Overpayments within 60 Days of Identification

The Affordable Care Act of 2010 imposed new federal requirements on Medicaid providers. Providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. Failure to report the overpayment in a timely manner may be subject to liability under the Ohio and federal False Claims Acts.

The Ohio Office of Medical Assistance (OMA) recognizes that many improper payments are discovered during the course of a provider's internal review process. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both Ohio and the provider involved.

Ohio's policy is to not charge interest on provider's self identified overpayments (in the absence of fraud), and the OMA, within its authority, is willing work with individual providers. This joint effort will assist the State in combating fraud, waste, abuse or inappropriate payment of funds under the State's Medicaid program.

Providers should contact the Surveillance and Utilization Review Section (SURS) to report overpayments at:

OMA – SURS
P.O. Box 182709
Columbus, OH 43218-2709

FAX: 614-644-2217

The Surveillance and Utilization Review Section will contact the provider upon receipt of the information.

Ohio Site Visit: ICD-10 Impacts & Opportunities

The ICD-10 conference hosted by Noblis, a healthcare innovative non-profit organization, was held on October 17-18, 2012. The goal of the seminar was to gain awareness of the complexity of ICD-10 and the challenges that implementation will bring to the healthcare operations. It also demonstrated how ICD-10 training could be used as an advantage to leverage the State Medicaid Agencies (SMAs) as well as best practices for implementation.

One of the sessions featured the in-depth changes of the diagnosis codes. It explained the upstream impacts that the providers and practitioners will feel as a result of these drilled down descriptions of each code. It demonstrated the downstream impacts to the payer.

Examples include the billing systems that will have to be revamped to handle the complexity of these codes; the EDI transactions and the paths that they must take to be compliant; and the output of what the Data Warehouses have to be able to handle. The impact to the provider penalties for non-compliance is $50,000 for each violation, not to exceed $1,500,000 during a calendar year.

With the ICD-10 coding implementation there is an upstream impact: the clinical documentation (organized textual description of a medical encounter, which may include complaint, history and physical, assessment and plan, orders, medication, lab results. etc.), terminology (computer processing way to index, store, retrieve and aggregate clinical data across specialties and sites of care), and classification (aggregation of descriptions of medical diagnoses and procedures into universal codes primarily for use with reimbursement, decision-support, and analytics and reporting). With this new upstream impact, the coder is faced with the various ways in which they will have to change the coding mechanics of each claim. Also, coders will

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have to be cautious because the same content can be found in many places.

Examples of the number of codes for specific conditions:

Condition	Tabular Category	# of Codes
Hypertension	Hypertensive Disease	14
	Other Categories (14)	
Pneumonia	Influenza and Pneumonia	38
	Other Categories (18)	
Genitourinary Disorders	Diseases of the Genitourinary System	587
	Other Categories (14)	

Examples of of changes in anatomy terms:

ICD-9 Term	ICD-10 Term
Bunionectomy	Resection of Metatarsal
Amputation	Detachment
Closed Reduction	Reposition (also repair) of (right or left), (percutaneous, endoscopic, external)
Debridement	Excision, Extraction, Irrigation, Extirpation

The challenges to mapping the translations of the ICD-9 and ICD-10 have two different approaches:

1. Creating Crosswalks (definitions for the conversion of one source code to one or more target codes)
2. Creating Equivalent Groups (defining medical concepts that drive policies, rules and categorizations in ICD-10 that are consistent with the intent of those policies, rules and categorizations).

There are challenges with the crosswalks in that less than 5% of all ICD-9 and ICD-10 codes match. The other 95% of the codes will either lose information or pick up information that may not necessarily be accurate for the code. This imperfect mapping has a direct correlation to the processing and analytics that ultimately impact revenue, costs, risk, and provider abrasion. Currently there is no default crosswalk and each organization must determine the appropriate mapping from ICD-9 to ICD10 and ICD-10 to ICD-9.

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CODING CORNER

Meniscectomy and Meniscus Repair

In this issue of the Coding Corner, we would like to discuss the correct coding and identification of complications of Meniscectomy and Meniscus repair.

Meniscectomy is the surgical removal or repair of either of two C-shaped bans of cartilage in a joint, most commonly the knee (knee meniscus). The meniscus forms a buffer between leg bones (the tibia, fibula, and femur); serves as a shock absorber; assists in lubrication of the joint; and limits the joint's flexion, extension, and rotation. Twisting or hyperflexion of the joint are the most common causes of meniscal tears. The location and type of tear determines how much of the meniscus needs to be removed. The entire meniscus is rarely removed due to the increased risk of knee instability and osteoarthritis. Many meniscal injuries are sports-related and without proper technique while playing, meniscus tears may not be preventable.

SIGNS OF MENISCUS INJURY

- typically a "pop" noted at the time of injury
- joint tenderness, knee pain
- recurrent knee catching and or knee "locking"

POSSIBLE COMPLICATIONS

- nerve or blood vessel damage
- bleeding
- infection
- stiffening of the knee joint
- failure of the procedure

PROGNOSIS AND REHABILITATION

The predicted outcome of a meniscectomy procedure is good, as most individuals who undergo this procedure can expect significant improvement without complications.

The primary focus of rehabilitation following a meniscectomy is to control pain and restore function. The rehabilitation program is dependent on the extent of the surgical procedure and the protocol of the attending physician.

CPT Assistant, January 1, 2012 has revised the procedure code (29881), Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), to include debridement/shaving of articular cartilage (chondroplasty), same or separate compartment (s), when performed together.

As always, documentation by the provider is imperative to allow the coder to assign the appropriate procedure code to the claim. If there is any question, the coder should always query the physician for clarification.

Medical Director *dialogue*

By Anthony J. Beisler, MD, MBA, FACS
Medical Director, Permedion

ICD-10 for Physicians

Many physicians are wondering, "Why are we moving to ICD-10?" The answer to that question is somewhat complex. We all know that ICD-9 is not perfect and definitely has deficiencies.

Of the many noted issues with ICD-9, two are the most prominent: Not enough detail for analysis as there is inadequate attention to the continuum of disease and clinically relevant subsets; and not enough detail for proper coding and payment as ICD-9 is out of room for new codes.

ICD-10 addresses these issues by providing much greater levels of detail. It will allow for appropriate payments via a stratification of morbidity. It affords the specificity which will be needed for episodes of care as we move into Affordable Care Organizations. It will also allow for Hierarchical Condition Categories, and enable a greater degree of quality monitoring. Proponents also note that ICD-10 will provide significantly improved quality of data for use in research/clinical trials (as it has been employed in Europe) by allowing for identification of consistent cohorts and help clinicians using that data to achieve improved outcomes from population analysis. It will also allow the healthcare system as a whole to target resources to specific diseases in a multitude of ways such as specialty, county, environment, etc. It should be noted that this increased level of detail required in and by ICD-10 is demanded not by the government nor by payers but by our specialty societies.

ICD-10 was originally released in 1993 and has been in use by other countries since then. It has approximately 2000 diseases (families) and approximately 70,000 specific codes. For example, currently in ICD-9-CM there are just a couple basic codes for Angioplasty. In ICD-10-PCS, there are 854 codes specifically related to Angioplasty. Physician documentation is going to need to rise to the level of detail that ICD-10 demands to enable accurate and complete coding.

ICD-10-CM (diagnoses) will be used by all providers in every health care setting and has a significant increase in the level of detail that the coding requires. ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures. ICD-10-PCS will not be used on physician claims, even those for inpatient visits (procedure coding system). There will be no impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes – CPT and HCPCS will continue to be used for physician and ambulatory services including physician visits to inpatient.

While the implementation date for ICD-10 is October 1, 2014, the time to start preparing is now. Physicians and providers need to be familiar with the new system and trained so that they understand the concepts driving the ICD-10 system and appreciate the significant requirement for detailed documentation. Hospitals and physician practices alike need to develop a conversion plan. The best advice is, "Be ready!" Remember, "When did Noah build the Ark? Before the rain…" For more information please check out:

http://www.cms.gov/ICD10/05a_ProviderResources.asp

*(**ICD-10** Continued from page 3)*

Permedion must develop and implement its own mapping from ICD-9 to ICD-10 and vice versa. There are 159,100 maps that must be created to be in compliance with the conversion. Noblis indicated that the quality of the crosswalks, at best, will still result in loss of some concepts or adding concepts that may or may not be true.

The CMS determined time-line states that between May, 2012 and July, 2013, Level 1 & Level 2 End to End testing should be conducted. From July 2013 through September, 2014 the Implement Policy, Process and System changes should occur, and on October 1, 2014 the ICD-10 should be established and will go live.

Precertification Review

OAC rule 5101:3-2-40 Pre-certification Review describes the pre-certification review program for inpatient and outpatient services. Precertification assures that covered medical and surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting. It may be determined that an in-patient stay is not required for the provision of covered medical or surgical care and the location of service delivery may be altered as a result of pre-certification.

Pre-certification is required for all elective admissions designated by the department. The Hospital Pre-certification Code List has been reviewed and it now has the most updated codes. Several codes have been added, as well as the deletion of one code that is outdated. The complete revised list is available on the Permedion website: www.hmspermedion.com/OhioMedicaid. The updated changes to the Ohio Medicaid Utilization Review Program Precertification Manual, are also available on the website. The effective date of the revisions will be announced in a future transmittal letter. At that time, a mailing will be sent out to notify providers of these changes. The new list is provided to the left for your review. Any questions from providers should be directed to the Permedion precertification department at 1-800-473-0802 or 614-895-9900.

HOSPITAL PRE-CERTIFICATION CODE LIST

The Ohio Medicaid Utilization Review Program has made changes to reflect the most current version of procedure codes. The procedures/services requiring precertification have not changed, only the current version of the codes.

Both inpatient and outpatient settings require Precertification:

Hysterectomy — ICD9 codes: 68.31, 68.39, 68.41, 68.49, 68.51, and 68.59; CPT codes: 51925, 58150, 58152, 58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, and 58951

Inpatient setting Only requires Precertification:

Cervical laminectomy
ICD9 codes: 81.02 – 81.03; CPT codes: 22554, 22556, 22558, 22585, 22808, 22810, 22812, 22590, 22600, 22610, 22614, 22800, 22802, 22840, 22851, 63075, and 63076

Esophagogastroduodenoscopy (EGD)
ICD9 code: 45.13 (without biopsy) and 45.16 (with biopsy); CPT codes: 43235, 43238, 43239, 43242, 44360, 44361, 44376, and 44377, 44385 and 44386

Injection or infusion of cancer chemotherapeutic substance
ICD9 code: 99.25; CPT codes: 36823, 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96521, and 96522

Laparoscopic cholecystectomy
ICD9 codes: 51.23, 51.24; CPT codes: 47562 – 47564

Laparoscopic- diagnostic
ICD9 code: 54.21; CPT codes: 49320 – 49323, 49329

Lumbar laminectomy – posterior
ICD9 codes: 80.51, 81.05 and 81.08; CPT codes: 22610, 22612, 22614, 22630, 22632, 22633, 22634, 22800, 22802, 22804, 22842, 22843, 22844, 22851, 63030, 63035, 63042, 63044, and 63047

Percutaneous angioplasty – non coronary vessel
ICD9 code: 39.50; CPT codes: 35471, 35472, 35475, 35476, 37228 - 37235

PTCA- coronary angioplasty
ICD9 code: 00.66; CPT codes: 92982, 92984, 92995, and 92996

Contact Information

Permedion • Sue Hackett, Project Manager
350 Worthington Rd., Suite H • Westerville, OH 43082 • 614/895-9900 • fax 614/895-6784
www.hmspermedion.com • shackett@hms.com
Ohio Department of Job and Family Services – Surveillance and Utilization Review Section
Rachel Jones, Contract Administrator / Linda McCabe, Contract Manager
30 E. Broad St. • Columbus, OH 43215-3414 • 614/752-3179 • fax 614/644-2217 • www.jfs.ohio.gov

350 Worthington Rd., Ste. H
Westerville, OH 43082