Ohio | Department of Job and Family Services

Ohio medicaid QUALITY MONITOR

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A New Quality Project is in the Works

The Ohio Department of Job and Family Services (ODJFS) performs quality improvement activities which include evaluations that encompass quality of services delivered, access to care, regulatory impact on care and recommended changes to delivery systems. As part of the ongoing efforts to help ensure the best use of Ohio fee-for-service Medicaid funds, the *Comparison of Hospital and Physician Procedure Codes Project* is currently being designed. Selected Ohio providers will be asked to collaborate by providing records for this project.

The basis for the project was identified by the discovery of some cases where the inpatient hospital claims indicated specific procedures but the physician claims documented that different procedures had been performed. The hospitals routinely submit claims for inpatient stays with the diagnoses and procedures using ICD-9 codes. The hospital outpatient claims are submitted with ICD-9 codes for the diagnoses and the CPT codes for the procedures. The physicians submit claims for their services including the procedures using ICD-9 codes for the diagnoses and CPT codes for the procedures. Consequently, two coding systems are used for the same inpatient procedures.

Although two coding systems are used for inpatient claims, there is an available crosswalk between the types of codes. The Procedural Cross Coder by Ingenix is designed to act as a bridge to connect the coding systems. It provides a reference for selecting the correct CPT procedural code from the ICD-9 procedural codes.

For outpatient stays, the hospital submits claims with the diagnoses and procedures the same as the physician, using ICD-9 codes for diagnoses and CPT codes for procedures. Outpatient claims

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PERMEDION
an HMS company

Advisory: Bill Audit Project

Hospital bill audits are necessary to ensure that the appropriate checks and balances are in place between the hospital and payers that conduct business with each other (Bowman, 2005). The hospital bill audit process is complicated and requires both clinical review and claims auditing. The *Bill Audit Project* that was recently completed provides a detailed summary of the initial medical bill audit/review findings.

The purpose of the medical *Bill Audit Project* was to compare the services and supplies documented as provided in the medical record to the charges listed on an itemized bill and that appropriate billing rules were used. The project identified billing trends of hospital providers, types of billing errors, and the potential for changes from cost outliers to DRGs.

To ensure accurate hospital charges, the audits were based on documented services rendered to patients and the use of appropriate billing rules for the services. The National Uniform Editor (Ingenix, 2010), American Medical Association ICD-9 guidelines (AMA, 2009), and Ohio Administrative Code rules (Lawriter, 2009) were used to determine the validity of the charges.

The following refinements were applied in the selection methodology for auditing outliers:

❶ Cases with charges of over $100,000
❷ Cases with a relatively high ratio of billed charges to length-of-stay
❸ Cases where the charge exceed the relevant trim-point such that the charge amount exceeds the threshold as an outlier
❹ Cases with specific revenue codes and units of service that may be indicative of unnecessary and/or undelivered services.

The sample included 30 bill claims from 13 hospitals. To prevent provider abrasion, no more than three cases were requested from any individual hospital.

Review of the overall volumes of cases with charges of over $100,000 during the study period by peer group revealed a total of 449 cases out of 65,256 admissions. There were 416 cases identified in the DRG hospitals and 33 cases in the DRG exempt hospitals.

Of the peer groups paid by DRGs, as a group, the Children's Hospitals had the highest percentage of claims with charges over $100,000, 2.24%, and

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accounted for 31.75% of this group's total inpatient reimbursements. The Out-of-State group was next with 1.07% of cost outliers and 17.25% of total inpatient reimbursements.

For the DRG Exempt peer group, over 3% of all this group's inpatient claims were for claims which exceeded $100,000 in charges. These claims accounted for over 17% of the total reimbursements to the peer group's facilities. It should be noted that the peer groups of Hamilton-Middletown & Lorain-Elyria, Rural Referral Centers, MSA-Lima, MSA Parkersburg-Marietta and Steubenville-Weirton, and the Non-MSAs of less or equal to 100 beds did not have any cases over $100,000 during the study period.

Analysis of the bill audit findings provided information on the "unsubstantiated" charges per case and per provider. Unsubstantiated charges were categorized into five types of billing errors. The types of billing errors included: Unbundled Charges; Clarification Needed; Lack of Supporting Documentation; Duplicate Charges; and Disallowed Charges.

When reviewing the unsubstantiated charges, the Unbundled Charges were the most common type of billing errors and accounted for 51% of the unsubstantiated charges. The billing error types Clarification Needed and Lack of Supporting Documentation together accounted for 48% of the unsubstantiated charges. It should be noted that both of these types of billing errors could refer to lack of or need for further documentation in the medical records.

The total billed charges of all 30 cases were $17,969,514. The initial unsubstantiated charges found during the bill audits were $2,801,557, which is 16% of the total charges. It should be noted that unsubstantiated charges were determined from the initial bill audit reviews. The final amount of unsubstantiated charges was not determined, as we did not provide the hospitals the initial results of the bill audit findings and therefore the opportunity to provide additional medical information and/or explanations of the charges.

The percent of unsubstantiated charges varied from case to case. The percentage of unsubstantiated charges ranged from 3% to 51% error rates. According to companies that specialize in medical bill auditing, the average error rate per chart is 3 to 10% and errors are found in at least 80% of the audits (Connolly, 2010, Viant, 2010).

This project provided information that could be used to identify DRG hospital claims where the potential subtraction of unsubstantiated charges could result in a change of the outlier status of claims.

Recommendations

The findings of the initial inpatient bill audits of 30 Ohio Medicaid fee-for-service hospitalization charges support the following specific recommendations to identify opportunities to ensure that reimbursement is based on the actual services rendered to recipients.

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CODING CORNER

Are You Ready for ICD-10-CM?

In this issue of the Coding Corner, we discuss the preparation needed prior to implementing ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) coding systems.

The Center for Medicare and Medicaid Services (CMS) reports that payors must implement ICD-10-CM and ICD-10-PCS by **October 1, 2013**. Providers will not be able to continue to report ICD-9-CM codes for services provided on or after October 1, 2013. The following are a few highlighted areas that you will need to address:

- ICD-10-CM (diagnoses) will be used by all providers in every health care setting.
- ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures.
- ICD-10-PCS (procedures) will not be used on physician claims, even those for inpatient visits, they will need to continue to use ICD-9, CPT, and HCPCS coding systems.
- Ambulatory, outpatient, and physician services provided on or after October 1, 2013 will use ICD-10-CM for diagnosis codes.
- Inpatient discharges occurring on or after October 1, 2013 will use ICD-10-CM and ICD-10-PCS codes.
- ICD-9-CM codes will not be accepted for inpatient services provided on or after 10/1/2013.
- ICD-10-CM and ICD-10-PCS will not be accepted before 10/1/2013.

ICD-10 codes are very different from ICD-9 codes, as the ICD-10 codes provide a greater detail in describing the diagnoses and procedures. ICD-10 codes are longer and use more alpha characters and there are more ICD-10 codes than ICD-9 codes. Most importantly, system changes will be required to be able to accommodate the new coding system. This will include coding and billing systems, internal and external reporting processes, electronic health record systems, registration and scheduling, etc. The process for this implementation will be time consuming, so the time to start is now.

Several departments are impacted by these changes so training and education is imperative.

Complete versions and annual updates for each ICD-10-CM and ICD-10-PCS systems are posted on the ICD-10 website at: *http://www.cms.gov/ICD10.*

Medical Director *dialogue*

By Anthony J. Beisler, MD, MBA, FACS
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EHRs and Meaningful Use

Recent data from the National Center for Health Statistics (NCHS) shows that adoption of Electronic Health Records (EHR) seems to be increasing. The number of primary care physicians who have already adopted a basic EHR has risen from 19.8% in 2008 to 29.6% in 2010, but only 6% have a "fully functional" system. While a basic EHR is a good starting point for electronic health records in physician offices, this data tells us that most physicians will need to upgrade their systems and/or increase their use of the systems in order to meet the criteria for "meaningful use" incentive payments.

The detailed definition of "meaningful use" will be rolled out in three stages over a period of time until 2015. Thus far, only stage one has been published by CMS. In short, it calls for 15 core measures: CPOE for Medication Orders, Drug Interaction Checks, Up-to-date Patient Problem List, "e-Prescribing," Medication Allergy List, Patient Demographics, Vital Signs, Smoking Status, Clinical Quality Measures, Clinical Decision Support, Electronic Copy of Health Information for Patients, Clinical Summaries, Electronic Exchange of Clinical Information, and Protect Health Information. The Health Information Technology Policy Committee (HITPC) is currently inviting input at their website to help them shape the stage two definition.

Incentive payments for the adoption and "meaningful use" of certified EHR technology were authorized in the Health Information Technology Economic and Clinical Health Act (HITECH) of 2009. The payments are made through the Medicare and Medicaid programs. The Office of the National Coordinator for Health Information Technology (ONC) predicts that these incentives could result in as much as $27 billion in payments to physicians over the next ten years. Many physicians may be eligible to participate in either program, but they cannot participate in both programs. They must choose one or the other. They can switch between Medicare and Medicaid or vice versa once over the life of the program.

According to the ONC, non-hospital-based physicians and other eligible professionals can obtain incentive payments of as much as $44,000 under Medicare or $63,750 under Medicaid. Under both Medicare and Medicaid, eligible hospitals may receive millions of dollars for implementing and demonstrating meaningful use of certified EHR technology.

Provider registration for the Medicare EHR Incentive Program and some Medicaid EHR Incentive Programs opened Jan. 3, 2011. The Ohio Department of Job and Family Services has indicated that Ohio's Medicaid EHR Incentive Program will launch in June 2011.

A press release by CMS and ONC identified the following key dates for the Medicare and Medicaid incentive programs' first year:

- January 3, 2011 – Registration for the Medicare EHR incentive program begins.

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EDI Protocols

One sure thing in this ever evolving world is that change is inevitable. The retrospective review process carried out by ODJFS through its contractor Permedion to review the necessity and appropriateness of health care services is no exception. The newest step in the process for many providers in Ohio is the use of EDI to transmit medical records.

Electronic data interchange (EDI) is the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system.

Why use EDI?

EDI Saves Time: Sending an electronic message requires only seconds or minutes rather than days. Once the message is received, information is available for use immediately without costly and time-consuming hand preparation.

EDI Improves Accuracy: Every time information is copied from one place to another, there is opportunity for error. Electronic transfer eliminates the need for copying information from one paper document to another.

EDI Reduces Cost: Overhead costs are reduced by eliminating or reducing human handling in such areas as:

- Mailroom sorting and circulation.
- Reduced postage and handling costs.
- Reduced costs for sorting, distributing, filing, and storage of documents.

Providers in Ohio are encouraged to explore the option of submitting their medical records via an EDI transmission. When a provider decides that this is the best option all you need to do is contact Permedion (614.895.9900) and speak to a project specialist to initiate the process. Providers can then expect to be contacted by the Permedion-HMS EDI department to formalize a protocol. A protocol is necessary because the Federal Government of the United States of America, under the Health Insurance Portability and Accountability Act (HIPAA) regulations, mandates that all transmission of healthcare information that is electronically transmitted be formatted in a specific structural format.

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from both the hospital and physician will also be reviewed for accuracy.

This project will include the comparison of the hospital and physician procedure codes and procedure reports by Permedion/HMS coding specialists. The results will provide information to determine if the coding of hospital diagnoses and procedures listed on claims agree with physician diagnoses and procedures for the same inpatient or outpatient stay. By reviewing the procedure reports, the correct codes will be identified.

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Recommendations

Routine reports of high level cost outlier-related data mining on post payment cost outliers can identify overall and individual provider trends in the number of cost outliers, appropriate revenue codes and services, and reasonable charges. Comparison of these results to industry and local standards will yield selection criteria to pursue bill audits on only the cases with potential billing errors.

With this information, the causes of medical claim errors can be identified. Types of billing errors can be recognized and medical billing education can be presented to providers in order to reduce the occurrence of future errors. This information could reduce the need for bill audit reviews or create the need for retrospective review targeting.

Claim Resubmission Address Correction

The address for which hospitals should use to resubmit claims as a result of a retrospective review decision was previously incorrectly communicated. Please use the following address:

Ohio Department of Job and Family Services
Provider Services Section
PO Box 1461
Columbus, OH 43216

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- January 3, 2011 –States that are ready may launch their incentive programs for Medicaid providers.
- January 2011 – Some state agencies begin issuing Medicaid EHR incentive payments.
- April 2011 – Attestation for the Medicare EHR incentive program begins.
- May 2011 – Issuing of Medicare EHR incentive payments expected to begin.
- July 3, 2011 – Last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR incentive program for federal FY 2011.
- September 30, 2011 – Federal FY 2011 payment year ends at midnight for eligible hospitals and critical access hospitals (CAHs).
- October 3, 2011 – Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 to demonstrate meaningful use for the Medicare EHR incentive program.
- November 30, 2011 – Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for federal fiscal year 2011.
- December 31, 2011 – Calendar 2011 payment year ends for eligible professionals.

Are you READY?

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