KEPRO

CONNECT OHIO

Quarter 2, 2018

Welcome to the second edition of the KEPRO Connect Ohio newsletter! We'll be issuing a new edition every quarter to keep you updated on all the latest news regarding the Ohio Department of Medicaid and KEPRO's work. Our goal is to keep you informed on the latest updates and announcements, important information and to provide tips and guidance to help you work more efficiently and effectively.

Proper Billing of Private Room Days

Although Ohio Medicaid does not generally cover private rooms, we recognize that at times, private rooms may be necessary. Ohio Administrative Code 5160-2-03 sets for the conditions in which Ohio Medicaid covers private rooms. Ohio Medicaid will reimburse private room rates only under the following conditions:

1. When a private room is medically necessary for the health and safety of the patient or others,
2. When a hospital has no semi-private room; or
3. When the patient chooses a private room and agrees, in advance in writing, to pay the difference between the private and semi-private rates.

If one of these conditions is met, then the inpatient claim with a private room revenue center code must include either:

1. Condition Code 39 (private room medically necessary),
2. Value Code 02 (hospital has no semi-private rooms); or
3. Value Code 31 (patient liability – patient chooses private room and agrees to pay room differential).

If Value Code 31 is used, the charges related to the private and semi-private room differential must appear in Form Locator 48 (Non-Covered Charges).

Please refer to Section 1.2, Form Locator 42, of the Hospital Billing Guidelines for further clarification regarding proper billing guidelines for private rooms. If a private room was necessary but proper billing guidelines were not followed, then the charges for the private room will be denied as non-allowed charges.

As a result, for hospitals subject to DRG reimbursement, those charges will be subtracted from the claim's total charges, which then affects the outlier add-on payment calculation. For non-DRG hospitals, the detail line containing private room charges will be denied, and payment for that inpatient stay will be for all other covered detail lines.

Ohio Medicaid – Retrospective Review Reconsideration Process and Timelines

Provider has 30 days after records are requested to submit records to KEPRO, in accordance with Ohio Administrative Code (OAC) rule 5160-1-17.2(E).

KEPRO has 30 business business days after records are received to issue decision.

Provider has 60 calendar days to submit appeal to either KEPRO or ODM-SURS (depending on review type).

ADMINISTRATIVE APPEALS

- All other appeals to SURS
- ODM has 30 business days to issue final and binding response

2nd LEVEL ADMINISTRATIVE APPEAL

- Provider has 30 calendar days to submit appeal to ODM for admin review
- ODM has 30 business days to respond (final & binding)

KEPRO APPEALS

- IP/Med. Necessity & DRG Reviews
- OP/Inappropriate Setting
- DRG Exempt Facilities/Bill Audits
- KEPRO has 30 business days to respond to provider

KEPRO Appeals must be submitted by mail (DO NOT submit appeals in the Atrezzo portal).

Failure to produce records within 30 days shall result in withholding or recoupment of Medicaid payments, per 5160-2-07.13(H).

Two-Day Rule for Missing/Incomplete Records: If the provider's submitted request for a reconsideration is incomplete, the department or the medical review entity will notify the provider of missing documentation. The notice will give the provider two business days to submit the missing documentation, per OAC 5160-2-07.12(B)(2).

Administrative Reversal: Either ODM or contractor may reverse audit findings at their discretion in cases of contractor/ODM error.

Technical Denials: If no records are submitted by the provider within 30 days, the contractor's denial constitutes the first-level appeal determination.

Review of Late Record Submissions (>30 days < 60): The provider is given 30 additional calendar days to produce records during the vendor transition period, at the Department's discretion per OAC 5160-2-07-12(B)(4).

1. Providers may submit the records within 30 calendar days of the date of the contractor's technical denial notice.
2. If the records are received timely, the contractor will review them as an appeal.
3. If the case is approved, a provider letter is issued over-turning the original denial.
4. If the case has a clinical issue, it is referred to a specialty-matched physician reviewer for a determination.
5. If the case has a denial, the provider is issued a modified determination letter stating that the technical denial is overturned, but there are new findings that the provider may appeal to ODM.
6. If requested, ODM/SURS performs an administrative review and issues a final and binding. determination.

ODM – HOSPITAL UR DENIALS & APPEAL OPTIONS

No Appeal Permitted	One Appeal Permitted to ODM-SURS	Two Appeals Permitted – KEPRO then ODM
1. Inpatient/ Outpatient No Documentation (Technical Denial)	1. Inpatient/Readmission 2. Inpatient/Transfer 3. Inpatient/Compliance (medical precertifications are no longer required) 4. Inpatient Billing Error: a. B1 - Admit source incorrect b. B2 - Patient (discharge) Status code incorrect c. B3 - Medicaid # incorrect d. B4 - Age is incorrect e. B5 - The admission should have been billed as an outpatient observation stay, as the patient did not remain an inpatient past midnight on the date of admission and/or no order for admission. f. B6 - Unsubstantiated billed charges g. B99 - Other not listed above (i.e., Hospital Acquired Conditions, Present on Admission, AN condition code, Hospice patient)	1. Inpatient/Medical Necessity 2. Inpatient DRG Coding/ Reassignment 3. Outpatient Billing Errors h. Coding corrections i. Inappropriate Setting 4. Bill Audits

Additional information on the retrospective review process and timelines: https://www.ohiohospitals.org/getmedia/56f8d0db-58d6-45d7-9511-5eb8fc11c588/KEPRO-Presentation-Ohio-Retro-052018.aspx

Providers are required by rule to submit a copy of their retro review denial with their appeal request; it speeds processing time.

- OAC 5160-2-07.12 (B) Utilization review reconsideration (1) The request for reconsideration must include: (a) A copy of the written determination;
    - Retro appeals are to be submitted to KEPRO via mail only, not the portal.
        - If documents are password protected, include the password in a clinical note.
        - http://ohmedicaid.kepro.com/media/1772/kepro-presentation-ohio-retro-05102018.pdf

Transition of BH PAs to Managed Care

Managed care plans have taken over PA responsibility effective July 1, 2018 except for consumers who remain in FFS status.

Medicaid benefit year is the calendar year (Jan-Dec).

Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.

- MCPs must follow ODM policy for 12 months.
- MITS BITS (which covers the behavioral health transition): http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_5-16-2018.pdf

Please utilize the 'Preparing for BH Redesign' section found on the home page of the BH Redesign website http://bh.medicaid.ohio.gov/ for the latest updates from the July 1, 2018 BH Redesign implementation.

- Manuals, Rates & Resources
- Training Opportunities
- MITS Bits Provider Information Releases

Questions may be directed to BH-Enroll@medicaid.ohio.gov

Behavioral Health Prior Authorization Required Documentation Reminders

ALL documentation needs to contain signatures. Cases are being pended because of this deficiency and review process timelines are being extended as a result. Please be sure to include signatures on **ALL** documentation.

Documentation submitted to support an approved prior authorization must include either:

1. Practitioner's physical signature, or
2. An electronic signature, which is only acceptable if it clearly delineates who signed along with the date and time of signature. Typed or stamped signatures are never accepted.

From the Medical Director

Many hospitals are sending in "limited" records for retrospective review of outpatient chemotherapy and radiotherapy claims. These records are often insufficient to assess medical necessity under Milliman Care Guidelines criteria, because they don't contain enough information.

- Chemotherapy and radiotherapy documentation often includes only record of the therapy administration, not the complete indication. The indication might need to include the patient's disease history, recent screening tests, and documentation of lack of contraindications.
- Many therapies are only medically indicated after certain screening tests are performed, if particular tumor morphologies are documented, after history of prior relapse on more routine therapies, or in conjunction with or to the exclusion of other medications or therapies.
- Some hospitals combine several encounters for outpatient chemo- or radiotherapy into a single claim, then only provide records for the first-dated encounter, because the initial date was the date under which the claim was filed.

These limited records result in our clinical reviewers requesting additional information, which is not always received, perhaps because providers believe they have already provided the entire record, so that there is no additional information available. Failure to provide the needed documentation then results in our inability to accurately assess the claim, and therefore a denial is issued.

KEPRO Contact Information

Toll free line: 844.854.7281
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Email: OHMedicaid@KEPRO.com

SURS' Contact Information

ODM-SURS Hospital Appeals
Phone: 1-866-841-0002
Fax: 614-644-2217
Fax by email: Bacs_fax@medicaid.ohio.gov

ODM-SURS Mailing Address
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Surveillance and Utilization Review Section
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