STATE OF NEW YORK
DEPARTMENT OF HEALTH

Riverview Center 150 Broadway, Suite 6E Albany, New York 12204-2736

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 22, 2005

«Title» «First_Name» «Last_Name»
«Company_Name»
«Address_Line_1»
«Address_Line_2»
«City» «State» «ZIP_Code»

Dear «Title» «Last_Name»:

The Office of Medicaid Management has received approval for a new high-cost outlier process. This process will provide your hospital with a partial high-cost outlier payment when you submit your high-cost outlier claim. In addition, it will streamline the process to reduce the time it takes to complete a review. Please refer to the enclosed document for details.

Two information sessions will be held in September to address questions you may have about the new process. Greater New York Hospital Association (GNYHA) will be hosting a session and the second session will be held at the Office of Medicaid Management (OMM) in Albany.

- September 20, 1 p.m. to 3 p.m. GNYHA offices at 555 West 57th Street, New York
  GNYHA will be distributing a meeting notice to their members. For more information, you may wish to contact Ms. Lillian Forgacs at 212-506-5534 or forgacs@gnyha.org or Mr. Stewart Presser at 212-506-5444 or presser@gnyha.org.

- September 22, 11 a.m. to 1 p.m. – OMM office at 150 Broadway, Albany
  Directions and sign-up information are included on the enclosed document. Space is limited. It is necessary to limit attendance to two persons from each hospital.

We hope to see you in September. Thank you for your continued participation in the New York State Medicaid Program.

Sincerely,

Joseph L. Guy, Ph.D., Director
Bureau of Medical Review and Payment

Enclosures
cc: Hospital IPRO Liaison

NEW HIGH-COST OUTLIER PROCESS

Recognizing that high-cost outlier reviews are time-consuming and, therefore, fiscally detrimental to a hospital's Medicaid reimbursement, the Office of Medicaid Management has received approval to amend the current process. The new system will provide hospitals with a partial high-cost outlier payment when their claim is received by the Medicaid Program and reduce the time it takes to complete a review by Island Peer Review Organization (IPRO).

WHAT'S NEW:

Payment:

When you submit a Medicaid claim that meets the technical payment requirements for high cost outlier payment with a discharge date of 10/1/05 and later, it will be paid upon receipt. The reimbursement amount will be 50% of the expected cost outlier reimbursement based on the total charges on your claim form (this payment cannot exceed $150,000 on a case). When IPRO completes the review of the case, the Medicaid Program will remit the balance of the cost outlier payment to you. Partial or full payments will be recovered by the Office of Medicaid Management, if necessary.

Case Reviews:

One of the goals of the new process is receipt by IPRO of the medical record and itemized bill at the same time. Recognizing this will require changes to your internal process, you will have a three-month grace period where medical records and itemized bills can continue to be sent to IPRO separately. Beginning January 1, 2006, please send all documentation in one mailing.

IPRO will develop a checklist for use by hospitals. The checklist should be sent to IPRO with the medical record and itemized bill. The goal of the checklist is to assist hospitals in preparing their documentation for IPRO's review. The new process eliminates IPRO's current step of requesting additional pieces of the chart (usually done with a documentation letter). To achieve a fair and complete high-cost outlier review, it is critical that the hospital be sure that all documentation is submitted to IPRO at the beginning of the process and within required timeframes. The medical record, itemized bill and checklist must be received by IPRO within 60 days of the IPRO request. This is an increase of 30 days from current processing.

When IPRO issues a pre-denial letter, the provider can choose to accept IPRO's determination which means waiving the pre-denial and all subsequent review opportunities. This waiver will result in the case being completed quicker and final payment being issued sooner.

Technical denials can be detrimental to a cost outlier payment. In the new process, two things will close a case to a cost outlier payment:

1. Two technical denials are issued. A technical denial is issued when the medical record is not received, the itemized bill is not received, the checklist is not received, or any combination of these reasons.
2. A new claim is not resubmitted within 6 months of the initial technical denial. Submitting a new claim (adjustment to the last paid claim) will restart the process so IPRO will again request the required documentation.

Payment Recoveries

Discharge Dates >/= 10/1/05

If the reason for closing a cost outlier case is because the medical record was never submitted to IPRO, the entire inpatient payment will be recovered. However, if the reason for closing a cost outlier case is because of non-submission of the checklist and/or itemized bill and the medical record was submitted, only the 50% upfront payment will be recovered.

Discharges Dates < 10/1/05

There will be no recovery of inpatient payments on cases with a discharge date before 10/1/05. However, if two technical denials are issued after 10/1/05 or a new claim is not submitted within 6 months of a technical denial issued after 10/1/05, the case will be closed to cost outlier reimbursement.

NOTE: When IPRO issues a technical denial, the only notification will be a notice to the IPRO liaison. Currently, providers are also made aware of the technical denial when the pending claim is denied. Since there will be no pending claim in the new process, there will be no pending claim to deny. Therefore, it is critical that the IPRO liaison notify the hospital's Medicaid billing representatives when the initial technical denial is issued.

IPRO HIGH COST OUTLIER REVIEW PROCESS
EFFECTIVE OCTOBER 1, 2005

I. MEDICAL RECORD/ITEMIZED BILL REQUEST

IPRO receives a transmittal from DOH requesting IPRO to open (or reopen) a high cost outlier case. Within 48 hours of receiving this request IPRO sends a medical record and itemized bill request to the hospital and the hospital has ***60 days*** from the date of the request to send in the medical record and itemized bill. (This is an increase of 30 days.) The goal of this increase in days is to give the hospital sufficient time to prepare the medical record and itemized bill and submit them to IPRO *at the same time.* A checklist has been developed that should assure that all required elements of the medical record and the itemized bill have been included. Beginning January 1, 2006 the hospital must submit the medical record, itemized bill and the completed checklist to IPRO together. (Attachment – copy of Checklist Letter.)

Because this new process should assure the completeness of the medical record and itemized bill IPRO will no longer send out a Documentation Request Letter. Review decisions will be based on the medical record/itemized bill received, therefore, to achieve a fair and complete high-cost outlier review, it is critical that the hospital be sure that all documentation is submitted to IPRO at the beginning of the process and within required timeframes.

II. TECHNICAL DENIALS

Please note the significant changes in the technical denial process, as technical denials can be detrimental to high cost outlier payment.

- Beginning October 1, 2005 **technical denials will be capped at two per high cost outlier case.** The case will be closed to further review after the second technical denial has been issued. All cases, including those that are already in process and that may already have multiple technical denials will be allowed up to two additional technical denials after October 1, 2005.
- Technical denials will be issued when the medical record is not received, the itemized bill is not received and when after a 30 day grace period to send in the checklist, it is not received, or any combination of these reasons.

A new claim must be resubmitted within 6 months of the initial technical denial. Submitting a new claim (adjustment to the last paid claim) will restart the process at DOH so that IPRO can be notified to request the required documentation. You must be prepared to send in the documentation that resulted in the technical denial when you rebill the case.

Please Note: When IPRO issues a technical denial, the only notification will be a notice to the IPRO Liaison. There will be no pended high cost outlier claims so therefore there will be no pended claim denials to alert the billing office to rebill the claim. Therefore, it is critical that the IPRO Liaison notify the hospital's Medicaid billing representative when the initial technical denial is issued.

III. ITEMIZED BILL FORMAT

All high cost outlier cases must be submitted with an itemized bill. The itemized bill format has not changed in this new process. The itemized bill format is described below:

- An itemized bill in **chronological order** by date of service for charges accrued during the **acute care period only**. (Charges accrued during an ALC, Alternate Level of Care period are not eligible for cost outlier reimbursement.) Accordingly, the hospital must identify only the dates of acute care on the itemized bill.

  If a hospital cannot document a charge(s), please inform IPRO when submitting the medical record and itemized bill so that IPRO staff does not attempt to locate the service(s).

  A sample of the Itemized Bill format is enclosed. Additional columns have been added to provide for IPRO's indication of question charges – according to IPRO's denial reason code legend – directly on the bill so as to expedite "turn-around-time".

- The bill must **clearly** identify the **TOTAL AMOUNT OF ACUTE CARE CHARGES** for which the hospital is requesting payment. "Adjustments" should be calculated prior to submitting the itemized bill to IPRO in order to reflect the "true" total amount clearly on the bill. Please note that if your billing system cannot delete adjustments, you will need to note with a line through the adjustment(s)and clearly indicate the total charts either by highlight or underline total charges and initial.

- **"PHARMACY" Charges** must appear in chronological order on the itemized bill by date administered, drug name, dose, unit price, quantity, charge and total pharmacy charges. If pharmacy charges are not identified in this manner on the itemized bill, a separate listing may be submitted according to the format in the attached example. In this instance, the itemized bill must be annotated to identify the total amount of pharmacy charges.

- **"Medical Supplies"** charges must specify the date, item, charge and quantity.

Please Note: When abbreviations are used on the itemized bill, please provide an explanation when submitting the itemized bill and chart in order to avoid having these charges questioned as "not clear on the bill".

IV. The following is a summary of the cost outlier review process that IPRO follows upon notification of a case by DOH:

- Initial Chart/Bill is requested. The hospital has **60 days** from the date of the request letter to send in the chart, itemized bill and signed checklist. If either is not received within the 60 days a Technical Denial is issued. This will begin with on or after October 1, 2005.

- When a Technical Denial is issued, the hospital IPRO Liaison will receive a notice. The IPRO Liaison must notify the Billing Department of the Technical Denial. There will be no pended claim to notify the Billing Department so there will be notification to rebill. Failure to rebill the case within 6 months will result in the closure of the case to high cost outlier payment.

- Once the first level of review is complete and issues are identified a Preliminary Cost Outlier Notice is sent to the hospital. The hospital has **45 days** from the date of the Preliminary Notice letter to respond to the issues identified.

  If the hospital agrees with the identified denials they should notify IPRO. This will result in IPRO closing the case and immediately notifying the DOH. Payment on the case will be processed by DOH at this point.

When the hospital does not respond to a Preliminary Denial letter within the 45-day time frame a "No Response Final" letter is sent to the hospital. The hospital has now lost this level of response and only has the appeal level left. IPRO will wait the 60 days for the hospital to send in an appeal before notifying the DOH that the case is closed and they should process claim. If a hospital wishes to agree and have payment processed before this 60-day period, they must respond to the Final Letter and indicate this by signing the Final Letter in the appropriate area.

- When a DRG issue is identified and proceeds to a denial, the hospital must rebill the revised DRG. IPRO must receive notification from DOH to proceed with a cost outlier review.

- When a hospital receives a Final Denial letter they have 60 days from the date of the letter to file an appeal. (30 days for a DRG Final Denial Letter) When an appeal is not received within 60 days the case is closed. After a case is closed no further review activity will occur.

Attachments: I. Itemized Bill Format
II. Pharmacy Bill Format
III. Checklist Letter

SAMPLE ITEMIZED BILL FORMAT

MEDICAID COST OUTLIER
HOSPITAL:
PATIENT NAME:
MEDICAID #:
ADMISSION DATE:
PAGE #:

DATE OF SERVICE	REVENUE CTR CODE	SPECIFIC DESCRIPTION OR NAME OF ITEM OR DRUG	CHARGE PER UNIT OR DOSE	# OF UNITS OR # OF DOSES	TOTAL CHARGES	IPRO REASON CODE FOR QUESTIONED CHARGED	HOSPITAL RESPONSE

SAMPLE PHARMACY PROFILE

DATE OF SERVICE	SPECIFIC DESCRIPTION OR NAME OF ITEM OR DRUG	CHARGE PER DOSE	# OF DOSES	TOTAL CHARGES	IPRO REASON CODE FOR QUESTIONED CHARGED	HOSPITAL RESPONSE
03/15/05	Zantac 50 mg	$3.85	3	$11.55		
03/15/05	Dopamine 800 mg	$3.33	2	6.66		
03/15/05	Clindamycin 600 mg	$4.40	1	4.40		
TOTAL CHARGES ARE INDICATED AT END OF LISTING				$22.61		

Cost Outlier Hospital Checklist
Submission of Cost Outlier

Date:

Kathleen M. Fox RN, MSA
Senior Director Medicaid/State Healthcare Assessment
IPRO
1979 Marcus Avenue
Lake Success NY 10042

Dear Ms. Fox:

As per your request, enclosed is the medical record and itemized bill requested for:
IPRO case #: _____, admission and discharge dates of: ___/___/___ to ___/___/___.

The medical record is complete and ready for cost outlier review and all parts of the chart checked below are present in the medical record. We understand that IPRO will issue a "Technical Denial" if the bill is not in the appropriate format and that chart review decisions will be based on the enclosed medical record that we have submitted as complete and ready for review.

All the following chart documents are present as indicated by each checkmark below:

- ☐ Emergency Room Notes
- ☐ Admitting H&P
- ☐ Progress Notes (MD, RN, Consults)
- ☐ Laboratory Results
- ☐ Radiology Results (CT, MRI, X-ray)
- ☐ Test Reports (EKG, Echo, EEG etc.)
- ☐ Interventional Radiology Reports
- ☐ Patient Activity Reports (I&O, V/S etc.)
- ☐ MD Orders
- ☐ Medication Administration Records
- ☐ OR Reports
- ☐ Rehabilitation Notes and time sheets
- ☐ Type & Crossmatch & Transfusion slips and RN signatures verifying transfusion times
- ☐ Discharge Planning and Summary
- ☐ Itemized Bill in Chronological Order

☐ Chart areas (list) are missing/incomplete but we believe items can be substantiated from other documentation in the chart. (list) _____
_____

Signature: _____

Title: _____

Hospital Name: _____

Phone Number: _____