I. COST OUTLIER PAYMENT

DOH determines that hospitals will receive a partial payment of 50% (up to a maximum of $150,000) of the cost outlier payment from DOH at the time the case meets cost outlier criteria. There is no time limit associated with this up-front payment. As long as the case is undergoing cost outlier review at IPRO, DOH will not recover the funds. Once IPRO complete its review and notifies DOH of its determination, the final payment will be process by DOH and any adjustments to the up-front payment will be made accordingly.

II. MEDICAL RECORD/ITEMIZED BILL REQUEST

IPRO receives a transmittal from DOH requesting to open (or re-open) a high cost outlier case. Within 48 hours of receiving this request, IPRO sends a Medical Record/Itemized Bill Request to the hospital; the hospital has **60 days** from the date of the request to submit the medical record and itemized bill. This 60 day timeframe was put in place to give the hospital sufficient time to prepare the medical record, itemized bill, and Hospital Submission Checklist to be submitted **as one submission**. A checklist has been developed that should assure that all required elements of the medical record and the itemized bill have been included. **As of January 1, 2006, hospitals must submit to IPRO the following: (1) a complete medical record, (2) an itemized bill (in chronological order), and (3) the completed Hospital Submission Checklist (see Exhibit A), as part of a complete submission package.**

Note: With the implementation of this revised High Cost Outlier Review Process on October 1, 2005, IPRO discontinued issuing Documentation Request notifications, based on the assumption that hospitals will submit complete documentation for the review. As of that effective date, review decisions are based on the medical record and 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.

III. ITEMIZED BILL FORMAT

All high cost outlier cases must be submitted with an itemized bill. A sample of what an itemized bill should is include is attached (see Exhibit B). *(Note: Two columns (optional) are shown on this sample format: (1) IPRO Reason Code for Questioned Charge and (2) Hospital Response. If your itemized bill format can accommodate these columns, they should be left blank on the itemized bill submission and would be available for IPRO USE when reviewing the bill, to record information regarding IPRO's denial reason codes for questioned charges and the hospital's response to the questioned charge. This formatting is optional, but can expedite the "turn-around-time" of a bill review.)*

The following describes the key points that need to be followed when preparing an itemized bill submission:

1. Submit an itemized bill **(in chronological order)** by date of service for charges accrued during the **acute-care period only**.
2. **Charges accrued during an alternate level of care (ALC) period are NOT eligible for cost outlier reimbursement.** Accordingly, the hospital must identify only the dates of service associated with acute-care on the itemized bill.
3. If a hospital cannot document specific charge(s), please specify these charges in your submission of the medical record and itemized bill these item, so that IPRO staff does not attempt to locate the service(s).

4. The itemized bill must **clearly** identify the **TOTAL AMOUNT OF ACUTE CARE CHARGES** for which the hospital is requesting payment. Any adjustments (i.e. undocumented charges, charges associated with ALC days, etc.) should be accounted for (removed from) the itemized bill submitted to IPRO, in order to reflect the total charges of the requested payment amount. *Note: If your billing system cannot delete adjusted item(s), you will need to (1) identify them with a line through the adjusted item(s), and (2) clearly indicate the a summary of the* **TOTAL (ADJUSTED) AMOUNT OF ACUTE CARE CHARGES** *on the itemized-bill, along with signing your initials to the changes.*
5. In the itemized bill, **Medical Supplies Charges** must appear in chronological order and be itemized as detailed items specifying the (a) date of service, (b) item description, (c) unit price, (d) number of units (quantity), and (e) total line-item charge. **DO NOT bundle medical supplies under a generic description (i.e., "Medical Supplies").**
6. In the itemized bill, **Pharmacy Charges** must appear in chronological order and be itemized as detailed items specifying the (a) date of service, (b) drug name and dosage, (c) unit price, (d) number of doses (quantity), and (e) total line-item charge. In addition, **a summary of Total Pharmacy Charges should be listed on the itemized bill**. *(Note: If pharmacy charges are not identified in this manner on the itemized bill, a separate listing may be submitted based on the format shown in Exhibit C. If using this alternate listing with your itemized bill submission, the itemized bill must be annotated to identify the Total Pharmacy Charges.)*

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

IV. TECHNICAL DENIALS

As of October 1, 2005, technical denials were capped at two (2) per high cost outlier case. Technical denials will be issued when the hospital fails to send a complete submission of the documentation for a high cost outlier review, which includes the following: (1) a complete medical record, (2) an itemized bill, and (3) the Hospital Submission Checklist.

Effective, as of July 1, 2012, a new claim must be re-billed by the hospital within 60 days of the date of notification of an Initial Technical Denial (as described in Medicaid Administrative Memorandum #2012-02). 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 re-bill the case. **The case will be closed to further review after a second technical denial has been issued.**

V. DRG CHANGE NOTICE

Effective, as of July 1, 2012, a new claim must be re-billed by the hospital within 60 days of the date of notification of a DRG Change (as described in Medicaid Administrative Memorandum #2012-02).

VI. COST OUTLIER REVIEW WAIVERS

In an effort to expedite the payment of a high cost outlier case, hospitals have the ability to submit a waiver agreement during the process, notifying IPRO that they agree with a determination and agree to waive the right to further levels of review. These waivers are discussed in more detail in the next section, **Section VII: Summary of the Cost Outlier Review Process.**

VII. SUMMARY OF THE COST OUTLIER REVIEW PROCESS

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

Process Step	Hospital Action/ Response Timeframe	Notes
Initial Medical Record/Itemized Bill Request	Upon receipt of a transmittal request from DOH, IPRO will issue a notification to the provider for a medical record, itemized bill, and Hospital Submission Checklist. **The hospital has 60 days from the date of notification to send to IPRO the medical record, itemized bill, and signed Hospital Submission Checklist in one submission.**	Failure to submit this information in a timely manner will result in IPRO issuing an Initial (1st) Technical Denial Letter.
Initial (1st) Technical Denial Notification	When an Initial (1st) Technical Denial is issued, the hospital IPRO Liaison will receive a notification of failure to submit requested documentation in a timely manner. **The IPRO Liaison must notify the hospital's Billing Department of the technical denial, to re-bill the claim within 60 days of the notification date**. There will be no pended claim issued notifying the Billing Department to re-bill the claim.	**Failure to re-bill the claim within 60 days will result in the closure of the case to cost outlier review & payment.**
Second Medical Record/Itemized Bill Request	If the hospital received an Initial Technical Denial and re-billed the claim within 60 days, DOH will allow the cost outlier review to be re-opened and will inform IPRO to issue a second medical record/ itemized bill request. The hospital has **60 days** from the date of notification to send in the medical record, itemized bill and signed Hospital Submission Checklist.	Failure to submit this information in a timely manner will result in IPRO issuing a Second Technical Denial Letter.
Second (2nd) Technical Denial Notification	When a Second (2nd) Technical Denial is issued, the hospital IPRO Liaison will receive a notification of failure to submit requested documentation in a timely manner.	**The case will be closed to cost outlier review & payment after the issuance of a second technical denial.**

Process Step	Hospital Action/ Response Timeframe	Notes
DRG Review	At the start of the high cost outlier review process, IPRO conducts a DRG-coding validation to determine that the correct DRG was billed for the claim. If IPRO identifies a potential DRG-coding concern, the review progresses through a multi-level review which can result in one or more of the following notifications:	
	DRG Preliminary Notice – The hospital has **45 days** to respond to potential findings cited in a preliminary notice for DRG. The hospital can respond in either agreement or disagreement to any or all of the findings cited in the preliminary notification(s).	Those concerns responded to in disagreement must be accompanied with supporting documentation substantiating the hospital's request of another level of review.
	In the event that a hospital does not respond to this preliminary notice, a **No-Response DRG Final Notice** will be issued confirming the findings of the preliminary notice. **The hospital loses a level of review and has 30 days to appeal the No-Response DRG Final Notice.**	No further consideration for review will be granted after an appeal-level review.
	DRG Final Notice – Any concerns denied based on a second-level review will be cited in the final notice(s), as well as, all concerns where the hospital agreed or did not respond. The hospital has **30 days** to appeal a final notice for DRG Change.	**When a DRG Change is confirmed, The IPRO Liaison must notify the hospital's Billing Department to re-bill the revised DRG within 60 days from the notification date of the last determination.**
	DRG Appeal Notice – For all appeal requests received in a timely manner, IPRO will conduct an appeal-level review which will result in either a reversal, modification or upholding of the final concern(s) appealed.	**After the claim has been re-billed, IPRO must receive notification from DOH to proceed with a cost outlier review.**
	DRG Waiver Agreement – Included with the DRG Preliminary and Final Notices is a DRG Waiver Agreement that this hospital can submit to IPRO informing that they waive the right to further DRG review. Signing this waiver will expedite the next steps of the review process.	
	If the hospital submits the waiver, they are agreeing with the DRG Change and must re-bill the revised DRG within 60 days from the notification date of the last determination.	

Process Step	Hospital Action/ Response Timeframe	Notes
Cost Outlier Review	Once the correct DRG has been confirmed and the case is deemed eligible for cost outlier review, the review of the itemized bill and medical record is started. The review progresses through a multi-level review which can result in one or more of the following notifications:	
	Cost Outlier Preliminary Notice – The hospital has **45 days** to respond to potential findings cited in a preliminary notice for the cost outlier review. The hospital can respond in either agreement or disagreement to any or all of the findings cited in the preliminary notification(s).	Those concerns responded to in disagreement must be accompanied with supporting documentation substantiating the hospital's request of another level of review.
	In the event that a hospital does not respond to this preliminary notice, a **No-Response Cost Outlier Final Notice** will be issued confirming the findings of the preliminary notice. **The hospital loses a level of review and has 60 days to appeal the No-Response Cost Outlier Final Notice.**	No further consideration for review will be granted after an appeal-level review.
	Cost Outlier Final Notice – Any concerns denied based on a second-level review will be cited in the final notice(s), as well as, all concerns where the hospital agreed or did not respond. The hospital has **60 days** to appeal a final notice for a cost outlier review.	**Note: The timeframe for a Cost Outlier Appeal Request is 60 days.** This is longer than the DRG Review and UR/Quality Review appeal request timeframe of 30 days.
	Cost Outlier Appeal Notice – For all appeal requests received in a timely manner, IPRO will conduct an appeal-level review which will result in either a reversal, modification or upholding of the final concern(s) appealed.	**If an appeal is not received within 60 days the case is closed. After a cost outlier review is closed, no further review activity will occur.**
	Cost Outlier Review Waiver Agreement – Included with the Cost Outlier Preliminary and Final Notices is a Cost Outlier Waiver Agreement that this hospital can submit to IPRO informing that they waive the right to further cost outlier review in the case. Signing this waiver will expedite the closure of review process and payment processing.	
	If the hospital submits the waiver, they are agreeing with the determinations of the cost	

Process Step	Hospital Action/ Response Timeframe	Notes
	outlier review and IPRO will close the case at that time and notify DOH of the findings in order for DOH to process the final high cost outlier payment.	
Utilization/Quality Review	Also, as part of the high cost outlier review process, IPRO conducts a utilization and quality review of the case. This process mirrors the retrospective review process IPRO conducts for other (non-cost outlier) inpatient claims. If IPRO identifies a potential UR or Quality concern, the review progresses through a multi-level review which can result in one or more of the following notifications: **UR/Quality Preliminary Notice(s)** – The hospital has **45 days** to respond to potential findings cited in a preliminary notice for UR and/or Quality. The hospital can respond in either agreement or disagreement to any or all of the concerns cited in the preliminary notification(s). In the event that a hospital does not respond to this preliminary notice, a **No-Response Final Notice** (for UR and/or Quality) will be issued confirming the findings of the preliminary notice. **The hospital losses a level of review and has 30 days to appeal the No-Response Final Notice(s).** **UR/Quality Final Notice(s)** – Any concerns denied based on a second-level review will be cited in the final notice(s), as well as, all concerns where the hospital agreed or did not respond. The hospital has **30 days** to appeal a final notice for UR and/or Quality. **UR/Quality Appeal Notice(s)** – For all appeal requests received in a timely manner, IPRO will conduct an appeal-level review which will result in either a reversal, modification or upholding of the final concern(s) appealed.	Those concerns responded to in disagreement must be accompanied with supporting documentation substantiating the hospital's request of another level of review. No further consideration for review will be granted after an appeal-level review.

Exhibits:

A. Sample Cost Outlier Hospital Submission Checklist
B. Sample Cost Outlier Itemized Bill Format
C. Sample Cost Outlier Pharmacy Bill Format

EXHIBIT A
FOR DEMONSTRATION PURPOSES ONLY

NEW YORK STATE MEDICAID COST OUTLIER REVIEW
HOSPITAL SUBMISSION CHECKLIST

Kathleen M. Fox, RN, MSA
Senior Director, Medicaid/State Health Care Assessment
IPRO
1979 Marcus Avenue
Lake Success, NY 11042

RE: MEDICAL RECORD/ITEMIZED BILL SUBMISSION FOR COST OUTLIER REVIEW

IPRO Case #: Medical Record #:

Patient Name: Medicaid #:

Admit Date: Discharge Date:

Provider Name:

Dear Ms. Fox:

As per your request, enclosed is the entire medical record (including, but not limited to, the items checked off below) and itemized bill requested for the above referenced case.

I have verified that all items checked off below are included in the attached submission of the medical record and itemized bill for the above referenced case, and that this submission is complete and ready for cost outlier review by IPRO. I understand chart review decisions will be based on the enclosed medical record as submitted. I also understand that if the itemized bill is not submitted in the appropriate format, as described in Medicaid Administrative Memorandum #2012-02, IPRO will issue a "Technical Denial" for the case.

- ❑ A complete Medical Record is enclosed that includes, but is not limited to, the following items:

❑ Emergency Room Notes	❑ UR Review Level of Care Changes/Letters
❑ Admitting History and Physical	❑ Patient Activity Reports (I & O's, V/S, etc.)
❑ Progress Notes (MD, RN, Consults)	❑ Medication Administration Records
❑ MD Orders	❑ OR Reports, Anesthesia & Recovery Room Notes
❑ Laboratory Results	❑ Rehabilitation Notes and Timesheets
❑ Radiology Reports (CT, MRI, X-Ray)	❑ Respiratory Therapy/Ventilator Flow Sheets
❑ Interventional Radiology Reports	❑ Transfer Notes/Orders
❑ Test Reports (EKG, ECHO, EEG, etc.)	❑ Discharge Planning and Summary

- ❑ Type & Crossmatch, Transfusion Slips, RN signatures verifying transfusion times
- ❑ Other: _____

- ❑ The following medical record items are missing/incomplete, but can be substantiated from other documentation included in this submission (continue on back of page, if necessary):

_____ is missing, look in _____
_____ is missing, look in _____
_____ is missing, look in _____
_____ is missing, look in _____

- ❑ Itemized Bill (in required format)

Name: _____ Title: _____

Date: _____ Phone: _____

NYS MEDICAID COST OUTLIER ITEMIZED BILL

HOSPITAL NAME:		**PAGE # OF ##:**	
PATIENT NAME:		**ADMIT DATE:**	
MEDICAID #:		**DISCH DATE:**	

						(OPTIONAL COLUMNS) FOR IPRO USE	
DATE OF SERVICE	**REVENUE CENTER CODE**	**ITEM DESCRIPTION**	**UNIT PRICE**	**QUANTITY (NUMBER OF UNITS/ DOSES)**	**TOTAL CHARGES**	**IPRO REASON CODE FOR QUESTIONED CHARGE**	**HOSPITAL RESPONSE**
		TOTAL ACUTE CARE CHARGES:					

NYS MEDICAID COST OUTLIER PHARMACY CHARGES

HOSPITAL NAME:		**PAGE # OF ##:**	
PATIENT NAME:		**ADMIT DATE:**	
MEDICAID #:		**DISCH DATE:**	

					(OPTIONAL COLUMNS) FOR IPRO USE	
DATE OF SERVICE	**ITEM DESCRIPTION (NAME OF ITEM/DRUG AND DOSAGE)**	**UNIT PRICE**	**QUANTITY (NUMBER OF DOSES)**	**TOTAL CHARGES**	**IPRO REASON CODE FOR QUESTIONED CHARGE**	**HOSPITAL RESPONSE**
TOTAL PHARMACY CHARGES: (TOTAL PHARMACY CHARGES SHOULD ALSO BE INCLUDED AS A LINE-ITEM ON THE ITEMIZED BILL)						