Use of EOB 776

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- The policy applies to all MCOs who are responsible for the reimbursement of medical services/supplies to all providers including hospitals, ambulatory surgery centers, physician and non-physician providers and addresses the appropriate and inappropriate use of EOB 776.

Use of EOB 776

- EOB 776 is an override explanation of benefits code:
  - payment is being made for a non-allowed, but related condition.
- Goal of EOB 776 policy:
  - appropriate payment of billed services on the initial submission, using EOB 776 rather than inappropriately denying bills and delaying reimbursement.

Use of EOB 776

- **<u>State, ex rel. Miller v. Indus. Comm.</u> (1994),**
  71 Ohio St.3d 229
  - The Court found that the payment for weight loss does not require that obesity be first formally recognized as an allowed condition. The court held that Ohio Revised Code 4123.84, which required (prior to 1999) that specific notice of the part of the body injured be indicated or forever barred does not apply to obesity because obesity is usually a generalized condition.

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The Court further stated :

- that an additional allowance must be causally related to the industrial injury either directly or by aggravation.
- A claimant who is overweight when injured cannot establish a causal relationship for an additional allowance.
- Therefore, the court held that the additional allowance of obesity is not a prerequisite to consideration of payment for a weight-reduction program.

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- From this decision is derived the three **"Miller Criteria,"** which must be applied in authorization of medical services. These criteria include:
  - Are the medical services reasonably related to the industrial injury, that is the allowed conditions?
  - Are the services reasonably necessary for the treatment of the industrial injury (allowed conditions)?
  - Is the cost of such service medically reasonable?
- All three parts of the test must be met to authorize reimbursement of medical services.

Use of EOB 776

- Application of Miller Criteria with EOB 776
  - Miller must be applied on a request-by-request basis.
  - Subsequent court cases determined that Miller does not excuse the requirement for formal allowance of conditions
  - Most important factor to consider for treatment requests is whether the requested treatment is for a specific body part of psychiatric/psychological condition as opposed to a generalized body condition

Use of EOB 776

- Application of Miller Criteria with EOB 776
  - When a specific treatment is requested for allowed condition in claim, the “reasonably related” prong of the Miller test is satisfied.
  - When specific treatment is requested for non-allowed conditions in a claim, the “reasonably related” prong of the miller test is satisfied if the services requested are:

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- for generalized condition(s) (e.g. diabetes, hypertension, obesity) and
- treatment of the generalized condition would have a positive impact on the outcome of the allowed conditions in the claim

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- When a specific treatment is requested for non-allowed conditions in a claim, and the services requested are for a specific body part or psychological/psychiatric condition(s) the reasonably related prong of the miller test is NOT satisfied.
  - Treatment should NOT be further considered for authorization unless the claim is additionally allowed for the specific body part(s) or psychological condition(s)

Use of EOB 776

- Ramifications of Miller Case
  - MCO must document all reviewed medical evidence in the V-3 claim notes showing Miller criteria were applied
  - Eligibility of services must be evaluated solely upon meeting the three pronged test

- Special Considerations
  - MCOs may utilize the 776 EOB override when treatment not requiring prior authorization is provided and billed with a non-allowed ICD-9 code if the provider's documentation supports that the treatments and the non-allowed condition is related to the allowed claim condition.

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- Appropriate use of EOB 776:
  - Treatment was authorized by an MCO based on Miller criteria for a condition not allowed in the injured worker's (IW) claim, but related to the allowed condition.
    - IW develops post op infection which may resolve in a few weeks. Treatment may include oral antibiotics. MCO should pay bills using EOB 776.
    - IW develops a post op or post injury condition such as osteomyelitis which would require long-term treatment, MCO should pay bills using EOB 776 but shall work with the customer service team (CST) regarding the need for the additional condition allowance.

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- Appropriate use of EOB 776 cont'd
  - IW develops post op complications such as Deep vein thrombosis or pulmonary embolism
  - Results in re-hospitalization for treatment such as anti-coagulation, placement of Greenfield filter etc.
  - MCO shall pay the related bills using EOB 776
  - MCO shall work with the CST regarding the need for an additional allowance.

Use of EOB 776

- Appropriate use of EOB 776 cont'd
  - IW has an adverse reaction to medication prescribed for the treatment of the allowed conditions.
  - Related bills should be paid using EOB 776.
  - MCO will contact the CST regarding the need for an additional claim allowance if the adverse reaction requires continued treatment

Use of EOB 776

- Appropriate use of EOB 776 cont'd
  - IW has generalized condition such as diabetes or hypertension-not allowed as claim condition
  - Diabetes/hypertension out of control as a result of treatment for the allowed condition
  - MCOs must pay related bills for the treatment of the generalized condition using EOB 776

Use of EOB 776

- If treatment becomes long term and is related to allowed claim condition:
  - MCO shall work with the CST regarding a possible request for additional claim allowance
  - Each situation must be reviewed on a case-by-case basis

Use of EOB 776

- Appropriate use of EOB 776 cont'd:
  - BWC will accept valid V codes for the principal diagnosis on all bills.
    - IW received PT, OT, ST services related to allowed claim condition. Services are billed with a V code, such as V57.1.
    - IW received chemotherapy or radiotherapy for treatment of allowed claim condition. Services are billed with V code, such as V58.1 Encounter for antineoplastic chemotherapy .

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- Appropriate use of EOB 776 cont'd:
  - BWC will accept valid V codes for the principal diagnosis on all bills.
    - IW enters hospital for removal of hardware from previous surgery for allowed claim condition, fracture femur shaft, 821.01. Services billed with V54.01 Encounter for removal of fixation device
    - MCO reviews medical documents to confirm relatedness
    - MCO shall pay the bill using EOB 776.

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- **Appropriate use of EOB 776 cont'd**
  - IW has allowed claim condition, such as strain of knee coded as 844.9. Symptoms indicate further diagnostics needed
    - MCO authorizes diagnostic arthroscopy. New diagnosis, tear of ACL,, 844.2 is confirmed. Provider repairs the ligament
    - Surgery billed with the new condition, 844.2
    - MCO shall pay bill using EOB 776.
    - Further treatment for new condition should not be paid until new condition tear of ACL is allowed in claim.
    - MCO shall contact CST regarding adding new claim allowance.

Use of EOB 776

- Appropriate use of EOB 776 cont'd: Expansion of number of digits in ICD-9 code.
  - Three digit code may be expanded to four digit or four digits to five digits
  - IW's claim has an allowed condition with ICD-9 code that has been expanded since the claim allowance
  - MCO shall pay bill with the current expanded code with EOB 776

Use of EOB 776

- Inappropriate use of EOB 776
  - Use of EOB 776 is prohibited when a condition is expressly disallowed in the claim
  - Use of EOB 776 is not appropriate unless the MCO documents the following:
    - Requested medical services are reasonably related to the industrial injury (allowed conditions)
    - Requested medical services are reasonably necessary and appropriate for treatment of the industrial injury (allowed conditions)

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- The costs of the services are medically reasonable.

- Example :
  - IW has generalized condition such as diabetes or hypertension that is not an allowed claim condition. IW requires surgery for treatment of the allowed claim condition.
  - IW cannot receive the surgery because the generalized condition is not under control.
  - MCO shall not pay bills for treatment of the generalized condition. Use of EOB 776 is not appropriate.

Use of EOB 776

- Inappropriate use of EOB 776
  - 1983 claim allowed for leg sprain (844.9) and medial meniscus tear(836.0).
    - In 1990, the IW is evaluated and treated for arthritis of knee (715.6).
    - Paid with EOB 776, although arthritis had not been allowed in the claim.
    - Use of EOB 776 is inappropriate.

Use of EOB 776

- Inappropriate use of EOB 776
  - A 1987 claim was allowed for lumbar sprain(847.2)
  - In 1990, the IW seeks evaluation and treatment of low back pain. The provider bills with the code 724.2, low back pain.
  - The provider's medical record documents lumbar Degenerative Disc Disease (DDD),722.52.
  - Miller criteria not me. EOB should not be used

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- Inappropriate use of EOB 776
  - 2002 claim allowed for tear of medial meniscus (836.0) and sprain of medial collateral ligament (844.1)
  - In 2004, IW receives treatment for chondromalacia of patella (717.7) which is not allowed in claim
  - Use of EOB 776 to pay bill for treatment of chondromalacia is inappropriate.

Use of EOB 776

- Inappropriate use of EOB 776
  - Services rendered within 72 hours of date of injury
    - Cambridge will pay any ICD-9-CM book valid diagnosis code for services rendered in the first 72 hours of injury in an allowed claim
    - Use of EOB 776 to pay bill is inappropriate.

Use of EOB 776

- Unnecessary Use of EOB 776
  - When services are billed with the allowed claim condition. Example: claim allowed for unspecified RSD (337.20). Bill for E/M service coded with 337.20.
  - When services are billed with an ICD-9 CM code that is in the same ICD-9CM group as the allowed condition. Example:

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- **Unnecessary Use of EOB 776**
  - Claim allowed for sprain of ankle(845.00) and knee(844.9)
    - MCO receives bill for EM services with ICD-9-CM code of other ankle sprain (845.09). The billed ICD-CM code is in the same ICD-9- CM group as the allowed ICD-9-CM code.
    - Use of EOB 776 is unnecessary. Cambridge billing system will automatically pay for this bill.

Use of EOB 776

- Documentation
  - Use these steps before using EOB 776
    - Contact the provider for medical records
    - Have medical documents imaged into claim file
    - MCO nurse or coder will review the medical documentation and enter a V-note into claim file

Use of EOB 776

– Contents of V-3 note to include:
  - MCO reviewer’s rationale for utilizing EOB 776
  - Citing of specific documents used in the decision
  - Analysis of how the three prong miller test was satisfied to justify payment of the medical services in the claim.

Use of EOB 776

- Other DOs and Don’ts
  - Don’t use EOB 776 based solely on the request of the provider.
  - Don’t ask or require providers to change ICD-9-CM codes, but contact the provider to determine if there was a billing error or if a new condition is being requested

Use of EOB 776

- Do use EOB 776 in catastrophic or settlement claims when appropriate.
  - The MCO shall place a V3 note in the claim stating the bill was paid pending settlement or as part of a CAT claim, and the reason use of EOB 776 is appropriate.
- The application of EOB 776 will not pay bills with invalid ICD-9CM codes
  - The MCO must request an adjustment of the denied bill

Use of EOB 776

- Do explore with the provider the possibility of claim allowance update in appropriate situations
- If proactive allowance is not appropriate, contact the CST regarding possible motion from IW for new allowance

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- Summary
  - MCOs are required to use EOB 776 as outlined in the policy
  - Each use of EOB 776 must be reviewed on a case-by-case basis
  - Inappropriate use of EOB 776 may result in recovery from the MCO.