

Ohio Bureau of
Workers' Compensation

Provider Update

Billing and Reimbursement

Clinical Editing

BWC has acquired a clinical editing software package from The MedStat Group, Inc., of Thomson Healthcare. The software will ensure a consistent and well-defined process for reviewing medical bills.

This system does not supplant that of the managed care organization's (MCO's) review of medical. Instead, it provides for a second-level review to create a consistent and standardized approach to the screening and reimbursement of provider medical bills.

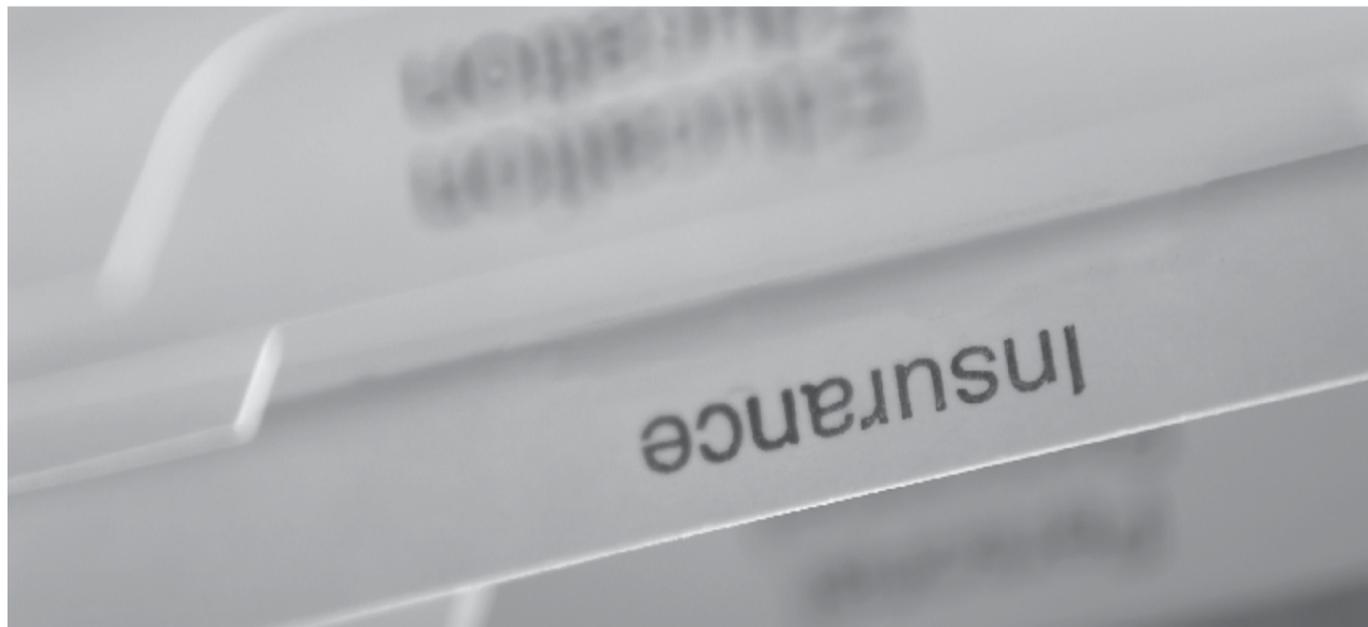
Thomson bases the edits included in the methodology on nationally recognized coding standards and protocols. They include those from the American Medical Association, American College of Physicians, Journal of the American Medical Association (AMA), Federal Register, and the Centers for Medicare and Medicaid Services.

BWC will install edits to its payment system in multiple phases. The new target date for first phase of implementation is April 28. First phase edits and corresponding descriptions and explanation of benefits (EOBs) are below.

Edit	Description/EOB
Inappropriate assistant surgeon	Identifies procedures that do not warrant payment for an assistant surgeon. EOB 407 – Payment is denied as this procedure does not warrant an assistant surgeon.
Surgical global fee period	Identifies separately billed visits or procedures billed by the operative provider with a related diagnosis that are part of the surgical global fee package. EOB 408 – Payment is denied as this is considered to be part of a global fee.
New patient code frequency	Identifies inappropriately billed new patient codes. EOB 409 – Payment is denied because history shows a previously reimbursed visit with this provider within the past three years and therefore does not meet AMA "new patient" definition.
Post operative care by non-operating provider	Identifies post-operative care provided by a non-operative provider within the same global period of the surgery for a related diagnosis. EOB 410 – Payment is denied as the office/hospital visit falls within the post-surgical follow-up period.
Pre-operative care by non-operating provider	Identifies pre-operative care provided by a non-operative provider within the same global period of the surgery for a related diagnosis. EOB 411 – Payment is denied as the office/hospital visit falls within the pre-operative global period.
Chemistry Lab Unbundled	Identifies line records containing individual lab codes that can be grouped together and paid under a single laboratory panel code. EOB 412 – Payment is denied because the set of codes listed should be grouped together under one procedure code as a panel.

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April 2008

Ohio Bureau of Workers' Compensation
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Global surgical care: Services Included in global package

Providers may furnish services included in the global package in a variety of settings. Examples include ambulatory surgical centers, physicians' offices, etc. The following services are not payable to the operating surgeon during the global period:

- Preoperative visits beginning with the day before a major surgery and the day of surgery for minor procedures;
- Intra-operative services that are a usual and necessary part of a surgical procedure;
- Postoperative visits after the surgery related to the recovery from the surgery that occurs within the designated postoperative period.
- Routine postoperative care;
- Post-surgical pain management by the surgeon;
- Supplies, except for selected procedures;
- Miscellaneous services, such as dressing changes; local, incision care; removal of operative packs, cutaneous suture and staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

An injured worker may have a complicated postoperative period. Thus, BWC may consider care for complications following surgery that are a major and/or significant condition for reimbursement within the designated postoperative period (e.g., treatment for significant post-operative infections, deep vein thrombosis, wound dehiscence, non-healing wounds, seroma or hematoma). Providers must use the appropriate evaluation and management code with a modifier for the service. All complications resulting in a return to the operating room are reimbursable. For more information, call 1-800-OHIOBWC.

BWC's hospital inpatient payment methodology

Per Ohio rules, BWC implemented a DRG-based payment system in 2007. BWC has contracted with a DRG vendor for a Medicare DRG grouper and pricer that calculates a payment for in-hospital discharge care according to the Centers for Medicare and Medicaid (CMS) logic.

By contract, the vendor keeps the grouper, pricer and ICD-9-CM coding standards current and in line with Medicare. CMS adopted a severity-adjusted DRG system known as Medicare Severity Diagnosis Related Groups (MS-DRGs) effective for fiscal year 2008 (Oct. 1, 2007). BWC adopted MS-DRGs for discharges occurring on or after Jan. 1, 2008.

Direct medical education payment

Hospitals that operate approved graduate medical education programs and receive additional reimbursement from Medicare for associated costs will receive an additional per diem amount for direct graduate medical education costs associated with hospital inpatient services reimbursed by BWC. BWC updated hospital specific per diem rates for direct graduate medical education on Oct. 1, 2007. Find details of the DGME calculation in the *Provider Billing and Reimbursement Manual*.

The bureau calculates the BWC MS-DRG payment with the formula below using the core elements of the CMS/Medicare Inpatient Prospective Payment System payment:

$$[(\text{Standardized Amount Labor} \times \text{Area Wage Index}) + \text{Standardized Amount Non-labor}] \times \text{DRG Weight} + \text{Outlier} + \text{Indirect Medical Education} + \text{Capital} + \text{New Technology} + \text{Disproportionate Share}]$$

Per Medicare definition, discharge dates will pay at 2008 rates.

You can find CMS/Medicare definitions related to the MS-DRG payment, as well as details and payment calculations for hospital re-admission, transfers and late charges in the *Provider Billing and Reimbursement Manual*, Chapter 3, Section B, Hospital Services.

Outpatient medication prior authorization

In the coming months, BWC will implement many changes to the outpatient drug policies. The changes will include reimbursing certain drugs only when the FDA-approved indication of the drug is an allowed condition in the claim; placing quantity limits on select drugs; and changes to the non-preferred drug list including movement of select drugs to non-covered status requiring prior authorization for select drug classes once a given amount of time has passed since the date of injury.

Telephone call codes (99371 – 99373)

BWC is exempt from the Health Insurance Portability and Accountability Act. Therefore, BWC will continue to recognize and reimburse the discontinued CPT® codes for telephone calls made by the appropriate provider. For details see the medical documentation policy. BWC will not reimburse the new 2008 CPT codes for evaluation and management services provided per telephone. It is BWC's position that an injured worker should have his or her care rendered in person.

Local Anesthetic Caine Drugs

BWC does not cover anesthetic drugs, such as Bupivacaine (Marcaine), Bupivacaine (Sensoricaine), Chlorprocaine (Nesacaine), Lidocaine (Xylocaine), Mepivacaine (Carbocaine), etc., when administered for chronic pain control. BWC will not allow separate payment for the surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure. According to coding rules, such costs are contained in the procedure fee schedule.

Hospital inpatient medical documentation requirements

BWC has processed inpatient hospital bills using the Medicare prospective payment system since Jan. 1, 2007. As part of the implementation process, we informed hospitals through our Provider Billing and Reimbursement Manual and other communications that certain medical documents are required to: verify diagnosis and procedure codes are related to claim allowances on inpatient hospital bills; ensure correct coding; and ensure correct payment amounts.

BWC adds, deletes and re-orders ICD diagnosis and procedure codes on inpatient bills based on the medical documentation on file to support the billed codes and per correct coding guidelines and the *AHA Coding Clinic*.

Initially, to aid transition of the hospital billing processes to the DRG methodology, BWC and the managed care organizations (MCOs) took extra steps to obtain missing medical documentation. This included requesting specific documentation and holding

incomplete invoices for up to 30 days from the BWC receipt date to allow the hospital to submit the missing documentation.

BWC will not take these extra steps as of May 1, 2008. As of that date, hospitals are responsible for submitting the mandatory documentation to the MCO.

Medical documentation required from hospitals

- Admission history and physical;
- Emergency department report (if the patient was treated in the emergency room);
- Operative report (if the patient had surgery);
- Discharge summary and/or progress notes (if the confinement period was 48 hours or more in duration);
- Discharge note (if the confinement period was less than 48 hours in duration).

If BWC denies reimbursement due to incomplete medical documentation, the hospital must re-submit the bill, and re-submit the specific required documentation for reconsideration of reimbursement. Additional documentation may be necessary in special circumstances and for retrospective reviews.

Please ensure your hospital sends all medical documentation to the MCO's toll-free fax number. BWC's Provider Billing and Reimbursement Manual publishes MCO fax numbers. The manual is available on BWC's Web site, ohiobwc.com. This will ensure the MCOs and BWC receive images of the documentation and will expedite bill payment.

MCO Open Enrollment 2008

Ohio employers will have the opportunity to select a new managed care organization (MCO) during BWC open enrollment from May 5-30. Access the *MCO Enrollment Guide and Report Card* at ohiobwc.com. An MCO selection form will be available online for those who decide to select a new MCO. The new MCO will begin to manage the medical part of that employer's claims beginning June 30.

Prior to the effective date, BWC will mail a letter to all injured workers who have an active claim, identifying the newly selected MCO. In addition, physicians of record who are treating injured workers will receive a copy of this letter.

Send bills to the new MCO starting June 30. If the preceding MCO receives a bill after June 30 with a date of service before the cut off, it will review and process the bill appropriately. If the preceding MCO receives a bill with a date of service on or after June 30, it will forward the bill to the new MCO to process. The preceding MCO will inform the provider that the destination MCO will manage the medical services in the claim effective June 30. If the destination MCO receives a bill with a date of service before June 30, it will review and process the bill. It will not forward the bill to the preceding MCO.

To verify any MCO assignment after June 30, the Employer/MCO Look-Up can be accessed via the BWC Web site by selecting Medical Providers and then Look-Ups. For more information, call 1-800-OHIOBWC.

C-9 form update

BWC has updated the *Physician's Request for Medical Service or Recommendations for Additional Conditions for Industrial Injury or Occupational Disease* (C-9) effective Feb. 15, 2008. Copies of this form are available at ohiobwc.com.

MCO update

Current MCO information can be located in the *Billing and Reimbursement Manual* and at ohiobwc.com. The tables include case-management contacts and telephone numbers for each managed care organization (MCO).

Contact

- Call** 1-800-OHIOBWC
(Includes provider questions pertaining BWC fee schedule or billing)
- Log on** ohiobwc.com, Medical Providers or Ohio Employers
- Mail** Ohio Bureau of Workers' Compensation
30 W. Spring St., 20th Floor
Columbus, OH 43215-2256