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Simplifying the Complicated: A Hospital Overview to Unraveling Complex Workers’ Compensation Cases

presented by
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Simplifying the Complicated: A Hospital Guide to Unraveling Complex Workers’ Compensation Cases
Today’s Agenda

- Review the “assembly line” of the start of the claim & alleviating front end hiccups with FROI’s & Payer
- Understand that Ohio WC processes are part of a law and not just a payer
- Provide Solutions for the Common Denial Areas
- Course of Action for Diagnosis Coding Discrepancies
- Billing/Payment Updates
- Expectations & Requirements of Workers’ Compensation Payers (MCO’s vs. SI)
- Entertain hospital specific questions
Ohio BWC, Department of Labor (DOL) and Department of Energy (DOE) claims make up about 3-5% of a hospital’s total overall revenue stream yet create the most re-work of any financial class.

- Have the lowest clean claim payment percentage due to the omission of key elements on the UB such as claim number, correct payer ID or diagnostic coding discrepancies.

- Can include a legal component(s) that impacts care delivery through delays due to claims determination status such as: Alleged vs. Allowed and Hearings. These also impact payments and ATB groupings for this payer.

- Have an expectation for providers to determine “causal relationship” of the alleged injury that it is due to “arising out of and in the course of employment”.
REPORT THE INJURY

- **ED’s, Urgent Care’s and Occ. Health Centers** are the first to identify if the claim is work-related. The simple inquiry of: "is this visit related to a work related injury" can identify the proper financial class (FC) even if the payer selection is incorrect.

- Regarding the First Report of Injury (FROI completion): The next most important step would be to have the patient complete the injury description, and the employer on the FROI itself. The employer name is linked to the correct MCO in order to file the FROIs searched ad the FROI.

- This crucial document creates the Claim Number. ( $$ can sit in unbilled accounts due to the lack of a Claim Number).
Once the Financial Class is determined, verifying the correct payer can be a tedious step to ensuring the claim is established & paid in a timely fashion. In order to find the payer, you must know the employer of the injured patient.

Where can I research to locate the correct payer?

- Ohio BWC Employer/MCO Lookup at ohiobwc.com
- Employer phone call to verify patient's employment and their selected Managed Care Organization (MCO) or Third Party Administrator (TPA) for Self Insured Employers
- BWC List of Self Insured Employers

Employer Open Enrollment is every 2 years on even years (2018!) and allows for employers to switch their MCO. The employers have all of May to decide and the new MCO, if changing, goes into effect on July 1st, 2018.
<table>
<thead>
<tr>
<th>TASKS</th>
<th>TIMELINES</th>
<th>DATA ELEMENTS</th>
<th>METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating physician identifies the IW's MCO</td>
<td>Same day as initial treatment</td>
<td>N/A</td>
<td>ohiobwc.com, call employer, call 1-800-OHIOBWC, option 3</td>
</tr>
<tr>
<td>Treating physician reports injury to the MCO or to BWC through ohiobwc.com</td>
<td>Within 24 hours from initial treatment or knowledge of work related injury</td>
<td>IW name/address/phone #, DOB, gender, SSN &amp; occupation. Designation of injury, occupational disease or death, and date of injury or death, causal relationship statement, accident description, injury description. Determine if 7 or fewer days (medical only) or 8 or more days (lost time) will be missed. Employer name/address/phone #. Initial treating physician &amp; provider of record name and number. Notice to MCO if the IW will be off work for more than two calendar days.</td>
<td>Phone, EDI, fax (FROI or other comparable form), ohiobwc.com (preferred method)</td>
</tr>
<tr>
<td>MCO reports injury to BWC</td>
<td>70% within 3 days; 100% within 5 days</td>
<td>Data elements listed above, as well as date reported to employer and date reported to MCO. (MCO is responsible for gathering missing data elements.)</td>
<td>EDI</td>
</tr>
<tr>
<td>BWC assigns claim number</td>
<td>Within 24 hours from date of notice or assigned at the time of filing on ohiobwc.com</td>
<td>Explanation of HPP, IW right to compensation, 1-800-OHIOBWC number, purpose of attached ID card, IW name, claim number, injury date, Customer Service Specialist name, phone/fax #, and service office, MCO name &amp; phone #.</td>
<td>Letter, EDI</td>
</tr>
<tr>
<td>Provider sends subsequent data to MCO. MCO sends data to BWC.</td>
<td><strong>Provider:</strong> within 5 days from notice of injury  <strong>Hospital:</strong> within 2 days from initial treatment  <strong>MCO:</strong> within 7 days from notice of injury</td>
<td><strong>Expected:</strong> Date of initial treatment, date last worked/date returned to work, ICD-9 code(s) (5 days for hospitals)/location/site  <strong>Other:</strong> Initial Treatment Plan, as appropriate</td>
<td>EDI, phone, fax, mail (FROI or other comparable form), face sheet (hospitals)</td>
</tr>
<tr>
<td>Provider forwards hard-copy medical documentation to MCO for allowance of claim.</td>
<td>Within 5 days from date of request by MCO.</td>
<td>Radiological interpretations, nuclear medicine, diagnostic interpretations, ER reports, operative/hospital admission/history/physical reports, and initial treating report</td>
<td>Fax (stored electronically in Medical Repository), EDI, mail, face sheet (hospitals)</td>
</tr>
</tbody>
</table>
Requires knowledge of various processes to resolve claims including clinical infrastructures at MCOs and BWC.

OHIO BWC
**DID YOU KNOW?**

- **Ohio BWC law** requires a new injury to be reported within 24 hours.

- **Ohio Revised Code 4123.52** requires **ALL Workers’ Compensation bills** to be submitted and resolved within one year of the date of service.

- **Billed diagnosis does not have to match identically to the “allowed” condition (ICD10)** of the claim providing the date of service is within the first 72 hours of the date of injury (DOI). A request can be done for a review as long as it is causally related to the alleged/allowed condition.
# THE COMMON DENIALS

<table>
<thead>
<tr>
<th>DIAGNOSIS CODE</th>
<th>REASON</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>276</td>
<td>Diagnosis Not Allowed</td>
<td>Payment is denied as the billed diagnosis is not allowed in the claim. Can be used if pending allowance.</td>
</tr>
<tr>
<td>353</td>
<td>Prior Authorization Needed</td>
<td>Payment is denied as prior authorization is required for this service.</td>
</tr>
<tr>
<td>522</td>
<td>Medical Documentation Needed</td>
<td>Payment is denied pending receipt of report for medical review.</td>
</tr>
<tr>
<td>265</td>
<td>Inactive Claim</td>
<td>Payment is denied as the claim is inactive and current treatment must be investigated for relatedness.</td>
</tr>
<tr>
<td>553</td>
<td>Non-Covered Procedure</td>
<td>Payment is denied as this procedure is not covered by BWC.</td>
</tr>
<tr>
<td>256</td>
<td>Disallowed Claim</td>
<td>This claim has been disallowed. The injured worker is responsible for bills.</td>
</tr>
</tbody>
</table>
“WALKS LIKE A DUCK, QUACKS LIKE A DUCK, IS A CHICKEN.”

A claim is not a bill

- In workers' comp the BWC uses "claim" to refer to everything related to an injury/illness report (FROI) and the injured worker's eligibility for benefits.
- The claim has a specific number assigned to it that refers to the specific accident or disease that led to the industrial injury or illness. (Most time starting with the year of the injury, ex: 18-XXXXXX)
- For claims (FROIs and additional allowances), we need specific diagnosis information, including site and location.

Billing on an UB 04

- For medical bills, the BWC asks providers to follow national billing standards, which allow for less specific coding.
- MCO’s representing the BWC use the UB (bill) to refer to the request for provider reimbursement (health-care claim). The bill must always contain the injured worker's BWC claim number specific to the related injury/illness for state-funded claims. The internal claim number is suggested for self-insured claims. This info can reside in either the group number or policy number fields.
- Suggest to create edits to hold bills from submission that do not have claim numbers in the required fields.
UNDERSTANDING BWC CODING

BWC Coding Differences vs. Commercial Insurance

- The BWC is ICD9/ICD10 Code specific
- Each code submitted by the provider as a primary or related diagnosis is individually considered. There is a monetary, actuarially driven figure tied to each diagnosis for the employer.
- If a code is causally related, but not part of the “allowed condition(s)”, follow-up staff can ask for a one time consideration—if the condition is chronic an additional ICD10 code will need requested (via treating physician using a C9).
- BWC arranges codes into numeric groups. Codes in that group are interchangeable and can be used for allowance and reimbursement purposes.

BWC “Invalid” Codes

- A code for an injury/condition that is not causally related to an industrial injury or occupational disease.
- Symptom codes in the primary position (Pain Codes—pain is considered a symptom in WC).
- The primary diagnosis code placement is the most significant on the UB, however, other co-morbidity codes can impact claims payments.
- Using now, Version 4.3 Data spreadsheet that contains updated groups that include new codes effective October 1, 2017. Version 4.3 contains 282 new ICD-10 codes.
NEWER CHANGES FOR PATIENT/EMPLOYER
DEADLINE TO ESTABLISH A CLAIM
(Statute of Limitations)

• Before 9/29/17: 24 months (2 years) from Date of Injury (DOI).
• After 9/29/17: 12 months (1 year) from Date of Injury (DOI).

Prior to September 29, 2017, injured workers had 2 years from the date of injury to file a claim with the Ohio Bureau of Workers Compensation.

Now, they must file within 1 year. People in Ohio that are hurt on the job sometimes hesitate to file a workers comp claim for many reasons. Some even consciously choose their commercial carrier at the time of treatment.

With this new change, the patient/employee should not "wait and see" how it goes. They need to file quickly to ensure the injury has been recorded and documented with their employer and Ohio BWC.
NEWER CHANGES FOR PATIENT/EMPLOYER DEADLINE TO ESTABLISH A CLAIM (CON’T) (Statute of Limitations)

• Hospital Follow-Up teams MUST turn around swiftly any accounts incorrectly registered. (For example: EOB reflects a denied claim from a Commercial/Family Medical Carrier) the WC team would need immediate notification to establish the WC Claim.

• Anecdotal comment: symptoms of registration errors can be: an increase in the request by a WC payer for medical records, many times the request indicates an incorrect payer registration process and the MCO’s inability to establish the claim.

Remember:

• Providers only have one year from the date of service to have the bill paid (regardless of all the issues which may need resolved leading up to that year such as: coding, authorization, establishment of claim number).

• Outsourcing has never been more attractive as the SOL Clocks keeps ticking
AUTHORIZATIONS

• The Form of Authorization with this Payer is entitled a C9.

• C9’s are most often already completed for technical services (therapies, lab services, surgeries) because the Physician of Record (POR) or referring Physician are responsible to secure them.

• Retro C9’s are most often needed for claims needing additional diagnostics due to the presentation of new yet possibly related conditions or additional testing/treatment that fell out of range from the original C9.
2018 Reimbursement Updates

- Adopt Medicare 2018 final rule including, but not limited to, update the previously adopted joint replacement procedures
- Modify BWC payment adjustment factor (PAF) to reflect the statewide reimbursement to cost benchmark of 114%
- Children’s Hospital Factor: 266.4% / Non-Children’s Factor: 144.7%
- Adopt Section 603 of the Bipartisan Budget Act of 2015 for reimbursement of off-campus hospital departments
- Adopt reimbursement methodology for outpatient detoxification services

Source: OHA
Medicare Base + PAF = BWC Payment

BWC Goal is to pay hospital at 114% of cost
Hospital Cost = $100
Reimbursement Calculation Results = $1

Year 1  Year 2  Year 3  Year 4  Year 5

$70  $72  $74  $76  $78
Target BWC Payment Rate  Hospital Cost  Medicare Rate

PAF = 1.50  PAF = 1.39  PAF = 1.28  PAF = 1.17
How are the BWC’s PAF derived?

They are charged to modify current Payment Adjustment Factor (PAF) to reflect the statewide reimbursement to cost benchmark of 114%:

- 109.5% for MS-DRG and direct graduate medical education (DGME) services
- 171.5% for outlier services

BWC’s hospital inpatient services reimbursement methodology is based on Medicare’s Inpatient Prospective Payment System (IPPS), which is updated annually. Therefore, BWC must also annually update OAC 4123-6-37.1 to keep in sync with Medicare.
New BWC Program for Opioid Detox

Outpatient detoxification services (OAC 4123-6-21.7)

- Allows payment of inpatient and outpatient detoxification services without an additional claim allowance over an 18 month period
- Per diem = all inclusive rate
- Appendix table to outpatient rule establishes local level codes for per diem structured programs and services
Proposed 2018 Arthroplasty Program Expansion

• **Implemented initially May 1, 2016**

• ASCs have additional certification criteria

• Adopted two procedures in 2017; CMS adopted one procedure of the two BWC added for 2018

• Six additional codes recommended for 2018

• **Procedures:**

  – Reconstruction of shoulder joint, partial hip replacement, total hip arthroplasty, revision of knee joint, and reconstruction of ankle joint
# PROPOSED 2018 ARTHROPLASTY EXPANSION

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2018 Medicare Base Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>23472</td>
<td>Total shoulder replacement</td>
<td>$10,122.22</td>
</tr>
<tr>
<td>27125</td>
<td>Partial hip replacement</td>
<td>$10,122.22</td>
</tr>
<tr>
<td>27132</td>
<td>Previous hip surgery converted to total hip replacement</td>
<td>$10,122.22</td>
</tr>
<tr>
<td>27445</td>
<td>Total knee replacement</td>
<td>$10,122.22</td>
</tr>
<tr>
<td>27702</td>
<td>Total ankle replacement</td>
<td>$10,122.22</td>
</tr>
<tr>
<td>27703</td>
<td>Revision of total ankle replacement</td>
<td>$10,122.22</td>
</tr>
</tbody>
</table>
Section 603 Provider-Based Departments

• Provision goal - equalize payments between:
  – Free-standing physician office setting, and
  – Off-campus provider based departments

• No longer pay hospitals OPPS rates for non-grandfathered outpatient departments
  – Beginning January 1, 2017
  – For 2018, non-grandfathered departments paid at 40% of OPPS rates

Source: OHA
Section 603 Provider-Based Departments

- BWC to require mandatory submission of modifiers:
  - PO (excepted service provided at an off-campus, outpatient, provider-based department of a hospital) and
  - PN (non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) – 60% reduction
FINAL BILLING CONSIDERATIONS

• Is BWC Provider Number with correct suffix on the bill?

• BWC or SI Internal Claim Number on bill?

• Late Charges (if a non-bundled service) addressed via a request for an adjustment.

• Test electronic submission with payers.

• PO, CL and CH modifiers are invalid for BWC

• CPT G0283 must be revised to 97014 (therapy bills)
INPATIENT BILLING APPEALS

• Hospitals may appeal coding changes & denials to MCO/BWC in writing with supporting documentation. I recommend including ordering providers on these claims.

• Follow the MCO processes initially. Providers can submit appeals to BWC provider relations – Call 1-800-OHIOBWC or see BWC Provider Billing & Reimbursement Manual for details.

• Understand charges that bundle vs. perceiving as true underpayments.
REMITTANCE ADVICE

Coding changes communicated by EOBs including but not limited to:

**EOB 195:** DRG changed as a result of coding modification. (BWC reviewing changing coding)

**EOB 212:** Sequence of ICD codes changed to match medical documentation. (BWC reviewing changing coding)

**EOB 246:** Co-morbid/complication diagnosis deleted as not supported by medical documentation received by BWC, resulting in DRG change.
Most bills require only the core medical documents:

- Admission history & physical
- Emergency department report if patient admitted through ED
- Operative report (if bill contains OR charges)
- Discharge summary and/or progress notes if admission was \( \geq \) 48 hours
- Discharge note if admission < 48 hours
- See BWC Provider Billing & Reimbursement Manual
4123-6-37 Payment of hospital bills.

A. Direct reimbursement will not be made to members of a hospital resident staff.

B. Payment for personal comfort items, which include, but are not limited to, telephones, television, and private rooms provided at the patient's request, are not compensable.

C. Bureau fees for hospital inpatient services.
   1. Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital cost to charge ratios or percent of allowed charges.

   2. Except in cases of emergency, prior authorization must be obtained in advance of all hospitalizations. The hospital must notify the bureau, the injured worker's MCO, QHP, or self-insuring employer of emergency inpatient admissions within one business day of the admission. Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the bureau, MCO, QHP, or self-insuring employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.
ORC REGARDING PAYMENTS

4123-6-37 Payment of hospital bills.

D. Bureau fees for hospital outpatient services.
   1. Bureau fees for hospital outpatient services, including emergency services, will be reimbursed in accordance with usual and customary methods of payment which may include prospectively determined rates, allowable fee maximums, ambulatory payment categories (APC), hospital cost to charge ratios, or a percent of allowed charges, as determined by the bureau.
   2. Treatment in the emergency room of a hospital must be of an immediate nature to constitute an emergency as defined in this chapter. Prior authorization of such treatment is not required. However, in situations where the emergency room is being utilized to deliver non-emergency care, notification will be provided to the injured worker, the hospital, and the provider of record that continued use of the emergency room for non-emergent services will not be reimburse.

E. The bureau may establish the same or different fees for in-state and out-of-state hospitals based on the above reimbursement methodologies.

F. Payment will be made for hospital services in accordance with rule 4123-6-10 of the Administrative Code.
MOST COMMON CASES NEEDING INTERVENTIONAL APPEALS

• ICD-10 Coding Issues: rehab codes, pain codes, inpatient codes differing from ‘allowed codes’ but causally related.

• Claims in Hearing Status

• Underpayments

• Retro C9’s for date outliers/missed procedures

• Manual Override Requests

• Post-Op Surgical Complications requiring additional allowances.
ICD-10 IMPACT TO C-9’S

• **Section III.** Of the C-9 Authorization requests a narrative description of requested conditions. The narrative should be as specific as possible.
Questions? Thank you for your time!

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