



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

February 1, 2007

TO: Interested Party
RE: Consultation Summary
Project #0542-OPH

Thank you for your comment(s) to the Medical Services Administration relative to Project Number 0542-OPH. Your comment(s) has been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

Comment: The impetus for the development of the observation stay policy requirement in the FY 06 Appropriations Act was the recommendations by MAHP for a series of cost-savings opportunities for both Medicaid Health Plans (MHPs) and Medicaid Fee For Service (FFS) without affecting the benefits offered to Medicaid beneficiaries. Rates paid to MHPs are fixed and remain "flat" and we cannot support any Medicaid policy that increases the costs of health care unless such change is accompanied by rate adjustments. The revised methodology Michigan Department of Community Health (MDCH) uses to certify MHP rates is predicated on MHP actual cost experience, and it is clear that MDCH did not assume that MHPs would absorb additional cost or the ability to certify rates would have been in doubt.

Response: MHPs will need to interact directly with their contracted and non-contracted hospitals to reach payment agreement and may continue to follow their MHP specific established observation care coverage process when signed agreements are in place. There should be no additional financial impact by contracted MHPs since they already require Prior Authorization (PA) for observation services and additional documentation from hospitals unless specified per established signed agreements.

Comment: Implementing this policy will reduce the number of claims we are able to reimburse at an Observation rate by as much as 77% due to the limited list of diagnoses included in the policy. We understand MDCH does not intend for this policy to interrupt existing contracts that MHPs have, however, it's been our experience that the implementation of a policy that hospitals find financially favorable results in hospitals demanding a change in the MHP reimbursement to match Medicaid FFS. Such a change without additional funding from MDCH would have a negative impact on the MHP.

Response: MHP contracts and scheduled changes consider MHP rates. The decision to implement Medicare's diagnosis-based coverage for observation services does not preclude Medicaid MHPs from continuing their current criteria-based observation coverage and reimbursement process for network hospitals.

Comment: We strongly support the development and implementation of an observation room policy based on clinical criteria and PA from the observation setting to the inpatient setting. In the absence of a criteria-based policy, we recommend that the current reimbursement status for observation services be maintained.

Response: MDCH requested MHP data to review and use for comparable analysis; however, the response was limited. The data reviewed supports implementing Medicare's coverage policy related to observation care services. This allows consistent hospital billing for observation services and monitoring data post implementation.

The current FFS observation policy and reimbursement are Michigan Medicaid specific and do not align with any other payer. Implementing observation coverage in line with Medicare should relieve administrative burden for hospitals and MDCH, promote standardized billing and reimbursement, and facilitate coordination of benefits and crossover claims.

Comment: We request the observation stay component of the APCs currently under development be removed for the initial implementation, and remain excluded from APC reimbursement until all impacted parties have the opportunity to collaborate on the development of a policy that is clinically appropriate and results in the cost savings intended by the legislature.

Response: Based on comments received from MHPs, MDCH requested additional information and conducted further analysis. Based on that analysis, MDCH will implement Medicare's coverage policy related to observation care services.

Comment: We recommend the Medicaid program provide coverage for all beneficiaries determined by a physician to require observation care based on the McKesson InterQual Observation criteria. Without covering the pediatric and maternity populations, the policy would fail to cover a significant portion of the Medicaid population and many medical conditions, including the following: 8.61 Rotavirus, 8.8 Viral Enteritis, 464.4 Croup, 486 Pneumonia, 558.9 Gastroenteritis, and 780.39 Convulsions. These are common diagnoses requiring observation care among infants and children.

We believe the intent of expanded observation coverage would include covering all categories of the Medicaid population, particularly pediatrics and maternity. Without covering these, we believe the policy falls significantly short of the initial intent.

Continual maintenance of a diagnosis list can also be problematic, however, following a list allows for disputing which diagnosis should be included or excluded.

Response: MDCH compared criteria-based observation diagnosis with diagnosis-based observation. Following this review and analysis, MDCH believes that the policy, as being implemented, addresses the majority of observation stays. It is not feasible to presume all ongoing short-term treatment is reasonable and necessary (regardless of diagnosis) as an observation service. MDCH is, however, committed to monitoring the impact and review of the diagnosis list.

Implementing this policy does not preclude Medicaid MHPs from continuing their current criteria-based coverage. Providers currently using InterQual criteria to assist in decision making during case management may continue to use it as a resource.

MDCH does not anticipate frequent or significant changes to the diagnoses list. Decisions on additional diagnoses to be added will be made through the policy promulgation process which allows for input from all concerned parties.

Comment: Observation stays should be developed utilizing criteria-based methodologies versus diagnosis based as proposed. Most MHPs currently use InterQual to judge appropriateness. MPRO (entity contracted to perform PA for MDCH) also utilizes InterQual for its processes. It appears that managed care and MPRO have defined criteria in place that could be utilized for observation stays as well.

Response: MHPs may follow their existing observation protocol as long as they follow the FFS observation care services coverage.

Comment: If following a criteria-based policy is not possible, it is recommended that MDCH expand the list of diagnosis qualifying for an observation stay. The list should not be all inclusive, but used as a guideline and include a disclaimer stating "the diagnosis qualifying for an observation stay may include, but are not limited to, the diagnosis included in this policy." This would allow MHPs to cover observation stay through a PA process based on the member's medical condition and not simply based on a diagnosis. If this approach is not possible for FFS, it is suggested a sentence be added at the end of the policy to state "Managed care plans may approve reimbursement for observation services for other diagnoses".

Response: MHPs may continue with or implement criteria based observation coverage or expand the list of covered diagnoses for their contracted hospitals.

Comment: Instead of a diagnosis driven policy, the observation policy should be a function of criteria and time. However, if the State insists that the policy has to be diagnoses driven, then it should be clear that it is a function of diagnosis and time. In this case, the diagnosis requirements should be expanded to include pneumonia, bronchiolitis and bronchitis.

Response: MDCH will implement Medicare's observation criteria for initial implementation with the understanding that we will continue to monitor observation service coverage outcomes. Aligning with Medicare includes time guidelines for reporting observation services. MHPs may follow their existing protocol as long as they follow the FFS observation coverage policy. MDCH will closely monitor data post implementation that includes reviewing diagnoses.

Comment: Due to Medicare's very limited payment policy for observation services the following payment policy for Medicaid FFS and MHP patients is recommended: Pay all diagnoses codes for observation services; observation time must exceed 2 hours; hospital must provide a specific service (Emergency Department [ED], Critical Care or Clinic visit) on the same day or the day before and report on the same claim.

We recommend a direct admission to observation services require HCPCS code G0379 and no procedure with a T Status Indicator (SI 'T' Significant Procedure, Multiple Reduction applies) can be reported on the same day or day before observation care is provided. An observation stay must meet InterQual observation criteria as published by McKesson Corporation and as documented on the Utilization Review Worksheet. If an MHP agreement exists that provides for payment for observation services, that agreement will apply. Recommendation is made for observation services to be paid \$37 per hour of observation time.

MDCH and MHPs cannot use the outpatient observation payment policy to change inpatient admissions to outpatient observation cases. If an inpatient admission has a physician admit order and the inpatient admissions meet inpatient InterQual criteria at the time of admission, these cases must be paid as an inpatient case and not arbitrarily turned into an outpatient observation case for payment purposes.

Response: By aligning with current Medicare observation services policy, MDCH will adhere to specific criteria that include observation time and APC assignment supported by consistent Outpatient Code Editor (OCE) management. The Correct Coding Initiative (CCI) edits are included in the OCE.

Under OPPTS, observation services are packaged into the payment for other separately reimbursed services rendered on the same day or a separate APC payment is made for observation services under specific conditions (diagnosis and time specific). Additional information specific to billing instructions is addressed in the policy. The OCE processing logic recognizes: the Status Indicator (SI) assignment; identifies billing data; HCPCS and ICD-9-CM coding for coverage and validity; determines if observation is packaged with other separately payable hospital services or if a separate APC Payment is appropriate.

Providers currently using InterQual criteria to assist in decision making during case management may continue to use it as a resource. Per uniform billing standards, Condition Code 44 - Inpatient Admission Changed to Outpatient is used on outpatient claims only when the physician ordered inpatient services and the hospital utilization review/case management determines the services did not meet its inpatient criteria. A hospital reports this condition code only if all conditions are met including physician documentation of agreement/physician order to change the patient status from inpatient to outpatient.

Comment: The proposed policy requires observation services be included on a claim with an ED, clinic or critical care visit on the day before or the same day of observation (G0378 only) and no services with payment Status Indicator "T" on the claim ("T" or "V" for G0379) ("V" SI Clinic or ED visit) with DOS equal to, or one day prior to, the observation service date.

These requirements present issues with claim adjudication. If the policy is implemented based upon diagnoses, it will not be possible to adjudicate these types of codes. Implementation of this type of stay would allow for the continual confusion of the admitting diagnosis versus the discharge diagnosis. This generates many provider appeals due to how the claim was coded and what actually should have been presented as the true diagnosis.

Response: Claim completion requirements are consistent with Medicare and uniform billing. The qualifying ICD-9-CM diagnosis code(s) must be reported as the Patient Reason for Visit or as the principal diagnosis, or both. A separate APC payment is not payable without an admitting or principal diagnosis and the OCE processing logic does not edit the admitting versus the discharge diagnosis.

Comment: We recommend that MSA develop an hourly rate of payment of observation services. The policy should reimburse hospitals in a manner similar to observation coverage provided by other payers. Several payers reimburse hospitals for observation services provided for a medical condition based on the number of hours (limited to 24 hours or less).

Response: MDCH is implementing observation coverage consistent with the Medicare definition of observation services, coverage policy and uniform billing guidelines. An observation service is considered as acute or short term and usually does not exceed 24 hours and is reasonable and necessary as ordered. Medicare does not separately pay for units/hours over 24 hours and includes those costs in the APC payment. Observation services under OPSS may be billed as packaged or as a separately payable APC when meeting certain conditions. MDCH did contact other payers regarding their observation services, however did not identify areas of concern specific to coverage variables.

Aligning with Medicare's observation coverage policy allows MDCH to gather information necessary for further analysis of observation services. This information will be necessary for consideration in reviewing or making allowances for changes to observation coverage policy. This information also addresses future compliance concerns in managing observation services.

Comment: The policy addresses the minimum hours of duration, but does not address the maximum number of hours. Careful consideration has to be taken to make sure that the policy either addresses observation stay in its truest form or one-day length of stays, or both. If an inpatient authorization is given for a stay expected to exceed 24 hours and the actual stay was less than 24 hours, the payer may deny the inpatient payment and reimburse the provider at the outpatient observation rate.

Response: Billing instructions for OPH observation services under OPSS require reporting the total number of units/hours for the entire observation stay on a single claim line and align with Medicare's definition of observation time. An observation service is considered as acute or short term and which usually does not exceed 24 hours, is reasonable and necessary as ordered. Medicare does not separately pay for units/hours over 24 hours and includes those costs in the APC payment.

Under OPSS, there are additional billing instructions addressing a separate APC payment that is made under specific conditions that includes an observation period that must equal or exceed 8 hours (and meet diagnosis criteria). Medical necessity that does not support inpatient admission (not the number of units/hours documented as observation time) will not be reimbursed as an inpatient stay.

This policy does not replace the physician order for an inpatient admission. MDCH recognizes the National Uniform Billing Committee (NUBC) billing guidelines. Per NUBC, Condition Code 44 Inpatient Admission Changed to Outpatient is used on outpatient claims only when the physician ordered inpatient services and the hospital utilization review/case management determines the services did not meet its inpatient criteria. A hospital reports this condition code only if all conditions are met, including physician documentation of agreement/physician order to change the patient status from inpatient to outpatient.

Observation services are covered only when provided by order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to outpatient services. Medical record documentation must support medical necessity of the patient status.

Comment: Please remember to address this policy as it relates to the ABW beneficiary who does not have inpatient coverage.

Response: ABW coverage policy applies to outpatient services only. A beneficiary is considered a hospital outpatient when admitted to Observation status. Under OPSS, observation is an outpatient service until a physician decides medical necessity for outpatient discharge or medical necessity for inpatient admission.

Comment: We have concerns with your proposal of using (G0378) hospital observation per hour instead of a flat rate for a single DOS for Revenue Code 762.

Response: HCPCS Procedure Code G0378 by definition must be billed to indicate the number of hours the patient is in observation status in the quantity field, and the payment (per APC assignment) will be a calculated rate to be paid when a minimum of 8 hours of care is provided.

Comment: MHPs require PA and additional documentation and most MHPs follow FFS guidelines for PA. The MDCH contract with MHPs require that MHPs not require any additional fields completed or information to authorize a service or process a claim than the provider would have to do in the FFS arena. As written, the policy has potential to generate different processes by 17 different MHPs resulting in an increase in provider complaints, appeals, and contracting issues.

Response: Medicaid FFS policy acknowledges MHPs are responsible for reimbursing a contractor or subcontractor for services according to conditions stated in their subcontract. MHPs must reimburse non-contracted providers for properly authorized, medically necessary covered services. MHPs may follow their existing protocol as long as they follow FFS observation care services coverage.

Pre-Paid Inpatient Health Plan (PIHP) Community Mental Health Services Programs (CMHSP's) do not authorize observation services except as authorized in the Mental Health Substance Abuse Chapter of the Michigan Medicaid Provider Manual.

Comment: We recommend language that clearly states that all claim lines for any observation service are rolled up into the normal DRG payment when the observation status is converted to a formal inpatient DRG.

Response: Outpatient observation services rendered to a beneficiary who is admitted as an inpatient should be included on the inpatient claim. The charges are considered inpatient and are reflected in the DRG payment.

Comment: The proposed policy excludes maternity services from observations. Ruling out pre-term labor is probably one of the most common medical conditions that get resolved within 24 hours. I strongly suggest that maternity-based conditions be considered for observation.

Response: MDCH hospital policy does not currently cover pre-term labor as observation. MDCH reimburses for the labor and/or delivery room or when an active labor does not progress to delivery when billed with the appropriate diagnosis code. When there is no active labor, MDCH does not cover labor and/or delivery room charges for fetal monitoring or treatment of other medical conditions.

Comment: Address the reimbursement rules for observation services that are derived out of a trip to the ED. We need clarification of whether or not the observation rates include the ED facility rates or whether it is an additional payment, and what ancillary services are or are not included in the observation rates.

Response: Observation services reimbursement under OPSS is packaged into the payment for other separately reimbursed services rendered on the same day, or must meet criteria for a separate APC payment only under the following conditions: the beneficiary must have a diagnosis of asthma, chest pain, or congestive heart failure; and the observation period must equal or exceed 8 hours. The qualifying ICD-9-CM diagnosis code(s) must be reported as the Patient Reason for Visit or as the principal diagnosis, or both.

Observation maybe assigned to beneficiaries who presented to the emergency department because they require additional monitoring before deciding their admission or discharge status. A separate APC payment is made only if all the specific criteria is met. Payments for all other reasonable and necessary observation services are packaged into payments for the other separately payable services (on the same day). You may report any OPS ancillary services while the beneficiary is in observation status using the appropriate combination of Revenue and HCPCS codes.

Comment: The policy states reimbursement of these MHP services will be at the current Medicare rate with MDCH reduction factor applied. Most MHPs provide reimbursement at the current Medicaid rate for 99% of, if not all, services. The applicable rate must take into consideration the applicable MDCH reduction factor that maintains current MHP rates as actuarially sound. MHPs are faced with providing the current benefit and any additional services with no additional funding. The lack of attention to this detail presents cause for concern and generates additional funding issues to MHPs providing this benefit.

Response: Separately payable observation service will be reimbursed at the current Medicare APC rate with the MDCH reduction factor applied. Additional financial information is available under Project 0666-OPSS along with the reports generated by the State Actuarial, Milliman, Inc., Actuarial Consultants.

Comment: We propose an alternative policy for short stay services be developed for cases with duration of care between 8 and 23 hours to be paid at a case rate. Short stay services include categories of cases: medical observation (no procedures or surgeries); procedure observation (endoscopies, stress test, diagnostic cath); and surgical observation (surgical procedure performed and stay between 8 and 23 hours). A case rate could be developed for each category of short stay.

Response: MDCH is not considering an alternative policy for "Short Stay Services."

Comment: If a patient is in an observation bed and is moved inpatient will the observation payment be rolled up into the inpatient payment or is it paid in addition to the inpatient payment?

Response: Yes – it is rolled into the inpatient DRG payment.

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I trust your concerns have been addressed. If you wish to comment further, send your comments to Susan Schwenn at:

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Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Sincerely,

A handwritten signature in black ink that reads "Paul Reinhart". The signature is written in a cursive, slightly slanted style.

Paul Reinhart, Director
Medical Services Administration