Medicaid Acute Care Annual Report

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CHAPTER 1

EXECUTIVE SUMMARY

CFMC's Acute Care Review Services program conducted 12,191 reviews for the Colorado Department of Health Care Policy and Financing (the Department). These activities prevented $9,047,816 from being spent on inappropriate and unnecessary medical care in Colorado. This translates into a savings of $672 for every review conducted during FY 06.

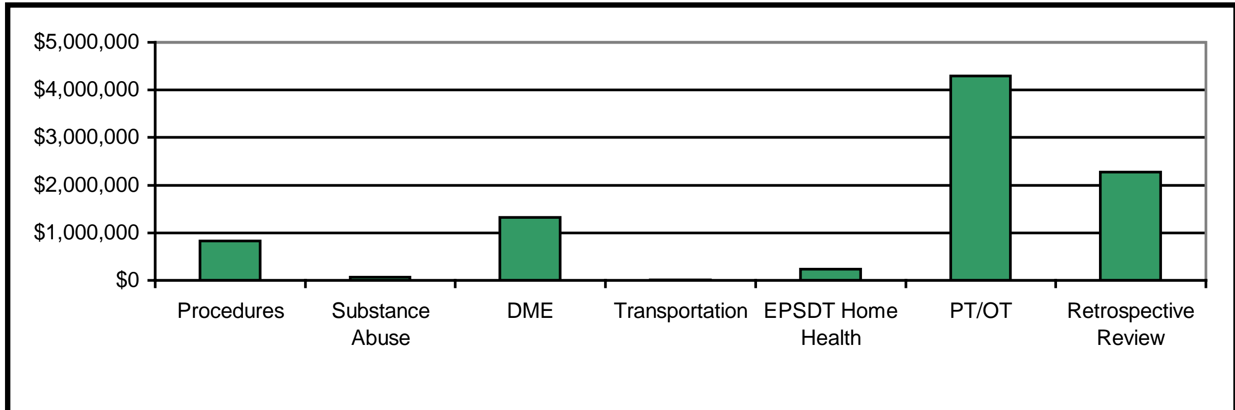
CFMC, working in partnership with the Department, conducted two types of reviews, prospective and retrospective. Prospective reviews are conducted prior to the delivery of services. Requests are reviewed to ensure that the service is a covered benefit and that the service is medically necessary and appropriate. The denial of inappropriate prospective request reviews discourages potential abuse of the system while minimizing duplication of services. CFMC reviewed 8,140 prior authorization requests for nine different Medicaid services. Using reimbursement figures provided by the Department, CFMC estimates that $6,768,965 was prevented from being spent by denying inappropriate services. This figure represents a 42% increase over FY 05.

The types of prospective review remained unchanged in FY 06, although many changes in review demand were seen. Total review volume increased 19%. Most categories of review experienced increases in volume, but the effect was most notable in durable medical equipment (DME) and physical and occupational therapies (PT/OT). In addition to increased review volumes, up 22% for DME and 13% for PT/OT, the complexity of each review increased. Because every item or unit on a request has to be evaluated for medical necessity, time spent on each review has increased. Requests that do not meet medical necessity continue to be sent to a physician for a final determination. CFMC continues to work closely with DME and PT/OT providers to improve clinical documentation in support of their requests for treatment authorization.

Retrospective reviews are conducted on inpatient stays after the hospital claims have been paid. Examining paid claims ensures that the care paid for was medically necessary, required acute level of care, was coded correctly, and was of high quality. The majority of cases are selected using criteria that target specific types of cases known to, or expected to, contain a large percentage of errors. No errors are found in the vast majority of cases (88%), but the potential financial impact of the other 12% is substantial. If a provider is unable to produce evidence to support the payment received, the Department is entitled to recover the funds paid. If the admission was not medically necessary, was billed or coded incorrectly, or the facility failed to comply with record requests, the Department works with the fiscal agent to recover funds. Retrospective review activities identified $2,278,851 in unsubstantiated payments, a 17% increase over the previous fiscal year.

Figure 1.1 illustrates the financial impact of both prospective and retrospective reviews. A total of $9,047,816 is estimated to be conserved during FY 06. Prospective review of PT/OT services had the most impact, just under 50%, preventing $4,297,356 from being spent on medically unnecessary services. Taken together, prospective reviews accounted for 75% of the impact compared to 25% for retrospective reviews.

FIGURE 1.1 – TOTAL COSTS AVOIDED BY PROGRAM



After factoring in the cost of CFMC's FY 06 contract, the Department netted $8,190,190 in savings. This is $4 million more than any previous year. Return on investment is the best way to assess value of a program. For each dollar spent on CFMC's acute care review activities in FY 06, $10.55 was saved from being spent inappropriately. While the Department shares the cost of providing services with federal agencies, only 25% of the contract is paid with Colorado dollars. As a result, the Department paid $214,407 to fund activities that saved $4,523,90, a return on investment of $21.10 for every dollar spent. These figures do not include the $692,531 in potential savings from 105 cases CFMC referred to the Third Party Resources unit.

In addition to review activities, this report discusses CFMC's role in third party liability referrals, administrative law judge hearings, special service requests, fraud and abuse prevention, and the Colorado Medicaid FirstHelp telephone triage program. CFMC offers recommendations in this report that are intended to increase both the quality and cost-effectiveness of healthcare.

Please Note:

The figures on the next page are provided as a one-page reference for general information concerning review volumes, approval rates, and fiscal impact. Each figure is explained in detail in the report. After reading the entire report, the reader may find this page a valuable tool for locating numbers quickly.

TABLE 1.1 – FISCAL YEAR 06 KEY TABLES

Total Review Volumes	
Prospective Reviews	8,140
Retrospective Reviews	4,051
	12,191

Total Costs Avoided	
Prospective	$6,768,965
RETROSPECTIVE	$2,278,851
Costs Avoided	**$9,047,816**

Prospective Review Volumes	
Transplants	50
Select Procedures	404
Out-of-state Admissions	51
Mental Health Services	1
Substance Abuse	70
DME	2,962
Transportation	480
EPSDT Home Health	107
PT/OT	4,015
Total Reviews	**8,140**

Prospective Review Approval Rates	
Transplants	88%
Select Procedures	65%
Out-of-state Admissions	65%
Mental Health Services	100%
Substance Abuse	73%
DME	93%
Transportation	95%
EPSDT Home Health	95%
PT/OT	88%
Total Reviews	**89%**

Retrospective Review Selection Rates	
Focused Inliers	1,083
Random Selection	970
Provider Focus	898
DRG Focus	562
DRG Inlier Focus	355
Readmissions	213
DRG Outlier Focus	95
DRG 871 as Readmission	39
State Request	7
Total Reviews	**4,051**

Retrospective Review Outcome Rates	
Approved	3,559
Admission Denial	170
Technical Denial	46
Billing Error Denial	276
Total Reviews	**4,051**

Net Costs Avoided	
Gross Costs Avoided	$9,047,816
Contract Price	($857,626)
Net Savings	**$8,190,190**

Colorado Net Costs Avoided	
Gross Costs Avoided	$4,523,908
Contract Price	($214,407)
Net Savings	**$4,309,501**

Return on Investment	
Colorado Funds	21.10
Federal Funds	7.03
Total Return	**10.55**

Costs Avoided Per Review	
Colorado Funds	$354
Federal Funds	$318
Net Per Review	**$672**

CHAPTER 2

REVIEW ACTIVITY OVERVIEW

CFMC's Medicaid medical care review program conducted two forms of review during FY 06:

- Prospective reviews – Reviews conducted prior to performance of services
- Retrospective reviews – Reviews conducted following payment for services rendered

Most reviews conducted by CFMC nurse and physician reviewers use nationally recognized Milliman Care Guidelines. Milliman Care Guidelines provide evidenced-based criteria for providing the right care, at the right time, in the right setting in a high quality and resource efficient manner. Milliman Care Guidelines were adopted in FY 05 because they offer evidenced-based criteria that are annually updated by specialists familiar with the latest medical research. Milliman Care Guidelines also include reference material to support each guideline, material that can be used to support the reviewer's decision in the case of an appeal.

Milliman Care Guidelines are currently not available for all types of medical products and services. CFMC uses criteria published by the Department for determining medical necessity, appropriateness of care, cost effectiveness of care for DME, physical and occupational therapy services, and the DSM-IV guidelines for inpatient substance use disorder treatment.

Internal Monitoring Process

To ensure high quality standards, CFMC has established an internal quality management policy consistent with CFMC's ISO 9001:2000 certification. ISO 9001:2000 certification is an international quality management standard published by the International Organization for Standardization. This certification represents an international consensus on what constitutes quality management practices that help organizations provide appropriate products or services and meet client requirements. This ongoing process measures quality standards and provides ongoing training and education. If deviations in standards are identified, process improvements and/or individual guidance and instruction are promptly implemented.

CFMC monitors the inter-rater reliability of both nurse and physician review on a monthly basis. Each month, a set of cases is randomly selected and reviewed for validity and reliability measures. From these reviews, CFMC has been able to identify opportunities for improvement, plan educational sessions, and revise systems and processes using the plan/do/study/act quality improvement principles. The Centers for Medicare & Medicaid Services performance standards define acceptable inter-rater reliability as 80%, and 90% is considered excellent. The most recent data available indicates that CFMC physician reviewer inter-rater reliability is 88%, while the same measure for CFMC non-physician reviewers remains above 94%. Outcomes of this process are reported to the Department every six months.

CHAPTER 3

PROSPECTIVE REVIEW HIGHLIGHTS

CFMC reviewed 8,140 prior authorization requests, from nine different service categories, to ensure that each request was a covered Medicaid benefit, that the request was medically necessary, and was appropriate based on the established criteria. These activities prevented $6,768,965 from being spent inappropriately during FY 06. These numbers constitute a 19% increase in review volume and a 42% increase in avoided costs based on CFMC review results and do not reflect review determinations by the Department or the fiscal agent.

Review of outpatient hospital-based physical and occupational therapy (PT/OT) services in the prospective review process produced the greatest impact during FY 06. While the number of PT/OT reviews increased 15% over FY 05 to 4,015, cost avoidance from these reviews increased 67% to $4,297,356. PT/OT reviews accounted for 64% of the prospective review fiscal impact.

Durable medical equipment (DME) reviews totaled 2,962, an increase of 22%. The number of power wheelchairs and power wheelchair accessories increased the most, up 25%. Total costs conserved were $1,320,833. While both the number of high-dollar items requested and the complexity of the requests increased, CFMC continued to review each item requested to ensure it is medically necessary, as required by contract.

Results of the other prospective review programs varied on a smaller scale. The number of requests for transplants and select procedures were up 22%, preventing $833,728 from being spent inappropriately. Total savings were up 125% in FY 06; the number of transplant requests as well as the type of transplant requests determines savings figures. The number of requests for out-of-state elective admissions also varies each year, but with 51 during FY 06, they constitute less than 1% of review volumes.

Inpatient mental health services and inpatient substance abuse rehabilitation services are the two newest review programs. CFMC received only one request for mental health services during FY 06, compared to 27 in FY 05. In contrast, the number of substance abuse rehabilitation requests increased 75%, from 40 in FY 05 to 70 in FY 06.

The number of select non-emergent medical transportation service reviews totaled 480, a 77% increase over FY 05. The majority of these reviews involved meals and lodging, low cost services compared to air transport and bariatric ambulance services, so savings were limited to $11,268, a 48% decline.

The opposite happened with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) home health service reviews. The number of reviews declined 48% to 107. Savings, however, totaled $236,694, an increase of 120%.

TABLE 3.1 – NUMBER OF PROSPECTIVE REVIEWS

Prospective Request	FY 04	FY 05	FY 06
Transplants	52	37	50
Select Procedures	363	335	404
Out-of-state Elective Admissions	31	36	51
Inpatient Mental Health Services	12	27	1
Inpatient Substance Abuse Rehabilitation	NA	40	70
Durable Medical Equipment	2,598	2,424	2,962
Select Non-emergent Medical Transportation	204	272	480
EPSDT Home Health Services	174	186	107
Physical & Occupational Therapy	677	3,490	4,015
Total Prospective Reviews	**4,099**	**6,847**	**8,140**

TABLE 3.2 – PROSPECTIVE REVIEW OUTCOMES

Prospective Request	Approved	Partially Approved	Denied	Total Reviewed[1]	Approval Rate[2]
Transplants	43	1	6	50	88%
Select Procedures	202	61	141	404	65%
Out-of-state Elective Admissions	33	0	18	51	65%
Inpatient Mental Health Services	1	0	0	1	100%
Inpatient Substance Abuse Rehabilitation	51	0	19	70	73%
Durable Medical Equipment	2,302	466	143	2,962	93%
Select Non-emergent Medical Transportation	443	20	14	480	95%
EPSDT Home Health Services	99	4	3	107	95%
Physical & Occupational Therapy	3,267	266	481	4,015	88%
Totals[1]	**6,438**	**826**	**820**	**8,140**	**89%**

1. Totals include 56 cancelled requests, including 51 DME, three non-emergent transportation, one home health and one physical therapy.
2. Percentage of requests approved or modified.

TABLE 3.3 – PROSPECTIVE REVIEW TOTAL COSTS AVOIDED

Prospective Request	FY 03	FY 04	FY 05	FY 06
Transplants	$254,343	$515,486	$336,644	$811,092
Select Procedures	$27,852	$15,256	$34,273	$22,636
Inpatient Mental Health Services	NA	$0	$33,784	$0
Inpatient Substance Abuse Rehabilitation	NA	NA	$0	$69,086
Durable Medical Equipment	$1,452,138	$2,447,571	$1,650,172	$1,320,833
Select Non-emergent Medical Transportation	NA	$8,955	$21,603	$11,268
EPSDT Home Health Services	$192,367	$88,366	$107,444	$236,694
Physical & Occupational Therapy	$344,529	$870,273	$2,579,195	$4,297,356
Total Prospective Review Costs Avoided	**$2,271,229**	**$3,945,907**	**$4,763,115**	**$6,768,965**

TABLE 3.4 – PROSPECTIVE REVIEW COST RATIOS

Key Prospective Review Ratios	FY 03	FY 04	FY 05	FY 06
Costs Avoided Per Review	$461	$963	$696	$832

Prospective Review – Discussion

Prospective reviews are conducted prior to the delivery of services. By requiring prior authorization, the Department is able to ensure that clients receive medically necessary services and equipment. CFMC reviews each request to verify that it is a covered benefit and that the request is medically appropriate. Prospective review ensures high quality service is being provided to Medicaid clients while conserving limited resources and eliminating unnecessary costs by denying inappropriate requests, discouraging potential abuse of the system, and minimizing duplication of services. If trends or other concerns about provider quality or consistency are identified, the Department is notified. The positive working relationship CFMC has with the Department has produced a refined review process that provides clients with the services they need in a timely manner while eliminating unnecessary costs.

The Review Process

The Department contracted with CFMC to conduct prospective reviews for services that are either high cost or high volume. Registered nurse review coordinators review requests from providers to ensure that the request is a covered Medicaid benefit, that the request is medically necessary, and is appropriate based on established criteria. Milliman Care Guidelines are used for the prospective review of surgical procedures, including transplants, and inpatient mental health admissions. Criteria published by the Department are used to review requests for DME, physical and occupational therapy services, and inpatient substance abuse rehabilitation disorder treatment. CFMC reviews prospective authorization requests for the following Medicaid benefits:

- Organ and bone marrow transplantation
- Select inpatient and outpatient surgical procedures
- Out-of-state elective inpatient hospital admissions
- Inpatient mental health services
- Inpatient Substance abuse rehabilitation
- Durable medical equipment – Both adult and Early and Periodic Screening, Diagnosis and Treatment programs
- Select non-emergent medical transportation services
- Home health services for the Early and Periodic Screening, Diagnosis and Treatment program
- Physical & occupational therapy

Initially, requests are reviewed to ensure that all demographic information has been provided to comply with new regulatory transmission requirements. If the PAR request is incomplete, a technical denial is issued and the PAR is returned to the provider for completion. This step ensures that all review documentation complies with the strict formatting rules of the X12N 278

Health Care Services Review Standard. Compliance with the new data exchange format will allow direct transmission of the PAR outcome to the fiscal agent.

If clinical information supporting the request is missing, the nurse reviewer issues a document-tracking letter requesting the missing clinical information from the provider. The provider has 10 working days to submit the information. If the clinical information is not received within that time frame, the request is denied. Automation of the process enables CFMC reviewers to quickly identify previous denials and duplicate requests, saving both time and money. The nurse reviewer has 10 days to determine that the request meets all criteria. The inpatient mental health and inpatient substance abuse admission reviews must be completed within 48 hours. All prior authorization requests where medical necessity cannot be substantiated are referred to a CFMC specialty-matched physician reviewer for a final decision. Upon physician reviewer determination, the authorization is sent to the fiscal agent for provider and member notification.

CFMC review services and information technology departments participated in the Department's development of the X12N 278 Health Care Services Program. CFMC worked in collaboration with the fiscal agent and the Department to design a system that ensures all review determinations are submitted according to the strict formatting rules mandated by the Centers for Medicare & Medicaid Services. As of March 2006, CFMC's information system changes were in place and functioning as designed. Operational meetings with the fiscal agent and the Department will continue until the project is completed.

Impact Calculation Methodology

Prospective reviews preserve funds by preventing inappropriate and unnecessary expenditures before they occur. The "costs avoided" through prospective review do not represent savings that can be passed back to Colorado's general budget. However, by eliminating unnecessary and inappropriate expenses, the Department is able to address the medical needs of a larger number of Medicaid clients.

Since prospective reviews prevent funds from being spent inappropriately, the true financial benefits of prior authorization reviews must be estimated. While CFMC has continually refined its impact analysis processes to provide the most accurate projections possible, the cost avoidance figures are only estimates. Because of differences in billing for the various programs requiring prospective review, CFMC uses different methodologies to calculate the fiscal impact of each category of review.

Both transplants and inpatient surgical procedures are paid using the diagnosis related group (DRG) payment system. The DRG classification system allows inpatient providers to categorize patients by diagnoses, treatment, and resource consumption. Under this system, providers receive a predetermined, fixed payment based on the DRG for each admission. The costs avoided from a denial of one of these procedures are estimated by multiplying the hospital's base rate by the weight of the DRG expected for the denied procedure. The Department supplies the hospital base rates and DRG weights used for this calculation. The DRGs used in these calculations assume an otherwise healthy individual with no complicating conditions. A case involving co-morbid conditions can be much more expensive than the costs estimated by CFMC.

Outpatient procedures and durable medical equipment costs are estimated by calculating the average Medicaid payment during the year for each particular procedure or unit of equipment. Costs avoided through transportation, EPSDT home health, and physical and occupational therapy reviews are calculated using the fee schedule allowed for each unit of the services denied. Inpatient mental health treatment costs are calculated using the facility's per diem rate times 14, the maximum number of days that may be requested at one time. No impact is calculated for out-of-state elective admissions because payment data from other states is not available.

It should be noted that CFMC receives prior authorization requests for items or services that do not require prior authorization or that are covered under another program. These items and services have not previously been separated out statistically. These requests are denied and included in the review volume calculations. A special code is used, however, to ensure they do not impact CFMC's impact calculations. Process changes were put into place during FY 06 to more accurately capture this data in the system. CFMC began tracking these requests in FY 06. A total of 245 requests not requiring authorization by CFMC were captured during FY 06 (see Table 3.5). More accurate capturing of this data is anticipated in FY 07.

TABLE 3.5 – UNNECESSARY PROSPECTIVE REVIEW REQUESTS

Prospective Request	FY 06
Admission/Treatment/Procedures	189
Durable Medical Equipment	52
Transportation	5
Total Unnecessary Requests	**245**

Prospective Review Activity Outcomes

The following sections discuss each of the review categories in greater detail.

Organ And Bone Marrow Transplants

The Department requires facilities to receive prospective authorization for certain types of organ and bone marrow transplants. Many highly specialized procedures are done only at National Centers of Excellence facilities outside of Colorado. All requests for out-of-state procedures, including transplants, are sent to a CFMC specialty-matched physician reviewer for determination. The physician determines medical necessity, verifies that the procedure is not investigational or experimental, and verifies that the procedure cannot be done within Colorado.

In-state transplant requests are approved by CFMC if they are on the approved transplant list established by the Department, and meet Milliman Care Guidelines or are approved by a specialty-matched physician reviewer. If they are not on the Department approved transplant list, a CFMC specialty-matched physician reviewer determines medical necessity and verifies that the procedure is not experimental or investigational. The physician reviewer's determination is forwarded to the Department for consideration. The Department makes the final decision on whether to approve or deny the transplant procedure.

Requests for transplant authorization are generally submitted well in advance of the actual procedure. In fact, approval of a request does not necessarily mean that a transplant will take place. Many factors, including the client's overall health and the availability of organs, ultimately determine if and when a transplant is performed. Sometimes these factors cause a facility to cancel a request before a determination is made.

Outcomes

The number of prospective transplant reviews conducted during a given year varies due to the volume and type of transplant requests (see Table 3.6).

TABLE 3.6 – PROSPECTIVE TRANSPLANT REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	47	33	43
Denied	5	4	6
Modified	0	0	1
Canceled	0	0	0
Total Reviewed	**52**	**37**	**50**

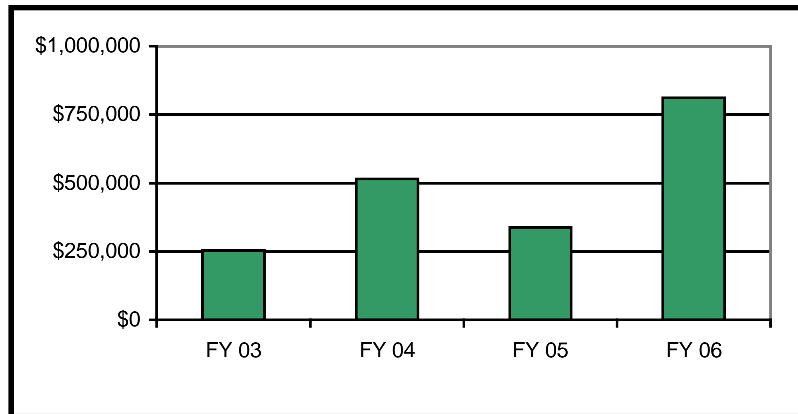
Bone marrow/stem cell and liver transplants continue to account for three-quarters of the requests (see Table 3.7).

TABLE 3.7 – PROSPECTIVE TRANSPLANT REVIEW DETAILS

Type of Request	Approved	Denied	Modified	Total
In-state Transplants				
Bone/Stem Allo	13	1	0	14
Liver	8	4	0	12
Bone/Stem Auto	11	1	0	12
Heart	10	0	0	10
Lung/Lung	1	0	0	1
Kidney/Pancreas	0	0	1	1
Out-of-state Transplants	0	0	0	0
Totals	**43**	**6**	**1**	**50**

The figures in this report provide a visual representation of the costs avoided for each of the programs. Figure 3.1 illustrates the financial impact of the prospective transplant review program. A total of $811,092 was conserved during FY 06. Given the high cost of these procedures, even a small number of denials is cost effective. Conservative estimates suggest a liver transplant costs $117,000 while the costs of a bone marrow transplant start at around $170,000. During FY 06, four liver transplants and two bone marrow transplants were denied for lack of medical necessity.

FIGURE 3.1
COSTS AVOIDED – PROSPECTIVE TRANSPLANT REVIEWS



Trends

For the fourth-consecutive straight year bone marrow/stem cell transplant authorizations were the most frequently requested type of transplant. Liver transplant requests were second for the fourth year as well. Combined, these two procedures continually account for 75% of the transplant requests. Because of the number of variables involved, it is difficult to predict the number of requested transplants in any given year. As transplants have become more widely available with improved outcomes the expectation is for an increased numbers of requests.

Select Procedures

The Department requires a prospective authorization review for a select group of inpatient and ambulatory procedures. Reviews are conducted by CFMC nurse reviewers to ensure Milliman Care Guidelines for medical necessity and level of care are met. Procedures not meeting Milliman Care Guidelines are reviewed by a CFMC specialty-matched physician reviewer for medical necessity determination. Among the procedures requiring prospective approval are septoplasty, gastric bypass, and gastroplasty. Review of these procedures ensures that the procedure is not being done for strictly cosmetic purposes and meets medical necessity guidelines.

During FY 06, CFMC and the Department developed prospective review criteria for breast reduction in clients with a history of breast cancer to ensure that these clients receive their medical care in the most efficient manner. The Department initially asked CFMC to develop recommendations regarding the authorization of reduction mammoplasty/reconstruction of the non-affected breast to produce a symmetrical appearance. CFMC surveyed local board certified plastic surgeons and general surgeons familiar with the procedure, performed an extensive literature search for the most current standards of practice, and closely reviewed the Woman's Health and Cancer Right's Act of 1997. After reviewing the recommendations, the Department agreed that mastopexy within five years of the original breast cancer surgery does not necessitate

prospective authorization review. Cases that fall outside this time period continue to require prospective authorization review.

Outcomes

The number of prospective select procedure requests conducted during a given year varies each year (see Table 3.8).

TABLE 3.8 – PROSPECTIVE SELECT PROCEDURE REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	274	205	202
Denied	88	130	141
Modified	0	0	61
Canceled	1	0	0
Total Reviewed	**363**	**335**	**404**

The increase in review volume was driven primarily by the number of requested nasal procedures (see Table 3.9). If the requests submitted for procedures that do not require prospective authorization are excluded, nasal procedures constitute 57% of the review volume. The number of requests for procedures that do not require prospective authorization was up 25% in FY 06. The number of breast procedures requested declined due to the new review guidelines regarding breast reductions following breast cancer surgery as outlined above.

TABLE 3.9 – PROSPECTIVE SELECT PROCEDURE REVIEW DETAILS

Type of Request	Approved	Denied	Modified	Total
Nasal Procedures	91	10	40	141
Gastric Procedures	44	7	10	61
Breast Procedures	24	14	1	39
Ear Implant Procedures	22	4	0	26
Dermatological Procedures	18	3	0	21
Genital & Intersex Procedures	1	0	0	1
Other Procedures[1]	2	103	10	115
Totals	**202**	**141**	**61**	**404**

1. CFMC continues to receive a large number of requests for procedures that do not require prospective review. These requests are denied.

Trends

With an approval rate of 65%, select procedures, along with out-of-state elective admissions, continue to have the lowest approval rates of all prospective authorization reviews (see Table 3.2 on page 6). The number of requests for procedures that do not require a prior authorization, however, impacts this rate. These "I" code denials will be more accurately reported in FY 07 following the system changes in FY 06.

Out-of-state Elective Admissions

Out-of-state elective inpatient admissions are reviewed to determine medical necessity as well as to determine whether the procedure is experimental, whether the procedure is a covered Medicaid benefit, and whether the requested care can be obtained within Colorado. All prospective out-of-state requests are sent to a CFMC physician reviewer to determine whether treatment is medically necessary and whether it can be provided within the state.

The number of out-of-state elective admissions has historically accounted for less than 1% of the prospective reviews requested each year (see Table 3.10).

TABLE 3.10 – PROSPECTIVE OUT-OF-STATE ELECTIVE ADMISSION REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	21	27	33
Denied	9	9	18
Modified	0	0	0
Canceled	1	0	0
Total Reviewed	**31**	**36**	**51**

Clients living in border communities frequently receive care at hospitals located in one of Colorado's neighboring states. The Department's Border Hospital program allows Colorado clients to receive services at one of these facilities without prior authorization. These admissions only become problematic when one of the rural facilities needs to transfer a client to an urban facility with greater resources and expertise. In some cases, the closest major facility is in Albuquerque, not Denver.

Trends

The increase in review volume may be due to increase in clients but is also indicative of the increasing complexity of medical treatment. Many procedures require a level of technology and specialization that are available only at certain Centers of Excellence around the country.

Inpatient Mental Health Services

Individuals under the age of 21 may be eligible for additional mental health services. Services beyond the limit for clients enrolled in fee for service must be prior authorized by CFMC, the acute care utilization review contractor for the Department. Regulations limit the number of days a client can spend in an inpatient psychiatric hospital to 45 days per fiscal year. Prospective authorization is required for inpatient mental health services beyond 45 days. It should be noted that court-ordered services are not subject to prior authorization requirements.

Outcomes

As a program designed to assist clients with extended inpatient mental health treatment needs, the number of prospective mental heath reviews is expected to be small (see Table 3.11).

TABLE 3.11 – PROSPECTIVE INPATIENT MENTAL HEALTH REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	12	21	1
Denied	0	6	0
Modified	0	0	0
Canceled	0	0	0
Total Reviewed	**12**	**27**	**1**

Trends

This program targets clients with specific needs requiring services that are more extensive. The inpatient needs of most clients can usually be met within the original 45 days allotted. Then they transition to outpatient care.

Inpatient Substance Abuse Rehabilitation Services

Inpatient substance abuse rehabilitation was added to the list of services requiring prospective authorization during FY 05. To qualify for the substance abuse rehabilitative program clients must be under age 21, have a history of substance abuse, and an aggravating physical or mental illness that necessitates treatment in an intensive setting. Reviewers with specialized mental health experience and training conduct both substance abuse rehabilitation and mental health service reviews. The admission criteria were developed by the Department and are used to establish medical necessity.

Outcomes

FY 06 was just the second year for prospective review of clients entering this program. Table 3.12 illustrates the relative growth in the program.

TABLE 3.12 – PROSPECTIVE INPATIENT SUBSTANCE ABUSE REHABILITATION REVIEWS

Review Outcome	FY 05	FY 06
Approved	40	51
Denied	0	19
Modified	0	0
Canceled	0	0
Total Reviewed	**40**	**70**

Trends

The inpatient substance abuse rehabilitation program is too new, and the volumes too small, to draw accurate conclusions about trends. CFMC continues to monitor the program and the types of requests submitted.

Durable Medical Equipment – All Programs

Durable medical equipment (DME) are devices that assist persons to function normally outside a medical facility, can withstand repeated use, and have a defined medical purpose. DME enables clients to remain outside an institutional setting by promoting, maintaining, or restoring health, or by minimizing the effects of illness, disability, or handicapping condition. DME is a Medicaid benefit for eligible clients when ordered by a physician and is part of a comprehensive treatment plan.

CFMC reviews requests for DME that are highly complex or expensive to provide, such as power wheelchairs, power scooters, rehabilitation equipment, respiratory aids, augmentative communication devices, and certain orthotics and prosthetics. Review of these items is complex because each request often includes requests for numerous components and additional accessories. Each item must be reviewed to determine whether the item was prescribed by a physician, is in accordance with current medical standards of practice, is appropriate for the client's clinical condition, and that appropriate alternatives either do not exist or do not meet the client's treatment requirements. CFMC participates in the monthly DME Advisory Board meeting with the Department in order to continue to interface with providers and the Department, keep abreast of changes, and provide information as needed.

Outcomes

The 2,962 prospective DME reviews in FY 06 was a 22% increase over FY 05 (see Table 3.13). A request can be approved, modified, or denied. If all the equipment requested meets guidelines, the entire request is approved. If some of the items requested are not medically necessary, those items can be denied while the necessary pieces are approved. This is referred to as a modified approval. If none of the equipment is clinically necessary, the entire request is denied.

TABLE 3.13 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REVIEWS - TOTAL

Review Outcome	FY 04	FY 05	FY 06
Approved	1,834	1,773	2,302
Modified	282	203	143
Denied	482	447	466
Cancelled	0	0	51
Total Reviewed	**2,598**	**2,424**	**2,962**
Approval Rate[1]	**81%**	**82%**	**83%**

1. Percentage of requests approved or modified.

Prospective DME requests are categorized according to the primary piece of equipment requested. The three primary categories are power wheelchairs, power scooters, and orthotics and prosthetics. If a request does not fall under one of these categories, it is placed into the "Other" category. Items such as wheelchair parts and labor, respiratory devices, and rehabilitation equipment fall into this category. Table 3.14 summarizes the number and outcome of the prospective requests conducted during FY 06.

TABLE 3.14 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REQUEST DETAILS – TOTAL

DME Category	Approved	Modified	Denied	Total Reviewed[1]	Approval Rate[2]
Power Wheelchairs	576	78	165	821	80%
Power Scooters	91	9	42	142	70%
Orthotics/Prosthetics	167	6	29	202	86%
Other[3]	1,468	50	230	1,797	84%
Totals[1]	**2,302**	**143**	**466**	**2,962**	**83%**

1. Totals include two power wheelchair requests and 49 "Other" requests that were cancelled.
2. Percentage of requests approved or modified.
3. Other reviews include requests for wheelchair parts and labor, respiratory devices, and rehab equipment other than orthotics/prosthetics.

Table 3.15 shows the distribution of the increased number of reviews in FY 06. Power wheelchairs experienced the largest growth, up 25% from FY 05. Requests for power scooters were up 20% while the category "Other," which includes items related to power wheelchairs and scooters, was up 22%. Requests for orthotics and prosthetics were up 13%.

TABLE 3.15 – DURABLE MEDICAL EQUIPMENT ITEM REQUEST OUTCOMES – TOTAL

DME Category	FY 04	FY 05	FY 06
Power Wheelchair	698	657	821
Power Scooter	154	118	142
Orthotics/Prosthetics	170	179	202
Other[1]	1,576	1,470	1,797
Totals	**2,598**	**2,424**	**2,962**

1. Other reviews include requests for wheelchair parts and labor, respiratory devices, and rehab equipment other than orthotics/prosthetics.

Because more than one unit of DME is typically included within each prospective authorization request, it is useful to track the number and types of equipment being requested. For example, an augmentative communication device may include a series of switches, a keyboard mounting system, component software, and a carrying case. It is worth noting that while the number of prospective review requests was up 22% in FY 06 (see Table 3.13 on page 15), the number of individual units requested increased by 30% (see Table 3.16).

TABLE 3.16 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES – TOTAL

Review Outcome	FY 04	FY 05	FY 06
Units Approved	17,485	17,181	23,730
Units Denied	9,889	5,790	6,181
Total Units Reviewed	**27,374**	**22,971**	**29,911**
Percent Approved	**64%**	**75%**	**79%**

The mean number of units per request was 10.1 in FY 06, compared to 9.5 in FY 05. The mean for power wheelchair requests, however, was 16.5 units. These units include accessories to accommodate the client's musculoskeletal, respiratory, and/or neurological needs but exclude labor and service units. Table 3.17 summarizes the types of equipment requested, the number of each, and the review outcome. Because each unit is reviewed independently, each unit is either approved or denied.

TABLE 3.17 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES BY CATEGORY – TOTAL

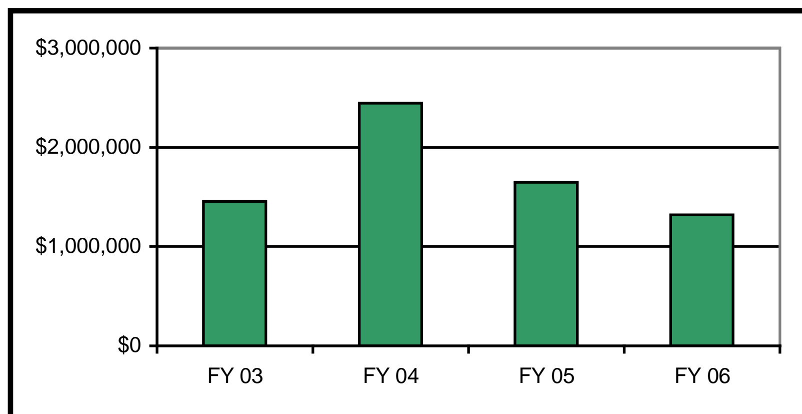
Type of Equipment	Units Approved	Units Denied	Total Units Reviewed	Percentage Approval
Wheelchair Accessory	10,419	2,299	12,718	82%
Labor/Service/Repair	6,930	2,122	9,052	77%
Orthotics/Prosthetics	5,258	517	5,775	91%
Power Wheelchair	655	178	833	79%
Rehabilitation Equipment	27	267	294	9%
Power Scooter	111	42	153	73%
Communication Device	112	18	130	86%
Respiratory Device	53	49	102	52%
Back-up Manual Wheelchair	11	23	34	32%
Miscellaneous[1]	154	666	820	19%
Totals	**23,730**	**6,181**	**29,911**	**79%**

1. Miscellaneous items are those products, such as safety equipment, that do not fit into an established category.

Impact

CFMC's prospective review of complex DME requests prevented $1,320,833 from being spent on unjustified equipment, a 20% decline from the $1,650,172 total in FY 05 (see Figure 3.2). This decline is due to the higher approval rate for DME units. The average cost avoided per unit denied was $214. Although there is a decline, many unnecessary, high cost items continue to be requested.

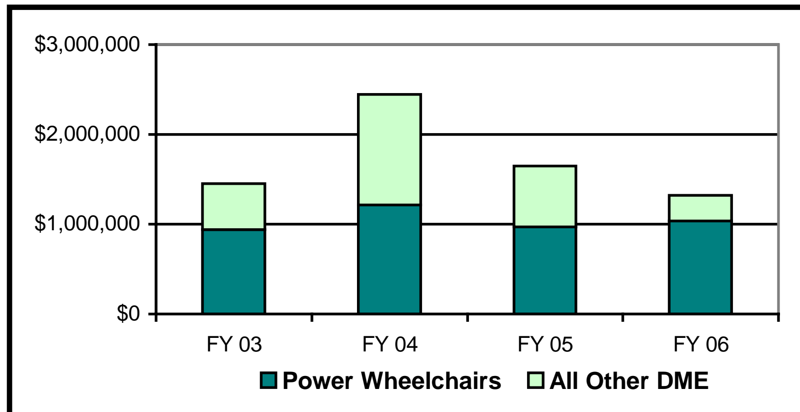
FIGURE 3.2
DOLLARS CONSERVED – PROSPECTIVE DME REVIEWS



Power Wheelchairs

Because the cost of basic power wheelchairs models start around $3,000, and can easily surpass $20,000 when accessories are added, the Department has been interested in the results of the power wheelchair prospective review process. Historically, cost avoidance from unnecessary power wheelchairs and wheelchair accessories have accounted for at least half the total amount conserved through prospective DME reviews (see Figure 3.3). Of the $1,320,833 in DME costs avoided during FY 06, 78% ($1,033,907) was directly related to reviews of power wheelchair and power wheelchair accessories. Of the $6,768,965 conserved through the entire prospective review program, 15% was due to power wheelchair and power wheelchair accessory reviews.

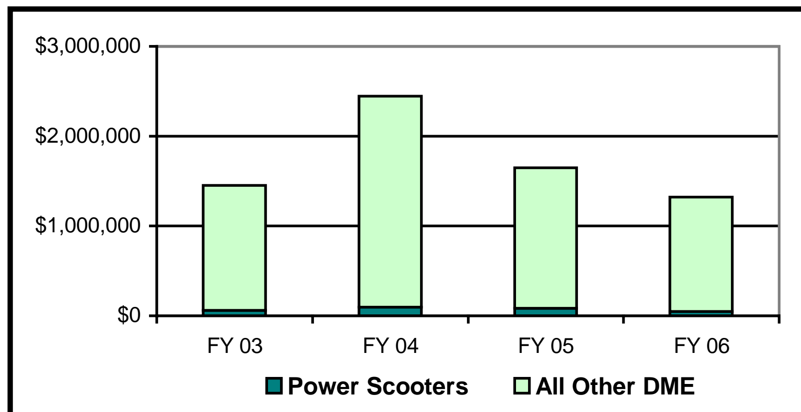
FIGURE 3.3
DOLLARS CONSERVED – POWER WHEELCHAIR REVIEWS



Power Scooters

Like power wheelchairs, power scooters are expensive items with strict clinical criteria. Of the 142 requests for power scooters reviewed in FY 06, 70% met medical guidelines. The approval rate for scooters has always been lower than for wheelchairs. Their lower volume also means that power scooters produce smaller savings (compare Figures 3.3 and 3.4). The 42 denials prevented $47,183 from being spent inappropriately, an average of $1,123 per denied request. As with power wheelchairs, the review process has shown to be an effective deterrence against fraud and abuse.

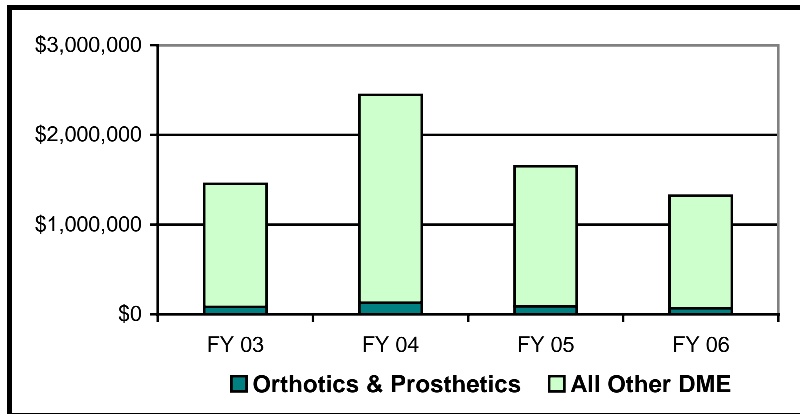
FIGURE 3.4
DOLLARS CONSERVED – POWER SCOOTER REVIEWS



Orthotics and Prosthetics

A policy change in FY 03 eliminated the prospective review requirement for most orthotic and prosthetic equipment. Because the items affected were rarely denied, the efficiency of the review process was increased without negatively impacting financial outcomes. In FY 06, orthotics and prosthetics accounted for 5% of the cost conserved through prospective review activities (see Figure 3.5).

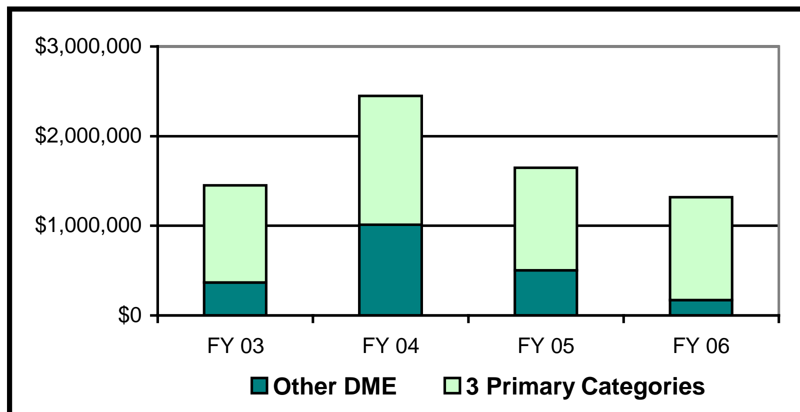
FIGURE 3.5
DOLLARS CONSERVED – ORTHOTIC/PROSTHETIC REVIEWS



Other DME

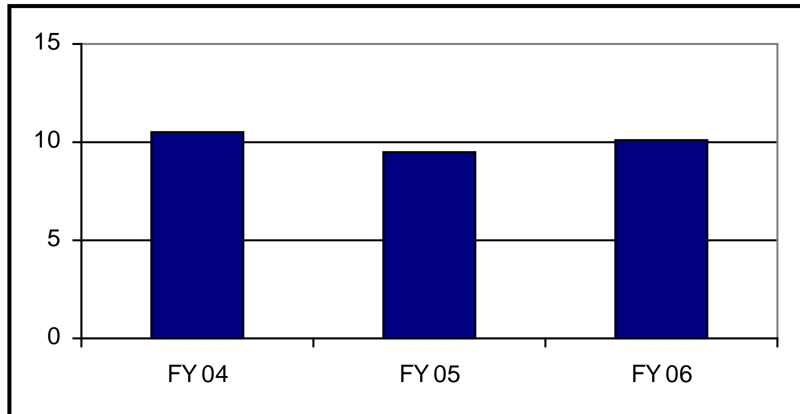
The increase in dollars conserved in FY 04 was due to regulatory changes that reclassified many DME items into the "Other" category. The 50% drop in dollars conserved in FY 05 was due almost entirely to a 50% reduction in costs avoided from unnecessary respiratory aids (see Figure 3.6). In FY 04, 285 respiratory aids, primarily the very expensive airway clearance systems, were requested. Fully 57% were denied leading to a conservation of $871,174. Of the 232 respiratory aids requested in FY 05 a smaller percentage were airway clearance systems. This resulted in $431,110 in avoided costs for all respiratory aids. FY 06 saw the figures fall even more. Only 102 respiratory aids were requested, 48% were denied, and the resulting dollars conserved were $56,530, down 87% from FY 05.

FIGURE 3.6
DOLLARS CONSERVED – OTHER DME REVIEWS



Trends

FIGURE 3.7
AVERAGE UNITS REQUESTED PER DME REVIEW



The approval rates for DME have gradually increased over the past three fiscal years (see Tables 3.13 and 3.16 on pages 15 and 16 respectively). After two years of declines, the average number of units per request began to increase in FY 06 (see Figure 3.7). CFMC has noted that DME requests are becoming more complex with an increase in accessories requested and these figures would support that observation. Given the increasing number of fraud and abuse cases nationally, CFMC remains diligent in its review processes.

In FY 05, CFMC began capturing the diagnosis codes used for power wheelchair requests. Tracking diagnosis codes enables CFMC to monitor requests for indications of inappropriate activities. Table 3.18 lists the 20 most frequent diagnosis codes and number of clients in each diagnosis code.

TABLE 3.18 – MOST FREQUENT DIAGNOSES FOR POWER WHEELCHAIR REQUESTS

Diagnosis	FY 05	FY 06
Cerebral Palsy	63	93
Multiple Sclerosis	62	76
Infantile Cerebral Palsy	37	29
Chronic Airway Obstruction	36	28
Cerebral Vascular Accident	30	26
Congestive Heart Failure	19	24
Paraplegia	14	21
Other Paralytic Syndromes	17	21
Progressive Muscular Dystrophy	21	21
Rheumatoid Arthritis	14	19
Osteoarthrosis – Unspecified	7	15
Quadriplegia C5-C7 – Complete	7	14
Amputation Below Knee, Unilateral	7	14
Neurogenic Arthropathy	8	13
Morbid Obesity	4	10
Myalgia and Myositis	7	9
Muscular Dystrophies	8	9
Quadriplegia C1-C4 – Complete	23	8
Congenital Quadriplegia	8	8
Spina Bifida	1	7

Durable Medical Equipment - Adult

CFMC reviews DME prior authorization requests for eligible clients: adult and the Early and Periodic Screening, Diagnosis and Treatment (EPSDT). While the figures above represented a cumulative total of both programs, the following figures represent the reviews conducted for the adult DME program only. A total of 1,777 adult prospective DME reviews were conducted during FY 06 (see Table 3.19).

TABLE 3.19 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REQUEST DETAILS – ADULT

DME Category	Approved	Modified	Denied	Total Reviewed[1]	Approval Rate[2]
Power Wheelchairs	481	53	151	687	78%
Power Scooters	85	6	40	131	69%
Orthotics/Prosthetics	38	3	9	50	82%
Other[3]	693	25	155	909	79%
Totals[1]	**1,297**	**87**	**355**	**1,777**	**78%**

1. Totals include two power wheelchair requests and 36 "Other" requests that were cancelled.
2. Percentage of requests approved or modified.
3. Other reviews include requests for wheelchair parts and labor, respiratory devices, and rehab equipment other than orthotics/prosthetics.

The total number of reviews was up 27% from FY 05 (see Table 3.20). After an unexplained drop in the number of requests in FY 05, review volume in FY 06 was consistent with the gradual increase in reviews over the previous four fiscal years.

TABLE 3.20 – DURABLE MEDICAL EQUIPMENT REQUEST OUTCOMES – ADULT

Review Outcome	FY 04	FY 05	FY 06
Approved	1,105	916	1,297
Modified	219	140	87
Denied	359	340	355
Cancelled	0	0	38
Total Reviewed	**1,683**	**1,397**	**1,777**
Approval Rate[1]	**79%**	**76%**	**78%**

[1] Percentage of requests approved or modified.

As noted previously, a single review may contain requests for more than one accessory or unit on a piece of equipment. The mean number of units per request showed a slight increase in FY 06 with the mean for the adult program being nearly three units higher than the mean for the EPSDT program.

TABLE 3.21 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES BY CATEGORY – ADULT

DME Category	Units Approved	Units Denied	Total Units Reviewed	Percentage Approval
Wheelchair Accessory	7,471	1,735	9,206	81%
Labor/Service/Repair	4,622	1,523	6,145	75%
Orthotics/Prosthetics	1,895	242	2,137	89%
Power Wheelchair	535	164	699	77%
Rehabilitation Equipment	27	245	272	10%
Power Scooter	102	40	142	72%
Communication Device	27	5	32	84%
Back-up Manual Wheelchair	11	21	32	34%
Respiratory Device	6	25	31	19%
Miscellaneous[1]	99	631	730	14%
Totals	**14,795**	**4,631**	**19,426**	**76%**

1. Miscellaneous items are those products, such as safety equipment, that do not fit into an established category.

The unit approval rate is the highest it has been in the past three fiscal years (see Table 3.22). Policy changes in FY 04 clarified the appropriateness of labor and dealer preparation units. The increased approval rates in FYs 05 and 06 are attributed to providers adjustment and compliance with the new regulations.

TABLE 3.22 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES – ADULT

Review Outcome	FY 04	FY 05	FY 06
Units Approved	12,640	10,647	14,795
Units Denied	7,950	4,192	4,631
Total Units Reviewed	**20,590**	**14,839**	**19,426**
Percent Approved	**61%**	**72%**	**76%**

Durable Medical Equipment - EPSDT

EPSDT is a preventive program to assist clients under the age of 21. This federally mandated program provides clients with equipment and supplies necessary for the treatment, prevention, and alleviation of an illness, injury, condition, or disability. The most common conditions associated with the need for DME equipment are neuromuscular conditions, with cerebral palsy being the most common diagnosis. Table 3.23 highlights both review volume and review outcomes for the EPSDT program during FY 06.

TABLE 3.23 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REQUEST DETAILS – EPSDT

DME Category	Approved	Modified	Denied	Total Reviewed[1]	Approval Rate[2]
Power Wheelchairs	95	25	14	134	90%
Power Scooters	6	3	2	11	82%
Orthotics/Prosthetics	129	3	20	152	87%
Other[3]	775	25	75	888	90%
Totals[1]	**1,005**	**56**	**111**	**1,185**	**90%**

1. Totals include 13 "Other" requests that were cancelled.
2. Percentage of requests approved or modified.
3. Other reviews include requests for wheelchair parts and labor, respiratory devices, and rehab equipment other than orthotics/prosthetics.

Table 3.24 shows the volumes and approval rates for the past three fiscal years. The volumes have continued to increase over the last three years with the approval rate being stable in the last two years.

TABLE 3.24 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REVIEWS – EPSDT

Review Outcome	FY 04	FY 05	FY 06
Approved	729	857	1,005
Modified	63	63	56
Denied	123	107	111
Cancelled	0	0	13
Total Reviewed	**915**	**1,027**	**1,185**
Approval Rate[1]	**87%**	**90%**	**90%**

1. Percentage of requests approved or modified.

As with all DME prior authorizations, each review may contain requests for more than one piece of equipment. The mean number of units requested per EPSDT DME was 8.8, up from 7.9 for FY 05. Table 3.25 summarizes the number and types of equipment requested by EPSDT program clients during FY 06.

TABLE 3.25 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES BY CATEGORY – EPSDT

DME Category	Units Approved	Units Denied	Total Units Reviewed	Percentage Approval
Orthotics/Prosthetics	3,363	275	3,638	92%
Wheelchair Accessory	2,948	564	3,512	84%
Labor/Service/Repair	2,308	599	2,907	79%
Power Wheelchair	120	14	134	90%
Communication Device	85	13	98	87%
Respiratory Device	47	24	71	66%
Rehabilitation Equipment	0	22	22	0%
Power Scooter	9	2	11	82%
Back-up Wheelchair	0	2	2	0%
Miscellaneous[1]	55	35	90	61%
Totals	**8,935**	**1,550**	**10,485**	**85%**

1. Miscellaneous items are those products, such as safety equipment, that do not fit into an established category.

The number of items requested was up 29% to go along with the 15% increase in the number of reviews. Table 3.26 shows the volumes and approval rates for the past three fiscal years.

TABLE 3.26 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES – EPSDT

Review Outcome	FY 04	FY 05	FY 06
Units Approved	4,845	6,534	8,935
Units Denied	1,939	1,598	1,550
Total Units Reviewed	**6,784**	**8,132**	**10,485**
Percent Approved	**71%**	**80%**	**85%**

Select Non-Emergent Medical Transportation

Federal regulations require that all states receiving federal Medicaid funds ensure Medicaid recipients who have no other means of transportation are able to access Medicaid covered services. Colorado uses a combination of regional brokers and county departments of human/social services to administer the program. As the Department's designee, CFMC is responsible for reviewing air ambulance requests and meals and lodging requests for recipients and escorts.

In FY 2003, over-the-cap prior authorization requests were designated to be reviewed by CFMC for medical necessity. Bariatric ambulance and mental health transports were a portion of those services that were added to the set of non-emergent medical transportation services requiring prospective review. Bariatric ambulances are special ambulances designed to handle obese clients who cannot otherwise be carried in a standard ambulance. Mental health transport services were also added for fee for service clients that were a risk to themselves or others and required clinical observation during transport. Mental health transports provide a safe environment for clients being transferred to Ft. Logan. Due to the expense of these services (over the capitation rate), CFMC

reviews prior authorization requests to ensure that the client meets all medical necessity criteria for these transports.

Outcomes

Table 3.27 summarizes the number of select non-emergent medical transportation requests and their outcomes. Volumes came close to doubling in FY 06. An increase of 86 reviews was due to increased use of the bariatric ambulances.

TABLE 3.27 – PROSPECTIVE SELECT NON-EMERGENT MEDICAL TRANSPORTATION REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	188	263	443
Modified	12	2	14
Denied	4	6	20
Cancelled	0	0	3
Total Reviewed	**204**	**272**	**480**
Approval Rate[1]	**98%**	**97%**	**95%**

1. Percentage of requests approved or modified.

Table 3.28 lists the numbers and outcomes of the various types of services reviewed in FY 06.

TABLE 3.28 – SELECT NON-EMERGENT MEDICAL TRANSPORTATION UNIT REQUEST OUTCOMES BY CATEGORY

Category of Service	Units Approved	Units Denied	Total Units Reviewed	Percent Approved
Lodging – Escort	3,125	503	3,628	86%
Meals – Escort	1,794	69	1,863	96%
Lodging – Recipient	1,196	23	1,219	98%
Meals – Recipient	966	7	973	99%
Over-the-cap Ambulance Services	102	5	107	93%
Travel – Escort	15	16	31	48%
Air Transport	23	0	23	100%
Travel – Recipient	1	0	1	100%
Non-reviewable Services	0	685	685	0%
Totals	**7,222**	**1,308**	**8,530**	**85%**

Table 3.29 compares the number of select non-emergent medical transportation units requested during the past three fiscal years, and the approval rate for each year.

TABLE 3.29 – SELECT NON-EMERGENT MEDICAL TRANSPORTATION UNIT REQUEST OUTCOMES

Review Outcome	FY 04	FY 05	FY 06
Units Approved	2,263	3,644	7,222
Units Denied	519	1,606	1,308
Total Reviewed	**2,782**	**5,250**	**8,530**
Approval Rate[1]	**81%**	**69%**	**85%**

1. Percentage of requests approved or modified.

The number of reviews for this program has tripled in the past three fiscal years. The automated review program of FY 04 did not capture the number of non-reviewable requests CFMC received. FYs 05 and 06 do account for these requests. If those requests are controlled to make valid comparisons across the three years, the number of units increased 61% in FY 05 and another 75% in FY 06. The number of transportation and lodging requests has increased, as more clients from rural areas must travel to see specialists in Colorado Springs or Denver. Many of the requests involve care provided by the Children's Hospital, University of Colorado Health Sciences Center, and their clinics.

To understand the increase in requests it is important to review what was requested. Each review may contain requests for more than one service. The number of lodging requests for escorts doubled and recipient lodging was up 82%. Requests for escorts' meal allowance was up 72% while requests for escort airfare was up 85%. This increase in units requested is due to increased understanding of the escort lodging and meal benefits. Mothers with newborns in an out-of-town hospital are allowed one unit of lodging benefit and three meal benefits per day while the child is hospitalized. Some newborns can spend 60 days in acute care before being discharged.

Impact

Based on a fee schedule provided by the Department, CFMC is able to estimate the costs avoided from unqualified meal and lodging expenses. Prospective review kept $11,268 from being spent inappropriately in FY 06. Denials of non-reviewable services are not factored into fiscal impact calculation.

EPSDT Home Health

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated benefit which provides clients under age 21 with services including equipment and supplies necessary for the treatment, prevention, and alleviation of an illness, injury, condition, or disability. The extraordinary home health services program provides medically dependent children with skilled medical care services and at-home services that cost more than $227 per day. Clients under age 21 may receive a portion of their benefits in a daycare or school setting. Therapy sessions are provided outside the home setting.

Outcomes

EPSDT Home Health serves the long-term needs of a very specific population. When clients reach the age of 21 years the Department facilitates the transition out of the EPSDT program and into one of the adult service programs as appropriate. The decline in reviews during FY 06 is a result of clients moving out of the EPSDT program in this manner (see Table 3.30).

TABLE 3.30 – PROSPECTIVE EPSDT HOME HEALTH REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	170	178	99
Modified	0	1	3
Denied	4	6	4
Canceled	0	0	1
Total Reviewed	**174**	**186**	**107**
Approval Rate[1]	**98%**	**96%**	**95%**

1. Percentage of requests approved or modified.

Table 3.31 summarizes the number and types of services reviewed. The type of unit requested is significant because of costs and services rendered by the different levels of care providers. For example, one unit of skilled nursing care includes up to 2.5 hours of service. Certified home health aide services, on the other hand, are calculated much differently. The first hour of home health aide during the day is billed as one unit. Each additional 15 minutes of extended home health aide visits required for the same day is also one unit. Each type of unit is paid a different rate.

TABLE 3.31 – EPSDT HOME HEALTH SERVICE OUTCOMES BY CATEGORY

Category of Care	Units Approved	Units Denied	Total Units Reviewed	Percent Approved
Home Health Aide - Extended	99,062	7,858	106,920	93%
Home Health Aide - Basic	23,380	1,564	24,944	94%
Skilled Nursing	8,002	33	8,035	99%
Physical Therapy	2,204	482	2,686	82%
Occupational Therapy	1,987	561	2,548	78%
Speech Language Therapy	1,706	592	2,298	74%
Totals	**136,341**	**11,090**	**147,431**	**93%**

Table 3.32 indicates that the number of units requested grew by 42% during the same period. This increase does not mean that clients are requiring more resources. The number of minutes included in a unit of service was reduced in FY 06. As a result, more units were required to provide the same level of service.

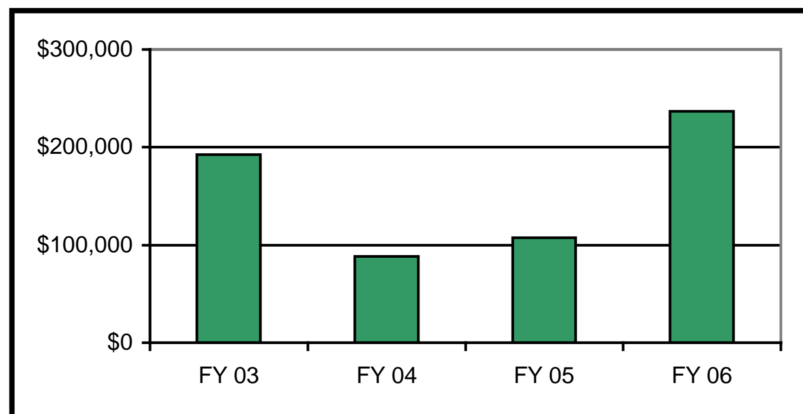
TABLE 3.32 – EPSDT HOME HEALTH SERVICE UNIT REQUEST OUTCOMES

Review Outcome	FY 04	FY 05	FY 06
Units Approved	66,357	100,109	136,341
Units Denied	4,774	3,937	11,090
Total Units Reviewed	**71,131**	**104,046**	**147,431**
Percent Approved	**93%**	**96%**	**93%**

Impact

Dollars conserved due to the home heath prospective review process doubled from $107,444 in FY 05 to $236,694 in FY 06 (see Figure 3.8). Again, comparisons to years prior to FY 04 may be confusing due to classification changes within the program. Costs avoided from unnecessary home health aide visits were up 118% to $126,332. Costs avoided from skilled-nursing visits were down 88%, from $19,597 in FY 05 to $2,404 in FY 06.

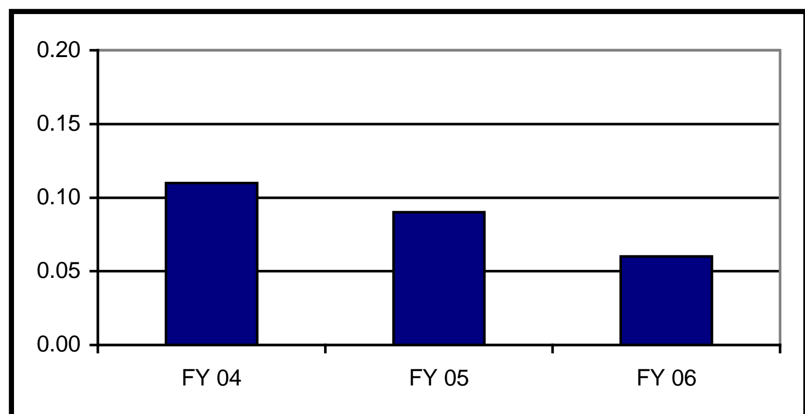
FIGURE 3.8
DOLLARS CONSERVED – HOME HEALTH REVIEWS



Trends

Analysis of unit volumes over the past several years indicated that a greater percentage of services were being provided by certified home health aides instead of registered nurses. Ensuring that the appropriate caregiver is used to provide each service increases the cost-effectiveness of the program. Figure 3.9 shows that the number of skilled nursing units has been declining in relationship to certified home health aide units, indicating that home health aids are assuming a greater percentage of duties that do not require the skills of a registered nurse.

FIGURE 3.9
RATIO OF SKILLED NURSING TO HOME HEALTH AIDE UNITS



Physical And Occupational Therapy

The Department rules and regulations allow registered practitioners to bill the Department for up to 24 units of service without seeking prior approval. A unit is defined as 15 minutes of therapy. Services provided in excess of the first 24 units require these independent providers to receive prior authorization.

In FY 05, the Department made two policy changes that impacted the PT/OT prospective review program. First, hospitals that provide outpatient physical and occupational therapy services were required to receive prospective approval for services provided beyond the initial 24 units as required of independent providers. Second, PT/OT services provided to clients in the Developmentally Delayed (DD) Waiver program were also required to be prospectively

approved. CFMC continues to offer training sessions regarding the clinical information required for documentation on a prior authorization request.

Outcomes

After the marked increase in FY 05 due to the inclusion of outpatient hospital based and DD waiver clients in the PT/OT prospective review program, the increase in review volumes was up 15% in FY 06 (see Table 3.33).

TABLE 3.33 – PROSPECTIVE PHYSICAL & OCCUPATIONAL THERAPY REVIEWS

Review Outcome	FY 04	FY 05	FY 06
Approved	443	2,907	3,267
Modified	146	239	266
Denied	88	343	481
Canceled	0	1	1
Total Reviewed	**677**	**3,490**	**4,015**
Approval Rate[1]	**87%**	**90%**	**88%**

1. Percentage of requests approved or modified.

Physical and occupational therapy reviews are complex due to the number of units requested. The average number of units requested per review in FY 06 was 183, but this number can be misleading. The appropriate number of therapy intervention units depends on the client's condition. For example, an adult with a knee replacement will require less therapy than a child with a diagnosis of cerebral palsy who may require numerous interventions for a long period of time.

The approval rate of 88% noted in Table 3.34 indicates that none of the units requested in 12% of the reviews were medically necessary.

TABLE 3.34 – PHYSICAL & OCCUPATIONAL THERAPY PROSPECTIVE REVIEW OUTCOMES

Prospective Request	Approved	Modified	Denied	Total Reviewed[1]	Approval Rate[2]
Physical Therapy	1,959	179	311	2,450	87%
Occupational Therapy	1,308	87	170	1,565	89%
Totals[1]	**3,267**	**266**	**481**	**4,015**	**88%**

1. Totals include one physical therapy request that was cancelled.
2. Percentage of requests approved or modified.

The approval rate of 65% in Table 3.35 indicates that 35% of the total units requested were not medically necessary.

TABLE 3.35 – PHYSICAL & OCCUPATIONAL THERAPY UNIT REQUEST OUTCOMES

Category of Therapy	Units Approved	Units Denied	Total Units Reviewed	Percent Approved
Physical Therapy	258,416	130,970	389,386	66%
Occupational Therapy	217,772	127,447	345,219	63%
Totals	**476,188**	**258,417**	**734,605**	**65%**

The percentage of units approved has remained fairly stable despite large increases in the number of requests (see Table 3.36).

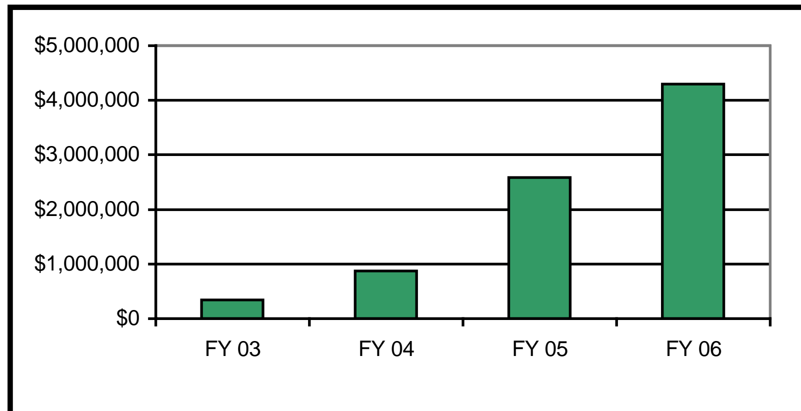
TABLE 3.36 – COMBINED PHYSICAL & OCCUPATIONAL THERAPY UNIT REQUEST OUTCOMES

Review Outcome	FY 04	FY 05	FY 06
Units Approved	116,757	429,072	476,188
Units Denied	63,122	203,438	258,417
Total Units Reviewed	**179,879**	**632,510**	**734,605**
Percent Approved	**65%**	**68%**	**65%**

Impact

A direct result of both the increased review volume and an increase in units within the request has been the four-fold increase in costs avoided since FY 04 (see Figure 3.10). The $870,273 costs avoided in FY 04 accounted for 22% of the total funds conserved by prospective reviews during the year. In FY 05, the total conserved was $2,579,195 and accounted for 54% of the prospective review fiscal impact. The dollar figure for PT/OT increased to $4,297,356 in FY 06, accounting for 64% of the total conserved from prospective review services.

FIGURE 3.10
COSTS AVOIDED – PROSPECTIVE PT/OT REVIEWS



Reconsiderations and Appeals

Prospective reviews contain program costs for the Department by denying inappropriate services. CFMC makes every effort to gather complete and accurate information in order to make appropriate medical necessity determinations for services requested for each Medicaid client. Providers and clients have the right to appeal the decision if they do not agree with the initial review outcome. Any new information provided for the appeal is considered as part of the review. For example, an update of the client's condition may make the request medically justified.

The client has the right to appeal CFMC's decision to an administrative law judge (ALJ) hearing. When notified of a hearing, CFMC provides the Department with a description of the specific

aspects of the case and reason(s) for denial. CFMC can also research similar cases and search for additional information applicable to the hearing. CFMC shares this insight with the Department prior to the hearing and is available to discuss the case and address any questions. When requested, CFMC's experienced review staff can provide testimony in support of the review determination process.

During FY 06, CFMC provided support for 34 client ALJ hearing requests. These hearings involved eight requests for therapy authorizations, seven requests for DME authorizations and three requests for procedure authorizations. The remaining 16 ALJ requests were researched and found to not involve the CFMC review services program. The information researched was submitted to the Department to be part of the hearing process.

CHAPTER 4

RETROSPECTIVE REVIEW HIGHLIGHTS

Contracted to conduct a minimum of 4,000 reviews, in FY 06 CFMC completed 4,051 retrospective reviews of inpatient stays. Retrospective reviews enable the Department to contain inpatient costs while ensuring high quality of care by identifying inappropriate admissions, unnecessary treatment, and incorrect coding and billing. CFMC calculates that these reviews identified $2,278,851 in inappropriate payments that the Department is entitled to recover.

Retrospective reviews examine medical records to ensure the care paid for was medically necessary, required acute level of care, was coded correctly, and free from quality of care concerns. If a provider is unable to produce evidence to support the payment received, the Department is entitled to recover the excess payments. The entire claim may be denied, resulting in the return of all funds, or payment may be adjusted to reflect the correct payment of the care provided based on the documentation available.

Results of the retrospective review findings were presented to the Department to assist the Department in determining the review selection for FY 06. After three years of increases, the percentage of claims with identifiable errors leveled out at 13%, the same as FY 05, although the value of the claims increased 17% over FY 05. Ongoing analysis of the previous review selection allows for identification of areas with the highest potential for error.

CFMC reports all review data to the Department. The Department works with the fiscal agent to recover any funds unsupported by the medical record. CFMC calculates that its retrospective review activities identified $2,278,851 in unsubstantiated payments, a 17% increase over the previous fiscal year. The continued refinement of the sampling methodology, including two new focused review categories, resulted in a 7% decline in admission denials, a 34% increase in billing errors and a 41% increase in DRG savings. Savings from technical denials were down 30%.

As of August 30, 2006, the Department had recovered $1,887,607. The remaining $391,244 (17%) represents unrealized savings to which the Department is still entitled. The ratio between realized and unrealized savings in FY 06 was close to 5:1, compared to 2:1 at the same point in FY 05. The appeal process and the fiscal agent's claims adjustment process combine to delay the collection of funds by several months.

TABLE 4.1 – NUMBER AND DISTRIBUTION OF MEDICAL NECESSITY REVIEW OUTCOMES

Final Review Outcome	FY 04		FY 05		FY 06	
Approved[1]	3,492	(88%)	3,289	(87%)	3,559	(88%)
Admission Denial	68	(2%)	188	(5%)	170	(5%)
Technical Denial	71	(2%)	59	(1%)	46	(1%)
Billing Error Denial	311	(8%)	261	(7%)	276	(7%)
Total Reviews	**3,942**		**3,797**		**4,051**	

1. Approved cases met medical necessity and level of care criteria, but may still be subject to a DRG change (see Table 4.2).

TABLE 4.2 – NUMBER AND FREQUENCY OF CODING CHANGES

Change Type	FY 04		FY 05		FY 06	
DRG Change[1]	37	(1%)	58	(2%)	50	(1%)
Total Changes	**37**	**(1%)**	**58**	**(2%)**	**50**	**(1%)**

1. These cases met medical necessity and level of care criteria, but were coded incorrectly.

TABLE 4.3 – RETROSPECTIVE REVIEW IMPACT – EXPECTED[1]

Review Impact	FY 03	FY 04	FY 05	FY 06
Admission Denial Savings	$282,356	$210,250	$608,823	$563,736
Technical Denial Savings	$76,120	$294,213	$405,735	$282,699
Billing Error Denial Savings	$505,780	$1,143,190	$939,494	$1,256,776
DRG Change Savings[2]	$19,847	$63,301	$124,513	$175,640
Total Retrospective Review Savings	**$884,103**	**$1,710,954**	**$1,951,458**	**$2,278,851**

1. Savings the Department has the right to expect. Actual savings may be realized or unrealized at the time of this report.
2. DRG changes can increase or decrease reimbursement to the provider.

TABLE 4.4 – RETROSPECTIVE REVIEW COST RATIOS

Key Retrospective Review Ratios	FY 03	FY 04	FY 05	FY 06
Costs Avoided Per Review	**$237**	**$434**	**$514**	**$563**

Retrospective Review – Discussion

Retrospective review of paid hospital claims allows the Department to control acute care costs while ensuring quality of care. CFMC's review process focuses on medical necessity and the appropriateness of the level of care provided within the hospital and the correct DRG assignment. CFMC's process also allows us to identify inappropriate payments and potential quality concerns. The Department is able to use this information to recover improper payments while looking towards quality improvement opportunities.

The Review Process

CFMC uses nationally recognized Milliman Care Guidelines to assess the appropriateness of the care provided. These guidelines are based on the latest medical knowledge, ensuring that the care is patient focused, of high quality, and resource efficient. Use of Milliman Care Guidelines for medical services review ensures Colorado Medicaid clients receive optimal health care treatment in the most cost effective manner. Registered nurse review coordinators review selected medical records for the following elements:

- Documentation – Assurance that required elements of the medical record have been provided
- Medical necessity – Verification that the hospitalization was medically justified
- Level of care – Verification that the client's treatment required inpatient admission
- Quality of care – Screening to determine the client received quality care
- Correct DRG assignment – Validation that the diagnosis/procedure coding was appropriate
- Medical benefit coverage – Verification that the service was a Medicaid benefit

Records are checked upon receipt to ensure that the documentation necessary for review is present. If the facility fails to supply the necessary documentation within the required time frame, a technical denial is issued and the Department is notified that recovery of payment is justified. A technical denial means the facility was not able to substantiate the care for which it was paid. Facilities are notified of technical denials and given the right to have the case reopened by supplying all missing information within Department specified timeframes.

When the necessary documentation is present, the nurse reviewer applies Milliman Care Guidelines to each case to determine if the hospitalization was medically necessary and if the level of care provided within the facility was appropriate. The additional elements of review are completed and if all screening guidelines are met, the nurse reviewer approves the admission. Over the past three fiscal years, 86-94% of the reviews conducted were approved by the nurse reviewer and required no additional action.

If the medical necessity, appropriateness of care, or level of care does not meet Milliman Care Guidelines the case is referred to a CFMC specialty-matched physician for review. Physician reviewers are Colorado licensed and board certified practicing physicians trained by CFMC for medical review. If the physician reviewer determines that the care was appropriate and medically necessary, the admission is approved and no further action is taken. If the physician reviewer determines that the admission was not medically necessary, or that the level of care was not appropriate for the client's condition, the admission is denied. A letter explaining the reason for the denial is sent to the facility, attending physician and client. The Department is also notified of the denial and that payment may be recovered.

TABLE 4.5 – NUMBER AND FREQUENCY OF REFERRALS TO PHYSICIAN REVIEWERS

Reason for Referral	FY 04[1]		FY 05[1]		FY 06[1]	
Medical Necessity of Admission	217	(5%)	537	(14%)	316	(8%)
Potential Quality of Care Problem	21	(1%)	6	(0%)	11	(0%)
Coding (DRG) Issue[2]	0	(0%)	3	(0%)	4	(0%)
Total Referrals	**238**	**(6%)**	**546**	**(14%)**	**331**	**(8%)**

1. Percent of the total retrospective reviews.
2. DRG issues which require physician determination; most DRG changes are technical changes made by the coding specialist.

Quality Review Process

In addition to medical necessity and level of care guidelines, each case is screened for quality of care. If the care provided fails the quality of care screen, the nurse reviewer refers the case to a CFMC specialty-matched physician reviewer for a final determination. Physician reviewers also may identify a quality of care concern. Quality of care concerns are trended by incidence and provider and are reported to the Department biannually. During FY 06, 15 cases of potential quality issues were identified. After further physician review, quality concerns were verified in four cases. Facility, practitioner or type of case selection identified no trends. Quality of care referrals do not impact payment, but provide insight into areas requiring additional provider education.

DRG Validation Review

The primary Medicaid reimbursement method used by Colorado acute care facilities is the diagnosis related group (DRG) payment system. The DRG classification system allows inpatient providers to categorize patients by diagnoses, treatment, and resource consumption. Under this system, providers receive a predetermined, fixed payment based on the DRG for each admission. The DRG payment system has been shown to be both statistically and medically meaningful. That is, patients within a given DRG tend to have similar clinical conditions and consume similar resources as measured by both length of stay and cost.

Reimbursement for most hospitals is based on the DRG rate set by Medicare. Rehabilitation and pediatric hospitals use a slightly different system. Each DRG has an assigned weight that is used for payment calculation at these facilities. The weight of the DRG is multiplied by the facility's base rate to determine actual reimbursement. Facilities have different base rates because they differ in the number, type, and complexity of cases they handle. Hospitals that typically treat cases that are more complicated have higher base rates to cover the costs of the added care required. At the request of the Department, CFMC periodically updates each facility's case mix index.

The nurse reviewer examines each case to determine whether the claim was billed correctly according to 10 C.C.R. 2505-10, Section 8.040 and Colorado Medicaid Provider Bulletins. If the nurse reviewer questions the appropriateness of the DRG, the case is referred to CFMC's coding specialist for review. The coding specialist determines the DRG best supported by the information available in the medical record. If the incorrect DRG was billed, the Department is notified of the potential adjustment. Changing a DRG determination is different from a denial in two regards. First, unlike a denial, a DRG change does not deny the entire payment. Only the difference between the correct DRG and the billed DRG is recoverable. Second, the correct DRG may indicate that the facility is due more money than it originally billed.

Third Party Liability Review

Nurse reviewers check all cases to verify that the service is a benefit of the Medicaid program, that Medicaid is the primary insurance provider, and that the case was correctly billed. Claims for services not covered by Medicaid are denied and the Department is notified. If the Department is not the party responsible for payment, CFMC refers the case to the Third Party Resources unit at the Department for further investigation. Third Party liability issues typically involve double billing in one of several forms:

- Service provided to a managed care client but billed as fee-for-service
- Client with private primary insurance billed to Medicaid
- Out-of-state resident billed as a Colorado client

The number of third party liability referrals continues to increase (see Table 4.6). Almost 3% of retrospective reviews conducted during FY 06 contained liability errors. The Department paid $692,531 for the 105 cases CFMC referred to the Third Party Resources unit.

TABLE 4.6 – SUMMARY OF THIRD PARTY LIABILITY REFERRALS

Referral Reason	FY 04	FY 05	FY 06
Enrolled in HMO	37	20	29
Private Primary Insurance	10	11	27
Medicare Primary Insurance	9	16	15
Medicaid Secondary Insurance	13	13	11
Out-of-state Home Address	0	6	2
Other	17	25	21
Total Referred	**86**	**91**	**105**

Medical Record Review Selection

Retrospective review of every acute care admission would be prohibitively expensive. Given the resources available, CFMC was contracted to conduct 4,000 retrospective reviews or 8% of the total admissions during FY 06. This relatively small number of reviews requires effective sampling to achieve maximum efficacy. CFMC and the Department work together to continually refine the sampling method to effectively balance the value of focused and random review selections. During FY 06 CFMC completed 4,051 unduplicated reviews (see Table 4.7).

TABLE 4.7 – NUMBER AND DISTRIBUTION OF SAMPLING CRITERIA

Sampling Criteria	FY 04		FY 05		FY 06	
Focused Inliers[1]			1,833	(47%)	1,083	(27%)
Random Selection	1,116	(28%)	655	(17%)	970	(23%)
Provider Focus					898	(21%)
DRG Focus			413	(10%)	562	(13%)
DRG Inlier Focus			273	(7%)	355	(8%)
Readmissions[2]	292	(7%)	84	(2%)	213	(5%)
DRG Outlier Focus			51	(1%)	95	(2%)
DRG 871 as Readmission[3]					39	(1%)
State Request			6	(0%)	7	(0%)
Inliers, Excluding Routine Deliveries	2,591	(65%)	628	(16%)		
Total Selections	**3,999**		**3,943**		**4,222**	
Total Unduplicated Cases[4]	**3,942**		**3,797**		**4,051**	

1. Focused inliers are hospital stays of less than two days, excluding routine deliveries and dialysis claims.
2. Readmissions are claims for the same patient readmitted to the same hospital within one day, excluding routine deliveries.
3. DRG 871 is "rehabilitation – unspecified."
4. Overlap in sampling criteria means a single case may be selected for review more than once. Because duplicate cases are only reviewed once, CFMC over samples (4,222 in FY 06) to ensure contacted review volumes are met.

Focused reviews target specific types of cases known to, or expected to, contain a large number of errors. Inlier claims, hospital stays of less than two days, have been the focus of the majority of reviews for the last three fiscal years. These cases are of interest because they historically contain a high number of admission denials and billing errors. The focus of the inlier cases sampled has become more specific as greater understanding of billing patterns has developed. During FY 06, facilities with the highest number of inlier errors were identified for provider-focused reviews.

In addition to inliers, FY 06 retrospective reviews focused on a few specific DRGs and readmissions. The DRG reviews focused on DRGs that have historically contained a large number of billing errors. Readmissions refer to clients who return to the hospital within one day of being discharged from the same hospital. CFMC noted many instances of a client being "discharged" from the acute care unit of a hospital and "admitted" to the rehabilitation unit of the same hospital. A special focus was given to DRG 871 to uncover these types of cases. DRG 871 is a nonspecific admission for rehabilitation services. A problem occurs when a client is discharged from an acute care unit then readmitted to the rehabilitation unit, creating two payments for services that should be covered by the first. In these cases, the Department is entitled to recover any payment made for the second admission.

In addition to focused reviews, a random sample of claims was selected for review. Random sample review provides timely information that allows CFMC and the Department to better focus ongoing review activities.

Impact Calculation Methodology

CFMC's Medicaid review program saves the Department money by identifying inappropriate admissions and inaccurate coding or billing that can result in the recovery of payments. For retrospective reviews, paid claims data are used to calculate savings. The ability to determine the actual dollar amount recovered improves the accuracy of the impact assessment.

Retrospective reviews can have a financial impact in one of four ways:

- Admission denial – Acute care admission deemed not medically necessary
- Technical denial – Failure of provider to supply documentation supporting the admission
- Billing error – Improperly billed admission resulting in denial of entire claim
- DRG change – Reassignment of the DRG based on evidence contained in the medical record

If an admission is denied, or a technical denial is declared, the entire amount of the claim is recovered. While some billing errors, such as incorrect dates of service, do not affect reimbursement, only billing errors that are expected to recover money have been included in impact calculations. Unlike a denial, a DRG change may result in either an increased or decreased payment to the facility. The financial impact of a DRG change is the difference between the amount originally paid and the amount that was deemed correct.

Realized Versus Unrealized Savings

Retrospective review results are reported to the Department for claim adjustment. When the claim is adjusted as expected, the fiscal agent recovers payment from the hospital and savings are "realized." Sometimes, the claim is never adjusted, or is adjusted as expected but the fiscal agent for reasons unknown to CFMC later restores payment to the hospital. These are considered "unrealized" savings. For this report, CFMC compares the expected savings from retrospective reviews with the paid claims available on August 30, 2006 to determine the amount of savings realized.

Retrospective Review Activity Outcomes

After three years of increases, the percentage of inappropriate claims remained at 13% during FY 06 (see Table 4.8). This means that 87% of claims reviewed met all screens. Past increases in error rates were the result of changes to the sampling methodology that enabled CFMC to better identify cases for review. Small refinements made during FY 06 resulted in a proportional increase in admission denials from 188 in FY 05 to 219 in FY 06. This increase was offset by a slight decline in the number of technical denials. Technical denials are dependent on numerous factors within individual facilities and therefore cannot be predicted.

TABLE 4.8 – NUMBER AND DISTRIBUTION OF REVIEW OUTCOMES

Review Outcomes	FY 04		FY 05		FY 06	
Approved[1]	3,492	(88%)	3,289	(87%)	3,509	(87%)
Admission Denial	68	(2%)	188	(5%)	220	(5%)
Technical Denial	71	(2%)	59	(1%)	46	(1%)
Billing Error Denial	311	(8%)	261	(7%)	276	(7%)
Total Reviews	**3,942**		**3,797**		**4,051**	

1. An approved admission may still be subject to a DRG change.

Impact

The financial impact of CFMC's retrospective review program topped $2 million in FY 06 (see Table 4.9). The Department has the potential to recover $2,278,851 it paid for medically unnecessary acute care services during the fiscal year. Of that amount, $1,887,607 had been collected as of August 30, 2006. As of this date, $391,244 (17%) had yet to be returned. The high proportion of realized savings versus unrealized savings, 83% to 17% respectively, suggest that the mechanisms for recovery have improved compared to 34% in FY 05.

TABLE 4.9 - RETROSPECTIVE REVIEW IMPACT – EXPECTED[1]

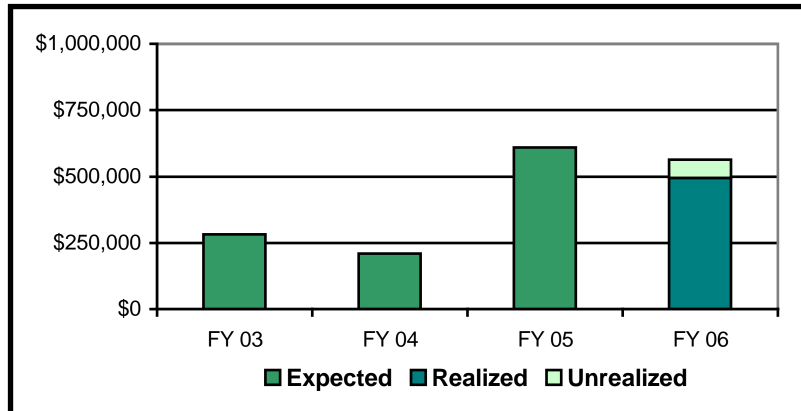
Retrospective Review Impact	FY 03	FY 04	FY 05	FY 06
Admission Denial Savings	$282,356	$210,250	$608,823	$563,736
Technical Denial Savings	$76,120	$294,213	$405,735	$282,699
Billing Error Denial Savings	$505,780	$1,143,190	$939,494	$1,256,776
DRG Change Savings[2]	$19,847	$63,301	$124,513	$175,640
Total Retrospective Review Savings	**$884,103**	**$1,710,954**	**$1,951,458**	**$2,278,851**

1. Savings the Department has the right to expect. Actual savings may be realized or unrealized at the time of this report.
2. Savings are a result of DRG changes made to approved admissions.

The financial impact of the four retrospective review outcomes is discussed below. To maintain consistency between reports, CFMC reports only the expected savings from previous fiscal years. The realized savings for FY 06 were as of August 30, 2006.

Admission Denials

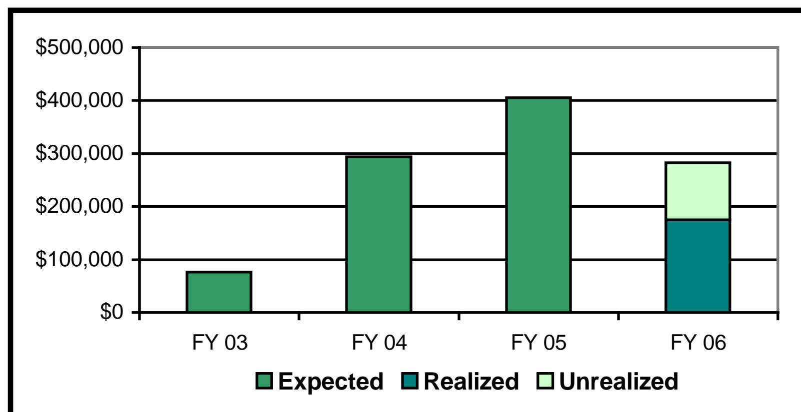
FIGURE 4.1
COST SAVINGS – RETROSPECTIVE ADMISSION DENIALS



Of the 4,051 retrospective reviews, 220 were denied because the documentation failed to support the need for inpatient level medical care. This means that almost 5.5% of the claims sampled were for admissions deemed medically unnecessary, compared to 5% in FY 05. The expected costs recovered from these claims totaled $563,736, down 7% from $608,823 in FY 05. Of the total for FY 06, $495,533 has been realized as of August 30, 2006 (see Figure 4.1).

Technical Denials

FIGURE 4.2
COST SAVINGS – TECHNICAL DENIALS

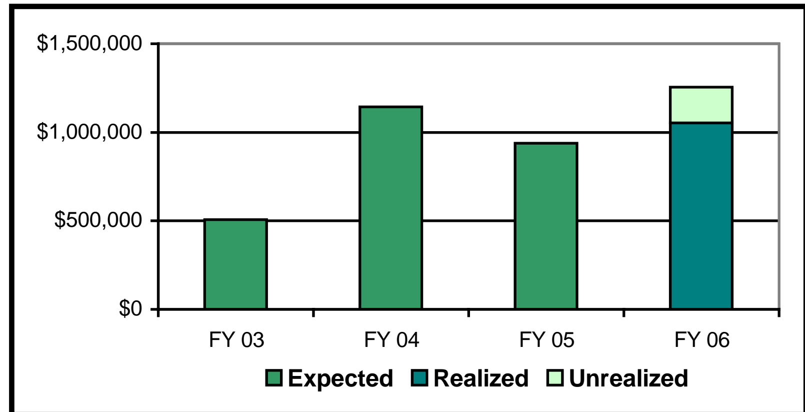


The number of technical denials declined 22% in FY 06 (see Table 4.8 on page 38) while the dollars saved were down 30% (see Figure 4.2). Lower numbers of technical denials indicate better compliance by the facilities. Because there are so many variables that impact the number of technical denials, it is difficult to predict cost savings from year-to-year. The ratio of realized and unrealized savings can also vary. Of the $282,699 expected savings identified in FY 06, $175,026 (62%) had been realized as of August 30, 2006. Only 36% of the expected savings from FY 05 had been recovered at the same point last year. In addition to the normal delays in the billing cycle, technical denials may be subject to reconsideration. This process can easily add 60 days to the recovery process.

Billing Errors

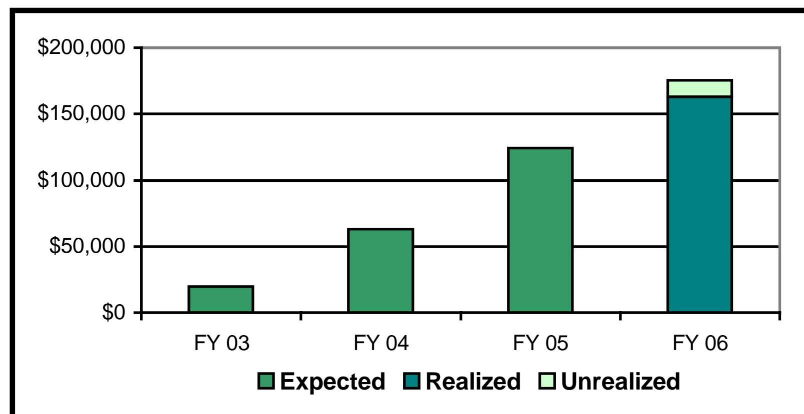
A direct result of the sampling methodology employed the past few years has been the identification of an increasing number of billing errors. This led to increased cost savings as well. Over $1.25 million was identified for recovery during FY 06 (see Figure 4.3). Over $1 million (84%) of the expected savings had been realized as of August 30, 2006.

FIGURE 4.3
COST SAVINGS – RETROSPECTIVE BILLING ERRORS



Diagnosis Related Group Changes

FIGURE 4.4
COST SAVINGS – RETROSPECTIVE DRG CHANGES



The Department uses the diagnosis related group (DRG) classification system for acute care reimbursement. The low number of errors encountered (50 in FY 06 compared to 58 in FY 05 and 37 in FY 04) and the relatively small recovery (see Figure 4.4) may suggest that reviewing DRGs is not the most cost effective use of review services. However, the DRG validation process as part of the review process makes any amount of recovery cost effective. In addition, validating the DRG assignment of every case allows CFMC to identify provider education opportunities while ensuring the integrity of the billing process. Individual facility education and training occurred during FY 06 with health information management, compliance, and billing staff.

Appeals

When the result of the review process is an admission denial or DRG change, the facility, attending physician and client receive written notification from CFMC that includes an explanation of the denial and a description of the appeal process. If an appeal is not received within 60 days, the case is closed. The attending physician or the facility may initiate an appeal on the behalf of the client during the 60-day period. If an appeal is received, the case is sent to a CFMC specialty-matched physician reviewer who was not involved in the initial determination. The facility, attending physician and the client are notified of the final determination. Table 4.10 shows the number of appeals and their final outcomes.

TABLE 4.10 – NUMBER OF APPEALS AND THEIR OUTCOMES

FY 06								
Outcome	**Admission Denial**		**DRG Change**		**Quality Concern**		**Totals**	
Initial Outcome	183		58		5		246	
Reconsidered	38	(21%)[1]	8	(14%)[1]	2	(40%)[1]	48	(20%)[1]
Upheld	25	(66%)[2]	0	(0%)[2]	1	(50%)[2]	26	(54%)[2]
Reversed	13	(34%)[2]	8	(100%)[2]	1	(50%)[2]	22	(46%)[2]
Final Denials	**170**	**(93%)[1]**	**50**	**(86%)[1]**	**4**	**(80%)[1]**	**225**	**(92%)[1]**

FY 05								
Outcome	**Admission Denial**		**DRG Change**		**Quality Concern**		**Totals**	
Initial Outcome	199		63		11		273	
Reconsidered	16	(8%)[1]	35	(56%)[1]	1	(9%)[1]	52	(19%)[1]
Upheld	11	(69%)[2]	24	(69%)[2]	0	(0%)[2]	35	(67%)[2]
Reversed	5	(31%)[2]	11	(31%)[2]	1	(100%)[2]	17	(33%)[2]
Final Denials	**188**	**(94%)[1]**	**58**	**(92%)[1]**	**10**	**(91%)[1]**	**256**	**(94%)[1]**

FY 04								
Outcome	**Admission Denial**		**DRG Change**		**Quality Concern**		**Totals**	
Initial Outcome	74		39		5		118	
Reconsidered	12	(16%)[1]	2	(5%)[1]	0	(0%)	14	(12%)[1]
Upheld	6	(50%)[2]	0	(0%)[2]	0	(NA)	6	(43%)[2]
Reversed	6	(50%)[2]	2	(100%)[2]	0	(NA)	8	(57%)[2]
Final Denials	**68**	**(92%)[1]**	**37**	**(95%)[1]**	**5**	**(100%)[1]**	**110**	**(93%)[1]**

1. Percent of initial outcome.
2. Percent of reconsiderations.

CHAPTER 5

PROGRAM RECOMMENDATIONS

Recommend….the collaborative work between the Department and CFMC in developing therapy guidelines and parameters for medically necessary services continue

- Ensure therapy services are provided appropriately to those members with true medical necessity needs
- Provide more consistent review determinations and provide medical necessity reasoning for decisions in appeal situations by using a more defined criteria

Recommend….the Department and CFMC develop a collaborative plan to identify DME provider trends in inappropriate DME requests and address these issues on a more consistent basis

- Create process to address these continuing issues
- Allow a more consistent application of the new CMS guidelines

Recommend….custom manual wheelchairs be added to CFMC review selection

- Ensure a more consistent monitoring of high dollar items
- Allow the reviewer flexibility to work with the provider in order to downgrade to a more appropriate less costly wheel chair when medically indicated
- Ensure cost savings and more appropriate fitting of individual needs

Recommend….CFMC initiate a process to handle the correspondence on all DME denials and maintain supporting documentation for these denials

- Ensure an improved system of notification to member and provider including all medical necessity denial reasons in the notification. Physicians currently review all DME denials and give explanations for those denials and CFMC has no way to notify the provider of the complete reasons through the ACS system.
- Allow a more timely notification ensuring timely appeals for these denials so that modifications to equipment or other options could be identified
- Ensure a more timely supply of equipment to the member
- Ensure a more systematic file management for ALJ hearing needs

CFMC already has a successful system in place in our retrospective review process to handle physician review, notification to member and provider of denials and appeal process this system could easily be adapted for DME reviews and be more timely, more efficient and allow for improved explanation of medical necessity denials to both members and providers.

CHAPTER 6

ANCILLARY ACTIVITIES

Special Service Requests

CFMC provides research and consultation hours to assist the Department in exploring, investigating and determining the appropriateness and/or feasibility of clinical and administrative practices. CFMC responded to seven of these service requests during FY 06. Six of these requests were completed while one was withdrawn for future investigation.

Two requests involved special onsite reviews at two facilities in the Denver area. One review was conducted concurrently during the client's hospitalization to determine the appropriateness of the acute inpatient admission. The other review was conducted following discharge to determine the duration of emergent care the client received.

A third request was for an expert consultative medical necessity opinion on a procedure benefit for circumcision. CFMC was asked to research the community standard of practice/standard of care related to circumcision in infants.

Another request involved identifying and categorizing the reasons for physical and occupational therapy denials and request modifications. Subsequently, the Department and CFMC formed a task force to look at currently available criteria and best practice guidelines. The outcome of this task force will eventually guide the processing of physical and occupational therapy prior authorizations requests.

One request was for a comprehensive retrospective analysis of a statistically significant sample of cases involving DRGs without complications, with outlier days. A statistically significant sample of 203 cases was identified for the period FY 01 through FY 05. The request called for the trending and analysis of findings, including a cost-benefit analysis, and to provide a report to the Department with recommendations for the development of a concurrent review process.

The final request was to assist the Department in identifying over usage of behavioral health visits to clients in nursing homes. The Department provided a list of practitioners with a large volume of claims for an in-depth review of their visits, their documentation, and their billing practices. CFMC was able to identify the practitioners and request records prior to the end of the contract period. The analysis of the documentation and the reporting will be completed during the next fiscal year.

Fraud And Abuse Prevention

While not directly responsible for investigating fraud and\or abuse cases, CFMC continues to work closely with the Department's Program Integrity Unit to identify inappropriate activities. Familiarity with both the clinical and financial aspects of healthcare makes CFMC an ideal resource for groups as diverse as the Department of Law, the Medicaid Fraud Unit, and the State Auditor's office. When requested, CFMC offers information on specific cases, an explanation of

processes, information on current standards of care, appropriate comparative data, and/or historical practice.

Colorado Medicaid FirstHelp Telephone Triage Program

The Colorado Medicaid FirstHelp telephone triage program was established to provide Medicaid clients with an alternative to emergency department care. By identifying the level of care required, clients are instructed to seek care in the most efficient manner, increasing access to services while reducing long waiting times in overcrowded emergency service departments. CFMC oversaw the development, implementation, and ongoing administration of the program. McKesson Health Solutions was contracted to provide the triage services.

Outcomes

After listening to the caller's concerns, a registered nurse uses a clinical algorithm to determine the best level of care based on the client's circumstances. Call volume decreased 7% in FY 06 (see Table 6.1). During FY 06, 76% of the triage line encounters were from persons with clinical symptoms, illness or injury, while 14% of encounters concerned issues such as general health information, available medical resources and provider services. For tracking purposes, triage staff attempt to identify the age and gender of the client with the medical issue. It was determined that 46% of the encounters concerned a child under the age of five and adult females accounted for 5% and adult males accounted for 2%. The remaining 47% were undeterminable.

TABLE 6.1 – NUMBER AND DISTRIBUTION OF FIRSTHELP CALL ACTIVITIES

Call Category	FY 04		FY 05		FY 06[1]	
Symptomatic Illness or Injury	9,512	(78%)	8,514	(82%)	7,412	(76%)
Emergency 911	24	(0%)	25	(0%)	20	(0%)
Provider Referral	506	(4%)	515	(5%)	431	(4%)
General Health Information	792	(6%)	593	(5%)	650	(7%)
Other & Rerouted Encounters	1,428	(12%)	792	(8%)	927	(10%)
Total Calls	**12,262**		**10,439**		**9,695**	

1. Of the 9,695 calls received in FY 06, only 9,440 were coded by category.

Of the 7,412 callers with symptomatic complaints, 17% were instructed to seek urgent or emergency level care (see Table 6.2). In contrast, 39% of the symptomatic callers were given directions for self-care thereby avoiding any additional medical intervention. The remaining callers were either instructed to call their provider for answers (36%) or instructed to make an appointment with their primary care physician (8%).

TABLE 6.2 – DISTRIBUTION OF SYMPTOMATIC CALL RECOMMENDATIONS

Call Category	FY 04[1]		FY 05		FY 06	
Emergency Care	715	(8%)	687	(8%)	668	(9%)
Urgent Care	720	(8%)	693	(8%)	618	(8%)
Provider Advice	3,271	(34%)	3,068	(36%)	2,695	(36%)
Make Appointment with PCP	783	(8%)	672	(8%)	602	(8%)
Self-care	3,438	(42%)	3,394	(40%)	2,829	(39%)
Total RN Encounters	**9,438**		**8,514**		**7,412**	

1. While 9,512 illness care calls were received in FY 04, only 9,438 were coded as to the level of action taken.

Impact

The goal of the FirstHelp program is to reduce the number of unnecessary costly emergency room (ER) visits while providing clients with appropriate levels of care. Of the callers who said they would have gone to either an urgent care clinic or ER had FirstHelp not been available, 78% were directed to a lower level of care. Approximately 40% of the callers who said they would have called or made an appointment with their health care professional were able to treat themselves. Of the 2,926 clients intending to visit the ER, 2,570 (88%) were directed to a lower level of care. With the average ER visit costing $187, the FirstHelp program potentially saved the Department $480,590 in unnecessary services. With a total cost of $274,350, the FirstHelp program potentially saved $1.75 for every dollar spent on the service.

It is not possible to accurately determine the actual savings, however. Some of the callers intending to seek care at the ER would have incurred costs at lower levels of care, thus offsetting the ER savings. Conversely, this figure does not account for the potential savings from callers who had intended to seek a lower level of care.

Trends

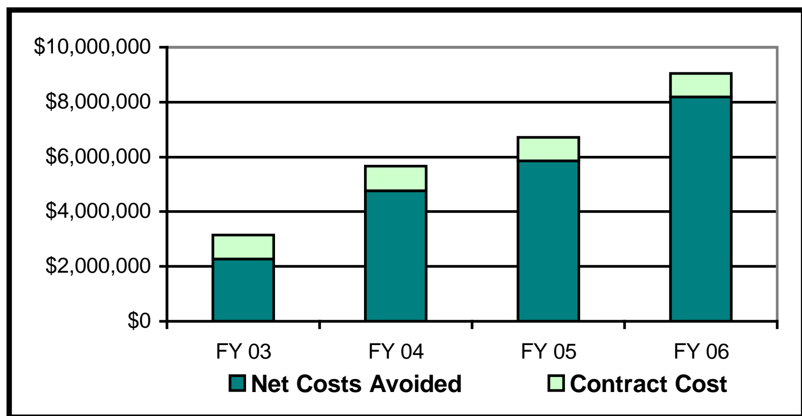
The annual call rate during FY 06 was 30 calls per 1,000 Medicaid clients. In an effort to increase client use of FirstHelp services, new clients were mailed information about the program and all Medicaid clients received an annual reminder letter. McKesson and CFMC worked with the Department to develop an evidence-based strategy for FY 07 that engages providers and other community resources in the promotion of the FirstHelp service.

CHAPTER 7

IMPACT SUMMARY

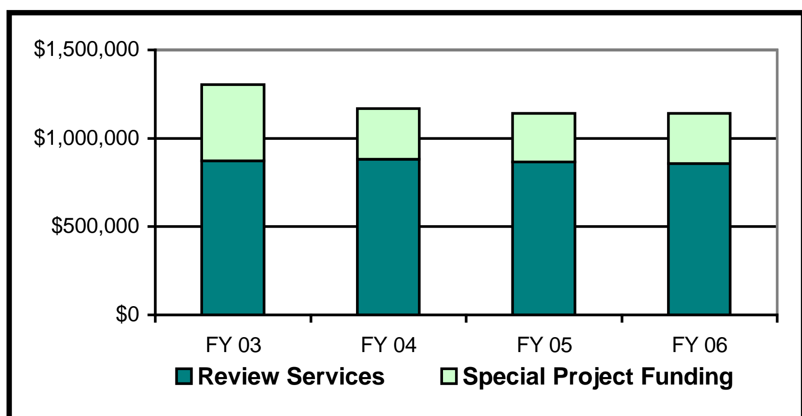
CFMC's acute care review program saves the Department funds by assisting the Department to avoid unnecessary costs through prospective and retrospective reviews. Prospective reviews prevent the inappropriate use of Medicaid dollars by denying payment for unnecessary or inappropriate procedures, equipment, and other services. Retrospective reviews identify inappropriate admissions and inaccurate coding or billing that can result in recovery of payment. The following figures do not include the potential savings from the FirstHelp triage program.

FIGURE 7.1
NET COSTS AVOIDED RELATIVE TO CONTRACT COST



CFMC's acute care review program prevented a record $9,047,816 (gross) from being spent on inappropriate services in FY 06. This is a 40% increase over FY 05. After factoring in the cost of the FY 06 contract, net costs avoided were $8,190,19, more than a $2.4 million increase over the previous fiscal year. Figure 7.1 illustrates the increasing efficiency of the acute care review process and the impact it has had on the program. Unless otherwise stated, all costs, savings, and ratios are presented as net figures; having had CFMC's contract expenses subtracted before calculations were made.

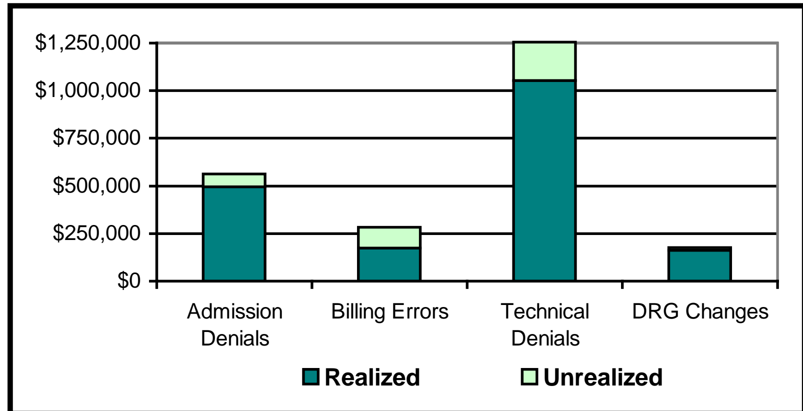
FIGURE 7.2
DISTRIBUTION OF FUNDS RECEIVED BY CFMC



Two factors must be kept in mind when assessing the net fiscal effects of the review process. First, the figures used to calculate net costs avoided include only the amounts spent on review activity. CFMC receives additional funding as part of its contract to fund the McKesson Medicaid FirstHelp triage program and any special studies requested by the Department (see Figure 7.2). While funds spent on non-review activities do not impact the financial success of the review process, they had been included in net savings calculations prior to FY 04. The figures presented here and in Table 7.2 (see page 50) have been adjusted to accurately assess the efficacy of the review process.

The second factor to keep in mind is that the savings reported here are estimates. The denial of a prospective request means that an inappropriate item or service was prevented. The actual amount saved from that item or service is not known so CFMC must estimate based on average costs. Savings from retrospective reviews are easier to calculate because CFMC knows exactly how much was paid for the admission. However, the recovery process takes time. The retrospective review savings reported here reflect the amounts the Department is expected to recover. As of August 30, 2006, 83% ($1,887,607) of the expected $2,278,851 savings had been realized (see Figure 7.3). The remaining $391,244 represents unrealized savings. The ratio between realized and unrealized savings in FY 06 was close to 5:1, compared to 2:1 at the same point in FY 05. The appeal process and the fiscal agent's claims adjustment process combine to delay the collection of funds by several months.

FIGURE 7.3
REALIZED VERSUS UNREALIZED SAVINGS

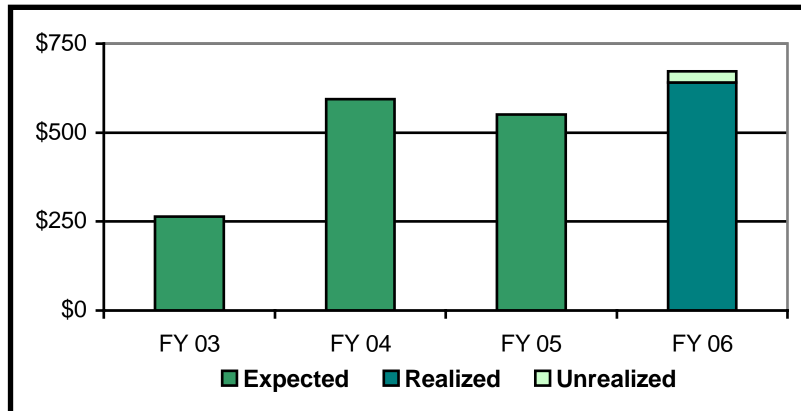


Savings Ratios

Average Cost Avoided Per Review

There are two good ways to judge the effectiveness of the acute care review process. The first method is to look at the average costs avoided per review. For each of the 12,191 reviews conducted in FY 06, the Department avoided $672 in unnecessary expenditures (see Figure 7.4). Of this amount, $640 had been recovered as of August 30, 2006.

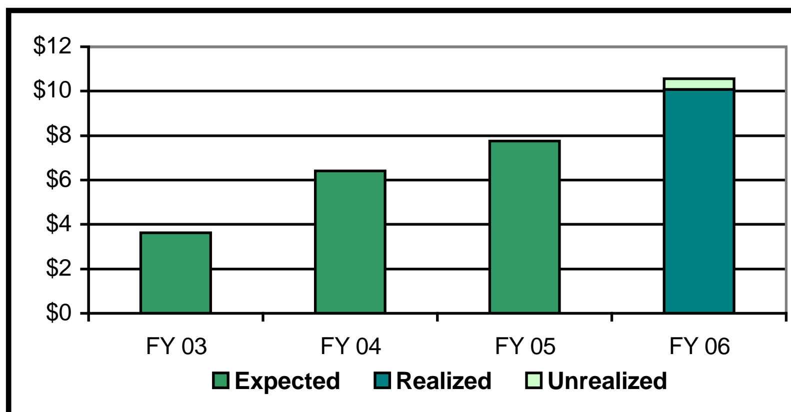
FIGURE 7.4
AVERAGE COST AVOIDED PER REVIEW



Return on Investment

The second, and perhaps the best way to assess the effectiveness of the process is to compare the costs of the program to the financial benefits it produces. Figure 7.5 shows the return on investment for the past four fiscal years. For each dollar spent on CFMC's acute care review activities in FY 06, $10.55 was saved from being spent inappropriately. This is a 36% increase over the $7.76 saved in FY 05. As of August 30, 2006, $10.09 of savings had been realized. The Department will save $10 for every dollar spent on acute care review activities in FY 06, even if no additional funds are collected.

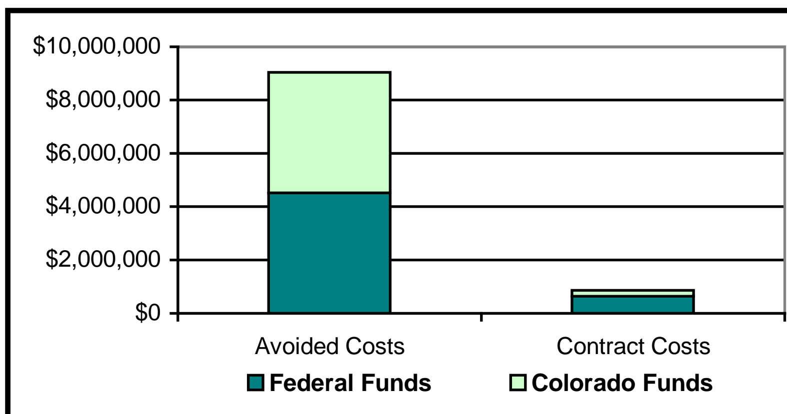
FIGURE 7.5
RETURN ON INVESTMENT



Impact for Colorado

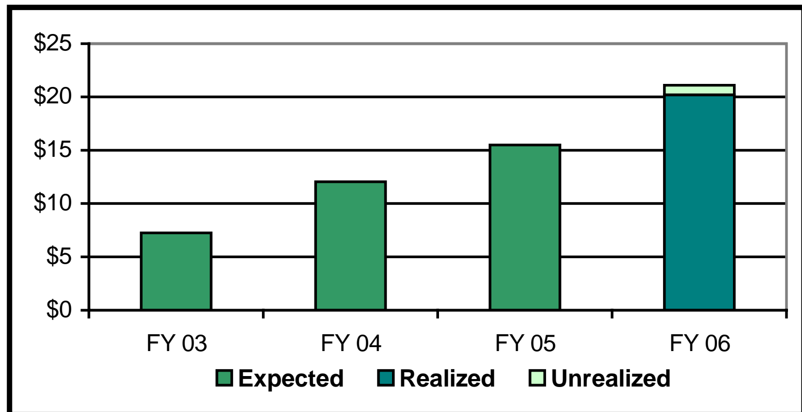
State and federal agencies share the costs of providing Medicaid services as well as the costs to conduct review activities. In FY 06 the state and federal governments each provided 50% of the funds necessary to provide Medicaid services and therefore benefited equally from the $9,047,816 in avoided costs during FY 06 (see Figure 7.6). Colorado, however, only pays 25% of the Medicaid acute care review program's contract; the remaining 75% comes from federal funding. As a result, it costs Colorado $214,407 to fund activities that saved $4,523,908.

FIGURE 7.6
COST AVOIDED V. CONTRACT COSTS



To appreciate the benefit of the review process it is necessary to compare how much the Department pays for review activities to the financial benefits received. Figure 7.7 shows that the return on investment increased 36% from $15.51 in FY 05 to $21.10 in FY 06. Data available as of August 30, 2006 indicate that the Department has already realized a return of $20.19 for every dollar spent on review activities.

FIGURE 7.7
COLORADO'S RETURN ON INVESTMENT



Consolidated Financial Impact Tables

TABLE 7.1 – TOTAL COSTS AVOIDED

Fiscal Impact	FY 03	FY 04	FY 05	FY 06
Gross Costs Avoided	$3,155,332	$5,656,861	$6,714,573	$9,047,816
Review Contract Expenditure	($870,754)	($882,421)	($865,754)	($857,626)
Net Costs Avoided	**$2,284,578**	**$4,774,440**	**$5,848,819**	**$8,190,190**

TABLE 7.2 – ACUTE CARE REVIEW CONTRACT EXPENDITURES

Contract Expenditures	FY 03	FY 04	FY 05	FY 06
Acute Care Review Services	$870,754	$882,421	$865,754	$857,626
Medicaid FirstHelp Triage Program	$274,350	$274,350	$274,350	$274,350
Special Studies	$157,500	$10,416	$0	$8,013
Total Paid to CFMC	**$1,302,604**	**$1,167,187**	**$1,140,104**	**$1,139,989**

TABLE 7.3 – COSTS AVOIDED – COLORADO FUNDS

Fiscal Impact – Colorado Funds	FY 03	FY 04	FY 05	FY 06
Gross Costs Avoided – Colorado Funds	$1,577,666	$2,661,553	$3,357,287	$4,523,908
Contract Expenditure – Colorado Funds	($217,689)	($220,605)	($216,439)	($214,407)
Net Costs Avoided – Colorado Funds	**$1,359,997**	**$2,440,948**	**$3,140,848**	**$4,309,501**

TABLE 7.4 – COSTS AVOIDED PER REVIEW

Source of Funds	FY 03	FY 04	FY 05	FY 06
Colorado Funds	$157	$304	$295	$354
Federal Funds	$107	$290	$255	$318
Costs Avoided Per Review	**$264**	**$594**	**$550**	**$672**

TABLE 7.5 – RETURN ON INVESTMENT

Source of Funds	FY 03	FY 04	FY 05	FY 06
Colorado Funds	7.25	12.06	15.51	21.10
Federal Funds	2.42	4.02	5.15	7.03
Return on Investment	**3.62**	**5.41**	**7.76**	**10.55**

Prospective Review Fiscal Impact Detail

TABLE 7.6 – PROSPECTIVE REVIEW TOTAL COSTS AVOIDED

Prospective Review	FY 03	FY 04	FY 05	FY 06
Procedures[1]	$282,195	$530,742	$370,917	$833,728
Inpatient Mental Health Services	NA	$0	$33,784	$0
Inpatient Substance Abuse Rehabilitation	NA	NA	$0	$69,086
Durable Medical Equipment[2]	$1,452,138	$2,447,571	$1,650,172	$1,320,833
Select Non-emergent Medical Transportation	NA	$8,955	$21,603	$11,268
EPSDT Home Health	$192,367	$88,366	$107,444	$236,694
Physical & Occupational Therapy	$344,529	$870,273	$2,579,195	$4,297,356
Total Prospective Review Costs Avoided	**$2,271,229**	**$3,945,907**	**$4,763,115**	**$6,768,965**

1. Combines transplants and select procedures. Avoided costs are not calculated for out-of-state admissions.
2. Totals for all durable medical equipment programs.

TABLE 7.7 – PROCEDURE REVIEW TOTAL COSTS AVOIDED

Procedure Review[1]	FY 03	FY 04	FY 05	FY 06
Organ Transplants – In-state	$254,343	$448,418	$336,644	$811,092
Organ Transplants – Out-of-State	$0	$67,068	$0	$0
Select Procedures	$27,852	$15,256	$34,273	$22,636
Total Procedure Costs Avoided	**$282,195**	**$530,742**	**$370,917**	**$833,728**

1. Avoided costs are not calculated for out-of-state admissions.

TABLE 7.8 – DURABLE MEDICAL EQUIPMENT REVIEW TOTAL COSTS AVOIDED

Durable Medical Equipment Review	FY 03	FY 04	FY 05	FY 06
Power Wheelchairs	$619,294	$639,325	$519,778	$572,028
Wheelchair Accessories	$323,841	$575,616	$452,949	$461,879
Orthotics/Prosthetics	$39,272	$46,878	$31,399	$69,535
Respiratory Devices	NA	$871,174	$431,110	$56,530
Communication Devices	$41,347	$80,950	$57,157	$55,745
Power Scooters	$61,393	$93,970	$85,020	$47,183
Labor/Service/Repair	NA	$99,704	$47,860	$30,061
Other DME	$366,991	$39,954	$24,899	27,873
Total DME Costs Avoided	**$1,452,138**	**$2,447,571**	**$1,650,172**	**$1,320,833**

TABLE 7.9 – SELECT NON-EMERGENT MEDICAL TRANSPORTATION REVIEW TOTAL COSTS AVOIDED

Transportation Reviews	FY 03	FY 04	FY 05	FY 06
Lodging – Escort	NA	$3,617	$19,612	$9,205
Meals – Escort	NA	$3,545	$1,381	$828
Lodging – Recipient	NA	$1,159	$311	$570
Over-the-cap Ambulance Services	NA	NA	$0	$533
Meals – Recipient	NA	$634	$299	$84
Travel – Escort	NA	NA	NA	$48
Air Transport	NA	NA	NA	$0
Travel – Recipient	NA	NA	NA	$0
Total Transportation Costs Avoided	**NA**	**$8,955**	**$21,603**	**$11,268**

TABLE 7.10 – EPSDT HOME HEALTH REVIEW TOTAL COSTS AVOIDED

EPSDT Home Health Reviews	FY 03	FY 04	FY 05	FY 06
Home Health Aid	$62,194	$49,873	$58,086	$126,332
Skilled Nursing	$93,774	$26,925	$19,597	$2,404
Physical Therapy	$19,658	$4,914	$13,284	$30,202
Occupational Therapy	$10,112	$4,110	$9,648	$37,329
Speech Therapy	$6,628	$2,544	$6,829	$40,428
Total EPSDT Home Health Costs Avoided	**$192,367**	**$88,366**	**$107,444**	**$236,694**

TABLE 7.11 – PHYSICAL & OCCUPATIONAL THERAPY REVIEW TOTAL COSTS AVOIDED

Physical & Occupational Therapy Review	FY 03	FY 04	FY 05	FY 06
Physical Therapy	$158,634	$364,855	$1,172,770	$2,386,973
Occupational Therapy	$185,895	$505,418	$1,406,425	$1,910,384
Total PT/OT Costs Avoided	**$344,529**	**$870,273**	**$2,579,195**	**$4,297,356**

Retrospective Review Fiscal Impact Detail

TABLE 7.12 – RETROSPECTIVE REVIEW TOTAL COSTS AVOIDED

Review Outcome	FY 03	FY 04	FY 05	FY 06
Admission Denials – Realized Savings				$495,533
Unrealized Savings				$68,203
Total Admission Denial Savings	**$282,356**	**$210,250**	**$608,823**	**$563,736**
Technical Denials – Realized Savings				$175,026
Unrealized Savings				$107,673
Total Technical Denial Savings	**$76,120**	**$294,213**	**$405,735**	**$282,699**
Billing Errors – Realized Savings				$1,053,880
Unrealized Savings				$202,896
Total Billing Error Savings	**$505,780**	**$1,143,190**	**$939,494**	**$1,256,776**
DRG Changes – Realized Savings				$163,168
Unrealized Savings				$12,472
Total DRG Change Savings	**$19,847**	**$63,301**	**$124,513**	**$175,640**
Retrospective Review – Realized Savings				$1,887,607
Unrealized Savings				$391,244
Total Retrospective Review Savings	**$884,103**	**$1,710,954**	**$1,951,458**	**$2,278,851**