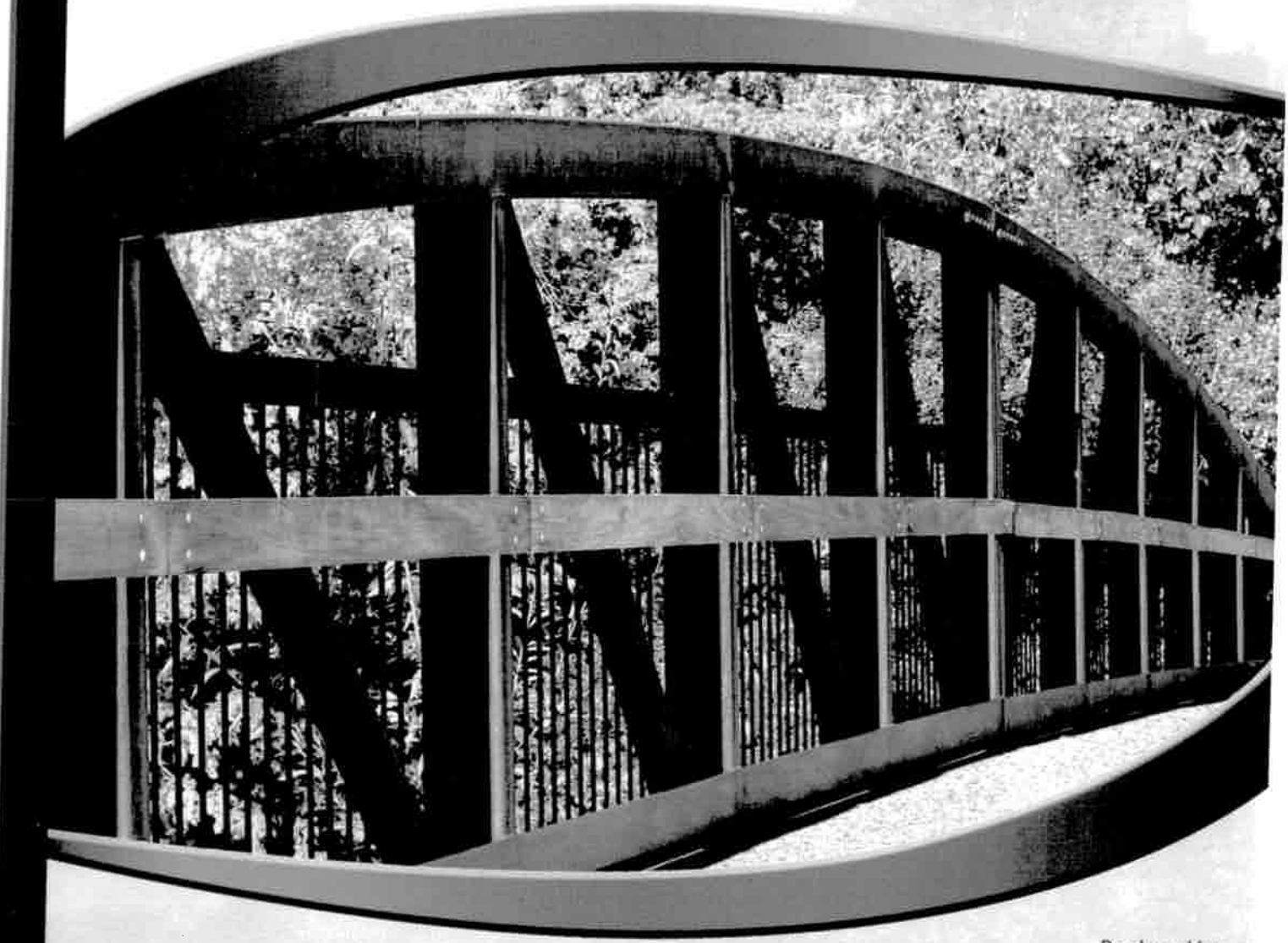
Medicaid Acute Care Annual Report

FY 2009
July 1, 2008 - June 30, 2009



Produced by:
Colorado Foundation for Medical Care
23 Inverness Way East, Suite 100
Englewood, Colorado 80112-5708

COLORADO FOUNDATION FOR MEDICAL CARE
ISO 9001 Certified

Table of Contents

CHAPTER 1

EXECUTIVE SUMMARY

During fiscal year 09 (FY 09) CFMC's acute care review services program conducted 16,921 reviews for the Colorado Department of Health Care Policy and Financing (the Department). These activities prevented inappropriate and unnecessary medical expenditures totaling $14,653,705. This translates into a net savings of $13,450,326 for FY 09, after factoring in the contract cost for review activities.

CFMC, working in partnership with the Department, conducted two types of reviews, prospective and retrospective. We conducted prospective reviews prior to the delivery of services. Requests were reviewed ensuring compliance with CFMC's policies and procedures and work instructions, as well as Department guidance maintained in the *Provider Services* section of *The State Official Web Portal*. We monitored this web portal monthly for changes. Additionally, CFMC's nurse reviewers used nationally accepted, evidence-based, annually updated, medical necessity screening criteria, and their clinical experience to ensure services are medically necessary and appropriate. Our established network of more than 100 credentialed physician reviewers, representing most medical specialties, reviewed cases that did not meet the screening criteria. The denial of inappropriate prospective requests discourages potential abuse of the system while minimizing duplication of services. CFMC reviewed 12,905 prior authorization requests for nine different Medicaid services. Using reimbursement figures provided by the Department, CFMC estimated that denial of inappropriate requests prevented $11,452,837 worth of unnecessary care and services, a 2% increase over FY 08. These "costs avoided" do not represent savings that can be passed back to Colorado's general budget and do not take into consideration any item or service that may have been provided in lieu of the denied request.

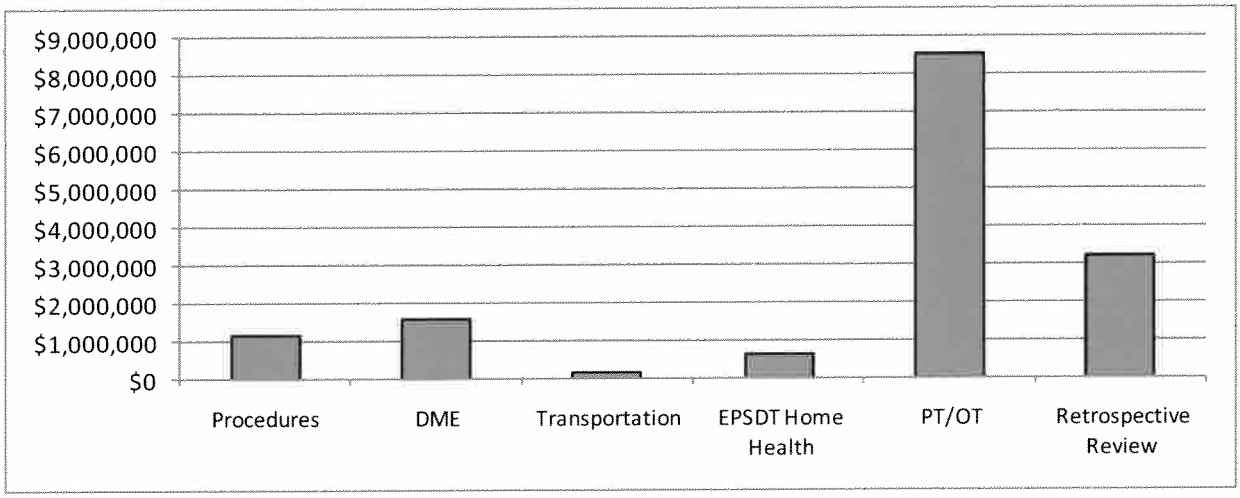
While the types of prospective review remained unchanged in FY 09, total review volume increased 17%. The Department's Budget Caseload Report showed an 11% increase in the average caseload for this same period, up from 391,962 clients in FY 08 to 436,812 in FY 09. Historically, requests for physical and occupational therapies (PT/OT) and durable medical equipment (DME) have had the largest volumes. PT/OT reviews (7,067) were up 18% and DME reviews (3,764) were up 11%. Together, these two programs accounted for 84% of the prospective review volume.

CFMC also conducted retrospective reviews of inpatient stays after the hospital claims were paid. Examining paid claims against the medical record ensures that the care paid for was medically necessary, required acute level of care, and was coded and billed correctly. We also reviewed these records for quality issues. The majority of cases were selected using criteria that targeted specific types of cases known to, or expected to contain a large percentage of errors. We found no errors in 87% of the 4,016 cases reviewed, but the potential financial impact of the other 13% was substantial. The Department is entitled to recover the funds paid to a facility in error. Errors include medically unnecessary admissions, cases billed or coded incorrectly, and when the facility fails to comply with record requests. In instances of an identified error or DRG change, the Department worked with the provider and the fiscal agent to recover funds. Retrospective review activities identified $3,200,868 in unsubstantiated payments, a 7% increase

over the previous fiscal year. These figures are based on CFMC review determinations and do not reflect later administrative payment determinations by the Department or fiscal agent.

Figure 1.1 illustrates the financial impact of both prospective and retrospective reviews. CFMC activities in FY 09 prevented medically unnecessary spending totaling an estimated $14,653,705. Prospective review of PT/OT services accounted for 58% of the total, $8,534,410. Taken together, prospective reviews accounted for roughly 78% of the impact compared to 22% for retrospective reviews. This breakdown of financial impact is consistent with previous years.

FIGURE 1.1 – TOTAL COSTS AVOIDED BY PROGRAM



After factoring in the cost of CFMC's FY 09 contract for review activities, the Department netted $13,450,326 in savings, a 2% increase. Return on investment is one way to assess value of a program. For each dollar spent on CFMC's acute care activities in FY 09, reviews prevented $12.18 in inappropriate spending. While the Department shares the cost of providing services with federal agencies, Colorado dollars only pay for 25% of the contract costs. As a result, the Department paid $300,845 to fund activities that saved $7,026,008, a return on investment of $24.35 for every dollar spent.

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

Please Note:
The figures on the next page provide a one-page reference for general information concerning review volumes, approval rates, and fiscal impact. Detailed explanations of the figures follow below. After reading the entire report, the reader may find this page a valuable tool for locating numbers quickly.

TABLE 1.1 – FISCAL YEAR 09 KEY TABLES

Total Review Volumes	
Prospective Reviews	12,905
Retrospective Reviews	4,016
Total Reviews	**16,921**

Total Costs Avoided	
Prospective	$11,452,837
Retrospective	$3,200,868
Costs Avoided	**$14,653,705**

Prospective Review Volumes	
Transplants	67
Select Procedures	940
Out-of-state Admissions	39
Mental Health Services	5
Substance Abuse	68
DME	3,764
Transportation	843
EPSDT Home Health	112
PT/OT	7,067
Total Reviews	**12,905**

Prospective Review Approval Rates	
Transplants	90%
Select Procedures	72%
Out-of-state Admissions	79%
Mental Health Services	80%
Substance Abuse	100%
DME	82%
Transportation	92%
EPSDT Home Health	87%
PT/OT	90%
Total Reviews	**87%**

Retrospective Review Selection Rates	
Provider Focus	1,971
Readmissions	899
DRG Focus	448
Random Selection	353
Focused Inliers	290
DRG Outlier Focus	55
Total Reviews	**4,016**

Retrospective Review Outcome Rates	
Approved	3,491
Admission Denial	48
Technical Denial	65
Billing Error Denial	412
Total Reviews	**4,016**

Net Costs Avoided	
Gross Costs Avoided	$14,653,705
Cost of Review Activity	($1,203,379)
Net Savings	**$13,450,326**

Colorado Net Costs Avoided	
Gross Costs Avoided	$7,326,853
Cost of Review Activity	($300,845)
Net Savings	**$7,026,008**

Return on Investment	
Colorado Funds	24.35
Federal Funds	8.12
Total Return	**12.18**

Net Costs Avoided Per Review	
Colorado Funds	$415
Federal Funds	$380
Per Review	**$795**

CHAPTER 2

REVIEW ACTIVITY OVERVIEW

CFMC's Medicaid medical care review program conducted two forms of review during FY 09:

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

Most reviews conducted by CFMC nurse reviewers use nationally recognized Milliman Care Guidelines. Milliman Care Guidelines are 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 offer evidenced-based criteria, updated annually by specialists familiar with the latest medical research. Milliman Care Guidelines also include reference material to support each guideline, material 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 incorporates other resources in the review process to determine medical necessity, appropriateness of care, and cost effectiveness of care. These resources include, but are not limited, to criteria published by the Department, Medicare Guidelines and DSM-IV Guidelines.

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 training and educational opportunities. Process improvements and/or individual guidance and instruction address identified deviations in standards.

CFMC maintains certification by a nationally recognized quality accreditation body, the Utilization Review Accredited Commission (URAC). The URAC Health Utilization Management standards establish consistency in processes. The standards ensure that appropriately trained clinical personnel conduct and oversee the utilization review process, that a reasonable and timely appeals process is in place, and that decisions use valid clinical criteria.

CFMC's internal quality control process monitors the inter-rater reliability for clinical reviews on a monthly basis. Each month, we review randomly selected cases for validity and reliability measures for clinical staff reviews. 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. Inter-rater reliability remained high during FY 09, 98.3% for prior authorization reviews and 99.1% for retrospective reviews.

CHAPTER 3

PROSPECTIVE REVIEW HIGHLIGHTS

CFMC reviewed 12,905 prior authorization requests, from nine different service categories, to ensure that each request was a covered Medicaid benefit and that the request was medically necessary and appropriate based on the established criteria. This reflects a 17% increase in review volume. Review activities prevented $11,452,837 in inappropriate spending during FY 09, a 2% increase. We estimated fiscal impact for the Department using the average cost of the item or service during the review period. Other items or services received by the client not requiring prior authorization, or authorized by the fiscal agent, are unknown to CFMC and do not figure into our cost avoidance calculations. The information that follows is a brief overview of the different prior authorization programs.

Review of outpatient physical and occupational therapy (PT/OT) prior authorization requests continues to produce the greatest impact of the prospective review program. While the number of PT/OT reviews increased 17% in FY 09 to 7,067, cost avoidance from these reviews increased 4% to $8,534,410. PT/OT reviews accounted for 75% of the prospective review fiscal impact.

Durable medical equipment (DME) reviews totaled 3,764, an increase of 11%. The number of power wheelchairs requests was up 3% while the number of power scooter requests continues a sharp decline, down 67% in FY 09. The total costs conserved were $1,584,267, a 21% increase. All categories of DME, with the exceptions of communication devices and power scooters, experienced increased fiscal impacts. We attribute the 6% decrease in costs conserved for communication devices ($164,654) to an increase in the appropriateness of requests.

Transplant reviews conserved $515,562 in FY 09. The number of transplants requested increased from 64 in FY 08 to 67 in FY 09, but the number of denials declined from eight to seven. With the average cost of the denied transplants over $157,000, even a single transplant denial can create a sizable financial impact.

The smaller prospective review programs produced a variety of results. Requests for select procedures were up 43%, largely due to 31 new providers requesting authorization for nasal procedures. While the number of select non-emergent medical transportation service reviews was up 23%, the number of units requested was up 53%. Escort lodging and meal services continue to lead the increase, up 62% and 42% respectively. Travel costs conserved were $169,861, more than doubling the previous year for the third consecutive fiscal period. Denials for escort lodging ($107,469) and escort meals ($39,381) accounted for 86% of total savings.

Prospective authorization is required for inpatient mental health services beyond 45 days, and CFMC received five such requests for FY 09 compared to one in FY 08. The number of substance abuse rehabilitation requests increased from 66 in FY 08 to 68 in FY 09. We approved all 68.

The number of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) home health service reviews continues to fluctuate based on the needs of the clients. While the number of requests increased from 99 in FY 08 to 112 in FY 09, the number of service units requested remained unchanged.

TABLE 3.1 – NUMBER OF PROSPECTIVE REVIEWS

Prospective Request	FY 07	FY 08	FY 09
Transplants	55	61	67
Select Procedures[1]	490	658	940
Out-of-state Elective Admissions	57	56	39
Inpatient Mental Health Services	9	1	5
Inpatient Substance Abuse Rehabilitation	61	66	68
Durable Medical Equipment	3,268	3,377	3,764
Select Non-emergent Medical Transportation	690	683	843
EPSDT Home Health Services	113	99	112
Physical & Occupational Therapy	5,340	6,007	7,067
Total Prospective Reviews	**10,083**	**11,008**	**12,905**

1. Selected procedures broken out by type in discussion below.

TABLE 3.2 – PROSPECTIVE REVIEW OUTCOMES

Prospective Request	Approved	Partially Approved	Medical Denial	Technical Denial	Not Reviewed	Total Reviewed	Approval Rate[1]
Transplants	60	0	1	6	0	67	90%
Select Procedures	657	16	4	100	163	940	72%
Out-of-state Elective Admissions	31	0	0	7	1	39	79%
Inpatient Mental Health Services	4	0	0	0	1	5	80%
Inpatient Substance Abuse Rehabilitation	68	0	0	0	0	68	100%
Durable Medical Equipment	2,988	111	5	516	144	3,764	82%
Select Non-emergent Medical Transportation	771	5	0	48	19	843	92%
EPSDT Home Health Services	96	1	0	3	12	112	87%
Physical & Occupational Therapy	6,185	179	0	686	17	7,067	90%
Totals	**10,860**	**312**	**10**	**1,367**	**356**	**12,905**	**87%**

1. Percentage of requests approved or modified.

TABLE 3.3 – PROSPECTIVE REVIEW TOTAL COSTS AVOIDED

Prospective Request	FY 06	FY 07	FY 08	FY 09
Transplants	$811,092	$603,529	$1,134,067	$515,562
Select Procedures	$22,636	$52,016	$12,858	$27,631
Inpatient Mental Health Services	$0	$0	$0	$0
Inpatient Substance Abuse Rehabilitation	$69,086	$9,137	$0	$0
Durable Medical Equipment	$1,320,833	$1,731,545	$1,306,215	$1,584,267
Select Non-emergent Medical Transportation	$11,268	$35,378	$78,998	$169,861
EPSDT Home Health Services	$236,694	$234,882	$412,203	$621,106
Physical & Occupational Therapy	$4,297,356	$5,822,073	$8,238,256	$8,534,410
Total Costs Avoided	**$6,768,965**	**$8,488,560**	**$11,182,597**	**$11,452,837**

TABLE 3.4 – PROSPECTIVE REVIEW COST RATIOS

Key Prospective Review Ratios	FY 06	FY 07	FY 08	FY 09
Costs Avoided Per Review	**$832**	**$842**	**$1,016**	**$887**

Prospective Review – Discussion

We conducted prospective reviews prior to the delivery of services. By requiring a prior authorization request (PAR), 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. We notify the Department of any trends or other concerns about provider quality or consistency we identify. The positive working relationship CFMC has with the Departme ' has produced a refined review process that provides clients with the services they need in a timely manner while eliminating unnecessary costs.

The CFMC review team works continually to improve both the process and timeliness of prior authorization review. In FY 09, CFMC collaborated with the fiscal agent, and the Department to implement electronic transmission of completed prospective reviews in compliance with the X12N 278 Health Care Services Review Standards. On January 5, 2009, CFMC initiated daily electronic transmissions of completed prospective reviews to the fiscal agent, eliminating the need to forward hardcopy review summaries for manual data entry by the fiscal agent. While this process improvement did not affect the amount of time required to complete reviews, it streamlined the notification process. Instead of waiting for courier delivery and data entry, the fiscal agent is able to generate approval letters automatically, following receipt of electronic submissions.

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 or non-physician review coordinators review requests from providers to ensure that the request is a covered Medicaid benefit and that the request is medically necessary and appropriate given established criteria. Milliman Care Guidelines are used for the prospective review of surgical procedures, including transplants, and inpatient mental health admissions. We also use criteria published by the Department to review requests for other DME requests, 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 EPSDT programs
- Select non-emergent medical transportation services
- Home health services for EPSDT
- Physical & occupational therapy

Our first step is to review requests to ensure that all demographic information complies with new regulatory transmission requirements. If the PAR request is incomplete, we issue a technical denial and return the PAR 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 allows direct transmission of the PAR outcome to the fiscal agent. We will also issue a technical denial if the provider does not supply required clinical documentation.

If clinical information supporting the request is missing, the clinical reviewer initiates a document-tracking letter requesting the missing clinical information from the provider. We fax this request to the provider. The provider has 10 working days to submit the information. We typically receive the required information promptly and the review is completed. Failure to provide the clinical information within this period results in a technical denial. The review process enables CFMC reviewers to identify quickly previous denials and duplicate requests, saving both time and money. Although the clinical reviewer has 10 working days to determine whether the request meets all criteria, in most instances we complete reviews in a much shorter time when the provider supplies all documents needed to complete the review. The exceptions are the inpatient mental health and inpatient substance abuse admission reviews that we complete within 48 hours. If the review coordinator cannot establish medical necessity, we refer the request to a CFMC physician reviewer for a final decision. Upon medical necessity determination by the physician, we send authorization to the fiscal agent who notifies the provider and client.

Impact Calculation Methodology

Prospective reviews preserve funds by preventing inappropriate and unnecessary expenditures before they occur. "Costs avoided" through prospective review do not represent savings that pass 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.

We must estimate the true financial benefits of prior authorization reviews. While CFMC has continually refined its impact analysis processes to provide the most accurate projections possible, the reduction in expenditures for the Department 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.

The diagnosis related group (DRG) payment system reimburses providers for both transplants and inpatient surgical procedures. 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. We estimate the costs avoided from a denial of one of these procedures 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 complications or co-morbid conditions can be much more expensive than the costs estimated by CFMC.

We estimate outpatient procedures and durable medical equipment costs by calculating the average Medicaid payment during the year for each particular procedure or unit of equipment. We use the fee schedule allowed for each unit of the services denied to estimate costs avoided through transportation, EPSDT home health, and physical and occupational therapy reviews. Similarly, we estimate inpatient mental health treatment costs by multiplying the facility's per diem rate by 14, the maximum number of days reviewed at one time. We are unable to calculate out-of-state elective admission costs because payment data from other states is not available.

CFMC may receive prior authorization requests for items or services that do not require prior authorization. We route these requests to either the fiscal agent or the appropriate program. We deny these requests and include the count in the review volume calculations, but use a special code to ensure they do not affect our impact calculations.

TABLE 3.5 – PROSPECTIVE REVIEW REQUESTS NOT REQUIRING REVIEW

Prospective Request	FY 07	FY 08	FY 09
Admission/Treatment/Procedures	74	78	165
Durable Medical Equipment	183	206	143
Transportation	7	8	19
Physical & Occupational Therapy	5	11	17
EPSDT/Home Health	4	19	12
Total Requests	**273**	**322**	**356**

Prospective Review Activity Outcome Discussion

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 available only at National Centers of Excellence facilities outside of Colorado. CFMC reviews all requests for out-of-state procedures, including transplants, using specialty-matched physician reviewers for determination. The physician determines medical necessity, verifies that the procedure is not investigational or experimental, and verifies that the procedure is not available within Colorado.

CFMC approves in-state transplant requests if they are on the approved transplant list established by the Department and either meets Milliman Care Guidelines or 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. We forward the physician reviewer's determination to the Department for consideration. The Department makes the final decision on whether to approve or deny the transplant procedure.

Submission of requests for transplant authorization typically occurs 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 ultimately determine if a transplant takes place, including the client's overall health and the availability of organs. Sometimes these factors cause a facility to cancel a request before CFMC is able to make a determination.

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 07	FY 08	FY 09
Approved	50	56	60
Medical Denial	3	2	1
Technical Denial	1	6	6
Modified	0	0	0
Not Reviewed	1	0	0
Total Reviewed	**55**	**64**	**67**

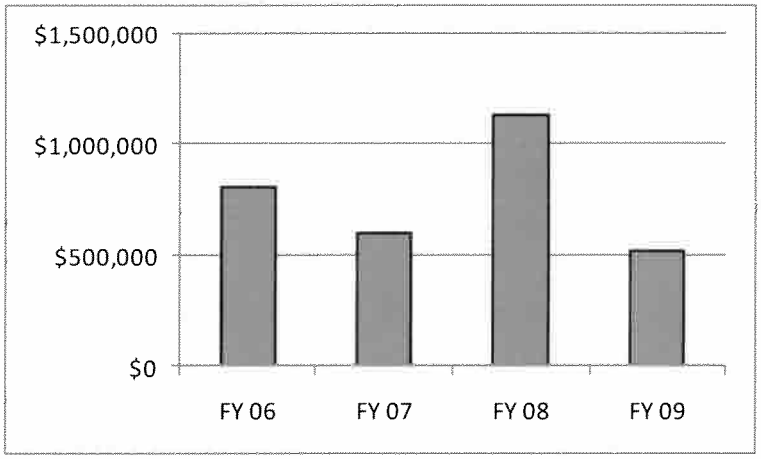
Bone marrow/stem cell transplant authorizations continue to be the most frequently requested type of transplant (see Table 3.7). Liver transplants are typically the second most frequently requested, but heart transplant requests were second in FY 09. As transplants have become more widely available with improved outcomes, the expectation is for continued modest increases in number of requests.

TABLE 3.7 – PROSPECTIVE TRANSPLANT REVIEW DETAILS

Type of Request	Approved	Medical Denial	Technical Denial	Modified	Not Reviewed	Total
In-state Transplants	**55**	**1**	**4**	**0**	**0**	**60**
Bone/Stem Auto	14	1	1	0	0	16
Bone/Stem Allo	13	0	1	0	0	14
Heart	12	0	1	0	0	13
Liver	10	0	1	0	0	11
Lung	3	0	0	0	0	3
Liver/Kidney	2	0	0	0	0	2
Lymphocyte Infuse	1	0	0	0	0	1
Out-of-state Transplants	**5**	**0**	**2**	**0**	**0**	**7**
Bilateral Lung	0	0	2	0	0	2
Liver/Pancreas/Kidney	1	0	0	0	0	1
Pancreas/Small Bowel	1	0	0	0	0	1
Renal	1	0	0	0	0	1
Small Bowel	1	0	0	0	0	1
Small Bowel/Liver	1	0	0	0	0	1
Totals	**60**	**1**	**6**	**0**	**0**	**67**

The figures in this report visually represent the costs avoided for each of the programs. Figure 3.1 highlights the variable nature of the prospective transplant review program. The total conserved in FY 09 was $515,562, less than half of the FY 08 total. This number can be deceiving because two of the FY 09 denials were for procedures unavailable in Colorado. CFMC is unable to estimate the costs avoided on these two procedures. With the average in-state request denied in FY 09 costing $157,000, it is reasonable to assume the true fiscal impact is at least $300,000 more than estimated.

FIGURE 3.1
COSTS AVOIDED – PROSPECTIVE TRANSPLANT REVIEW



Analysis

Of the five in-state denials in FY 09, CFMC denied one because Medicaid was not the primary payor, one because it failed to meet medical criteria, and two others because they lacked critical information necessary to determine the medical necessity of a transplant. The final in-state denial received approval on a second request. We did not include the cost of the initial denial in the fiscal impact calculations.

Select Procedures

The Department requires a prospective authorization review for a select group of inpatient and ambulatory procedures. CFMC nurse reviewers apply Milliman Care Guidelines for medical necessity and level of care. A CFMC specialty-matched physician reviewer reviews procedures that do not meet Milliman Care Guidelines to determine medical necessity. Among the procedures requiring prospective approval are mammoplasty, septoplasty, gastroplasty, and gastric bypass. Review of these procedures ensures that the procedures meet medical necessity guidelines and are not strictly cosmetic.

Outcomes

The number of prospective select procedure requests conducted has increased each of the past three fiscal years (see Table 3.8).

TABLE 3.8 – PROSPECTIVE SELECT PROCEDURE REVIEWS

Review Outcome	FY 07	FY 08	FY 09
Approved	337	466	657
Medical Denial	12	8	4
Technical Denial	49	67	100
Modified	27	41	16
Not Reviewed	65	77	163
Total Reviewed	**490**	**659**	**940**

The 43% increase in requests during FY 09 can be misleading if used to predict future volumes. Breast procedures accounted for almost a third of all select procedure requests in FY 09 (see Table 3.9), but this figure could have been higher. Working together, the Department, CFMC, and the fiscal agent identified nine mastectomy and breast reconstruction procedures with exceptionally high approval rates. As of February 1, 2009, these procedures no longer require prospective review. Of greater interest is the 47% increase in the number of nasal procedure requests.

TABLE 3.9 – PROSPECTIVE SELECT PROCEDURE REVIEW DETAILS

Type of Procedure	Approved	Medical Denial	Technical Denial	Modified	Not Reviewed	Total
Breast	270	3	23	7	17	320
Nasal	207	0	40	5	3	255
Gastric	129	1	7	3	0	140
Dermatological	19	0	3	0	0	22
Ear Implant	2	0	1	0	4	7
Genital & Intersex	2	0	0	0	0	2
Other	28	0	26	1	139	194
Totals	**657**	**4**	**100**	**16**	**163**	**940**

Analysis

With an approval rate of 72%, select procedures continues to have one of 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 is responsible for more than half of the denial rate. If the requests not reviewed are excluded from the totals, the approval rate would have been 87% and consistent with other programs.

We expect the number of breast procedures to decrease in FY 10, as this will be the first full fiscal year with the new prospective authorization policy.

Out-of-state Elective Admissions

CFMC reviews out-of-state elective inpatient admissions 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 is available within Colorado. A CFMC physician reviewer reviews all prospective out-of-state requests.

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 REVIEW

Review Outcome	FY 07	FY 08	FY 09
Approved	38	43	31
Medical Denial	2	4	0
Technical Denial	9	9	7
Modified	2	0	0
Not Reviewed	6	0	1
Total Reviewed	**57**	**56**	**39**

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.

Inpatient Mental Health Services

CFMC conducts a review of mental health services for clients excluded from the Colorado Medicaid Community Mental Health program that are under the age of 21 and who 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. Some requests may be the result of a court order, but CFMC has no way of determining whether a court initiated a particular request unless the medical record mentions the order.

Outcomes

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

TABLE 3.11 – PROSPECTIVE INPATIENT MENTAL HEALTH REVIEWS

Review Outcome	FY 07	FY 08	FY 09
Approved	9	0	4
Medical Denial	0	0	0
Technical Denial	0	0	0
Modified	0	0	0
Not Reviewed	0	1	1
Total Reviewed	**9**	**1**	**5**

Analysis

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

Inpatient Substance Abuse Rehabilitation Services

To qualify for the inpatient 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 Department developed the admission criteria we use to establish medical necessity.

Outcomes

The number of requests was up, from 66 in FY 08 compared to 68 in FY 09 (see Table 3.12).

TABLE 3.12 – PROSPECTIVE INPATIENT SUBSTANCE ABUSE REHABILITATION REVIEW

Review Outcome	FY 07	FY 08	FY 09
Approved	55	66	68
Medical Denial	2	0	0
Technical Denial	2	0	0
Modified	0	0	0
Not Reviewed	2	0	0
Total Reviewed	**61**	**66**	**68**

Analysis

As with FY 08, all requests in FY 09 met medical necessity criteria. The Department may wish to assess the cost effectiveness of continuing these reviews.

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 devises, 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.

CFMC continues to use a combination of Milliman Care Guidelines and criteria developed with the Department to determine medical necessity for DME. Beginning in FY 08, however, the nurse reviewer can no longer deny a DME request. We forward requests that do not meet criteria to physician review to determine medical necessity.

Outcomes

CFMC reviewed a record number of prospective DME requests in FY 09. The 3,764 reviews represent an 11% increase over FY 08, compared to the 3% increase between FY 07 and FY 08 (see Table 3.13). CFMC may approve, modify, or deny a request. The entire request is approved if all the equipment requested meets guidelines. If some of the items requested are not medically necessary, we deny those items while approving the necessary items. We refer to this as a modified approval. We deny the entire request if none of the equipment is clinically necessary. CFMC will frequently receive a prior authorization request for a device or service that does not require prior authorization or is a fiscal agent review. In FY 09, CFMC recognized 144 prior authorization requests that fell into one of these categories.

TABLE 3.13 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REVIEWS - TOTAL

Review Outcome	FY 07	FY 08	FY 09
Approved	2,246	2,587	2,988
Modified	140	140	111
Medical Denial	45	7	5
Technical Denial	654	437	516
Not Reviewed	183	206	144
Total Reviewed	**3,268**	**3,377**	**3,764**
Approval Rate[1]	**73%**	**77%**	**82%**

1. Percentage of requests approved or modified.

We categorize prospective DME requests according to the primary piece of equipment requested. The four primary categories are power wheelchairs, power scooters, orthotics/prosthetics, and communication devices. We place requests that do not fall under one of these categories 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 09.

TABLE 3.14 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REQUEST DETAILS – TOTAL

DME Category	Approved	Modified	Medical Denial	Technical Denial	Not Reviewed	Total Reviewed	Approval Rate[1]
Power Wheelchairs	567	74	2	166	0	809	79%
Power Scooters	6	0	0	6	0	12	50%
Orthotics/Prosthetics	1,885	23	0	203	25	2,136	89%
Communication Device	243	8	2	25	10	288	87%
Other[2]	287	6	1	116	109	519	56%
Totals	**2,988**	**111**	**5**	**516**	**144**	**3,764**	**82%**

1. Percentage of requests approved or modified.
2. 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 requests in FY 09. Requests for power wheelchairs and communication devices were up slightly, just 3% and 4% respectively. On the other hand, requests for orthotics and prosthetics were up 17% and requests for "Other" DME were up 13%. The number of power scooter requests fell 67% as demand continues to decline.

TABLE 3.15 – DURABLE MEDICAL EQUIPMENT ITEM REQUEST OUTCOMES – TOTAL

DME Category	FY 07[1]	FY 08	FY 09
Power Wheelchair	749	784	809
Power Scooter	64	36	12
Orthotics/Prosthetics	1,591	1,820	2,136
Communication Device	313	276	288
Other[2]	551	461	519
Totals	**3,268**	**3,377**	**3,764**

1. CFMC inadvertently reported 234 power wheelchair accessory requests as requests for actual wheelchairs in the FY 07 annual report. The numbers for Power Wheelchair and Other have been corrected to facilitate comparison across years and will not match the previous report.
2. Other reviews include requests for wheelchair parts and labor, respiratory devices, and rehab equipment other than orthotics/prosthetics.

DME requests usually include more than one unit within each prospective authorization request. Tracking the number and types of equipment requested is useful. For example, an augmentative communication device may include a series of switches, a keyboard mounting system, component software, and a carrying case. Despite an 11% increase in the number of requests (see Table 3.13 on page 16), the number of individual units requested increased just 4% (see Table 3.16).

TABLE 3.16 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES – TOTAL

Review Outcome	FY 07	FY 08	FY 09
Units Approved	27,878	19,661	19,569
Units Denied	10,114	5,126	6,294
Total Units Reviewed	**37,992**	**24,787**	**25,863**
Percent Approved	**73%**	**79%**	**76%**

While Cochlear implants no longer require prospective authorization as of June 2007, CFMC continues to receive requests. We deny these requests. While the number of such requests is small (24 in FY 09), included in the requests are large numbers of batteries (11,088 in FY 09). We handle these requests as all other reviews, but exclude them from the totals presented in the tables because they skew the data and may mask important trends.

Table 3.17 summarizes the types of equipment requested, the number of each, and the review outcome. We review each unit independently and approve or deny each unit.

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

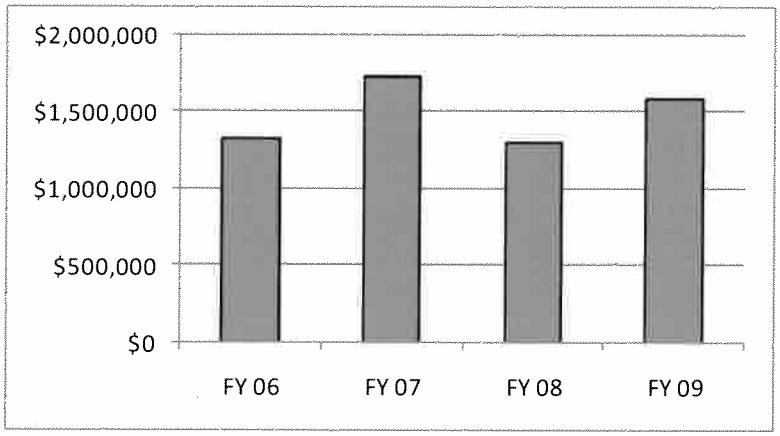
Type of Equipment	Units Approved	Units Denied	Total Units Reviewed	Percentage Approval
Wheelchair Accessory	8,810	2,056	10,866	81%
Labor/Service[1]	4,901	1,352	6,253	78%
Orthotics/Prosthetics	3,857	774	4,631	83%
Communication Device	948	167	1,115	85%
Power Wheelchair	645	172	817	79%
Respiratory Device	279	404	683	41%
Back-up Manual Wheelchair	1	121	122	1%
Power Scooter	6	6	12	50%
Rehabilitation Equipment	3	1	4	75%
Hearing Device or Service	0	4	4	0%
Miscellaneous[2]	119	1,237	1,356	9%
Totals	**19,569**	**6,294**	**25,863**	**76%**

1. Service charge for assembly/delivery of power wheelchair.
2. 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 conserved $1,584,267 on items not meeting medical necessity. This 21% increase is a result of increases across most categories of DME. The average cost avoided per unit denied was $421. We base the estimated reduced expenditure for the Department on the average cost of the denied item and does not take into consideration items not requiring prior authorization that may have been provided in lieu of the denied item.

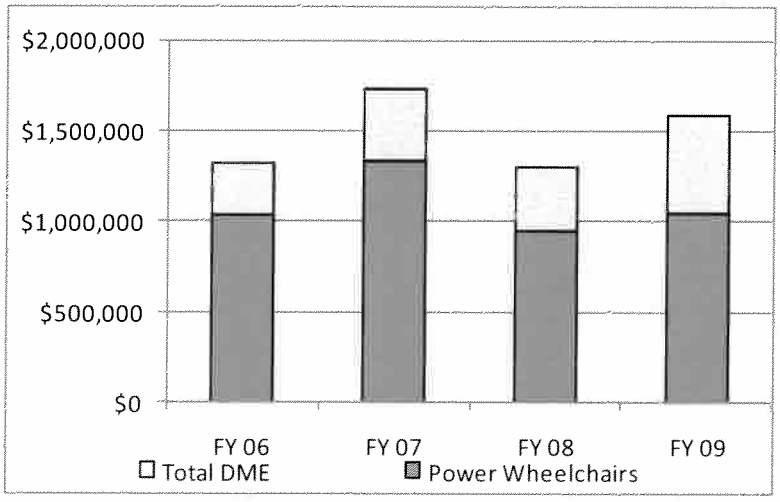
FIGURE 3.2
DOLLARS CONSERVED – PROSPECTIVE DME REVIEW



Power Wheelchairs

Because the costs of basic power wheelchair models start around $3,000, and can surpass $25,000, the Department has been interested in the review of the power wheelchair requests. Historically, cost avoidance from unnecessary power wheelchairs and wheelchair accessories has accounted for at least half the total reduced expenditure for the Department through prospective DME reviews (see Figure 3.3). Of the $1,584,267 in DME costs avoided during FY 09, 66% ($1,044,737) relates directly to reviews of power wheelchair and power wheelchair accessories. Of the $11,452,837 conserved through the entire prospective review program, 9% was due to power wheelchair and power wheelchair accessory reviews.

FIGURE 3.3
DOLLARS CONSERVED – POWER WHEELCHAIR REVIEW



Respiratory Devices

Like power wheelchairs, respiratory devices, such as mechanical high frequency chest wall therapy vests, are expensive items with strict clinical criteria. A total of 683 devices were requested in FY 09, twice the number as the previous year (see Table 3.18). Of the 683 requests, however, only 41% met review criteria. Denial of the other 404 devices conserved $182,616. As figure 3.4 illustrates, the fiscal impact of respiratory device reviews has been steadily increasing over the past four fiscal years.

FIGURE 3.4
DOLLARS CONSERVED – RESPIRATORY DEVICE REVIEW

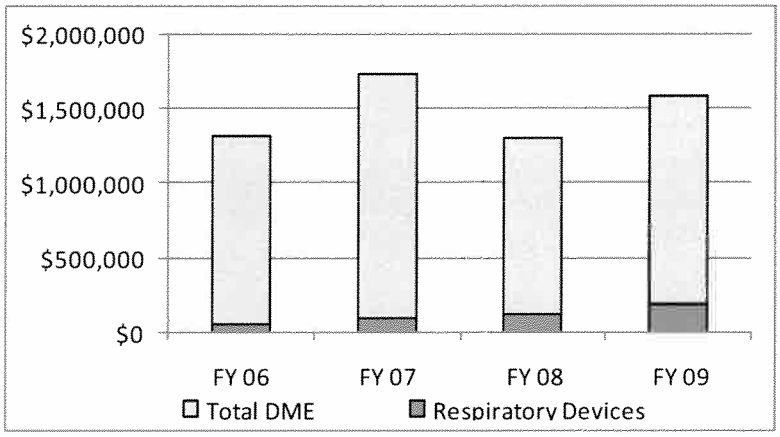


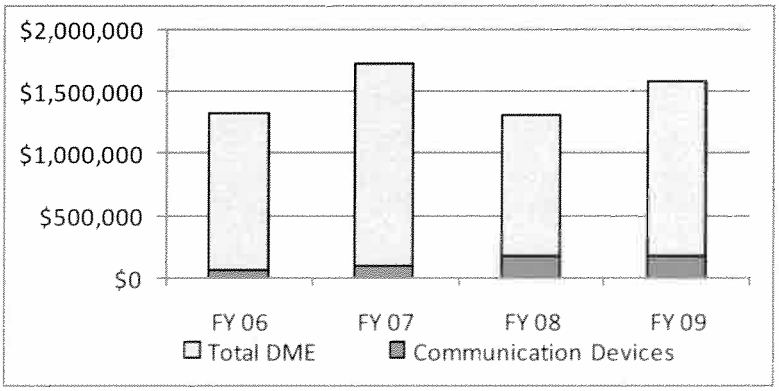
TABLE 3.18 – RESPIRATORY DEVICE REQUEST OUTCOMES – TOTAL

Review Outcome	FY 07	FY 08	FY 09
Units Approved	280	340	683
Units Denied	118	122	404
Total Units Reviewed	**162**	**218**	**279**
Percent Approved	**58%**	**64%**	**41%**

Communication Devices

The number of communication devices reviewed was up 4% in FY 09, while the approval rate increased from 78% in FY 08 to 87% in FY 09. The result was a slight decrease in the dollars conserved, from $175,656 in FY 08 to $164,654 in FY 09.

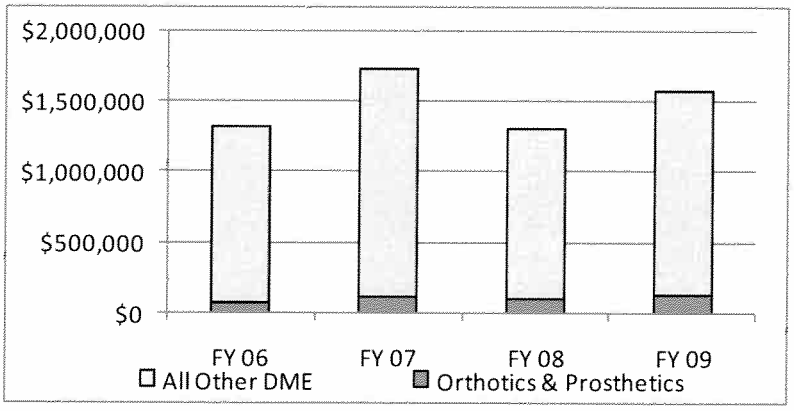
FIGURE 3.5
DOLLARS CONSERVED – COMMUNICATION DEVICES



Orthotics and Prosthetics

Dollars conserved from the prospective review of certain orthotic and prosthetic equipment was up 33% in FY 09, reaching a total of $127,326. The categories of respiratory aids and communication devices both surpassed orthotics and prosthetics in terms of dollars conserved. The remaining three categories of DME review (power scooters, labor/service, and "Other" DME) conserved a combined total of $64,934, up 16% from FY 08.

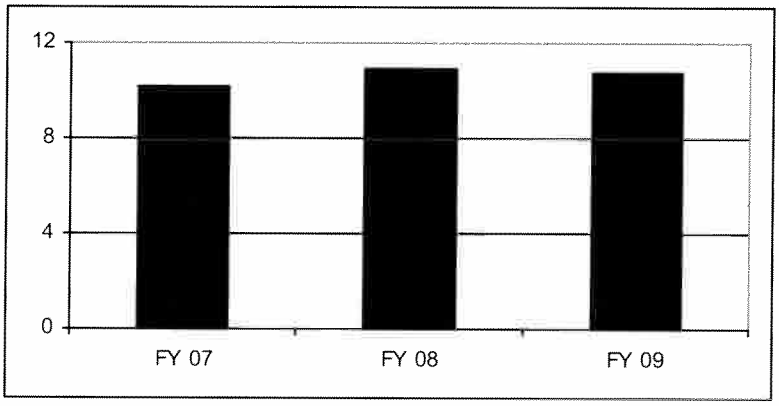
FIGURE 3.6
DOLLARS CONSERVED – ORTHOTIC/PROSTHETIC REVIEW



Analysis

CFMC has noted that DME requests are complex with an increasing number of accessories designed to meet specific needs of individual clients. While these items may improve the health and well-being of the user, CFMC must remain diligent in its review processes given the increasing number of fraud and abuse cases nationally. The average number of accessories requested with power wheelchairs dipped slightly in FY 09 (see Figure 3.7). While this variation may seem small, the cost of additional accessories can be significant. The approval rate for power wheelchair accessories remains high (81%), an indication that the additional accessories are medically necessary.

FIGURE 3.7
AVERAGE UNITS REQUESTED PER POWER WHEELCHAIR



CFMC captures the diagnosis codes used for power wheelchair requests. Tracking diagnosis codes enables CFMC to monitor requests for indications of inappropriate activities. Table 3.19 lists the most frequent diagnosis codes and number of clients in each diagnosis code.

TABLE 3.19 – MOST FREQUENT DIAGNOSES FOR POWER WHEELCHAIR REQUESTS

Diagnosis	FY 07	FY 08	FY 09
Cerebral Palsy	101	102	104
Multiple Sclerosis	59	59	52
Chronic Airway Obstruction	28	33	38
Paraplegia	18	24	22
Morbid Obesity	10	12	20
Quadriplegia C1-C4 – Complete	8	20	19
Osteoarthrosis – Unspecified	11	15	19
Progressive Muscular Dystrophy	24	15	19
Quadriplegia C5-C6 – Complete	17	5	17
Myalgia and Myositis	3	4	15

Durable Medical Equipment - Adult

CFMC reviews DME prior authorization requests for eligible clients: adult and EPSDT. While the figures in the previous section represented a cumulative total of both programs, the following figures represent the reviews conducted for the adult DME program only. A total of 2,118 adult prospective DME reviews were requested during FY 09 (see Table 3.20).

TABLE 3.20 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REQUEST DETAILS – ADULT

DME Category	Approved	Modified	Medical Denial	Technical Denial	Not Reviewed	Total Reviewed	Approval Rate[1]
Power Wheelchairs	475	55	1	146	0	677	78%
Power Scooters	6	0	0	6	0	12	50%
Orthotics/Prosthetics	860	18	0	145	20	1,043	84%
Communication Device	62	1	0	11	0	74	85%
Other[2]	154	5	1	75	77	312	51%
Totals	**1,557**	**79**	**2**	**383**	**97**	**2,118**	**77%**

1. Percentage of requests approved or modified.
2. Other reviews include requests for wheelchair parts and service, respiratory devices, and rehab equipment other than orthotics/prosthetics.

The total number of reviews in FY 09 was up 13% from FY 08 (see Table 3.21). Table 3.21 illustrates that while 23% of requests were either denied or not reviewed, only two of the denials were due to a lack of medical necessity. Review of each item in a DME request also allows for modification or line item denials of accessories or items not medically necessary while allowing approval of the equipment. The objective of the review is always to provide what is medically necessary for the client.

TABLE 3.21 – DURABLE MEDICAL EQUIPMENT REQUEST OUTCOMES – ADULT

Review Outcome	FY 07	FY 08	FY 09
Approved	1,063	1,338	1,557
Modified	75	88	79
Medical Denial	39	4	2
Technical Denial	478	309	383
Not Reviewed	121	130	97
Total Reviewed	**1,776**	**1,869**	**2,118**
Approval Rate	**64%**	**72%**	**77%**

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 for the adult program in FY 09 was 8.3, compared to 5.0 for EPSDT.

TABLE 3.22 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES BY CATEGORY – ADULT

DME Category	Units Approved	Units Denied	Total Units Reviewed	Percentage Approval
Wheelchair Accessory	6,216	1,532	7,748	80%
Labor/Service/Repair	3,517	1,089	4,606	76%
Orthotics/Prosthetics	1,894	605	2,499	76%
Power Wheelchair	532	151	683	78%
Respiratory Device	78	337	415	19%
Communication Device	246	49	295	83%
Back-up Manual Wheelchair	1	121	122	1%
Power Scooter	6	6	12	50%
Rehabilitation Equipment	3	0	3	100%
Miscellaneous[1]	78	1,200	1,278	8%
Totals	**12,571**	**5,090**	**17,661**	**71%**

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

The 19% approval rate of respiratory devices in the adult program, representing clients age 21 and over, was neither consistent with either approval rates for previous years nor with respiratory device reviews for the EPSDT program, representing clients under age 21, (75% approval rate in FY 09). An investigation identified three new providers and one existing provider that together requested 74 items that do not require prior authorization review. This represents an opportunity for provider education.

TABLE 3.23 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES – ADULT

Review Outcome	FY 07	FY 08	FY 09
Units Approved	12,750	12,160	12,571
Units Denied	6,040	3,563	5,090
Total Units Reviewed	**18,790**	**15,723**	**17,661**
Percent Approved	**68%**	**77%**	**71%**

Durable Medical Equipment - EPSDT

EPSDT is a preventive program to assist clients under the age of 21 years. 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 3.24 highlights both review volume and review outcomes for the EPSDT program during FY 09.

TABLE 3.24 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REQUEST DETAILS – EPSDT

DME Category	Approved	Modified	Medical Denial	Technical Denied	Not Reviewed	Total Reviewed	Approval Rate[1]
Power Wheelchairs	92	19	1	20	0	132	84%
Power Scooters	0	0	0	0	0	0	NA
Orthotics/Prosthetics	1,025	5	0	58	5	1,093	94%
Communication Device	181	7	2	14	10	214	88%
Other[2]	133	1	0	42	31	207	65%
Totals	**1,431**	**32**	**3**	**134**	**46**	**1,646**	**89%**

1. Percentage of requests approved or modified.
2. Other reviews include requests for wheelchair parts and service, respiratory devices, and rehab equipment other than orthotics/prosthetics.

While the number of requests increased slightly, the overall approval rate also increased (see Table 3.25).

TABLE 3.25 – PROSPECTIVE DURABLE MEDICAL EQUIPMENT REVIEW – EPSDT

Review Outcome	FY 07	FY 08	FY 09
Approved	1,183	1,249	1,431
Modified	65	52	32
Medical Denial	6	3	3
Technical Denial	176	128	134
Not Reviewed	62	76	46
Total Reviewed	**1,492**	**1,508**	**1,646**
Approval Rate[1]	**84%**	**83%**	**89%**

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 review was 5.0, 40% less than the adult program.

TABLE 3.26 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES BY CATEGORY – EPSDT

DME Category	Units Approved	Units Denied	Total Units Reviewed	Percentage Approval
Wheelchair Accessory	2,594	524	3,118	83%
Orthotics/Prosthetics	1,963	169	2,132	92%
Labor/Service/Repair	1,384	263	1,647	84%
Communication Device	702	118	820	86%
Respiratory Device	201	67	268	75%
Power Wheelchair	113	21	134	84%
Hearing Device or Service	0	3	3	0%
Rehabilitation Equipment	0	1	1	0%
Power Scooter	0	0	0	NA
Back-up Wheelchair	0	0	0	NA
Miscellaneous[1]	41	38	79	52%
Totals	**6,998**	**1,204**	**8,202**	**85%**

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

The number of items requested decreased 10%, but the approval rate increased. Table 3.27 shows the volumes and approval rates for the past three fiscal years.

TABLE 3.27 – DURABLE MEDICAL EQUIPMENT UNIT REQUEST OUTCOMES – EPSDT

Review Outcome	FY 07	FY 08	FY 09
Units Approved	15,128	7,501	6,998
Units Denied	4,074	1,563	1,204
Total Units Reviewed	**19,202**	**9,064**	**8,202**
Percent Approved	**79%**	**83%**	**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 an approved Medicaid transportation broker for the metro area and the remaining 56 county departments of human/social services are responsible for their respective counties to administer the program. As the Department's designee, CFMC is responsible for reviewing non-emergent air ambulance requests, commercial flights, and meals and lodging requests for recipients and escorts.

In addition, CFMC reviews requests that cost more than the allowed for standard transportation services. These "over-the-cap" reviews are for special situations such as bariatric ambulance and mental health transports. Bariatric ambulances are special ambulances designed to handle obese clients who cannot use a standard ambulance. Mental health transport services are for those

clients a risk to themselves or others and required clinical observation during transport. Mental health transports provide a safe environment for transport to State Mental Health Facilities. Due to the expense of these services ($250 to $600 plus $6 per mile for bariatric services and $550 to $811 for mental health transport to Pueblo), CFMC reviews prior authorization requests to ensure that the client meets all medical necessity criteria for these transports. As with all other prior authorization reviews, failure to respond to requests for missing information necessary to conduct the review results in the issuance of a technical denial.

Outcomes

The number of select non-emergent medical transportation requests increased 23% in FY 09 (see Table 3.28).

TABLE 3.28 – PROSPECTIVE SELECT NON-EMERGENT MEDICAL TRANSPORTATION REVIEW

Review Outcome	FY 07	FY 08	FY 09
Approved	616	629	771
Modified	44	9	5
Medical Denial	20	0	0
Technical Denial	22	37	48
Not Reviewed	7	8	19
Total Reviewed	**690**	**683**	**843**
Approval Rate[1]	**96%**	**92%**	**92%**

1. Percentage of requests approved or modified.

Table 3.29 lists the numbers and outcomes of the various types of services reviewed in FY 09.

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

Category of Service	Units Approved	Units Denied	Total Units Reviewed	Percent Approved
Lodging – Escort	7,759	2,903	10,662	73%
Meals – Escort	7,310	2,416	9,726	75%
Meals – Recipient	2,566	359	2,952	88%
Lodging – Recipient	2,459	379	2,838	87%
Air Transport	69	14	83	83%
Over-the-cap Ambulance Services	40	4	44	91%
Travel – Escort	8	5	13	62%
Travel – Recipient	0	0	0	NA
Totals	**20,211**	**6,080**	**26,291**	**77%**

Table 3.30 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 3.30 – SELECT NON-EMERGENT MEDICAL TRANSPORTATION UNIT REQUEST OUTCOMES

Review Outcome	FY 07	FY 08	FY 09
Units Approved	9,280	13,557	20,211
Units Denied	1,665	3,615	6,080
Total Reviewed	**10,945**	**17,172**	**26,291**
Approval Rate[1]	**85%**	**79%**	**77%**

1. Percentage of requests approved or modified.

Impact

Based on a fee schedule provided by the Department, CFMC is able to estimate the reduced expenditure for the Department from unqualified meal and lodging expenses. The prospective review of transportation prevented $169,861 in unnecessarily expenditures in FY 09, more than double FY 08. This increase was due largely to increased volume and increased costs associated with escort lodging. Requests for escort lodging were up 62% in FY 09, while the average cost of units denied increased from $23 in FY 08 to $37 in FY 09. Escort lodging ($107,469) and escort meals ($39,381) accounted for 86% of total savings.

Analysis

While the total number of requests in FY 09 was up 23%, the number of units requested increased 53%. The increase in units requested was due to large increases in the number of days lodging was requested for recipients and escorts, up 89% and 62% respectively. Further investigation suggested two contributing factors. First, the number of requests is increasing. The number of requests for recipient lodging increased 33%, from 367 in FY 08 to 487 in FY 09. Similarly, the number of requests for escort lodging increased 39%, from 247 in FY 08 to 344 in FY 09. The number of escort requests increased at a higher rate because a larger number of PARs contained requests for escort lodging only; no recipient lodging requests were included in these PARs. An examination of reviewer notes suggests that these are escorts of a young child receiving inpatient services. During FY 09, CFMC reviewed 199 such requests compared with 124 the previous year.

Longer lengths of stays were the second factor contributing to the rising number of lodging units (days) being requested. In FY 09, recipients requested 2,838 days of lodging, an average of 5.8 days per request. This represented a 41% longer length of stay for the average recipient. The length of escort stays increased a more modest 12%, but their average length of stay was 30.0 days. We expect the length of stay for escorts to be higher than recipients' because recipients are frequently receiving services in an inpatient setting during these times.

EPSDT Home Health

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated benefit which provides clients under the age of 21 years 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 the age of 21 years may receive a portion of their benefits in a daycare or school setting. Clients receive therapy sessions 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. Table 3.31 indicates that the number of PAR requests for EPSDT program services rose in FY 09. What Table 3.31 does not indicate is that the number of clients requesting EPSDT services actually declined during FY 09. Sixty clients requested reviews during FY 09, compared to 63 in FY 08. Because changes in client needs can necessity multiple requests (four clients in FY 09 submitted five requests), the numbers in Table 3.31 overstate the size of the program.

TABLE 3.31 – PROSPECTIVE EPSDT HOME HEALTH REVIEW

Review Outcome	FY 07	FY 08	FY 09
Approved	107	78	96
Modified	0	1	1
Medical Denial	0	0	0
Technical Denial	2	1	3
Not Reviewed	4	19	12
Total Reviewed	**113**	**99**	**112**
Approval Rate[1]	**95%**	**79%**	**87%**

1. Percentage of approved or modified

Table 3.32 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 3.32 – EPSDT HOME HEALTH SERVICE OUTCOMES BY CATEGORY

Category of Care	Units Approved	Units Denied	Total Units Reviewed	Percent Approved
Home Health Aide - Extended	61,672	15,546	77,218	80%
Home Health Aide - Basic	15,169	6,117	21,286	71%
Skilled Nursing	8,373	1,905	10,278	82%
Occupational Therapy	2,359	315	2,674	88%
Physical Therapy	2,206	139	2,345	94%
Speech Language Therapy	1,747	76	1,823	96%
Totals	**91,526**	**24,098**	**115,624**	**79%**

Table 3.33 indicates that the number of units requested remained stable, despite the increase in the number of requests. The number of units will vary depending on the number of clients in the

program and the status of their health. The units denied are due to the submission of retrospective PAR requests or Department administrative denial. CFMC issues technical denials for failure to provide adequate information necessary to conduct the review.

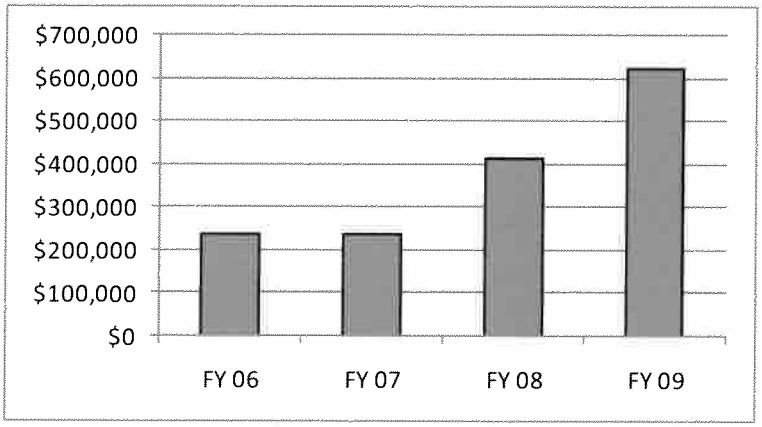
TABLE 3.33 – EPSDT HOME HEALTH SERVICE UNIT REQUEST OUTCOMES

Review Outcome	FY 07	FY 08	FY 09
Units Approved	152,865	98,541	91,526
Units Denied	8,456	16,936	24,098
Total Units Reviewed	**161,321**	**115,477**	**115,624**
Percent Approved	**95%**	**85%**	**79%**

Impact

The home health prospective review process conserved $621,106 in FY 09, 51% more than the $412,203 in FY 08 (see Figure 3.8). Costs avoided from unnecessary skilled nursing visits were up six-fold to $189,452. All other categories of care experienced more modest increases with the exception of physical therapy, which was down 40% to $15,118 in FY 09.

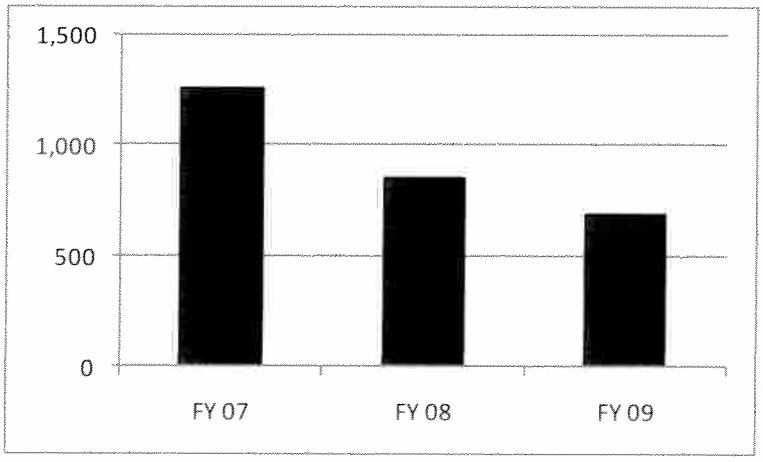
FIGURE 3.8 –
DOLLARS CONSERVED – HOME HEALTH REVIEW



Analysis

Previous reports looked at the ratio of services provided by certified home health aides versus registered nurses. Through FY 07, certified home health aides were assuming a greater role, ensuring that the appropriate level of caregivers provided each service in the most cost-effective manner. An unexpected turnaround occurred in FY 08 and continued in FY 09. Analysis found that the number of skilled nursing service units has remained stable over the past three fiscal years. The volume of certified home health aide services necessary to care for

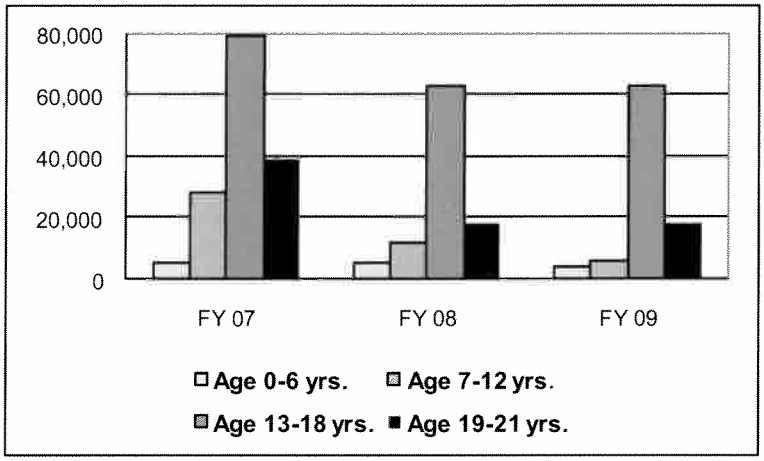
FIGURE 3.9
AVERAGE HOME HEALTH AIDE UNITS PER REQUEST



these clients, however, has declined from 1,258 in FY 07, to 853 in FY 08, to 686 in FY 09. These declines suggest that the ratio of skilled nursing units to certified home health aide units is no longer the best measure of program efficiency. Figure 3.9 illustrates the decline, but these numbers can vary as client needs change and new clients enroll, changing the case mix in the program.

Differences in unit utilization can be seen when clients are categorized by age group (see Figure 3.10). Clients aged 13-18 years require the largest share of services, while those aged 0-6 years require the least. The number of units requested by clients aged 7-12 years continued to trend down during FY 09. The relationship between age and service requirements can be useful in predicting future demand for services.

FIGURE 3.10 –
NUMBER OF UNITS REQUESTED BY AGE CATEGORY



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. In FY 09, 15 minutes of therapy constituted one unit. Services provided in excess of the first 24 units require providers to receive prior authorization. Independent providers and hospital outpatient providers are required to receive prospective approval for services beyond the initial 24 units. Physical and occupational therapy services provided to clients in the Developmentally Disabled (DD) Waiver program are also required to receive prospective approval for services for these clients.

Outcomes

The number of PT/OT prospective reviews has increased every year (see Table 3.34) and we expect it to grow again in FY 10. Clients in this program have long-term needs and most receive maintenance PT/OT services as part of their treatment plan. Every six months we review ongoing services to ensure continued medical necessity and to allow modifications based on the clients' medical needs and progress (and Table 3.35).

TABLE 3.34 – PROSPECTIVE PHYSICAL & OCCUPATIONAL THERAPY REVIEW

Review Outcome	FY 07	FY 08	FY 09
Approved	4,095	5,112	6,185
Modified	266	197	179
Medical Denial	16	18	0
Technical Denial	971	669	686
Not Reviewed	5	11	17
Total Reviewed	**5,353**	**6,007**	**7,067**
Approval Rate[1]	**81%**	**85%**	**90%**

1. Percentage of approved or modified.

TABLE 3.35 – PHYSICAL & OCCUPATIONAL THERAPY PROSPECTIVE REVIEW OUTCOMES

Prospective Request	Approved	Modified	Medical Denial	Technical Denied	Not Reviewed	Total Reviewed	Approval Rate[1]
Physical Therapy	3,547	105	0	419	10	4,078	90%
Occupational Therapy	2,638	74	0	267	7	2,989	91%
Totals	**6,185**	**179**	**0**	**686**	**17**	**7,067**	**90%**

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 09 was 166, down from 168 in FY 08 and 174 in FY 07. This number will vary because 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. The approval rate of 54% in Table 3.36 indicates that almost half of the total units requested did not meet medical necessity criteria.

TABLE 3.36 – PHYSICAL & OCCUPATIONAL THERAPY UNIT REQUEST OUTCOMES

Category of Therapy	Units Approved	Units Denied	Total Units Reviewed	Percent Approved
Physical Therapy	344,630	302,685	647,315	53%
Occupational Therapy	289,563	234,133	523,696	55%
Totals	**634,193**	**536,818**	**1,171,011**	**54%**

The percentage of units approved reached its lowest level in three years (see Table 3.37).

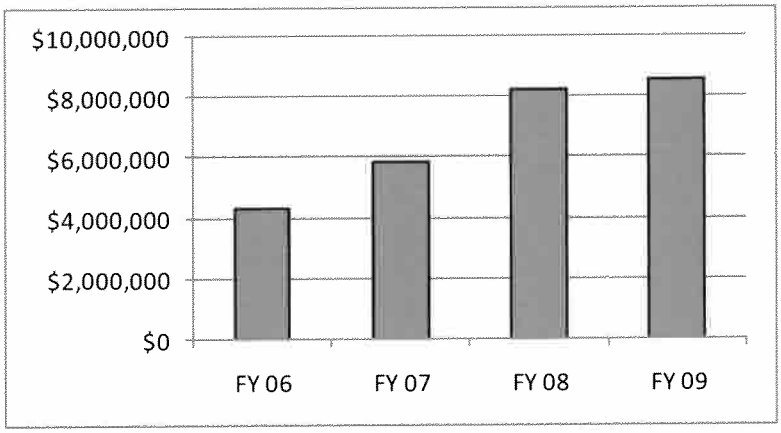
TABLE 3.37 – COMBINED PHYSICAL & OCCUPATIONAL THERAPY UNIT REQUEST OUTCOMES

Review Outcome	FY 07	FY 08	FY 09
Units Approved	509,386	312,371	634,193
Units Denied	422,119	495,289	536,818
Total Units Reviewed	**931,505**	**1,007,660**	**1,171,011**
Percent Approved	**55%**	**51%**	**54%**

Impact

After three years of steadily increasing reduced expenditures for the Department (see Figure 3.10), FY 09's increase was a modest 4%. The first year CFMC conducted prospective reviews of PT/OT requests (FY 04), the review process reduced expenditures by $870,273. This accounted for 22% of the total funds conserved by prospective reviews during that period. In the subsequent years, total fiscal impact has increased every year by no less than 36%. In FY 09, the impact of prospective review of PT/OT services totaled $8,534,410, accounting for 75% of the total reduced expenditure for the Department from prospective review services.

FIGURE 3.11 – COSTS AVOIDED – PROSPECTIVE PT/OT REVIEW



Analysis

To better understand the dynamics of the program, CFMC looked at the most frequent conditions and/or diagnoses associated with each therapy modality (see Tables 3.38 and 3.39). Tracking enables CFMC to monitor requests for indications of inappropriate activities. Table 3.38 lists the most frequent diagnosis codes used in FY 09 and number of requests for each over the past three fiscal years.

TABLE 3.38 – MOST FREQUENT DIAGNOSES FOR PHYSICAL THERAPY REQUESTS

Diagnosis	FY 07	FY 08	FY 09
Lack of Coordination	160	211	275
Cerebral Palsy	186	205	233
Lack of Normal Physiological Develop	133	121	229
Lumbago	131	125	157
Developmental Coordination	108	110	150
Joint Pain – Leg	109	124	138
Delayed Milestones	51	72	133
Torticollis	92	90	101
Down's Syndrome	71	90	92
Cervicalgia	85	83	91

Lack of coordination is now the most common condition cited on the requests. In fact, four of the top ten reasons given for therapy are not definitive diagnoses, but instead are signs and symptoms of a wide range of potential diagnoses. The use of these non-specific codes has increased over time. While the official ICD-9-CM outpatient coding guidelines state that codes describing signs and symptoms are acceptable when a confirmed diagnosis is not available, CFMC will encourage

providers to be more specific when a diagnosis is available. The use of precise diagnoses will better enable CFMC and the Department to determine the appropriateness of therapy and potentially identify alternative treatments and/or additional program and service opportunities.

TABLE 3.39 – MOST FREQUENT DIAGNOSES FOR OCCUPATIONAL THERAPY REQUESTS

Diagnosis	FY 07	FY 08	FY 09
Lack of Coordination	325	395	378
Lack of Normal Physiological Develop	139	173	336
Delayed Milestones	64	121	193
Mixed Development	98	153	186
Autistic Disorder	88	103	121
Cerebral Palsy	116	111	115
Feeding Problem	63	74	109
Infantile Autism	78	52	102
Down's Syndrome	84	108	82
Development Coordination	65	61	80

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 medical necessity decision to CFMC if they do not agree with the initial review outcome. We consider all new information provided as part of the appeal. For example, an update of the client's condition may make the request medically justified. We forward the additional information along with the original review and documentation to another specialty-matched physician reviewer for a second opinion. If upheld, 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 all prior authorization encounter information for a two-year period. We forward the description of the specific aspects of the appealed case and reason(s) for denial including deidentified physician comments to the Department. CFMC then collaborates with the Department prior to the hearing for documentation needs and is available to discuss the case and address any questions. When requested, CFMC's clinical review staff is available to provide testimony in support of the review determination process.

During FY 09, CFMC provided support to 32 client ALJ hearing requests. These hearings involved 21 requests for DME authorization, two requests for PT/OT services, and nine retrospective reviews. CFMC's involvement was limited to providing supporting documents for each of these appeals. In addition, CFMC supported another 32 ALJ hearing requests unrelated to CFMC review activities: four dental requests and 28 DME requests not involving CFMC review. CFMC's role was limited to searching our system to identify any documents that could support the Department.

CHAPTER 4

RETROSPECTIVE REVIEW HIGHLIGHTS

Contracted to conduct a minimum of 4,000 reviews, in FY 09 CFMC completed 4,016 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 calculations show that these reviews identified $3,200,868 in inappropriate payments that the Department is entitled to recover. These figures are based on CFMC review determinations and do not reflect later administrative payment determinations by the Department or fiscal agent.

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. Denial of the entire claim results in the return of all funds, while modification results in adjusted payment to reflect the correct payment of the care provided based on the documentation available.

CFMC presents the results of the retrospective review findings to the Department to assist the Department in determining future review selection. The report outlines providers and DRGs with the highest number of payment errors resulting in payment changes. The percentage of claims with identifiable errors was 13% in FY 09. Every year CFMC analyzes data from previous years to identify trends and identify areas with the greatest potential for fiscal impact. We present these findings to the Department and, working together, modify the methodology used to focus future chart review on 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 $3,200,868 in unsubstantiated payments. In FY 09 the number of admission denials decreased to 48, down 16% from FY 08, while the number of billing error denials decreased 9%, from 453 to 412 (see Table 4.1). Technical denials were down 58%, from 124 in FY 08 to 65 in FY 09. While the number of DRG changes is small (see Table 4.2), they were responsible for a savings of $215,047 (see Table 4.3).

As of September 25, 2009, the Department had recovered $2,016,467. The remaining $1,184,401 (37%) represents unrealized savings to which the Department is still entitled. The ratio between realized and unrealized savings in FY 09 was close to 2:1.

TABLE 4.1 – NUMBER AND DISTRIBUTION OF RETROSPECTIVE REVIEW OUTCOMES

Final Review Outcome	FY 07		FY 08		FY 09	
Approved[1]	3,536	(88%)	3,384	(84%)	3,491	(87%)
Admission Denial	50	(1%)	57	(1%)	48	(1%)
Technical Denial	124	(3%)	112	(3%)	65	(2%)
Billing Error Denial	320	(8%)	453	(12%)	412	(10%)
Total Reviews	**4,030**		**4,006**		**4,016**	

1. See Table 4.2 for DRG changes.

TABLE 4.2 – NUMBER AND FREQUENCY OF CODING CHANGES

Change Type	FY 07		FY 08		FY 09	
DRG Change[1]	21	(1%)	33	1%	35	1%
Total Changes	**21**	**(1%)**	**33**	**1%**	**35**	**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 06	FY 07	FY 08	FY 09
Admission Denial Savings	$563,736	$183,279	$199,927	$167,367
Technical Denial Savings	$282,699	$841,709	$667,091	$311,547
Billing Error Denial Savings	$1,256,776	$1,544,118	$1,977,770	$2,506,907
DRG Change Savings[2]	$175,640	$47,273	$144,484	$215,047
Total Retrospective Review Savings	**$2,278,851**	**$2,616,379**	**$2,989,272**	**$3,200,868**

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 06	FY 07	FY 08	FY 09
Costs Avoided Per Review	**$563**	**$649**	**$746**	**$789**

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 use 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

We check records upon receipt to ensure that the documentation necessary for review is present. If the facility fails to supply the necessary documentation within the required period, we issue a technical denial and notify the Department 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 deemed met, the nurse reviewer approves the admission. Over the past three fiscal years, the nurse reviewer approved 86% of the reviews conducted and no additional action was required.

If the medical necessity, appropriateness of care, or level of care does not meet Milliman Care Guidelines, we refer the case to a CFMC licensure-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, we approve the admission and take no further action. 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, we deny the admission. We send a letter explaining the reason for the denial to the facility, attending physician and client. We also notify the Department of the denial and the potential to recover payment.

TABLE 4.5 – NUMBER AND FREQUENCY OF REFERRALS TO PHYSICIAN/ CODING REVIEWERS

Reason for Referral	FY 07[1]		FY 08[1]		FY 09[1]	
Medical Necessity of Admission	101	(3%)	128	(3%)	123	(3%)
Potential Quality of Care Problem	26	(1%)	73	(2%)	55	(1%)
Coding (DRG) Issue[2]	7	(0%)	37	(1%)	21	(1%)
Total Referrals	**134**	**(4%)**	**238**	**(6%)**	**199**	**(5%)**

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, we screen each case for quality of care. If the care provided fails the quality of care screen, the nurse reviewer refers the case to a CFMC licensure-matched physician reviewer for a final determination. Physician reviewers also may identify a quality of care concern. During FY 09, reviewers identified 55 cases of potential quality issues. Further physician review verified quality concerns in 13 cases. Providers appealed 11 cases. CFMC sent these cases to another specialty-matched physician for a final determination. The second physician reviewer upheld seven cases and reversed four. Analysis of 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 relies on the DRG rate set by Medicare. Rehabilitation and pediatric hospitals use a slightly different system. Each DRG has an assigned weight 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 correct billing according to 10 C.C.R. 2505-10, Section 8.040 and Colorado Medicaid Provider Bulletins. Nurse reviewers refer questionable DRGs 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 DRG is incorrect, we notify the Department 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.

Medical Record Review Selection

Retrospective review of every acute care admission would be prohibitively expensive. Given the resources available, the Department contracted with CFMC to conduct 4,000 retrospective reviews of the total admissions during FY 09. 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 balance effectively the value of focused and random review selections. During FY 09, CFMC completed 4,016 unduplicated reviews (see Table 4.7).

TABLE 4.6 – NUMBER AND DISTRIBUTION OF SAMPLING CRITERIA

Sampling Criteria	FY 07		FY 08		FY 09	
Provider Focus	1,849	(44%)	1,872	(45%)	2,028	(49%)
Readmissions[1]	250	(6%)	649	(16%)	899	(22%)
DRG Focus	1,196	(28%)	976	(24%)	459	(11%)
Random Selection	616	(15%)	374	(9%)	379	(9%)
Focused Inliers[2]	182	(4%)	176	(4%)	316	(8%)
DRG Outlier Focus	32	(1%)	86	(4%)	59	(1%)
DRG 871 as Readmission[3]	4	(0%)	6	(0%)	-	-
DRG Inlier Focus	95	(2%)	-	-	-	-
State Request	3	(0%)	-	-	-	-
Total Selections	**4,227**		**4,139**		**4,140**	
Total Unduplicated Cases[4]	**4,030**		**4,006**		**4,016**	

1. Readmissions are claims for the same patient readmitted to the same hospital within one day, excluding routine deliveries.
2. Focused inliers are hospital stays of less than two days, excluding routine deliveries and dialysis claims.
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 (4,139 in FY 09) to ensure contracted review volumes are met.

Focused reviews target specific types of cases known to, or expected to, contain a large number of errors based on previous review data. Reviews primarily focused on facilities with the highest error rates. Sampling focused on 19 different facilities during FY 09. Six DRGs with a high volume of cases with errors and high cost per case were also part of the focus. We reviewed 100% of readmissions excluding deliveries. Readmissions refer to clients who return to the hospital within 24 hours of discharge with the same DRG or conditions related to the principal diagnosis of the initial stay.

In addition to focused reviews, we selected a random sample of claims for review. Random sample review provides timely information that allows CFMC and the Department to better focus ongoing review activities. After conducting the selected intensified review, data analysis can identify potential causes and contributing factors for billing errors and/or utilization denials. Based on this analysis, appropriate actions, such as provider education can be planned and offered by the Department.

Impact Calculation Methodology

CFMC's Medicaid retrospective 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, we used paid claims data to calculate savings. The ability to determine the actual dollar amount recovered improves the accuracy of the impact assessment. Savings are based on CFMC review determinations and do not reflect later administrative payment determinations by the Department or fiscal agent.

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

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

Realized Versus Unrealized Savings

CFMC reports the results of retrospective reviews to the Department for claim adjustment. When the fiscal agent recovers payment from the hospital, the savings are "realized." "Unrealized" savings occur if no adjustment to the claim occurs, or if the hospital receives payment following the initial adjustment. For this report, CFMC compared the expected savings from retrospective reviews with the paid claims available on September 25, 2009 to determine the amount of savings realized.

Retrospective Review Activity Outcomes

The percentage of inappropriate claims declined to 13% (see Table 4.8). This means that 87% of claims reviewed met medical necessity criteria. CFMC, however, continues to analyze the data to identify trends and increase the efficacy of the sampling process. Analysis of this data identified provider focus reviews as having the largest percentage of errors at 31%, with readmissions excluding deliveries at 29% and focused DRG at 34%. These three focus areas generated 84% of the denials in FY 09.

TABLE 4.7 – NUMBER AND DISTRIBUTION OF REVIEW OUTCOMES

Review Outcomes	FY 07		FY 08		FY 09	
Approved[1]	3,536	(88%)	3,384	(84%)	3,491	(87%)
Admission Denial	50	(1%)	57	(1%)	48	(1%)
Technical Denial	124	(3%)	112	(3%)	65	(2%)
Billing Error Denial	320	(8%)	453	(12%)	412	(10%)
Total Reviews	**4,030**		**4,006**		**4,016**	

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

Impact

The Department has the potential to recover $3,200,686 it paid for medically unnecessary acute care services during FY 09 (see Table 4.9). Of that amount, the Department recouped $2,016,467 as of September 25, 2009, leaving $1,184,401 (37%) un-recouped.

TABLE 4.8 - RETROSPECTIVE REVIEW IMPACT – EXPECTED[1]

Retrospective Review Impact	FY 06	FY 07	FY 08	FY 09
Admission Denial Savings	$563,736	$183,279	$199,927	$167,367
Technical Denial Savings	$282,699	$841,709	$677,091	$311,548
Billing Error Denial Savings	$1,256,776	$1,544,118	$1,977,770	$2,506,907
DRG Change Savings[2]	$175,640	$47,273	$144,484	$215,047
Total Retrospective Review Savings	**$2,278,851**	**$2,616,379**	**$2,989,272**	**$3,200,869**

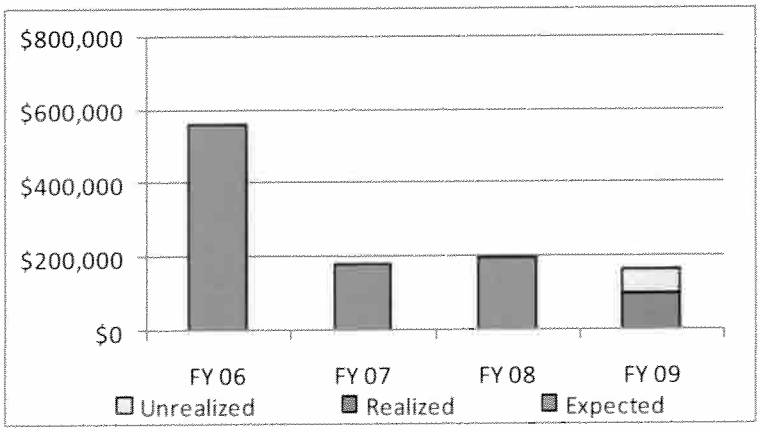
1. Savings the Department has the right to expect. Actual savings may be realized or unrealized at the time of this report.
2. Savings are a result of DRG changes made to approved admissions.

Below we discuss the financial impact of the four retrospective review outcomes. To maintain consistency between reports, CFMC reports only the expected savings from previous fiscal years. The realized savings for FY 09 were as of September 25, 2009.

Admission Denials

Of the 4,016 retrospective reviews, CFMC denied 48 because the documentation failed to support the need for inpatient level medical care. This is slightly lower than the 57 denials in FY 08. While the numbers may be small, the dollars involved are not. The expected costs recovered from admission denials totaled $167,367, down 16% from FY 08. The Department realized about 60% of the savings as of September 25, 2009 (see Figure 4.1).

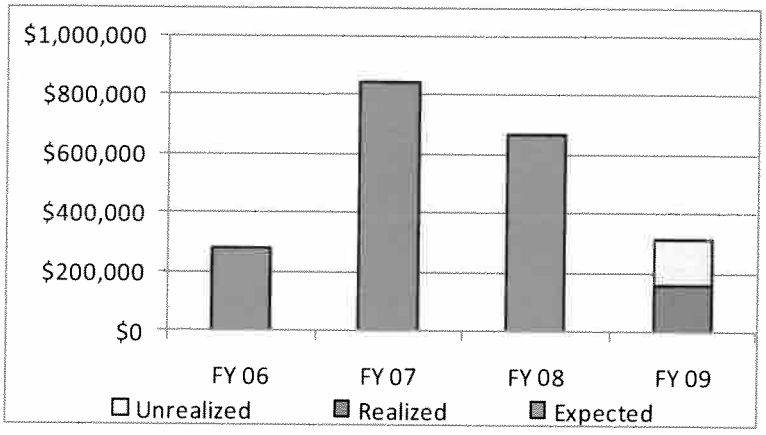
FIGURE 4.1
COSTS AVOIDED – RETROSPECTIVE ADMISSION DENIALS



Technical Denials

The number of technical denials was down 42% in FY 09 (see Table 4.7 on page 40) while the dollars saved were down 53% (see Figure 4.2). Of the $311,547 expected savings identified in FY 09, the Department realized $159,313 (51%) as of September 25, 2009.

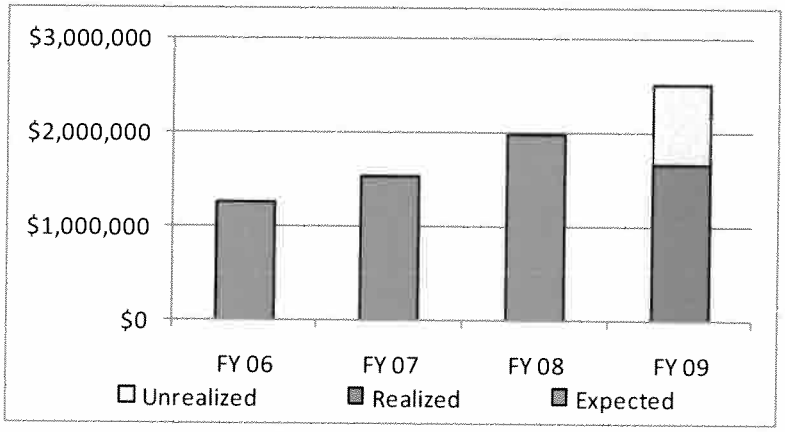
FIGURE 4.2
COSTS AVOIDED – TECHNICAL DENIALS



Billing Errors

CFMC's ongoing analysis of billing trends has enabled the Department to adjust the sampling methodology. The result has been a steady increase in the costs avoided from billing error employed the past few years (see Figure 4.3). The costs avoided topped $2.5 million in FY 09. The Department realized over $1.6 million (66%) of the expected savings as of September 25, 2009.

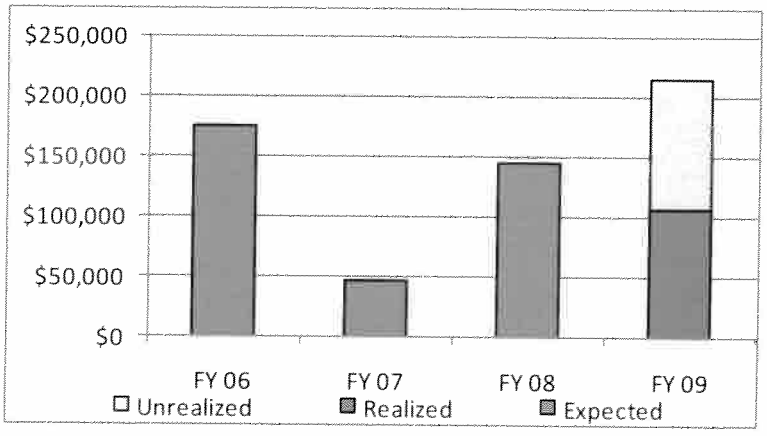
FIGURE 4.3
COSTS AVOIDED – RETROSPECTIVE BILLING ERRORS



Diagnosis Related Group Changes

The Department uses the diagnosis related group (DRG) classification system for acute care reimbursement. The DRG validation process is a part of every hospital review. In the course of the FY 09 reviews, CFMC made 35 DRG changes. These changes accounted for $215,047 in expected savings. Of this amount, the Department realized $106,508 (50%) as of September 25, 2009.

FIGURE 4.4
COSTS AVOIDED – RETROSPECTIVE DRG CHANGES



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 CFMC does not receive an appeal within 60 days, the case is closed. The attending physician or the facility may initiate an appeal during the 60-day period. If we receive an appeal, we send the case to a CFMC specialty-matched physician reviewer who was not involved in the initial determination. We notify the facility, attending physician and the client of the final determination. Table 4.9 shows the number of appeals and their outcomes.

TABLE 4.9 – NUMBER OF APPEALS AND THEIR OUTCOMES

FY 09								
Outcome	**Admission Denial**		**DRG Change**		**Quality Concern**		**Totals**	
Initial Outcome	53		37		13		103	
Appealed	10	(19%)[1]	6	(16%)[1]	11	(85%)[1]	27	(26%)[1]
Upheld	5	(50%)[2]	4	(67%)[2]	7	(64%)[2]	16	(59%)[2]
Reversed	5	(50%)[2]	2	(33%)[2]	4	(36%)[2]	11	(41%)[2]
Final Denials	**48**	**(91%)[1]**	**35**	**(95%)[1]**	**9**	**(69%)[1]**	**92**	**(89%)[1]**

1. Percent of initial outcome.
2. Percent of appeals.

FY 08								
Outcome	**Admission Denial**		**DRG Change**		**Quality Concern**		**Totals**	
Initial Outcome	74		43		20		137	
Appealed	17	(23%)[1]	14	(33%)[1]	10	(50%)[1]	41	(30%)[1]
Upheld	0	(0%)[2]	4	(29%)[2]	2	(20%)[2]	6	(15%)[2]
Reversed	17	(100%)[2]	10	(71%)[2]	8	(80%)[2]	35	(85%)[2]
Final Denials	**57**	**(77%)[1]**	**33**	**(77%)[1]**	**12**	**(60%)[1]**	**102**	**(74%)[1]**

1. Percent of initial outcome.
2. Percent of appeals.

FY 07								
Outcome	**Admission Denial**		**DRG Change**		**Quality Concern**		**Totals**	
Initial Outcome	56		27		13		96	
Appealed	12	(21%)[1]	7	(26%)[1]	11	(85%)[1]	30	(31%)[1]
Upheld	6	(50%)[2]	1	(14%)[2]	8	(73%)[2]	15	(50%)[2]
Reversed	6	(50%)[2]	6	(86%)[2]	3	(27%)[2]	15	(50%)[2]
Final Denials	**50**	**(89%)[1]**	**21**	**(78%)[1]**	**10**	**(77%)[1]**	**81**	**(84%)[1]**

1. Percent of initial outcome.
2. Percent of appeals.

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 service requests during FY 09 for a total of 150.25 hours.

The following list is a brief description of each service request processed:

- **Crosswalk for new ICD-9 codes:** CFMC created a crosswalk for the new ICD-9-CM codes effective October 1, 2008. We assigned each new code to an existing code recognized by the DRG grouper.
- **Appropriateness of care case review:** CFMC reviewed nursing facility and hospital medical records to ensure a Medicaid client received appropriate care throughout treatment from both facilities.
- **Review inpatient records:** CFMC reviewed hospital inpatient admissions to determine appropriateness of inpatient settings. We referenced the Medicaid client's admission dates to identify the criteria used for each review.
- **Review and provide analysis for CPT code:** CFMC reviewer assessed a list of CPT codes provided by the Department to determine if the list included all codes within the scope of practice for the dental specialty.
- **Review request for ergonomic chair:** CFMC conducted a prospective review to determine if a Medicaid client met medical necessity for an ergonomic chair. We conducted this review in preparation for an ALJ hearing.
- **Readmission review:** CFMC provided a 24-hour readmission report for a specific period to identify the number of readmissions, readmissions unrelated to the previous stay and an estimate of how many monthly requests for an unrelated readmission a provider would issue based on special circumstances.
- **Nurse Home Visitor Program (NHVP) Targeted Case Management (TCM) – Part 1 of 2:** CFMC conducted chart reviews and analysis of provider data to determine amounts of provider time spent on various activities for the NHVP. This service request overlapped into FY 10 and was completed as part 2.

In addition, CFMC used 15 consultation hours to conduct Hospital Backup Unit (HBU) reviews. The HBU program offers support to clients requiring complex wound care, has recognized medically complex condition(s), and/or ventilator-dependent. We share the physician reviewer's rationale with the Department and, if requested by the Department, can provide physician testimony at Administrative Law Judge (ALJ) hearings regarding the review, determination and actions. Under exceptional circumstances, the Department may request a specialty-matched physician review. We conduct HBU reviews within three business days and specialty-matched

physician reviews within seven business days. For detailed program rules, please see 10 CCR 2505-10, Section 8.470.

CFMC began conducting prospective HBU medical record reviews in August 2007. In FY 09, we conducted three HBU reviews compared to 21 reviewed conducted in FY 08. All three FY 09 reviews were ventilator-dependent reviews and resulted in approvals. We conducted two reviews in September 2008 and one in August 2008. The 22 reviews conducted in FY08 included eight complex wound reviews, 11 ventilator-dependent reviews, and three medically complex reviews. One review included a complex wound and medically complex case. We approved all but one review, a complex wound case.

Additionally, the Department and CFMC agreed to transfer 404 consultation hours to cover the costs of prior authorization reviews conducted in excess of contracted volumes.

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 Telephone Triage Program

The Department established the Colorado Medicaid telephone triage program in 1996 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 effective manner. This increases access to services while reducing long waiting times in over-crowded emergency departments. McKesson Health Solutions' subcontract with CFMC to provide these services expired in September 2008. The Denver Health and Hospital Authority currently provide triage services through its department, the Rocky Mountain Poison and Drug Center – Nurse Advice Line.

Outcomes – McKesson

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. McKesson Health Solutions provided services from July 1, 2008 through September 15, 2008 (see Table 6.1).

TABLE 6.1 – NUMBER AND DISTRIBUTION OF CALL ACTIVITIES – MCKESSON

Call Category	FY 07[1]		FY 08		FY 09[2]	
Symptomatic Illness or Injury	4,858	(78%)	4,502	(81%)	823	(78%)
Emergency 911	19	(0%)	12	(0%)	0	(0%)
Provider Referral	305	(5%)	233	(4%)	53	(5%)
General Health Information	449	(7%)	324	(6%)	65	(6%)
Other & Rerouted Encounters	582	(9%)	434	(8%)	112	(11%)
Total Calls	**6,338**		**5,505**		**1,053**	

1. Of the 9,695 calls received in FY 07, only 9,440 were coded by category.
2. Numbers through September 2008.

Of the 823 callers with symptomatic complaints, nurses instructed 22% to seek urgent or emergency level care (see Table 6.2). In contrast, nurses gave 33% of the symptomatic callers directions for self-care, thereby avoiding any additional medical intervention. Of the remaining callers, nurses instructed 36% to call their provider for answers and 9% to make an appointment with their primary care physician.

TABLE 6.2 – DISTRIBUTION OF SYMPTOMATIC CALL RECOMMENDATIONS - MCKESSON

Call Category	FY 07		FY 08		FY 09[1]	
Emergency Care	455	(9%)	466	(10%)	91	(11%)
Urgent Care	454	(9%)	437	(9%)	91	(11%)
Provider Advice	1,766	(37%)	1,780	(39%)	297	(36%)
Make Appointment with PCP	399	(8%)	335	(7%)	73	(9%)
Self-care	1,784	(37%)	1,484	(35%)	271	(33%)
Total RN Encounters	**4,858**		**4,502**		**823**	

1. Numbers through September 2008.

Impact – McKesson

The goal of the telephone triage program is to reduce the number of unnecessary costly emergency department (ED) visits while providing clients with appropriate levels of care. Of the 354 callers who said, they would have gone to either an urgent care clinic or ED had telephone triage not been available, nurses directed 74% to a lower level of care. While it is not possible to determine the actual savings because even callers directed to lower levels of care would have incurred some costs, McKesson attempted a conservative estimate. With the average ED visit costing $187, the telephone triage program potentially reduced expenditure for the Department of $49,181 in unnecessary services.

Outcomes – Rocky Mountain Poison and Drug Center – Nurse Advice Line

Beginning September 16, 2008, the Rocky Mountain Poison and Drug Center Nurse Advice Line (RMPDC-NAL) provided telephone triage services. Of the 4,308 calls fielded during the final nine months of FY 09, 51% (2,191) required RN triage and direction for care (see Table 6.3).

TABLE 6.3 – NUMBER AND DISTRIBUTION OF CALL ACTIVITIES – RMPDC-NAL

Call Category	FY 09[1]	
Symptomatic Illness or Injury	2,191	(51%)
Other & Rerouted Encounters	2,117	(49%)
Total Calls	**4,308**	

1. Numbers from October 2008 through June 2009.

Of the 2,191 callers with symptomatic complaints, nurses instructed 35% to seek urgent or emergency level care (see Table 6.4). In contrast, nurses gave 37% of the symptomatic callers directions for self-care, thereby avoiding any additional medical intervention. Of the remaining callers, nurses instructed 23% to call their provider for answers and 5% to make an appointment with their primary care physician.

TABLE 6.4 – DISTRIBUTION OF SYMPTOMATIC CALL RECOMMENDATIONS - RMPDC

Call Category	FY 09[1]	
Emergency Care	546	(25%)
Urgent Care	227	(10%)
Appointment with Health Provider	492	(23%)
Self-care	813	(37%)
Information	113	(5%)
Total RN Encounters	**2, 191**	

RMPDC-NAL reviewed client calls daily for triage service quality and a quarter of all triaged calls receive an in-depth case review for evaluation of the quality of triage assessment, treatment recommendations, and education provided. Case reviews demonstrate a high level of quality based on the accuracy of the above parameters. Additionally, any client having a disposition of calling 911 receives a follow-up phone call to assess their status. The staff in the call center initiated many of these 911 calls.

Impact – RMPDC-NAL

Using the McKesson estimate of $187 per ED visit, RMPDC-NAL estimates that its triage services prevented $300,000 in unnecessary expenditures. Using their estimate of $316 per ED visit, the estimated fiscal impact is closer to $500,000.

Program Marketing – RMPDC-NAL

In late spring 2009, RMPDC-NAL began focusing on Program Marketing in an effort to enhance call center awareness and utilization among clients and providers. In collaboration with CFMC and the Department, specific goals were developed to increase call volume and to improve the proportion of those calls as they relate to triage of illness or injury. For example, the total call volume for a month sometimes reflected a 50/50 split in calls between the two key categories of calls—Benefit Information calls and Triage calls. With improved marketing and communication to the clients, they expect Benefit Information calls to decline significantly as clients call the benefit office directly for needed information. Consequently, they expect more focused Nurse

Advice Line calls. As call utilization increases and clients use the service as an access point for health care, effective nurse triage will also demonstrate an improvement in health care delivery and related expenditures. RMPDC-NAL expects to reduce and replace costly and unnecessary ED visits with a significant volume of home care based on client health care teaching, or care at an alternative and appropriate health care site whether it is an Urgent Care or Office Visit. They intend to establish quantifiable marketing goals during first quarter of calendar year 2010, after reviewing the relevant data from the final quarter of calendar year 2009.

CHAPTER 7

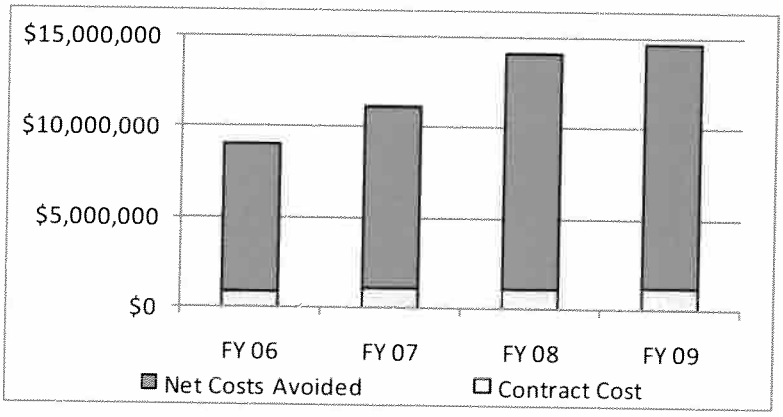
IMPACT SUMMARY

CFMC's acute care review services program reduces expenditure for the Department funds by assisting the Department in avoiding 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. We cannot know the actual amount saved from that item or service, so CFMC must estimate savings on the average cost of the item based on the reimbursement figures provided by the Department. Other items or services that do not require prior authorization and that may have been provided in lieu of the denied item or service is unknown and do not figure into CFMC costs avoided calculations.

Retrospective reviews identify inappropriate admissions and inaccurate coding or billing that can result in recovery of payment. Savings are based on CFMC review determinations and do not reflect later administrative payment determinations by the Department or fiscal agent. We calculate savings from retrospective review based on the actual hospital payment. The following figures do not include the potential savings from the telephone triage program.

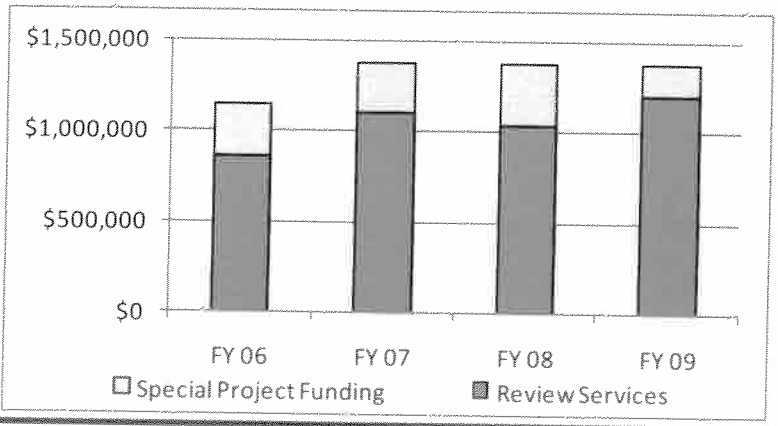
CFMC's acute care review program prevented $14,653,705 in inappropriate services in FY 09. This is a 3% increase over FY 08. After factoring in the cost of the FY 09 contract, net costs avoided were $13,450,326, more than a $300,000 increase over the previous fiscal year. Figure 7.1 illustrates the increasing efficiency of the acute care review process and the impact it has had on the program.

FIGURE 7.1
NET COSTS AVOIDED RELATIVE TO CONTRACT COST



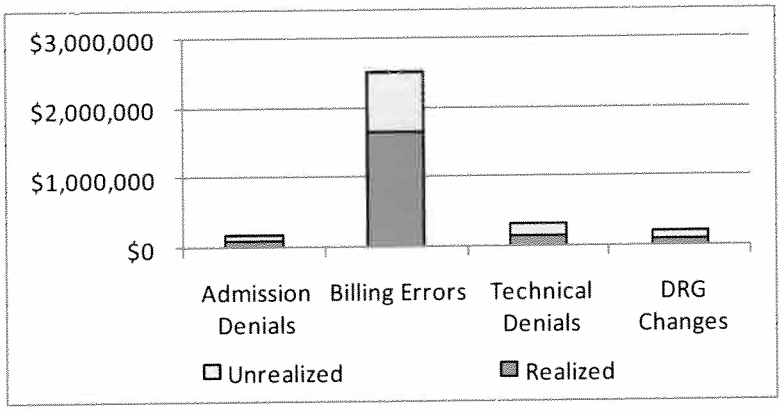
We must keep two factors in mind when assessing the net fiscal effects of the review process. First, the figures used to calculate net costs avoided include only the amounts spent on review activity. CFMC receives additional funding as part of its contract to fund the Medicaid triage program and any special studies requested by the Department (see Figure 7.2).

FIGURE 7.2
DISTRIBUTION OF FUNDS RECEIVED BY CFMC



The second factor to keep in mind is that we calculate retrospective reviews on the Department payment for the admission. However, the recovery process takes time. The retrospective review reduction in expenditure for the Department reported here reflects the amounts the Department expects to recover. As of September 25, 2009, the Department had realized 63% ($2,016,467) of the expected $3,200,868 savings (see Figure 7.3). The remaining $1,184,401 represents unrealized savings.

FIGURE 7.3
RETROSPECTIVE REALIZED VERSUS UNREALIZED SAVINGS

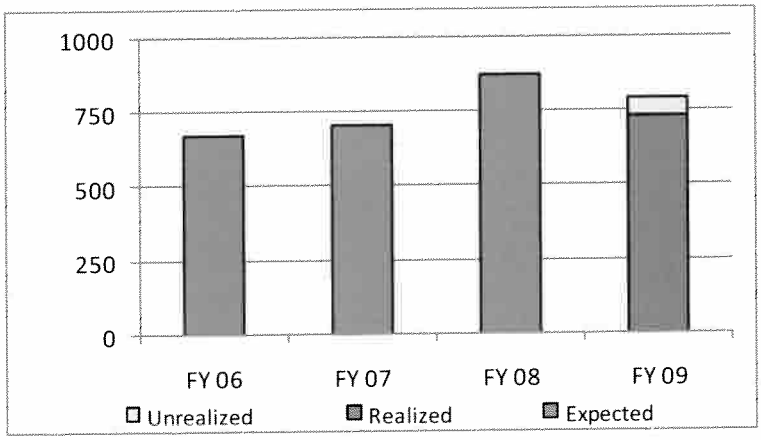


Savings Ratios

Average Cost Avoided Per Review

There are two good ways to assess the effectiveness of the acute care review process. The first is to look at the average costs avoided per review. For each of the 16,921 reviews conducted in FY 09, the Department avoided $795 in unnecessary expenditures. Of this amount, they had recovered $731 as of September 25, 2009.

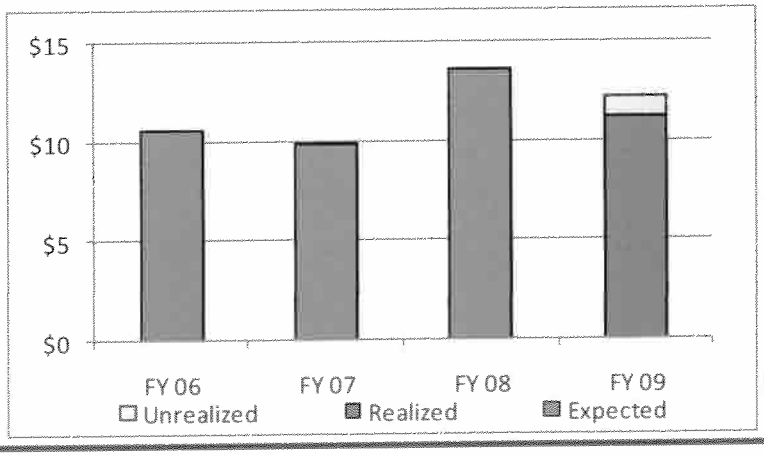
FIGURE 7.4
AVERAGE COST AVOIDED PER REVIEW



Return On Investment

The second 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 09, we prevented $12.18 from inappropriate use. As of September 25, 2009, CFMC

FIGURE 7.5
RETURN ON INVESTMENT

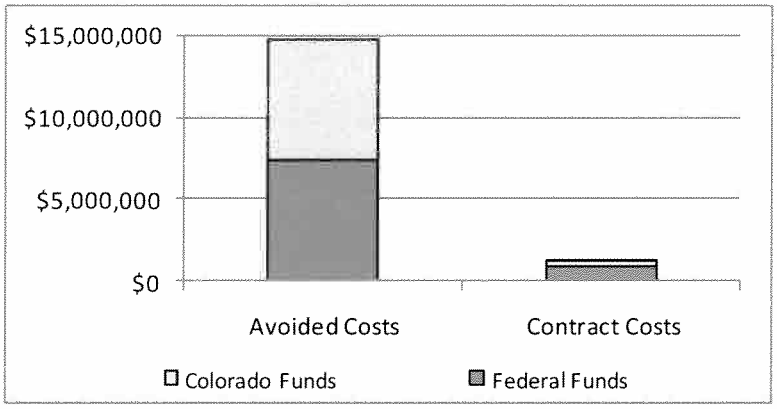


acute care review activities reduced expenditure for the Department of $22.52 for every dollar CFMC earned in FY 09, even if the Department realizes no additional funds.

Impact for Colorado

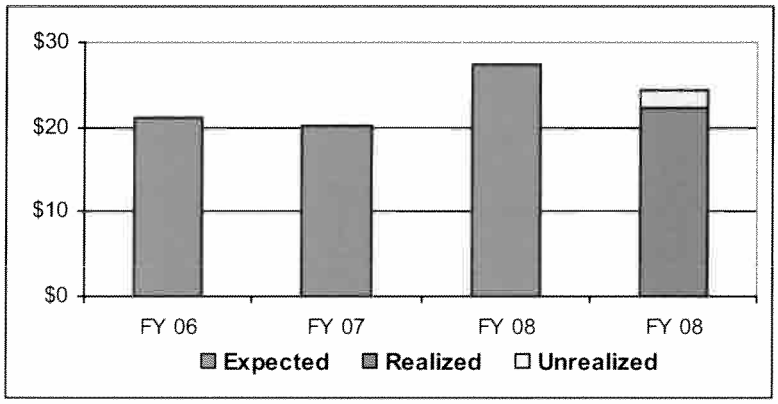
State and federal agencies share the costs of providing Medicaid services as well as the costs to conduct review activities. In FY 09 the state and federal governments each provided 50% of the funds necessary to provide Medicaid services and therefore benefited equally from the $14,653,705 in reduced expenditure during FY 09 (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 cost Colorado $300,845 to fund activities that saved $7,326,853.

FIGURE 7.6
COST AVOIDED VERSUS 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 the increased return on investment in FY 09 compared to previous years. Data available as of September 25, 2009 indicate that the Department has already realized a return of $22.38 for every Colorado 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 06	FY 07	FY 08	FY 09
Gross Costs Avoided	$9,047,816	$11,104,939	$14,171,869	$14,653,705
Review Contract Expenditure	($857,626)	($1,101,555)	($1,037,384)	($1,203,379)
Net Costs Avoided	**$8,190,190**	**$10,003,384**	**$13,134,485**	**$13,450,326**

TABLE 7.2 – ACUTE CARE REVIEW CONTRACT EXPENDITURES

Contract Expenditures	FY 06	FY 07	FY 08	FY 09
Acute Care Review Services	$857,626	$1,101,555	$1,037,384	$1,203,379
Medicaid Telephone Triage Program	$274,350	$274,351	$282,580	$172,527
Special Studies	$8,013	$0	$55,942	$0
Total Paid to CFMC	**$1,139,989**	**$1,375,906**	**$1,375,906**	**$1,375,906**

TABLE 7.3 – COSTS AVOIDED – COLORADO FUNDS

Fiscal Impact – Colorado Funds	FY 06	FY 07	FY 08	FY 09
Gross Costs Avoided – Colorado Funds	$4,523,908	$5,552,470	$7,085,935	$7,326,853
Contract Expenditure – Colorado Funds	($214,407)	($275,389)	($259,346)	($300,845)
Net Costs Avoided – Colorado Funds	**$4,309,501**	**$5,277,081**	**$6,826,589**	**$7,026,008**

TABLE 7.4 – COSTS AVOIDED PER REVIEW

Source of Funds	FY 06	FY 07	FY 08	FY 09
Colorado Funds	$354	$374	$455	$415
Federal Funds	$318	$335	$420	$380
Costs Avoided Per Review	**$672**	**$709**	**$875**	**$795**

TABLE 7.5 – RETURN ON INVESTMENT

Source of Funds	FY 06	FY 07	FY 08	FY 09
Colorado Funds	21.10	20.16	27.32	24.35
Federal Funds	7.03	6.72	9.11	8.12
Return on Investment	**10.55**	**10.08**	**13.66**	**12.18**

Prospective Review Fiscal Impact Detail

TABLE 7.6 – PROSPECTIVE REVIEW TOTAL COSTS AVOIDED

Prospective Review	FY 06	FY 07	FY 08	FY 09
Procedures[1]	$833,728	$655,545	$1,146,925	$543,193
Inpatient Mental Health Services	$0	$0	$0	$0
Inpatient Substance Abuse Rehab	$69,086	$9,137	$0	$0
Durable Medical Equipment[2]	$1,320,833	$1,731,545	$1,306,215	$1,584,267
Select Non-emergent Medical Transportation	$11,268	$35,378	$78,998	$169,861
EPSDT Home Health	$236,694	$234,882	$412,203	$621,106
Physical & Occupational Therapy	$4,297,356	$5,822,073	$8,238,256	$8,534,410
Total Prospective Review Costs Avoided	**$6,768,965**	**$8,488,560**	**$11,182,597**	**$11,452,837**

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 06	FY 07	FY 08	FY 09
Organ Transplants – In-state	$811,092	$603,529	$1,134,067	$515,562
Organ Transplants – Out-of-state	$0	$0	$0	$0
Select Procedures	$22,636	$52,016	$12,858	$27,631
Total Procedure Costs Avoided	**$833,728**	**$655,545**	**$1,146,925**	**$543,193**

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 06	FY 07	FY 08	FY 09
Power Wheelchairs	$572,028	$705,107	$405,271	$439,705
Wheelchair Accessories	$461,879	$632,458	$451,165	$605,032
Orthotics/Prosthetics	$69,535	$120,217	$95,901	$127,326
Respiratory Devices	$56,530	$92,299	$122,320	$182,616
Communication Devices	$55,745	$83,986	$175,656	$164,654
Power Scooters	$47,183	$49,182	$12,619	$3,523
Labor/Service	$30,061	$17,541	$26,337	$26,345
Other DME	$27,873	$30,755	$16,946	$35,066
Total DME Costs Avoided	**$1,320,833**	**$1,731,545**	**$1,306,215**	**$1,584,267**

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

Transportation Review	FY 06	FY 07	FY 08	FY 09
Lodging – Escort	$9,205	$13,999	$44,105	$107,469
Meals – Escort	$828	$12,161	$21,486	$39,381
Lodging – Recipient	$570	$1,638	$3,509	$14,031
Meals – Recipient	$84	$439	$2,079	$5,852
Air Transport	$0	$6,562	$7,819	$2,011
Over-the-cap Ambulance Services	$533	$541	$0	$1,083
Travel – Escort	$48	$31	$0	$34
Travel – Recipient	$0	$7	$0	$0
Total Transportation Costs Avoided	**$11,268**	**$35,378**	**$78,998**	**$169,861**

TABLE 7.10 – EPSDT HOME HEALTH REVIEW TOTAL COSTS AVOIDED

EPSDT Home Health Review	FY 06	FY 07	FY 08	FY 09
Home Health Aide	$126,332	$143,281	$333,612	$373,072
Skilled Nursing	$2,404	$74,039	$25,867	$189,452
Occupational Therapy	$37,329	$8,820	$26,855	$34,483
Physical Therapy	$30,202	$6,756	$25,287	$15,118
Speech Therapy	$40,428	$229	$582	$8,982
Total EPSDT Home Health Costs Avoided	**$236,694**	**$234,882**	**$412,203**	**$621,106**

TABLE 7.11 – PHYSICAL & OCCUPATIONAL THERAPY REVIEW TOTAL COSTS AVOIDED

Physical & Occupational Therapy Review	FY 06	FY 07	FY 08	FY 09
Physical Therapy	$2,386,973	$2,854,022	$3,880,342	$4,457,598
Occupational Therapy	$1,910,384	$2,968,051	$4,357,914	$4,076,812
Total PT/OT Costs Avoided	**$4,297,356**	**$5,822,073**	**$8,238,256**	**$8,534,410**

Retrospective Review Fiscal Impact Detail

TABLE 7.12 – RETROSPECTIVE REVIEW TOTAL COSTS AVOIDED

Review Outcome	FY 06[1]	FY 07[1]	FY 08[1]	FY 09
Admission Denials – Realized Savings				$100,522
Unrealized Savings				$66,845
Total Admission Denial Savings	**$563,736**	**$183,279**	**$199,927**	**$167,367**
Technical Denials – Realized Savings				$159,313
Unrealized Savings				$152,234
Total Technical Denial Savings	**$282,699**	**$841,709**	**$667,091**	**$311,541**
Billing Errors – Realized Savings				$1,659,124
Unrealized Savings				$856,783
Total Billing Error Savings	**$1,256,776**	**$1,544,118**	**$1,977,770**	**$2,506,907**
DRG Changes – Realized Savings				$106,508
Unrealized Savings				$108,539
Total DRG Change Savings	**$175,640**	**$47,273**	**$144,484**	**$215,047**
Retrospective Review – Realized Savings				$2,016,467
Unrealized Savings				$1,184,401
Total Retrospective Review Savings	**$2,278,851**	**$2,616,379**	**$2,989,272**	**$3,200,868**

1. To maintain consistency with past reports, only the expected savings are reported for previous fiscal years.