CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Evaluation and Management (E&M) Services

Rule Number(s):

RULES ADDRESSED IN BUSINESS IMPACT ANALYSIS:

To Be Rescinded: 5160-4-06

New: 5160-4-06

RULES NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

To Be Rescinded: 5160-4-06.1

Date: January 5, 2017

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Existing rule 5160-4-06, "Physician visits," sets forth coverage and payment policies for specific types of evaluation and management services (office visits). This rule is rescinded and replaced by a new rule of the same number, titled "Specific provisions for evaluation and management (E&M) services."

   Existing rule 5160-4-06.1, "Physician attendance during patient transport," sets forth coverage and payment policies for face-to-face services provided by a physician while an individual is being transported. This rule is rescinded, and its relevant provisions are incorporated into new rule 5160-4-06.

   The text of new rule 5160-4-06 is reorganized, streamlined, and clarified. Unnecessary definitions, explanations, and claim-submission instructions are removed. The word 'physician' is replaced by other terms such as 'practitioner' or 'consultant' in recognition of the expanded scope of non-physician medical professionals.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They publish payment formulas or schedules for the use of providers and the general public.

   The administrative rule for specific types of evaluation and management services performs these functions, and no alternative is readily apparent.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of these rules will be measured by the extent to which operational updates to the Medicaid Information Technology System (MITS) result in the correct payment of claims.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   On 10/12/2016, rule drafts were sent to the Medicaid managed care plans. On 11/14//2016, drafts were sent to 20 provider associations.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the agency?**

   One clarifying question (concerning after-hours care) was submitted by a managed care plan, and a response was provided. No comment was received from any provider association.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   No data were needed.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    These rules involve the coverage of and payment for evaluation and management (E&M) services. Whatever the policy may be, the form of the rule is the same; no alternative is readily apparent.

11. **Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.**

    The concept of performance-based regulation does not apply to these services.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to each provider type and item or service. In this instance, there was no duplication.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The policies set forth in these rules will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of the new rule. They therefore will be applied by the Department's electronic claim-payment system automatically and consistently whenever an appropriate provider submits a claim for an applicable service.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

These rules affect providers of evaluation and management (E&M) services (e.g., physicians, advanced practice registered nurses, physician assistants).

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

Paragraph (E)(2) of existing rule 5160-4-06 requires that the need for consultation, the consultant's opinion, and any services that were ordered or performed must be documented in the patient's medical record. Paragraph (E)(6)(d) of existing rule 5160-4-06 requires that any additional request for an opinion or advice regarding a current medical problem or a new medical problem be documented in the medical record. Paragraph (J)(2) of existing rule 5160-4-06 specifies that payment may be made for a long-term care facility (LTCF) visit only if the visit is documented in the resident's medical record.

Paragraph (B)(3)(b) of new rule 5160-4-06 provides that the request for a consultation, the need for a consultation, the consultant's opinion, and any services that were ordered or performed in relation to the consultation must be documented in the patient's medical record.

c. **Quantify the expected adverse impact from the regulation.**
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The adverse impact lies in the time needed by a provider to maintain documentation. Documentation is a standard part of every practitioner's routine, and these rule provisions do not increase the burden of documentation; they merely identify the areas of record-keeping in which Medicaid has a particular interest. The activities associated with these provisions — writing a sentence or two, photocopying, filing — take no more than a few minutes each.

The median statewide hourly wage associated with medical record documentation, according to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services, is $46.15; adding 30% for fringe benefits brings the figure to $60.00. So the estimated cost of documentation is approximately $1.00 per minute.

15. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

Proper documentation of services in a patient's medical record helps to ensure that appropriate treatment is provided. Although documentation is standard medical practice, specifying particular requirements in rule makes clear to providers which aspects are especially important to Medicaid in determining medical necessity.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

These rules outline actions all providers must take in order to receive Medicaid payment. The requirements are applied uniformly and no exception is made based on an entity's size.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau at noninstitutional_policy@medicaid.ohio.gov.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.