RETROSPECTIVE PREPAYMENT REVIEW & BILLING ERRORS

Presentation Overview

- eQHealth’s Role as QIO
- What is Retrospective Review?
  - Selection and notification process
- HFS Retrospective Review Requirements
  - Scope of review
- Prepayment Review Process
- Billing Errors
  - Description and examples
- eQHealth and HFS Educational Resources
- Q & A Session
eQHealth QIO Role

• Serving as the Illinois QIO since 2002, eQHealth is dedicated to serving healthcare providers of Illinois Medicaid patients to ensure they receive high quality, medically necessary care delivered in the most appropriate setting.

<table>
<thead>
<tr>
<th>eQHealth’s Scope of Work</th>
<th>Services Do Not Include (Ø)</th>
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<tbody>
<tr>
<td>✓ Medical necessity review for acute inpatient care STAC/LTAC</td>
<td>Ø Case Management</td>
</tr>
<tr>
<td>✓ Quality of care review for acute inpatient care STAC/LTAC</td>
<td>Ø Discharge Planning</td>
</tr>
<tr>
<td>✓ Focused quality studies and special projects for HFS</td>
<td>Ø Billing or Claims Services</td>
</tr>
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<td>Ø Fiscal Agent - Payment</td>
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Retrospective Review

• Prepayment Review (after discharge; before payment)
  – Selected weekly by HFS from hospital claims
  (these were not reviewed concurrently)
    • DRG codes on HFS Attachment D
    • Exceptions to mandatory concurrent review that HFS approves (hard copy claims)
Prepayment Review Selection

**Hospital** sends claim to HFS

**HFS** selects cases from claims for prepayment review. Sends list of cases to eQHealth each Friday.

**eQHealth** sends hospital Notice of Selection of Medical Records for Offsite Review – Prepayment, with a case listing and tracking sheets

**Hospital** copies medical record, attaches tracking sheet and sends to eQHealth within 14 calendar days from date on Notice of Offsite Review

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Retrospective Prepayment Scope

- HFS requires broad-scope, medical record review
  - Complete and accurate information
  - Information for requested dates of service only

**Required Medical Record Components**

- Physician Orders
- H & Ps
- Progress Notes
- Vitals and Labs/Diagnostics
- Treatment Plan and Meds
- Discharge plans and status

**eQHealth Prepayment Review Scope**

- Critical billing errors
- Medical necessity of each day of care and appropriateness of setting
- Quality of care review
- ICD-9-CM billing and DRG coding validation
Prepayment Review Process

If the medical record is received timely, there are no missing components and no critical billing errors are identified, the prepayment review process continues

- eQHealth’s Utilization Review Nurses
  - Validate ICD-9-CM and DRG coding (DRG reimbursed)
  - Apply Centers for Medicare & Medicaid (CMS)
    Quality of Care Review Category screens
    - Occurs separate and does not impede utilization review
  - Verify medical necessity of each day of care and appropriateness of setting
    - Apply criteria sets and length of stay norms

Prepayment Review Process

- Nurse Outcomes
  - Certify
    - Hospital information satisfies criteria
    - Quality of care screens are met
    - ICD9CM and DRG coding are validated
  - Refer to Physician
    - Hospital information does not satisfy criteria
    - Quality of care screen failure
    - Cannot validate DRG code
Prepayment Review Process

- **Physician Review**
  - Matched by physician specialty
  - Assigned to physician peer reviewer (PR)
    - Certify; or medical necessity denial
    - Change in DRG code (RHIA involved)
    - Potential quality of care concern
- **Notification Sent to Appropriate Hospital Staff**
  - Liaison
  - Physician
  - Quality contact

Reconsideration Process

- The hospital or physician may request a reconsideration within 60 calendar days of the date of eQHealth notification:
  - Medical necessity denial, or
  - Change in DRG
- Hospital completes the eQHealth form and provides supplemental information (to support the days denied or original DRG)
  - Website homepage or Provider Resources tab
  - Less than 10 pages may be faxed to 800# on form
  - More than 10 pages, send to eQHealth address on form
- Hospital receives notification
  - Receipt of Reconsideration Request; or
  - Cancellation of Reconsideration Request (untimely)
**Cancelled Prepayment Reviews**

Prepayment review is “cancelled” and can not proceed if:

1. The medical record is not received by the due date
   a. Notice of Cancelled Review
2. Necessary parts of the medical record are missing or record is for wrong dates of service
   a. Notice of Cancelled Review
3. Critical billing errors are found
   a. Notice of Incorrect Billing – Prepayment Review

**Critical Billing Errors**

- Critical billing errors - when medical record documentation indicates inaccuracy in any of the following HFS designated areas:
  - Incorrect inpatient admission date
  - Other – missing or ambiguous admitting orders
  - Incorrect discharge status
  - Incorrect category of service
  - Incorrect discharge date
  - Procedure performed prior to admission
  - Multiple categories of service
  - No record of the admission
Top 5 Billing Errors

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<th>Billing Errors (cancelled review)</th>
<th>Definition</th>
<th>Hospital Action</th>
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<tr>
<td>Notice of Incorrect Billing: Incorrect admit date</td>
<td>The inpatient admit date billed must match physician order for inpatient admission. Inpatient admission date must be billed (not observation)</td>
<td>Clarify inpatient admission date. Resubmit claim to HFS.</td>
</tr>
<tr>
<td>Notice if Incorrect Billing: BE Other</td>
<td>Missing or ambiguous physician order for inpatient admission. Physician order must be signed/dated.</td>
<td>Ensure orders are present in medical record and are signed/dated. Receive direction from UR committee for clarification orders. Resubmit claim to HFS.</td>
</tr>
<tr>
<td>Notice of Incorrect Billing: Incorrect Category of Service</td>
<td>Incorrect COS billed or multiple COS during hospitalization</td>
<td>Verify correct COS. Submit separate claims for each service type.</td>
</tr>
<tr>
<td>Notice of Incorrect Billing: Incorrect discharge status</td>
<td>The discharge status must match medical record.</td>
<td>Correct discharge status error. Resubmit claim to HFS.</td>
</tr>
<tr>
<td>Notice of Incorrect Billing: Incorrect discharge date</td>
<td>The discharge date must match medical record.</td>
<td>Correct discharge date error. Resubmit claim to HFS.</td>
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eQSuite™ Provider Reports

- Access Provider Web Reports Online 24/7
  - Self monitor atypical billing or utilization patterns
Run Provider Specific Report #11

Summary of Retrospective Billing Errors & Cancels

Track Your Billing Errors

Retrospective Billing Errors & Cancels

Cancelled Prepayment Review?

Hospital (re)submits inpatient claim to HFS

Do not submit medical records to HFS

HFS selects cases from claims for prepayment review. Sends list to eQHealth

eQHealth cancels review if incomplete / no medical record or incorrect billing - sends notice to hospital

eQHealth sends a Notice for Offsite Review with case listing and tracking sheets to hospital

Hospital sends medical records(s) for requested date of service with tracking sheet in 14 days to eQHealth

Hospital (re)submits corrected billing error(s) – when applicable

The hospital must receive a notice of cancellation or notice of incorrect billing before bill is resubmitted.
Provider Resources

**Utilization and Quality Review Services**
- eQHealth Provider Helpline
  - Monday through Friday, 8 am to 5 pm
  - eQSuite™ Online Helpline

**Website** [http://il.eqhs.org](http://il.eqhs.org)
- Provider Resource tab includes presentation materials and FAQs.

**Web system – eQSuite™**
- Reports #11 with real-time and historic review data
- Reports 41 Copy of Notice of Selection for Offsite Prepayment Review posted each Tuesday

**HFS Resources**
- Healthcare & Family Services
- Hospital Billing Consultants 877-782-5565

[www.hfs.illinois.gov/hospitals](http://www.hfs.illinois.gov/hospitals)
- Provider Notice 5/24/13 – Requirements for Inpatient Medical Records and Admission Orders
- eqhealthsolutions.org

Wrap Up

Our guest host from HFS will give a brief overview of the new 180-day claims submission process

Please wait for the Q&A session to begin
Questions and Answers

The lines are now open for the Q & A Session

- We will address review and billing questions pertaining to this presentation topic.
- Q & A’s will be posted to the eQHealth Website by the end of August.

Any specific billing or claims questions should be relayed to your hospital’s assigned HFS Billing Representative.