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
• 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>
</tr>
</thead>
<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>
<tr>
<td></td>
<td>Ø Fiscal Agent - Payment</td>
</tr>
</tbody>
</table>
• **Prepayment Review** (after discharge; before payment)
  – Selected weekly by HFS from hospital claims *(these were not reviewed concurrently)*
    • DRG codes on HFS Attachment D
    • Seven codes on HFS Attachment E for 1 day stays
    • 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*
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
  – Referred to Physician
    • Hospital information does not satisfy criteria
    • Quality of care screen failure
    • Cannot validate DRG code
Physician Referral Notice

eQHealth Solutions
2050-10 Finley Road
Lombard, Illinois 60148

TEST CONTACT
Test Provider
1234 Main St.
Test City, XX 12345

Date of Notice: 4/19/08
Review Request Date: 3/21/08
Hospital Name & Number: 999999
Test Provider
Category of Service: 20

Physician’s Name & Number: 999999
Test Physician
Patient Name: Test Bene
RIN: 999999 ACCT#: 222244
TAN: 999999
Admission Date: 1/10/08
Discharge Date: 1/25/08

PHYSICIAN PEER REVIEWER REFERRAL NOTICE – Prepayment Review

Dear Provider:

eQHealth Solutions (eQHealth) is the Quality Improvement Organization contracted with the Illinois Department of Healthcare and Family Services (HFS) to perform review of inpatient services provided to HFS Participants. We assure that the services meet guidelines for medical necessity, appropriateness, and length of stay certification.

The medical record for the patient and admission noted was selected for review. The purpose of this notice is to advise you that based upon the clinical information submitted our Utilization Review Coordinator could not approve the request using screening criteria. The case has been referred to an eQHealth Physician Peer Reviewer for the following reason(s).

We encourage you to discuss this case with the treating physician and to make him/her aware of the referral and to coordinate a response.

If our physician reviewer is unable to approve the admission, length of stay or DRG with the available information provided, this determination will be tracked and forwarded to the Illinois Department of Healthcare and Family Services. Our physician reviewer will contact the treating physician to afford an opportunity to discuss any serious quality of care concern prior to making a determination.
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)
Prepayment review is “cancelled” and cannot 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 - 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

<table>
<thead>
<tr>
<th>Billing Errors (cancelled review)</th>
<th>Definition</th>
<th>Hospital Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Incorrect Billing: Incorrect admit date</td>
<td>The inpatient admit date billed must match Physician order for <em>inpatient admission</em>. 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/timed. Phone or verbal orders must be authenticated.</td>
<td>Ensure orders are present in medical record and are signed/dated/timed. If no inpatient order only observation; rebill only for correct service. 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 on claim 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 on claim must match medical record.</td>
<td>Correct discharge date error. Resubmit claim to HFS.</td>
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Access Provider Web Reports Online 24/7
- Self monitor atypical billing or utilization patterns
# Billing Errors

*Retrospective Reviews Only*

**Provider**

**Review Date Range:** 1/1/2012 - 3/28/2012

<table>
<thead>
<tr>
<th>RIN</th>
<th>Last Name</th>
<th>Admit Date</th>
<th>Dsch Date</th>
<th>Medical Record Number</th>
<th>Phys Number</th>
<th>IDPA DCN</th>
<th>Review Date</th>
<th>Error Specifics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10/08/09</td>
<td>10/12/09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>According to the medical record, the patient was cancelled; incorrect admission date per medical. Patient was admitted inpatient on 4-10-10, hospital billed as inpatient on 4-11-10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>04/11/10</td>
<td>04/28/10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>According to the medical record, the patient was cancelled; incorrect admission date per medical. Patient was admitted inpatient on 4-10-10, hospital billed as inpatient on 4-11-10</td>
</tr>
</tbody>
</table>

**Cases for Code BE Admit Date**

2

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<thead>
<tr>
<th>RIN</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>01/19/12</td>
<td>01/20/12</td>
<td></td>
<td></td>
<td></td>
<td>03/21/12</td>
<td>the medical record provided contains no physician inpatient admission order</td>
</tr>
<tr>
<td></td>
<td></td>
<td>05/15/11</td>
<td>05/17/11</td>
<td></td>
<td></td>
<td></td>
<td>02/27/12</td>
<td>Review cancelled; the order for inpatient admission was neither dated nor timed per the physician.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11/30/11</td>
<td>12/01/11</td>
<td></td>
<td></td>
<td></td>
<td>02/10/12</td>
<td>per the medical record provided there is an inpatient admission order 11/30; another inpatient order for 12/1; then an observation patient order for 12/1 - so the pt was observation status.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12/15/11</td>
<td>12/15/11</td>
<td></td>
<td></td>
<td></td>
<td>02/08/12</td>
<td>according to the medical record provided admitted on 12/15.</td>
</tr>
</tbody>
</table>

**Cases for Code BE Other**

4

**Total Cases:** 6
The hospital must receive a notice of cancellation or notice of incorrect billing before bill is resubmitted.

Hospital (re)submits inpatient claim to HFS

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

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

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

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

Hospital rectifies billing error(s) – when applicable

Do not submit medical records to HFS
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™**
- Report #11 Billing Errors with real-time and historic review data
- Report #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