eQHealth/Kepro Retrospective Review & Billing Errors Webinar

December 7, 2022

1

Presentation Outline

- eQHealth/Kepro's role as Illinois' QIO
- Overview of Retrospective Review process
  - Focus on Prepayment Review Process
- HFS Critical Billing Errors
  - Description and examples
- Educational Resources
- Q & A Session

2

eQHealth/Kepro QIO Role

Serving as the Quality Improvement Organization (QIO) since 2002, eQHealth/Kepro is dedicated to supporting Providers of Illinois Medicaid fee-for-service patients to ensure they receive high quality, medically necessary care delivered in the most appropriate setting.

QIO Scope of Work	Services Do Not Include (Ø)
✓Medical necessity review for acute inpatient care STAC/LTAC	Ø Medicaid Managed Care - MCO
✓Quality of care review for acute inpatient care STAC/LTAC	Ø Discharge Planning
✓Medical necessity review for HFS' Family Support Program which provides access to intensive mental health services for Illinois youth	Ø Case Management
	Ø Billing or Claims Payment

3

Retrospective Review

Review Types	Overview
Retrospective Review (prepayment)	• Performed after discharge and prior to payment • Condensed medical record review • Selected weekly by HFS
Retrospective Review (post-payment)	• Performed after discharge and after payment • Condensed medical record review • Selected monthly from paid claims data

Retrospective review takes place within 30 calendar days after the 14-day period allotted to submit the medical record.

4

Retrospective Review

This presentation will concentrate on Prepayment Review (after discharge; before payment)

- **Prepayment cases are selected weekly by HFS from hospital claims for inpatient services that have not been reviewed concurrently. These include:**
  1. APR DRG codes subject to review on HFS Attachment D
  2. Admitting diagnoses on HFS Attachment E for 1-day stays
  3. Exceptions to mandatory concurrent review that HFS approves

     Admitting diagnoses subject to concurrent review listed on HFS Attachments A, B and C that the hospital did not submit to eQHealth/Kepro while patient was hospitalized

5

Retrospective Review

Exceptions to Mandatory Concurrent Review

HFS' Chapter H-200 Policy and Procedures For Hospital Services

The department will allow limited exceptions in the following circumstances:

- A participant's Medicaid eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment at the time of admission.
- The patient remains unresponsive or has a physical or mental impairment that prevents the hospital from identifying coverage under one of the department's medical programs.
- Other – the hospital must provide narrative description and supporting documentation.

6

Prepayment Review Selection

Hospital submits inpatient claim to HFS

HFS selects cases from claims for prepayment review and data file is issued to eQHealth/Kepro each Friday. The individual listed as the hospital-assigned Retro Chart Contact will receive an email reminder that cases have been selected and to check eQSuite®.

These HFS-selected cases are uploaded into eQSuite® each Friday.

Cases needing medical records appear in the Retro Chart Requests tab and are listed in eQSuite Report 41 Prepayment and Report 42 Post-Payment, by Hospital Medicaid Provider ID.

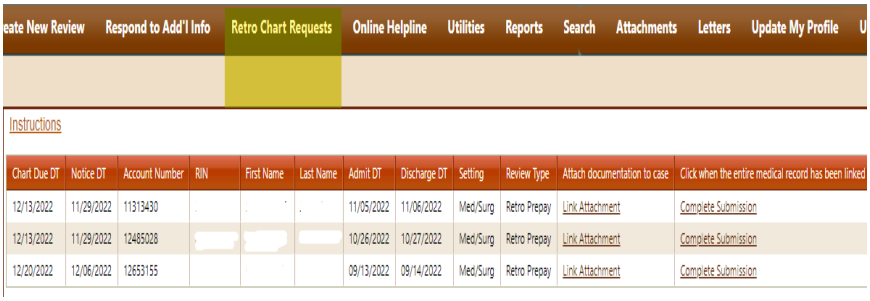
Hospital or Release of Information vendor creates PDF file of medical record (following condensed medical record requirement). Uploads PDF file into eQSuite® within 14 calendar days from Date of Notice, by the Due Date listed.

7

Prepayment Review Selection

The hospital-assigned RetroChart Contact(s) receives an automated email alert when retro prepayment or post-payment cases have been selected for review for their hospital(s).

These cases can be found under Retro Chart Requests tab within eQSuite®, for the medical record to be linked and uploaded.



8

Retrospective Prepayment Review

Condensed Medical Record Review Required Components

- History and Physical Examination Records
- ER/ED Records
- All Physician Orders (must include Inpatient admission order)
- Physician & Nurse Progress Notes (*)
- Discharge Summary

**DO NOT SUBMIT documentation such as daily assessments, weights,teaching/dressing changes, I/O's, consents, discharge instructions, shift changes, or flow sheets.*

Retrospective Prepayment Scope

A broad-scope, medical record review requires:

- ✓ ***Complete and accurate information***
  - *Condensed medical record documentation*
- ✓ ***Information for requested dates of service only***

eQHealth/Kepro Prepayment Review Scope

- **Critical billing errors**
- **Medical necessity of each day of care and appropriateness of setting**
- **Quality of care review**

Prepayment Review Process

The medical necessity review can only begin after:
1. **The medical record is received timely**
2. **There are no missing medical record components and**
3. **No critical billing errors have been identified**

The review process then begins when eQHealth/Kepro's Utilization Review Nurses:

- Verify medical necessity of each day of care and appropriateness of setting
- Substantiate the performance of any invasive procedures
- Apply Centers for Medicare & Medicaid (CMS) *Quality of Care Review Category screens*
  - *The quality-of-care review process occurs simultaneously to the medical necessity review*

11

Prepayment Review Process

eQHealth/Kepro Nurse Review Outcomes

1.Certify
- Hospital clinical information satisfies clinical criteria
- Centers for Medicare and Medicaid (CMS) *Quality of Care* Categories are met

2. Refer to eQHealth/Kepro Physician Reviewer
- Hospital clinical information does not satisfy criteria
- Quality of care screen(s) failure

12

Prepayment Review Process

Physician Review (PR) Process

- Matched by physician specialty and assigned to a PR, who uses their clinical expertise to render a determination or substantiate a quality-of-care issue. The Physician Reviewer can:
  - » Certify
  - » Render a medical necessity denial
  - » Confirm potential quality of care concern
- Notification letter sent to appropriate hospital staff
  - » Hospital-assigned Liaison
  - » Hospital-assigned Quality Contact

Reconsideration Process

The hospital or physician may request a reconsideration within 60 calendar days of the date of eQHealth Notice of Medical Necessity Denial:

- The hospital completes a reconsideration form, may request peer-to-peer and provides supplemental information to support the days denied.
- Reconsideration Form found under Provider Resources tab http://il.eqhs.com
  - Fax the form and additional information to the 800# on form
- Once received the hospital receives notification letter
  - Receipt of Reconsideration Request; or
  - Cancellation of Reconsideration Request (untimely)

Cancelled Prepayment Reviews

Prepayment review is considered "cancelled" and eQHealth/Kepro review cannot be performed if:

1. The medical record is not received by the due date; or the medical record sent is for wrong dates of service
   - Letter of Notice of Cancelled Review
2. The medical record submitted does not meet the Condensed Medical Record requirement (i.e. missing sections of medical record required for clinical review).
   - Letter of Notice of Cancelled Review
3. Critical billing errors are found
   - Letter of Notice of Incorrect Billing – Prepayment Review (**Also denotes a cancelled review**)

Critical Billing Errors

- Critical billing errors - when the medical record documentation shows an inaccuracy in any of the following HFS designated areas:
  - ✓ Incorrect inpatient admission date
  - ✓ Other – *missing inpatient orders, missing sections of medical record, hospital submitting claim with different Provider ID, when services were already approved upon admission, et al.*
  - ✓ Incorrect discharge status
  - ✓ Incorrect category of service
  - ✓ Incorrect discharge date
  - ✓ Procedure performed prior to admission
  - ✓ Multiple categories of service

Top 5 Billing Errors

Billing Errors (cancelled review)	Definition	Hospital Action
Notice of Incorrect Billing: Incorrect Admit Date	The inpatient admit date billed must match Physician order for inpatient admission. Inpatient admission date must be billed (not observation)	Clarify inpatient admission date. Resubmit claim to HFS.
Notice of Incorrect Billing: BE Other	Missing or ambiguous physician order for inpatient admission. Physician order must be signed/dated/timed. Phone or verbal orders must be authenticated. All physician orders must be included for medical necessity review.	Ensure orders are present in medical record and they are signed/dated/timed. If no inpatient order, only observation, evaluate if observation is to be billed vs. inpatient. Or if inpatient order is missing, must resubmit claim again to HFS and inform medical records of missing orders.

17

Top 5 Billing Errors Cont.

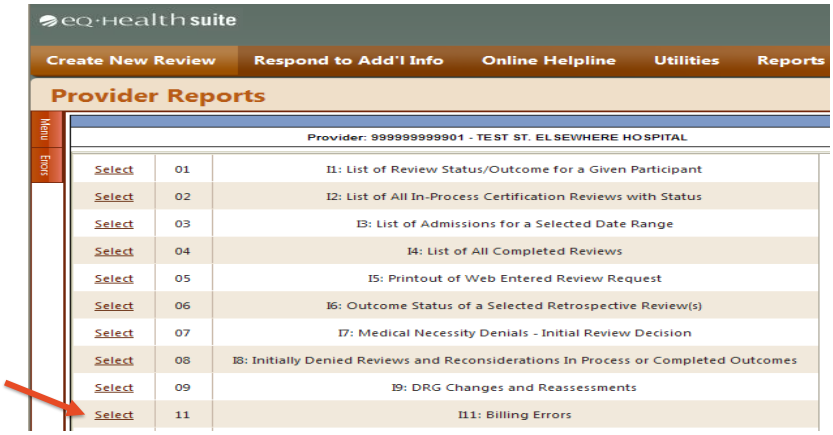
Billing Errors (cancelled review)	Definition	Hospital Action
Notice of Incorrect Billing: BE Other	Hospital submits claim to HFS using new HFS Provider ID; when the hospital already conducted review and received TAN under an older (incorrect) HFS Provider ID.	Hospital must check to see if inpatient dates of service were already billed to HFS. If HFS is rejecting original claim because it was billed using incorrect Provider ID, immediately request eQHealth to correct the Provider ID on the approved admission reviews.
Notice of Incorrect Billing: Incorrect Category of Service	Incorrect COS was billed, or multiple COS occurred during hospitalization	Verify correct COS . Must submit a separate claim for each service type.
Notice of Incorrect Billing: Incorrect Discharge Status or Discharge Date	The discharge status and the discharge date on the claim must match the medical record documentation.	Correct the discharge status error or the discharge date and resubmit the claim to HFS.

18

eQSuite® Provider Reports

Access Provider Web Reports Online 24/7

- Self monitor atypical billing or utilization patterns

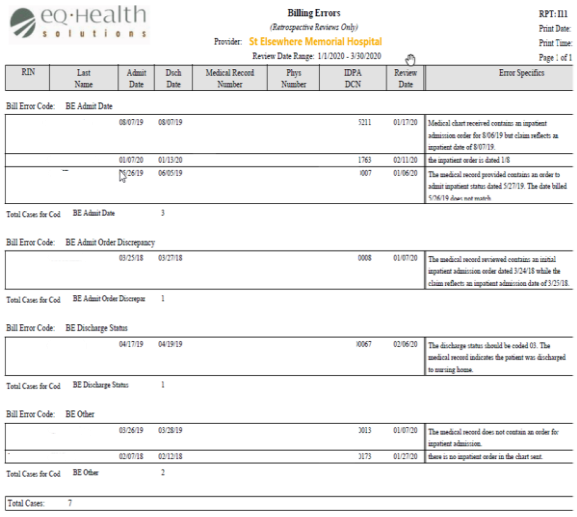


19

Track Your Billing Errors

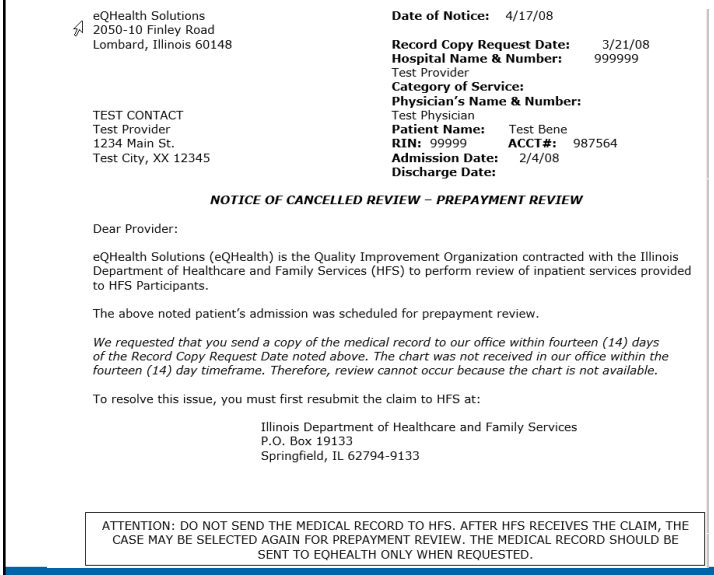
Provider Report #11

- Patient Medicaid RIN
- Last name
- Admit Date
- Discharge Date
- Medical Record Number
- Hospital Physician Number
- HFS Doc Control Number
- eQHealth Review Date
- ***Error Specifics - use to identify and track billing errors each month.***



20

Cancelled Prepayment Reviews



eQHealth Solutions
2050-10 Finley Road
Lombard, Illinois 60148

Date of Notice: 4/17/08

Record Copy Request Date: 3/21/08
Hospital Name & Number: 999999
Test Provider
Category of Service:
Physician's Name & Number:
Test Physician
Patient Name: Test Bene
RIN: 99999 **ACCT#:** 987564
Admission Date: 2/4/08
Discharge Date:

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

NOTICE OF CANCELLED REVIEW – 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.

The above noted patient's admission was scheduled for prepayment review.

We requested that you send a copy of the medical record to our office within fourteen (14) days of the Record Copy Request Date noted above. The chart was not received in our office within the fourteen (14) day timeframe. Therefore, review cannot occur because the chart is not available.

To resolve this issue, you must first resubmit the claim to HFS at:

Illinois Department of Healthcare and Family Services
P.O. Box 19133
Springfield, IL 62794-9133

ATTENTION: DO NOT SEND THE MEDICAL RECORD TO HFS. AFTER HFS RECEIVES THE CLAIM, THE CASE MAY BE SELECTED AGAIN FOR PREPAYMENT REVIEW. THE MEDICAL RECORD SHOULD BE SENT TO EQHEALTH ONLY WHEN REQUESTED.

Hospital Liaison will receive:

Notice of Cancelled Review

or

Notice of Incorrect Billing

Both are considered cancellations and need to be rebilled to HFS

21

Cancelled Prepayment Reviews

Patient Name: FISHER NET
RIN: 05_xxxxxxxx **ACCT#:** 3490778
Admission Date: 11/20/19
Discharge Date: 12/3/19
Discharge Status Billed: 62

GENERAL HOSPITAL
OAK PARK AVE
GENERAL CITY, USA

NOTICE OF INCORRECT BILLING - 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.

The above noted patient's admission was scheduled for prepayment review. Review was not completed because of the following incorrect billing information:

Incorrect inpatient admission date was billed. The actual date of admission was: The medical record contains an order for admission on 11/21/2019.

A corrected claim must be resubmitted to HFS. Attach a copy of this Notice to the corrected claim and send it to:

Illinois Department of Healthcare and Family Services
P. O. Box 19133
Springfield, IL 62794-9133

ATTENTION: DO NOT SEND THE MEDICAL RECORD TO HFS. AFTER HFS RECEIVES THE CORRECTED CLAIM, THE CASE MAY BE SELECTED AGAIN FOR PREPAYMENT REVIEW. THE MEDICAL RECORD SHOULD BE SENT TO EQHEALTH ONLY WHEN REQUESTED.

Sincerely,

Hospital Liaison will receive:

Notice of Cancelled Review

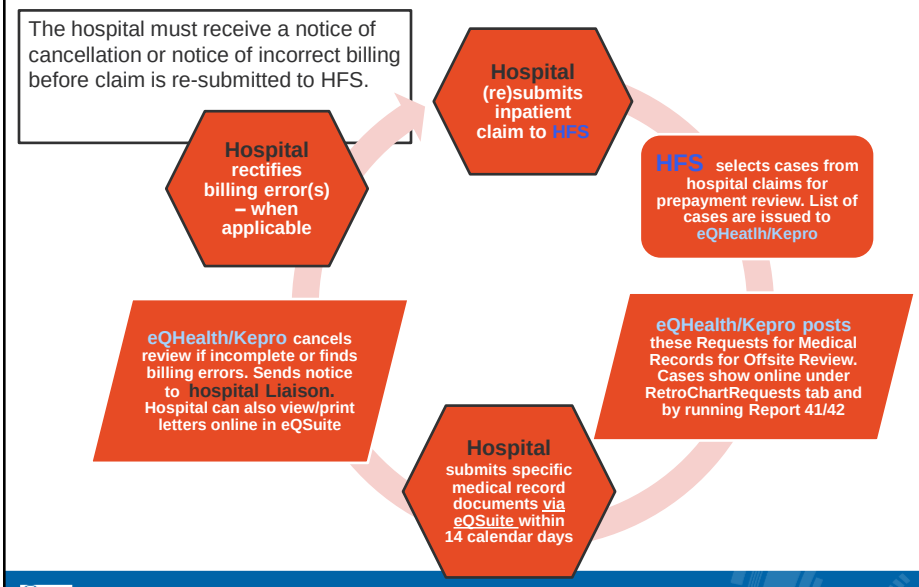
or

Notice of Incorrect Billing

Both are considered cancellations and need to be rebilled to HFS

22

Cancelled Prepayment Review?



23

Provider Resources

eQHealth Illinois Provider Helpline

- Submit Online Helpline Requests Monday through Friday, 8:30 am to 5:00 pm
- eQSuite® log in trouble, please call (800) 418-4045

eQSuite® Online Review System and Reports

- Report 11 Prepayment Billing Errors
- Report 11A Post-payment Billing Errors
- Report 41 Copy of Notice of Selection for *Prepayment* Review
- Report 42 Copy of Notice of Selection for *Post-payment* Review

HFS Resources

Healthcare & Family Services
Hospital Billing Consultants 877-782-5565

24

Thank You For Attending

We appreciate your time and attention

We will email you a link to a *quick survey*

Your response is very important to us

Have a great week!