DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	6-13-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000387	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Hess, Singleton, Vaughn, Mr. Keck	[X] Prepare reply for appropriate signature DATE DUE 6/27/13 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

ChamberlinEdmonds®
an Emdeon company

April 9, 2013

SCDHHS
Office of Communications,
1801 Main Street
Columbia, South Carolina 29201

RE: Regulatory Review Task Force

Dear Director Keck,

Thank you for the opportunity to provide information about an agency process that imposes a burden on the hospital community of South Carolina.

COMMENTING ENTITIY: This comment is provided by Chamberlin Edmonds & Associates (CEA) an Emdeon company. Contact information is as follows:

Rob Murr, Regional Vice President
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BRIEF STATEMENT OF THE ISSUE: DHHS has a manual paper process of providing the KePRO organization with the necessary retroactive Medicaid eligibility load date which is a condition precedent to granting of a retro prior authorization for a hospitalization.

SUGGESTED SOLUTIONS: Either enhance the daily electronic report sent to KePRO to include any retroactive Medicaid eligibility load dates or provide an electronic mechanism for hospitals to be able to research the retroactive load date and provide acceptable proof to KePRO of that load date.

BACKGROUND AND DETAILED DISCUSSION:

Chamberlin Edmonds & Associates, Inc. (CEA) an Emdeon Company has contracted with several major South Carolina healthcare systems, including Medical College of South Carolina, Greenville Health Systems, Conway

Medical Center, Palmetto Health, Providence Hospitals, Self Regional Healthcare, Bon Secours-St. Francis Health System, Baptist Easley, and Georgetown Hospital Systems.

CEA is engaged by hospitals to assist hospital patients who are uninsured to apply for any available benefits programs that might provide healthcare coverage. The most common coverages are direct state Medicaid and Medicaid as a byproduct of eligibility for the Supplemental Security Income (SSI) disability program. In the case of SSI related eligibility, Medicaid eligibility is retroactive to the date that the Social Security Administration determines that an applicant's disability began – the onset date. CEA services to hospitals include submission and processing of prior authorizations for hospitalizations. In the case of a SSI decision with a retroactive onset date, CEA must submit a "retro" prior authorization. This may seem a contradiction in terms, but as a program integrity measure it is necessary to assure that the hospital services were medically necessary. [See SCHHS Hospital Service Provider Manual, Section 1, pages 1-24 and 1-25 as well as Section 3. Page 3-2.]

Effective June 1, 2012, Keystone Peer Review Organization (KePRO) began operations as the Quality Improvement Organization (QIO) for the South Carolina Department of Health and Human Services (SCDHHS), Medicaid program. KePRO is responsible for prior authorization (PA) of hospital services as well as pre-payment and/or medical record review of other select services. All acute care hospital admissions, except deliveries and births, must be prior authorized. Requests for emergency admissions must be made within 48 hours of the date of the admission.

In order for KePRO to grant a request for prior authorization, KePRO requires proof of the date that an individual became Medicaid eligible. This is called the "load" date. This requirement is applicable in the case of retroactive eligibility as well as current determinations.

DHHS provides a daily report to KePRO detailing eligibility changes made for that day, but that daily report does not contain retroactive load dates.

In order to assist the hospital with submission of a retro prior authorization request, CEA must request a copy of the DHHS approval notice (Form 945 or 3229A) from the DHHS agency worker showing proof of when the retroactive eligibility date was loaded – the load date. Only after Chamberlin Edmonds receives the paper approval notice, can Chamberlin Edmonds submit the retro prior authorization request to KePRO. Only after the retro prior authorization approval is granted by KePRO and sent to the hospital can the hospital bill Medicaid for the services provided to the patient.

The paper intensive process of getting an approval letter showing the retroactive load date from DHHS and submitting that information to KePRO is slowing down hospitals' ability to bill for services rendered and receive reimbursement in a timely fashion. On average it takes 5 to 20 business days for DHHS to send the approval letter information. In dealing with particularly overburdened agency offices it can take longer.

We at CEA and our hospitals understand that DHHS agency offices are short staffed. We further understand that processing of current applications for assistance takes priority over provision of approval notices.

However, this burdensome retro prior authorization process has an adverse material financial impact on South Carolina hospitals. Not only does this process cause a delay in billing, it creates an additional paperwork burden on agency workers, on hospital billing staffs and on companies such as CEA who strive to assist hospitals with successfully meeting proper retro prior authorization requirements.

CEA provides retroactive prior authorization or pre-certification services to hospitals located in five (5) states other than South Carolina. In each of these states, information necessary to the submission of a complete request for a retroactive prior authorization is available to the hospital and CEA in an electronic form acceptable to the KePRO equivalent entities in those states. For example in Georgia, retroactive eligibility verification can be obtained via the Georgia Medicaid web portal at the time the prior authorization request is submitted. Medicaid eligible members can be searched using any one of the following: Member ID, Date of Service; Birth Date, Gender, Name, and Date of Service; Birth Date, SSN, and Date of Service; or Name, SSN, and Date of Service.

We would be glad to provide detailed information regarding the approaches used by other states.

Again, thank you for the opportunity to submit these comments. We are available to discuss this matter at your convenience.

Respectfully Submitted,

Rob Murr

Regional Vice President, Chamberlin Edmonds

Brenda –
Per Beth, pls log.
To: Deirdra/Zenoria
prepare for signature

[redacted]

Medicaid Authorization Concerns

DRAFT

May 10, 2013

The table below provides additional information regarding additional steps and effort required to obtain pre-certification for inpatient stays. In all cases cited, the patients were provided the care and compassion we want for our families and ourselves.

Concern Type	Problem Definition	Comparison to Commercial Carrier Protocols
Clinical documentation must be sent within first 24 hours or stay will not be authorized	Patient's initial symptoms may not represent the severity of condition and the final reason for the hospitalization. Therefore, reimbursement is denied for circumstances beyond provider's control. Example: Patient presents at emergency room with chest pain as the chief complaint. There are three (3) sets of enzymes needed over a 24 hour period to determine to determine AMI (heart attack). The patient's condition can worsen in the next 24 hours and the test results were such that we could send as clinical in the first 24 hours. Kepro will not look at the clinical after the first 24 hours and have indicated that the patient should be sent home and return if symptoms worsen.	• Approval not limited to clinical documentation obtained in the first 24-hours and submitted in the first 24 hours. • Subsequent documentation may be submitted and considered.
Kepro requires submission of narratives in addition to clinical documentation	A small time study was conducted to determine the impact on the organization. • Eight patients were selected (4 Kepro and 4 non-Kepro accounts); • Average time to provide documentation, including a narrative to Kepro was approximately 15 minutes; • Average time for the other two third party payors not requiring a narrative was approximately half the time. • Therefore, the narrative reduces by half our Utilization Review RNs productivity.	Other third-party carriers: • Do not require submission of a written narrative in addition to medical documentation; • Provide RNs to RNs contact to discuss the patient's diagnosis and symptoms, as needed;

[redacted]

Medicaid Authorization Concerns

May 10, 2013

DRAFT

Concern Type	Problem Definition	Comparison to Commercial Carrier Protocols
Inaccessible Kepro Staff	Multiple examples of additional effort required to connect with Kepro staff. For example, • Multiple voice mail messages left before calls returned; • Our team misinformed that direct lines do not exist; • Palmetto Health staff followed a Kepro representative from a SCHA meeting into the parking lot to ask about patient account because same Kepro employee was not returning her calls.	Other third-party carriers: • Provide designated key contacts; • Use email; • Return phone calls.
Duplicative and education-oriented communication required from service provider to Kepro staff	Multiple examples of additional effort required to submit clinical information and inform Kepro staff about diagnoses and symptoms. For example, • Kepro front line employees / gatekeepers look for all components of the InterQual criteria (Only a few criteria may be necessary to support inpatient admission.)Unnecessary denial of authorization becomes a denied claim requiring yet more administrative work to appeal; • Clinical information faxed through AllScripts application which also documents transaction, yet re-requested.	Third-party carriers provide: • RNs to RNs contact to discuss the patient's diagnosis and symptoms; • Some information may need to be re-submitted; however, not nearly the volume required by Kepro.

[redacted]

Medicaid Authorization Concerns

May 10, 2013

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Concern Type	Problem Definition	Comparison to Commercial Carrier Protocols
Administratively burdensome to communicate with Kepro on routine clinical/authorization processes	A patient's initial clinicals must be sent and received by Kepro within 24 hours and any follow up questions must be responded to within 48 hours of being sent. In cases where the fax is busy or tied up for long periods of time, the burden falls to us to show fax confirmation letters showing that information was provided.	Other third-party carriers: • Do not have strict guidelines on communication (i.e. must write within 24 hours and/or must respond within 48 hours to questions) without recourse
Administratively burdensome to file reconsideration and appeal	There is not a clear process for reconsiderations and appeals, and the representative from DHHS responsible for reconsiderations made clear he would only handle these if they were the result of an administrative issue (i.e. fax not sent in time limit, etc.) This leaves limited recourse for true medical necessity issues, and we are working to find the best way to handle these. As well, the appeal process must be done after a final denial is received. The process for this is to have a formal hearing with legal which is not feasible for a normal patient account.	Other third-party carriers: • Provide reasonable appeal standards and work with us in cases of medical necessity • Work through administrative issues related to processes/ communication instead of denying coverage

[redacted]

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Concern Type	Problem Definition	Comparison to Commercial Carrier Protocols
Requires retroactive authorization for patients that qualify for Medicaid after their stay	For patients that become Medicaid eligible during/after their stay, Medicaid will approve Medicaid and provide the patient with a Medicaid number. Once that is received, [redacted] must then obtain a DHHS form 945 and supporting eligibility documentation noting the patient's retro Medicaid coverage. Then, Palmetto Health begins the authorization process by submitting this DHHS form, along with clinical information. Once the authorization number is obtained the claim can be submitted. In some cases, this retro auth is not granted though there was medical necessity for the stay and usually the patient became eligible during the encounter. As well, a pre-authorization will be denied if the clinicals are submitted without the DHHS form. In some cases, we tried obtaining the auth without this form, and the auth was denied. We were not allowed a second submission of clinical with the form, so we were denied for a purely procedural issue. The communication between Medicaid and Kepro is limited as it relates to eligibility. Most of the MCO's receive monthly reports from Medicaid noting eligibility. However, Kepro requires the hospitals to obtain this DHHS form and prove eligibility.	N/A. Most carriers do not retroactively provide enrollment.
Administrative Challenges Obtaining Coverage and Payment for Department of Corrections Patients	Some Department of Corrections patients have Medicaid coverage, but we are not notified of this prior to their stay. (The Department of Corrections selectively applies for Medicaid coverage for some of their inmates.) When we have found this after discharge, Kepro has not allowed us to obtain a retro authorization or reconsideration letter. We have changed policies to ensure that these patients are screened for coverage now, but there are historical claims that we are working to receive payment on. The Department of Corrections will not make payment for these claims either.	Other commercial payors allow appeal/reconsideration in cases where coverage is identified after the patient's stay.