**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Myers / Giese | 9/17/09 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 09-133 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>_____<br>Emma Forkner<br>Cleared 10/1/09, letter attached. | [X] Prepare reply for appropriate signature<br>DATE DUE 9/28/09<br>[ ] FOIA<br>DATE DUE _____<br>[ ] Necessary Action |

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

SELF REGIONAL
HEALTHCARE



September 16, 2009

Felicity Myers, Ph.D.
Deputy Director of Medical Services
South Carolina Department of Health and Human Services
1801 Main Street, 11th Floor
Columbia, SC 29201

Dear Dr. Myers:

Self Regional Healthcare is committed to providing access to quality healthcare services to Medicaid beneficiaries. We value our relationship with the Department of Health and Human Services and have enjoyed a positive working relationship over the years. We are writing to request your assistance in addressing recent issues that have resulted in deteriorating relations between our facility and the Medicaid program.

Over the past several months, we have experienced difficulties in resolving outstanding claims that were submitted timely. We have attempted to resolve these billing issues with our provider representative, Mary Thomas, and her supervisor, Ervin Yarrell. Unfortunately, we have not been able to adequately resolve the outstanding billing issues and feel the relationship between the Department and the billing staff in the Patient Financial Services department of Self Regional has become somewhat strained over the past several months. Some of the specific issues encountered by our billing staff are outlined below for your consideration.

Excessive Processing Time

- ECFs requiring an override take 30-60 days to be reprocessed (e.g. mental health claims that start out as medical admission). Specifically, ECFs for CMS' 72 hour rule are generated for claims involving surgery as the admit dates are not allowed to be changed (combined) prior to billing. These generate an Edit Code "573" relating to the admission date, which subsequently requires a manual override by the provider representative, and these are taking excessive amounts of time to process.
- Some retroactive Medicaid claims are taking excessive amounts of time to process as well. For example, a $20,333 claim with May 2006 dates of service was submitted in May 2009 with an retroactive override letter dated March 18, 2009, and it is still in processing four months later. It has generated a "510" Edit Code (timed out). The override letter for this

claim is set to expire on September 18, 2009. Self Regional is concerned that once the override letter times out the entire process will have to be started over.

- Medical records are taking in excess of 90 days to be reviewed by assigned provider representative. For example, we had an $85,000 claim that took almost four months for the record to be reviewed in order for the claim to be paid.

Contradictory Guidance Regarding Policies and Procedures

Provider representative has provided inaccurate or poor guidance on numerous claims. For example, our assigned representative advised that a $457,000 inpatient hospital claim for an inmate was to be billed to the Department of Corrections even though the Medicaid Provider Manual indicates that Medicaid is primary. Billing staff spent several hours researching the Medicaid website and the billing manual and had to request a three-way conference call with the provider representative and the Department of Corrections to finally resolve this issue and show that DHHS was primary on the claim.

Provider Relations

- The practice of allowing providers only five billing inquiries per day is an impediment to resolving outstanding claims issues. When the provider representative is not available on a given day, the five inquiries are not allowed to carry over to the following day. There have been numerous occasions when the assigned provider representative was not available on all five days of the week to field calls from Self Regional, and during these weeks the allotted volume of claim inquiries has not been provided.
- There have been situations where calls to our assigned provider representative have resulted in sometimes difficult and contentious discussions. In fact, a call was made to Ervin Yarrell on August 21st in an effort to resolve several issues. Mr. Yarrell called the provider representative into his office to participate in the call. Regrettably, the call evolved into a somewhat unprofessional and accusatory tone by both Ms. Thomas and Mr. Yarrell. We would welcome a QA review of the telephone conversation if the Department records calls for such purposes.

We understand that you must consider the perspectives of both parties in addressing these issues and welcome your feedback and assistance to facilitate the resolution of outstanding claims and to restore the working relationship with the Department. Please do not hesitate to let me know if you have any questions or need additional information.

Sincerely,

Camie Patterson
Sr. Vice President, CFO
Self Regional Healthcare

Log 000133 ✓

South Carolina Department of Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

October 1, 2009

Ms. Camie Patterson
Senior Vice President and Chief Financial Officer
Self Regional Healthcare
1325 Spring Street
Greenwood, South Carolina 29646

Dear Ms. Patterson:

Thank you for your letter dated September 16, 2009. I appreciate the opportunity to address these issues. South Carolina Department of Health and Human Services (SCDHHS) is committed to maintaining our relationship with your organization and providing quality service to our customers. I understand that Zenovia Vaughn, Director for the Division of Hospital Services, spoke to you on September 29, 2009. In that conversation you discussed a need for a meeting, which is now set for October 7, 2009 at 2:00 pm in Columbia. In the interim, we offer the following responses in bold:

Excessive Processing Time

- ECFs requiring an override take 30-60 days to be processed (e.g mental health claims that start out as medical admission). Specifically, ECFs for CMS' 72 hour rule are generated for claims involving surgery as the admit dates are not allowed to be changed (combined) prior to billing. These generate an Edit Code "573" relating to the admission date, which subsequently requires a manual override by the provider representative, and these are taking excessive amounts of time to process.

  **A provider ECF is generated when the submitted claim has rejected. When it is returned to a central processing center, the ECF is time and date stamped, and then forwarded to your program manager. Depending on the edit or cause for the rejection, ECFs are reviewed, resolved and returned to the claims processing unit within 5 work days. If the edit requires research on our part or review of medical records, additional time may be required. Claims that require 30-60 days for processing are the exception.**

- Some retroactive Medicaid claims are taking excessive amounts of time to process as well. For example, a $20,333.00 claim with May 2006 dates of service was submitted on May 2009 with an retroactive override letter dated March 18, 2009, and it is still in processing four months later. It has generated a "510" Edit Code (timed out). The override letter for this claim is set to expire on September 18, 2009. Self Regional is concerned that once the override letter times out the entire process will have to be started over.

Medical Services
P. O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2501 • Fax (803) 255-8235

**Claims involving retroactive coverage require extra time for processing because it has exceeded the timeline policy for Medicaid payments. If we pay a claim that is more than a year from the date of service or discharge date, it must be supported by justification. In addition, all other edits or problems must be resolved before payment is considered. The policy as stated in the Code of Federal Requirements (CFR) 447.45 permits only "clean" claims to be processed and paid over the one-year policy. A "clean" claim is described as one with no errors. The override letter mentioned in your letter has no expiration date. Our policy states that the request for payment of a retroactive claim must be made within 6 months of the date that you become aware of the beneficiaries coverage.**

- Medical records are taking in excess of 90 days to be reviewed by assigned provider representative. For example, we had an $85,000 claim that took almost four months for the record to be reviewed in order for the claim to be paid.

  **Review of medical records is top priority with the Hospital's Division, and every effort is being made to ensure payments are not delayed unless additional information is needed. Weekly reviews are now being conducted to ensure timely processing of claims.**

Contradictory Guidance Regarding Policies and Procedures

- Provider representative has provided inaccurate or poor guidance on numerous claims. For example, our assigned representative advised that a $457,000 inpatient hospital claim for an inmate was to be billed to the Department of Corrections even though Medicaid Provider Manual indicates that Medicaid is primary. Billing staff spent several hours researching the Medicaid website and the billing manual and had to request a three-way conference call with the provider representative and the Department of Corrections to finally resolve the issue and show the DHHS was primary.

  **Program Staff has been instructed to ensure proper procedures and agency policies are relayed to all providers. The inpatient claim referenced in your letter, which contradictory guidance was given, has been addressed with staff members to ensure all providers are given accurate information in accordance with current policy.**

Provider Relations

- The practice of allowing providers only five billing inquiries per day is an impediment to resolving outstanding claims issues. When the provider representative is not available on a given day, the five inquires are not allowed to carry over to the following day. There have been numerous occasions when the assigned representative was not available on all five days of the week to field calls from Self Regional, and during these weeks the allotted volume of claim inquiries has not been provided.

**Providers requiring additional customer service are afforded the opportunity to establish specific time frames in which they are allowed to check status on claims that have not reported on remits and claims more than 45 days old. Providers are also encouraged to re-file claims if they are not reported on a remit within 45 days. The five per day limit on provider inquiries allows program staff to give equal attention to all providers while making every effort to expedite provider ECFs and review medical records that are received daily.**

- There have been situations where calls to our assigned provider representative have resulted in sometimes difficult and contentious discussions. In fact, a call was made to Ervin Yarrell on August 21st in an effort to resolves several issues. Mr. Yarrell called the provider representative into his office to participate in the call. Regrettably, the call evolved into a somewhat unprofessional and accusatory tone by both Ms. Thomas and Mr. Yarrell. We would welcome a QA review of the telephone conversation if the department records calls for such purposes.

**Professionalism is of the utmost importance to my management staff. Supervisors understand that nothing less than the best customer service will be tolerated to include being professional at all times. The situation in which Mr. Yarell and Ms. Thomas appeared to be unprofessional has been addressed, and they both understand the importance of maintaining professionalism at all times.**

If you have any additional questions or concerns, please contact Ms. Zenovia Vaughn, Director, Hospital Services at (803) 898-2665. We look forward to meeting with you and strengthening our professional relationship. Thank you for your continued support.

Sincerely,

Felicity Myers, Ph.D.
Deputy Director

FM/gvrb