

**DEPARTMENT OF COMMUNITY HEALTH**

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**GEORGIA FAMILIES**

**REPORT #18: ANALYSIS OF NEONATAL  
INTENSIVE CARE UNIT (NICU)  
SUPPLEMENTAL PAYMENTS**

**Myers and Stauffer LC**

**NOVEMBER 3, 2011**

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# REPORT GLOSSARY

The following listing of terminology and references may be used throughout this report:

- ***Affiliated Computer Services, Inc. (ACS)*** – State fiscal agent claims processor prior to November 1, 2010.
- ***Care Management Organization (CMO)*** – A private entity organized for the purpose of providing Health Care, has a Health Maintenance Organization Certificate of Authority granted by the State of Georgia, which contracts with Providers, and furnishes Health Care services on a prepaid, capitated basis to Members in a designated Service Region. These organizations include AMERIGROUP Community Care (AMERIGROUP), Peach State Health Plan (PSHP), and WellCare of Georgia (WellCare).
- ***Centers for Medicare and Medicaid Services (CMS)*** – The federal agency under the Department of Health and Human Services responsible for the oversight and administration of the federal Medicare program, state Medicaid programs, and State Children’s Health Insurance Programs.
- ***Department of Community Health (DCH or Department)*** – The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids™ programs.
- ***Diagnostic Related Group (DRG)*** – Any of the payment categories that are used to classify patients and especially Medicare patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred and that are based especially on the principal diagnosis, surgical procedure used, age of patient, and expected length of stay in the hospital.
- ***Discharge*** – Point at which Member is formally released from hospital, by a treating physician, an authorized member of physician’s staff or by the Member after they have indicated, in writing, their decision to leave the hospital contrary to the advice of their treating physician.
- ***Elizabeth Flynn, RHIT, CHP*** – A Registered Health Information Technician and Certified in Healthcare Privacy Professional, providing consulting services as needed for the analyses included in this project. Ms. Flynn has extensive experience in the management of medical information as well as consulting regarding proper coding of medical claims and quality assurance.

- **Encounter** – A distinct set of health care services provided to a Medicaid or PeachCare for Kids™ Member enrolled with a Contractor on the dates that the services were delivered.
- **Encounter Data** – Health Care Encounter Data include: (i) All data captured during the course of a single Health Care encounter that specify the diagnoses, co morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Member receiving services during the Encounter; (ii) The identification of the Member receiving and the Provider(s) delivering the Health Care services during the single Encounter; and, (iii) A unique, i.e., unduplicated, identifier for the single Encounter.
- **Fee-for-Service (FFS)** – A method of reimbursement based on payment for specific services rendered to a Member.
- **Fiscal Agent Contractor (FAC)** – The entity contracted with the Department to process Medicaid and PeachCare for Kids™ claim and other non-claim specific payments. Affiliated Computer Services, Inc. was the FAC for the Department for the dates of services analyzed in this report.
- **Georgia Families** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where the Department contracts with Care Management Organizations to manage and finance the care of eligible members.
- **ICD-9-CM (ICD-9) Codes** – The International Classification of Diseases, Clinical Modification, 9<sup>th</sup> Revision is used to code and classify morbidity data from the inpatient and outpatient records, physician offices, and hospitals onto claims to submit to a health plan. Codes are classified as either diagnosis-specific or procedure-specific.
- **Inpatient Facility** – Hospital or clinic for treatment that requires at least one overnight stay.
- **Medicaid** – The joint federal/state program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.
- **Medical Records** – The complete, comprehensive records of a Member including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating Primary Care physician or Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

- **Member** – A Medicaid or PeachCare for Kids™ recipient who is currently enrolled in a CMO plan.
- **Neonate** – A newborn in the first 28 days of life.
- **Neonatal Intensive Care Unit (NICU)** – Hospital unit that provides intensive care services for sick and premature newborns.
- **PeachCare for Kids™ Program (PCK)** – The Children’s Health Insurance Program (CHIP) funded by Title XXI of the Social Security Act, as amended.
- **Provider** – Any physician, hospital, facility, or other healthcare professional who is licensed or otherwise authorized to provide healthcare services in the state or jurisdiction in which they are furnished.
- **Provider Contract** – Any written contract between an entity and a provider that requires the provider to perform specific parts of the entity’s obligations for the provision of healthcare services under the terms of the contract.
- **Revenue Codes** – A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).
- **Traditional Medicaid and PeachCare for Kids™** – For purposes of this analysis, the portion of the Medicaid and PeachCare for Kids™ program that provides benefits to eligible members who are not participants in the Georgia Families program.
- **Uniform Billing (UB or UB-92 or UB-04) Claim Form** – Document most often required by payors to be utilized by hospitals and other institutional providers for submission of a claim request for reimbursement to the health care payor. The UB-92 version of the claim form was replaced by the UB-04 version in 2007. CMS refers to the UB-92/UB-04 claim form as the CMS-1450 claim form.

# PROJECT BACKGROUND AND OBJECTIVES

Beginning with claims incurred (i.e., dates of service) in July 2009<sup>1</sup>, the Department began making supplemental Neonatal Intensive Care Unit (NICU) payments to the Care Management Organizations (CMOs) for Georgia Families members when those members receive services in a NICU. In order to qualify for the supplemental payment, a CMO must reimburse the hospital for an associated hospital claim containing one of six diagnosis-related groups (DRGs) that the Department has determined are associated with higher cost NICU claims. These six DRGs include DRG 602, 604, 606, 609, 615 and 622 (Table 1, below). For claims associated with DRGs 606, 609 and 615, the claim costs must exceed a pre-determined outlier threshold to qualify for the supplemental payment.

**Table 1: NICU DRGs Qualifying for Supplemental Payment**

DRG	Description	Additional Requirements
602	Neonate, birthwt <750g, discharged alive	None
604	Neonate, birthwt 750-999g, discharged alive	None
606	Neonate, birthwt 1000-1499g, w signif or proc, discharged alive	Costs exceed Outlier Threshold
609	Neonate, birthwt 1500-1999g, w signif or proc, w mult major prob	Costs exceed Outlier Threshold
615	Neonate, birthwt 2000-2499g, w signif or proc, w mult major prob	Costs exceed Outlier Threshold
622	Neonate, birthwt >2499g, w signif or proc, w mult major prob	None

In a memorandum dated January 7, 2010, DCH provided clarification to the CMOs regarding the criteria for the NICU supplemental payment specific to State Fiscal Year 2010<sup>2</sup>. Those criteria are as follows:

- The date of birth must be during fiscal year 2010 (July 1, 2009 to June 30, 2010) and the newborn must be an eligible Medicaid or PeachCare member for their entire hospital stay with their enrollment date in the CMO the same as their date of birth. In cases where a member is transferred out of a CMO and into fee-for-service while hospitalized (such as with a Supplemental Security Income (SSI) case) but the CMO is still responsible for paying for the entire hospital stay, the CMO will still be eligible for the NICU supplemental payment for that member.

<sup>1</sup> The NICU payment process was implemented in February 2010.

<sup>2</sup> While the memorandum specifically references NICU payments related to State Fiscal Year 2010, we understand that the criteria outlined remains in effect for NICU payments in State Fiscal Year 2011 as well.

- The newborn must have been discharged from the hospital and a payment must have been paid by the CMO to the hospital based on one of the following DRGs: 602, 604, 606 (only if costs exceed the outlier threshold), 609 (only if costs exceed the outlier threshold), 615 (only if costs exceed the outlier threshold) and 622.
- The NICU supplemental payment rate was developed assuming that inpatient claim payments would be made using the TRICARE DRG Grouper version 24. If claims are paid under a different arrangement (such as TRICARE DRG Grouper version 16), the DRG and the outlier threshold amount will still be based on version 24.
- There has been no previous NICU supplemental payment made by DCH on this member. There will be only one (1) supplemental payment per individual regardless of the number of qualifying DRGs.
- The CMO's Encounter data submitted to DCH must accurately reflect the newborn's hospital claim payment.
- Medicaid or PeachCare must be the primary payor for the member. If the member has primary coverage through another payor, the case does not qualify for a NICU supplemental payment.
- In order to receive payment, the CMO must post a monthly list of NICU claims which they believe qualify for the supplemental payment to the Department's web portal by the fifteenth (15<sup>th</sup>) of the following month using a template provided by the Department. All requested data elements for each claim in which the CMO is requesting a supplemental payment must be provided, as well as, an attestation statement signed by the Chief Executive Officer or the Chief Financial Officer.

The Department requested that Myers and Stauffer LC (MSLC) perform several analyses to confirm claims submitted by the CMO requesting NICU supplemental payments qualified for the payment. Specifically, the analytical objectives of this initiative are as follows:

1. Analyze the medical and/or financial records from the CMO and/or the hospital provider to determine whether the services were appropriately and adequately documented as having been rendered to the member, and to determine whether the services were delivered by the institution in compliance with the physician's orders. This analysis includes a review of the medical record documents that contain clinical data on diagnoses, treatments and outcomes as well as other required documentation for services provided to the patient existing within the institutional provider's treatment logs, daily records, individual service or order tickets, and other documents.
2. Analyze the submitted DRG and outlier payment calculation to determine if these are supported by the items in #1, above.
3. Perform a test of reasonableness of the charges reported on the claim to determine whether they appear consistent with charges for similar services at the same hospital and for peer hospitals.

4. Verify that the NICU claim for which the CMO is requesting supplemental payment is accurately reflected in the encounter data submitted by the CMO to the Department's fiscal agent contractor.
5. Analyze the members' CMO enrollment status after discharge for at least a three month period to identify trends in member enrollment for all members found in the NICU sample and report findings.

# FINDINGS SNAPSHOT

Below is a summary of the potential issues identified upon completion of the analysis of the NICU supplemental payment process. This summary includes those issues that are significant to the NICU supplemental payment initiative as well as other issues noted during the analysis that the Department may wish to consider. Please note that Myers and Stauffer corresponded with each of the CMOs in an attempt to resolve any potential issue identified prior to the issuance of this report.

- The analysis of AMERIGROUP NICU claims identified no issues that could potentially require repayment of the supplemental payments paid by DCH.
- Myers and Stauffer was not able to confirm the appropriateness of the DRG assignment on one NICU claim submitted to DCH by PSHP. Despite an updated report submitted to Myers and Stauffer by PSHP, we were still unable to confirm that the claim had grouped to the appropriate DRG due to insufficient information. We recommend that the Department consider recouping the supplemental payment for this claim until such time that the requested documentation is submitted by PSHP and the DRG assignment is confirmed.
- Of the 63 WellCare claims analyzed, there are seven claims (or 11 percent), in which a potentially significant issue was identified. These seven cases were sent to WellCare for response.
  - One of the seven claims was previously identified in WellCare's Corrective Action and Preventive Action (CAPA) response to the Department. We recommend that the Department recoup the payment for this claim if it has not already been repaid.
  - WellCare confirmed that two claims, as a result of Myers and Stauffer's review of the medical records, should have grouped to a DRG that does not meet the criteria for the supplemental payment. We recommend that the Department recoup the supplemental NICU payments for these claims, detailed in Table 2, below.
  - The three claims listed in Table 3, below, were evaluated by the Myers and Stauffer Registered Health Information Technician (RHIT) coding consultant who concluded that all of these claims were coded incorrectly. The coding consultant could not locate two of the diagnosis codes billed on one claim, however, the omission of these two diagnosis codes did not affect the DRG grouping of the claim. Myers and Stauffer grouped this claim to DRG 622 which agrees with the submitted DRG on the claim and no further action is required. For the remaining two claims, based on the corrected coding provided by the RHIT consultant, Myers and Stauffer grouped these two claims to DRG 615 rather than DRG 622 which appeared on the submitted claim. We recommend that the CMO recoup the original payments made to the hospital providers and require the providers to submit corrected claims. DRG 615 is eligible for an outlier payment and the costs must exceed the outlier threshold for these claims

to be eligible for the supplemental payment. DCH may wish to recoup the supplemental payments until such time that the CMO completes the recommended actions and demonstrates the claims qualify for the supplemental payment.

- o Additionally, Myers and Stauffer was unable to confirm the assigned DRG on two WellCare claims due to lack of detailed information for the claims provided by WellCare. We recommend that the Department consider recouping the supplemental payments for these claims until such time that the requested documentation is submitted by WellCare.

**Table 2: WellCare Confirmed NICU Claims with DRG Ineligible for Supplemental Payment**

Number of Claims with Issue	Summary of Issue	Initial CMO Reported DRG	Corrected CMO DRG	NICU Supplemental Payment Recoupment Amount
2	Documented birth weight does not support birth weight diagnosis code submitted on the claim	602	617	\$158,623.72*

\*Supplemental payment is \$79,311.86 each.

**Table 3: WellCare NICU Claims Containing Unsupported Birth Weight**

Number of Claims with Issue	Birth Weight Range Documented in Medical Record	CMO Reported DRG	DRG 622 description
3	2000-2499 grams	622	Neonate, birthwt >2499g, w signif or proc, w mult major prob

Other items of note:

- The two WellCare NICU claims identified in Table 2, as well as the claim identified on WellCare's CAPA response dated August 2010, were all submitted by the same hospital provider. The number of claims with potential issues from this provider is suggestive that inappropriate activities could be occurring at the facility. Therefore, we recommend that the Department consider a more comprehensive review of this hospital provider.

# METHODOLOGY

## **Analyses One and Two**

The Department provided a comprehensive listing of NICU claims sent to the Department by each CMO for a supplemental payment through March 2010. This file contained a total of 160 NICU claims. From that listing, one hundred (100) percent or 63 NICU claims paid by WellCare through March 2010 and for which the Department paid a supplemental payment to WellCare were analyzed. Ten NICU claims each for AMERIGROUP and PSHP for the same time period were analyzed. When selecting the ten NICU claims for AMERIGROUP and PSHP, seven of the claims selected were claims where the supplemental NICU payment made by the Department exceeded the CMO payment to the hospital by the greatest amount and three claims were selected at random.

Each CMO was responsible for submitting to Myers and Stauffer the medical records and/or other documentation required for this analysis. This documentation was requested from each of the CMOs on September 9, 2010. In the event that the CMO did not have the medical records or other documentation required for the analysis, they requested the medical records from the hospital. In these situations, hospital providers were asked to send the medical records directly to Myers and Stauffer in a HIPPA-compliant manner. Upon receipt of the documentation, procedures were performed to ensure the completeness of the requested data. In cases where incomplete documentation was received, Myers and Stauffer contacted the CMO to request their assistance in obtaining any outstanding documentation. Myers and Stauffer determined that the documentation requested was substantially complete on January 4, 2011, and thus initiated audit activities.

In addition to the medical records and other documentation described above, the data sources listed below were also utilized as part of analyses one and two. In consultation with the Department, we analyzed the data and documentation received from these sources, including the CMOs and the hospital providers. Unless specified otherwise, we did not independently validate the authenticity of the information received from these entities.

## **Additional Data and Documentation Requirements for Analyses One and Two**

- Comprehensive listing of NICU claims sent to the Department by each CMO for supplemental payment through March 2010.
- Supplemental data submitted to Myers and Stauffer by each CMO, as applicable.
- Georgia Medicaid Rate Information.

- Provider contracts between the CMO and the provider, as applicable.
- CMO policies and procedures related to NICU supplemental claims.
- Medical records including, but not limited to, the following:
  - Physician orders
  - Physician progress notes
  - Graphic records, including indicators of blood pressure, respirations, pulse, temperature and EKG readings, Nursing flow sheets and narrative
  - Discharge summary;
  - Provider invoice and/or claim form as submitted to the CMO (e.g. copy of the UB-04 form submitted by the hospital);
  - Itemization of all charges on the claim; and,
  - Other items as required depending on the circumstances of the claim.

### **Assumptions, Limitations and Notes Relevant to Analyses One and Two**

- Myers and Stauffer utilized the claim form submitted by the provider to the CMO for reimbursement of NICU services to the hospital.
- Data listed on the UB-04 claim form found to be unsupported by the medical record was not included when Myers and Stauffer regrouped the claim. For example, if a documented birth weight did not support a diagnosis code which denoted birth weight, this code was omitted when grouping the claim. Myers and Stauffer did not attempt to add the “correct” code in these claims when performing the grouping. If our grouping then arrived at a different DRG assignment than what was reported by the CMO, we communicated with the CMO in an attempt to resolve the difference. For claims in which we were not able to resolve the difference, a Registered Health Information Technician was utilized to provide further analysis.
- Because the analysis of the NICU claims and the supplemental payment process relies heavily on medical records and other documentation containing protected health information (PHI) and because this report is subject to public review, this report addresses issues from a high level and does not include detail that would identify a specific claim, provider or member. This detailed information, however, can be provided directly to the CMOs as requested by the Department.

### **Analyses Three through Five**

In addition to verifying that the criteria for a NICU claim to qualify for the supplemental payment had been met, the Department directed Myers and Stauffer to perform certain analyses to provide the Department with information regarding enrollment, NICU claim data submitted to the fiscal agent contractor (FAC) by the CMOs and a test of reasonableness of the charges reported on the claim to determine whether they appear consistent with charges for similar services at the same hospital and for peer hospitals. Myers and Stauffer maintains a data warehouse that includes encounter data from each CMO, as well as traditional Medicaid and PeachCare for Kids™ fee-for-service (FFS) data from the FAC. The FAC provides Myers and Stauffer with updated member eligibility data, reference files, encounter data, and FFS claims data monthly in a

standardized extract. When necessary, additional data may be requested directly from the CMOs to supplement the data available in the data warehouse. The data included in the Myers and Stauffer data warehouse served as the basis for analyses three through five.

### **Additional Data and Documentation Requirements for Analyses Three through Five**

- Comprehensive listing of NICU claims sent to the Department by each CMO for supplemental payment through March 2010.
- Provider contracts between the CMO and the provider, as applicable.
- CMO policies and procedures related to NICU supplemental claims, as applicable.

### **Assumptions, Limitations and Notes Relevant to Analyses Three through Five**

- Myers and Stauffer, as a part of a separate initiative and on behalf of DCH, prepares monthly reconciliation reports in order to determine the completeness of the encounter data provided to DCH by the CMOs. As of October 2010, the reconciliation indicated that AMERIGROUP and WellCare had submitted approximately 100 percent of their encounter claims. PSHP had submitted approximately 99 percent of their encounters. Although the analysis was performed on a less than 100 percent complete set of encounter claims, we believe the potential that the findings in this section may reflect inaccurate results is minimal.

# DETAILED ANALYSES

## Analysis One

- *Analyze the medical and/or financial records to determine whether the services are appropriately and adequately documented as having been rendered to the member, to determine whether the services were delivered by the institution in compliance with the physician's orders.*

Myers and Stauffer analyzed medical records in an effort to determine if the medical records support the services billed on the provider claim form. Data elements analyzed included, at a minimum:

- a. Member First and Last Name
- b. Member Date of Birth
- c. Admission Date
- d. Discharge Date
- e. Discharge Status
- f. ICD-9-CM Diagnosis Codes
- g. ICD-9-CM Procedure Codes

As an additional step in performing a quality assurance analysis of the provider claim, room and board levels of care, as well as two additional revenue codes, were analyzed to determine if these services were appropriately documented in the medical record.

In addition to the medical records analysis, Myers and Stauffer also performed an analysis of the data submitted by the CMOs to the Department in requesting a supplemental NICU payment. The purpose of this analysis was to determine the completeness of submitted data and to identify instances where the submitted data might differ from the data supplied by the provider on the UB-04 claim.

## Findings

The following tables summarize the data elements analyzed and any findings related to the analysis. As appropriate, notes are included with each table to provide additional details regarding any findings.

**Table 4: Member Data Findings Summary**

<b>CMO</b>	<b>AMERIGROUP</b>	<b>Peach State</b>	<b>WellCare</b>
<b>Data Element Tested</b>	<b>Member First and Last Name</b>	<b>Member First and Last Name</b>	<b>Member First and Last Name</b>
<b>Variances Between Medical Record and UB-04 Identified</b>	None	None	None
<b>Variances Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	None
<b>Data Element Tested</b>	<b>Member Date of Birth</b>	<b>Member Date of Birth</b>	<b>Member Date of Birth</b>
<b>Variances Between Medical Record and UB-04 Identified</b>	None	None	None
<b>Variances Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	None
<b>Data Element Tested</b>	<b>Member Less Than 28 Days Old</b>	<b>Member Less Than 28 Days Old</b>	<b>Member Less Than 28 Days Old</b>
<b>Variances Between Medical Record and UB-04 Identified</b>	None	None	None
<b>Variances Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	None

**Table 5: Admission and Discharge Data Findings Summary**

<b>CMO</b>	<b>AMERIGROUP</b>	<b>Peach State</b>	<b>WellCare</b>
<b>Data Element Tested</b>	<b>Admission Date</b>	<b>Admission Date</b>	<b>Admission Date</b>
<b>Variations Between Medical Record and UB-04 Identified</b>	None	None	None
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	One <sup>1</sup>
<b>Data Element Tested</b>	<b>No Admission Date Prior to 7/1/09</b>	<b>No Admission Date Prior to 7/1/09</b>	<b>No Admission Date Prior to 7/1/09</b>
<b>Variations Between Medical Record and UB-04 Identified</b>	None	None	None
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	None
<b>Data Element Tested</b>	<b>Discharge Date</b>	<b>Discharge Date</b>	<b>Discharge Date</b>
<b>Variations Between Medical Record and UB-04 Identified</b>	None	One <sup>2</sup>	One <sup>3</sup>
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	One <sup>2</sup>	One <sup>3</sup>
<b>Data Element Tested</b>	<b>Discharge Status</b>	<b>Discharge Status</b>	<b>Discharge Status</b>
<b>Variations Between Medical Record and UB-04 Identified</b>	None	None	Six <sup>4</sup>
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	Six <sup>4</sup>

## Notes to Table 5

Note 1: One NICU claim for WellCare that was submitted to DCH for the supplemental payment contained an admission date that was one day earlier than the admission date indicated in the medical records. This finding did not impact the payment of the claim.

Note 2: One NICU claim submitted to PSHP had a discharge date that was one day earlier than the discharge date indicated in the medical record. Additionally, the NICU claim data submitted by PSHP to DCH for the supplemental payment also contained the earlier date rather than the correct discharge date shown in the medical record. This finding did not impact the payment of the claim.

Note 3: One NICU claim submitted to WellCare had a discharge date that was one day later than the discharge date indicated in the medical record. Additionally, the NICU claim data submitted by WellCare to DCH for the supplemental payment also contained the later date rather than the correct discharge date shown in the medical record. This finding did not impact the payment of the claim.

Note 4: Six NICU claims submitted to WellCare and subsequently submitted to DCH for supplemental payment had a variance where the discharge status in the medical record was not the same as the discharge status indicated on the claim submitted for payment. Of the six claims,

- One medical record indicated the member was transferred to another hospital and the provider's claim indicated the member was discharged home. Additionally, the encounter data for this claim shows that the member was discharged to home from the facility.
- Two medical records indicated the member had expired while the claim indicated the patient had been discharged home. The claims each listed a DRG of 622 which does not specify the member's discharge status as a factor in grouping to the DRG.
- One medical record noted the patient as discharged home while the claim contained a discharge status indicating the member was still a patient. Additionally, two claims were submitted to DCH by WellCare for the supplemental payment when the medical record and the claims indicated the members were still patients. The criteria provided by DCH for the supplemental payment indicates that the member must be discharged from the inpatient facility in order for the claim to qualify for the supplemental payment. Myers and Stauffer confirmed that the encounter data includes a final claim which includes the required discharge status for each of these members showing the member discharged from the facility.

**Table 6: Diagnosis and Revenue Code Findings Summary**

CMO	AMERIGROUP	Peach State	WellCare
<b>Data Element Tested</b>	<b>ICD-9-CM Diagnosis Codes<sup>5</sup></b>	<b>ICD-9-CM Diagnosis Codes<sup>5</sup></b>	<b>ICD-9-CM Diagnosis Codes<sup>5</sup></b>
<b>Variations Between Medical Record and UB-04 Identified</b>	None	None	Three <sup>8</sup>
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	None <sup>6</sup>	One <sup>7</sup>	Six <sup>8</sup>
<b>Data Element Tested</b>	<b>Revenue Codes</b>	<b>Revenue Codes</b>	<b>Revenue Codes</b>
<b>Variations Between Medical Record and UB-04 Identified</b>	None	None	None
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	None	None	None

Notes to Table 6

Note 5: Myers and Stauffer analyzed the first nine diagnosis codes listed on the provider-submitted UB-04 claim form. Only diagnosis codes which impacted the manner in which a claim grouped are listed on this table as variances.

Note 6: For each CMO, Myers and Stauffer identified instances where invalid diagnosis codes were included on the claim submitted to DCH. Examples include diagnosis codes which require a 4<sup>th</sup> or 5<sup>th</sup> digit but none was found on the claim.

Note 7: Although it appears the CMO’s are only required to provide the first nine diagnosis codes on the claim, Myers and Stauffer found instances where PSHP provided five or fewer diagnosis codes. For the sample of ten claims analyzed, nine claims had greater than five diagnosis codes reported on the provider UB-04 claim form submitted to Myers and Stauffer that were not found on the data PSHP submitted to the Department. We recommend that the Department take measures to correct this CMO practice.

Myers and Stauffer identified one claim PSHP sent to the Department in their request for a NICU supplemental payment which did not group to one of the six qualifying DRG’s due to a missing diagnosis code. PSHP did not report a diagnosis code which denoted the newborn’s birth weight which appeared to

affect the grouping of the claim. This issue was addressed with PSHP. Their response can be found in Note 19.

Note 8: Myers and Stauffer identified three WellCare claims where diagnosis codes submitted as part of their supplemental NICU payment request were invalid or missing and as a result the claims in question did not group to one of the six qualifying DRGs. See additional information regarding these claims in Note 20.

Additionally, there were three WellCare claims in which the diagnosis code in the medical record was not in agreement with the diagnosis code billed on the provider claim form. These variances impact the DRG assignment on the claim. Table 7 below provides a detailed description of each instance.

**Table 7: WellCare NICU Claims Unsupported Diagnosis Codes**

Number of Claims	Diagnosis Code	Diagnosis Code Description	Medical Record Birth Weight Range	CMO reported DRG
2 <sup>9,10,12</sup>	765.12	Other preterm infants, 500-749 grams	1500-1999 grams	602
1 <sup>11,12</sup>	764.01	Light-for-dates without mention of fetal malnutrition, less than 500 grams	2000-2499 grams	602

Notes to Table 7

Note 9: One NICU claim which included the unsupported diagnosis code of 765.12, “Other preterm infants 500-749 grams”, was identified by WellCare in its August 17, 2010 CAPA response to DCH. Although WellCare stated that “The encounter was submitted on 12/3/2009 and subsequently accepted by ACS as of 4/24/10 per [WellCare’s] audit findings” in response to our question about whether the encounter had been corrected, our review of the encounter data indicates that the claim still reflects the inaccurate 765.12 diagnosis code. We recommend that the Department require the claim to be corrected.

Note 10: A second NICU claim that appeared to include an unsupported diagnosis code of 765.12, “Other preterm infants 500-749 grams”, was identified and sent to WellCare for review. On January 31, 2011 WellCare responded, stating “The ICD9 codes on the claim submitted grouped to DRG 602. Medical records were not submitted at the time. Upon review of the medical record on 1/26/11, the provider incorrectly coded 765.12, preterm birth weight 500-749 grams. The documentation supports code 765.16, preterm birth weight 1500-1749 grams. The DRG should have been 617.”

Myers and Stauffer received a copy of the medical records for this claim that included a face sheet titled “WellCare Health Plans Retrospective Review”. It

appears WellCare requested medical records on February 24, 2010 from the provider and records were received on March 12, 2010 as indicated by the stamped received date. It appears that these records may have been received by WellCare as part of their required CAPA response to the Department. It is unclear why WellCare's review did not identify this issue at that time. It is the recommendation of Myers and Stauffer that DCH recoup the NICU supplemental payment made on this claim and require WellCare to provide documentation demonstrating the procedures that they performed for this review.

Note 11: One NICU claim appeared to include the unsupported diagnosis code of 764.01, "Light-for-dates without mention of fetal malnutrition less than 500 grams". Upon review, WellCare responded "The ICD9 codes on the claim submitted grouped to DRG 602. Medical records were not submitted at the time. Upon review of the medical record on 1/26/11, the provider incorrectly coded [sic], preterm birth weight 500-749 grams. The documentation supports code 765.16, preterm birth weight 1500-1749 grams. The DRG should have been 617."

DCH paid a NICU supplemental payment for this claim on February 23, 2010; therefore it appears this claim should have been included in the medical review performed by WellCare as part of their CAPA response to the Department. It is unclear why WellCare's review did not identify this issue at that time. WellCare has not made a repayment of the NICU supplemental payment for this claim. We recommend DCH recoup the NICU supplemental payment on this claim and require WellCare to provide documentation demonstrating the procedures that they follow when performing claim reviews of this type.

Note 12: All three of the claims identified in Table 7 were submitted to WellCare by the same provider.

**Table 8: Procedure Codes Summary**

CMO	AMERIGROUP	Peach State	WellCare
<b>Data Element Tested</b>	ICD-9-CM Procedure Codes <sup>13</sup>	ICD-9-CM Procedure Codes <sup>13</sup>	ICD-9-CM Procedure Codes <sup>13</sup>
<b>Variations Between Medical Record and UB-04 Identified</b>	None <sup>14</sup>	None <sup>14</sup>	None <sup>14</sup>
<b>Variations Between Medical Record and Data Reported to DCH by CMO Identified</b>	One <sup>15</sup>	Four <sup>16</sup>	16 <sup>17</sup>

## Notes to Table 8

- Note 13: Up to six procedure codes listed on the provider-submitted UB-04 claim form were analyzed to determine if the code provided was valid and if the code billed was supported by the medical records.
- Note 14: Myers and Stauffer found a small number of procedure codes that we were not able to locate in the medical records provided by the hospital. The omission of these procedure codes did not affect the grouping of these claims in the instances identified.
- Note 15: One claim submitted to DCH by AMERIGROUP contained an invalid procedure code which impacted the grouping of the claim. Additional information on how this issue was addressed can be found in Note 18.
- Note 16: PSHP did not provide any procedure codes for the NICU claims submitted to the Department as part of their request for a supplemental payment. Upon completion of our grouping activities for these claims, it appears four of the ten claims did not group to a DRG which qualifies for the supplemental payment based on the absent of procedure codes. Myers and Stauffer sent this issue to PSHP. Their response can be found in Note 19.
- Note 17: WellCare did not provide DCH with the principal procedure code billed on the provider UB-04 claim form for any of the 63 claims. Myers and Stauffer also identified 16 claims where either the absent of the principal procedure code or an invalid procedure code caused the claim to group to a DRG other than the six which qualify for the supplemental payment. Myers and Stauffer sent these claims to WellCare for review. Their response is included in Note 20.

## **Analysis Two**

- *Analyze the submitted diagnosis related group (DRG) and outlier payment calculation to determine if these are supported by the medical records, CMO policies and/or other supporting documentation.*

Upon completion of the analysis of the medical records, confirmed data elements on each NICU claim form were grouped utilizing the TRICARE Grouper Version 24 software. This included, at a minimum, the following data elements: admission date, discharge date, member date of birth, discharge status, diagnosis codes (the first nine submitted on the claim, as applicable), and up to six procedure codes, as applicable. The results of this analysis can be found in Table 9.

**Table 9: DRG Grouping Results based on Medical Record Analysis**

CMO	Number of NICU Claims	DRG Grouping Matched DRG Reported on Claim and by CMO	DRG Grouping Did Not Match DRG Reported on Claim and by CMO	Unable to Group Claim Due to Potential Coding Error
AMERIGROUP	10	10	0	0
PSHP	10	10	0	0
WellCare	63	57	0	6

While no issues were identified with the NICU claims for AMERIGROUP or PSHP, grouping activities completed on the WellCare NICU claims resulted in the identification of six claims where Myers and Stauffer could not regroup the claim due to potentially incorrect diagnosis codes or where diagnosis codes were absent. The three claims listed in Table 7 appear to have incorrect diagnosis codes which impact the grouping of these claims. Please see Analysis 1 for a detailed discussion on these three claims. Table 10 lists the remaining three claims in question. For these three claims, the documented birth weight in the medical records did not match the DRG description. WellCare's response regarding each of these claims follows the table.

**Table 10: Claims Where Birth Weight in Medical Records Do Not Match Birth Weight Range in DRG Description**

Number of Claims	CMO	Medical Record Birth Weight Range	CMO reported DRG	DRG 622 description
3	WellCare	2000-2499 grams	622	Neonate, birthwt >2499g, w signif or proc, w mult major prob

The claims included in Table 10 were sent to WellCare on January 24, 2011 for analysis. Myers and Stauffer received a response back from WellCare on January 31, 2011.

For the first claim, WellCare responded that "The ICD-9 codes on the claim submitted grouped to DRG 622. Medical records were not submitted at the time. Upon review of the medical record on 1/26/11, the provider did not code for preterm birth weight on the claim. The documentation shows a birthweight of [2000-2499] grams. The physician did not note the clinical significance of the birth weight or prematurity in the medical record. Therefore, code assignment for premature birth weight cannot be assumed & would be incorrect. CC 2Q, 1991, Page 19 which advises, "A diagnosis of prematurity should be based on the diagnostic statement of the attending pediatrician." Based on this review DRG 622 is appropriately billed."

While we appreciate WellCare's thorough explanation, we do not necessarily agree with their conclusions. Myers and Stauffer reviewed these diagnosis codes, as well as other required data and determined an appropriate diagnosis code based on the information contained in the medical chart. We subsequently confirmed our findings with our RHIT

consultant. Based on TRICARE Version 24 Grouper, we determined that the claim should be grouped to DRG 615 (Neonate, birthwt 2000-2499g, w signif or proc, w mult major prob). We recommend that DCH recoup the supplemental payment made on this claim or have WellCare submit additional supporting documentation in defense of their determination.

For the second claim, WellCare responded, “The ICD9 codes on the claim submitted grouped to DRG 622. Medical records were not submitted at the time. Upon review of the medical record on 1/26/11, the documentation indicates this is a term newborn. The birth weight was noted as [2000-2499] grams. The code assignment for a preterm birth weight would be incorrect.” Myers and Stauffer completed our review and entered the claim information, as confirmed by our RHIT consultant, into the TRICARE Version 24 Grouper with a resulting DRG of 622, as indicated by WellCare.

For the final claim, WellCare stated “Provider did not bill dx code for the baby weight with the claim. Upon review of the medical record on 1/26/11, the birth weight was identified at [2000-2499 grams]. If the claim had been submitted with codes for prematurity and birth weight, the DRG would have been 615.” Myers and Stauffer entered the claim information, as confirmed by our RHIT consultant, into the TRICARE Grouper Version 24, which resulted in a DRG 615. Therefore, we recommend DCH recoup the supplemental payment made for this claim and that WellCare also recoup the payment made to the provider and require a corrected claim to be submitted.

Myers and Stauffer then used the data as supplied by each CMO to the Department to regroup the sample of claims selected for analysis. Myers and Stauffer did not alter the CMO provided data. A summary of our findings is listed below in Table 11.

**Table 11: Grouping Results Based on CMO Submitted Data**

CMO	Number of Claims	Claims that Grouped to DRG from Claim	Claims that Did Not Group to DRG from Claim
AMERIGROUP	10	9	1 <sup>18</sup>
PSHP	10	4	6 <sup>19</sup>
WellCare	63	43	20 <sup>20</sup>

Notes to Table 11

Note 18: Using the data supplied by AMERIGROUP to the Department, Myers and Stauffer identified one claim in which the claim grouped to a different DRG than what was submitted by AMERIGROUP. Upon review, it appeared AMERIGROUP submitted a procedure code that might be missing one digit. The claim was sent to AMERIGROUP on February 3, 2011 for review. On March 2, 2011 AMERIGROUP provided several screen shots from their system denoting that the computed DRG for the claim in question was one of the six DRGs that qualify for the supplemental payment; however

AMERIGROUP did not provide what data was used in this determination. A follow-up request was sent to AMERIGROUP on March 3, 2011 asking for each piece of data that was used in making the DRG determination. On March 11, 2011, AMERIGROUP provided the diagnosis codes and procedure codes used to group the claim in question. This claim was grouped by Myers and Stauffer to DRG 622. We recommend that DCH require complete and accurate data to be submitted by each of the CMOs when requesting the supplemental payment.

It was noted that there was one claim (claim is not one of the ten sample claims Myers and Stauffer analyzed) where AMERIGROUP reported a DRG of 626 in detailed data submitted to the Department, however DRG is noted to be 622 in other documentation sent to the Department. It is the recommendation of Myers and Stauffer that AMERIGROUP provide an explanation to the Department as to why the DRG reported in the detailed data does not match the DRG they reported in their request for supplemental payment for the claim.

Note 19: PSHP did not provide all required procedure codes in the data they provided to DCH. Additionally, invalid and missing diagnosis codes were also found in the data PSHP submitted to the Department. This resulted in six claims which did not group to one of the DRGs which qualify for the supplemental payment. These six claims were sent to PSHP for review. PSHP responded, "As a follow-up to the appended request, please be advised that Peach State was able to identify blank spaces at the end of each of the six claim numbers causing the data extract to pull null values into the spreadsheet as no matching information could be found. The blank spaces were removed and the report re-ran. The revised report has been uploaded to the Myers & Stauffer ftp site for review." After certain corrections were made to the data by PSHP, the claims were then grouped by Myers and Stauffer and all but one of the claims grouped to a qualifying DRG. The remaining claim did not contain sufficient information to allow it to be grouped to the DRG submitted by PSHP to DCH. We recommend DCH recoup the supplemental payment for this claim or to require PSHP to submit all necessary data elements that support the DRG assignment as submitted.

In addition to the finding above, it is not clear why the inclusion of DRGs other than the six that qualify for NICU supplemental payments (such as 626 for example) were found in the detailed data submitted by PSHP to the Department. We recommend that the Department require PSHP to provide an explanation as to why these claims were submitted.

Note 20: A total of twenty WellCare NICU claims did not group to the DRG submitted to DCH by WellCare. For one claim, no detailed data was provided to permit Myers and Stauffer to regroup the claim. Upon further analysis, it was determined that this was the claim identified by WellCare in their CAPA as

not qualifying for the supplemental payment. For the remaining 19 claims, Myers and Stauffer requested WellCare review and provide a detailed response including any missing data elements and the rationale for the DRG grouping. WellCare responded that, per their review, DRG 622 is valid for all 19 claims reviewed. No rationale for the DRG grouping was received by WellCare. A follow-up request was sent to WellCare asking for each piece of data that was used in make DRG determination. WellCare sent a listing of the diagnosis and procedure codes used to group each claim to its respective DRG. Data received from WellCare was grouped by Myers and Stauffer, which resulted in 17 of the 19 claims grouping to a DRG that qualifies for the supplemental payment. For the remaining two claims, we were unable to verify that the DRGs, as reported to the Department by WellCare, were appropriate due to insufficient information. Because adequate documentation was not submitted, we recommend that the Department consider requesting a recoupment of the supplemental payment for these two claims or to require WellCare submit all missing data elements that support the DRG assignment as submitted.

Myers and Stauffer also found instances in the detailed data submitted by WellCare to the Department in their request for the supplemental NICU payment where the DRG listed would not qualify for the NICU supplemental payment. It is our recommendation DCH require WellCare provide clarification as to why there is a discrepancy between the DRG reported in the detailed data and the DRG reported as part of their request for the NICU supplemental payment.

### **Outlier Payments**

Myers and Stauffer used data supplied to the Department by each CMO to identify claims with a DRG of 606, 609 or 615 where the payment of an outlier payment was required in order to qualify a NICU supplemental payment. Using the applicable provider contracts as well as the Georgia Medicaid base rates, Myers and Stauffer attempted to re-price each claim that required an outlier payment. In addition, we requested copies of each CMO's policies and procedures related to the processing of NICU claims. The policies indicated the following relative to outlier payments:

- AMERIGROUP did not address outlier payments in the policies provided. We recommend that AMERIGROUP address in writing their procedures for accepting requests for and calculating outlier payments.
- PSHP's outlier policy indicates that a provider may request an outlier appeal after the DRG payment has been received. Documentation required for an outlier appeal includes a cover letter, copies of the original claim and explanation of payments (EOP), as well as the itemized fees including revenue codes.
- WellCare's policy states that hospitals requesting an outlier payment must submit medical records as WellCare performs a medical review on outlier cases.

If the Myers and Stauffer calculated outlier amount did not match what the CMO paid the provider for the outlier, the claim was sent to the CMO to request the detailed outlier payment methodology, rates and other required pricing information.

Included in the sampled claims, there was one AMERIGROUP claim and one WellCare claim identified that qualified for an outlier payment. Each of these outlier payments, as a result of additional information received from the CMOs, appears to have been appropriately calculated.

### **CMO Policies for the Processing of NICU Claims**

Myers and Stauffer requested each CMO provide copies of their policies and procedures effective for services beginning on or after July 1, 2009 related to the processing of NICU claims.

### **AMERIGROUP**

AMERIGROUP provided one policy related to the processing of NICU claims. The policy states that authorization is required for a “sick” newborn DRG (DRGs 602-636) and that Champus Grouper Version 24 is utilized.

The AMERIGROUP policy does not address how NICU claims with a DRG of 602,604,606,609, or 615 are identified as qualifying for the NICU supplemental payment nor does the policy address quality measures in place to ensure that NICU claims qualify for the supplemental payment.

### **Peach State Health Plan (PSHP)**

In response to Myers and Stauffer’s request for policies related to the processing of the NICU claims, PSHP provided two documents. One document was a copy of Appendix C Description of Diagnosis Related Group (DRG) Prospective Payment System from the Georgia Medicaid Hospital Services manual and the other document was a policy related to the outlier payment process. The PSHP policy did not include any specific information on processes in place to identify NICU claims or what quality assurance measures are performed before the claim is sent to the Department for a request for a supplemental NICU payment.

### **WellCare**

In regards to inpatient care for NICU services, WellCare’s newborn policy did not address the process of handling NICU claims that will be submitted to the Department for a supplemental payment. WellCare did provide evidence of high dollar claim reviews during which it appears a determination of whether the claim was paid correctly is performed.

We recommend that the Department require each of the CMOs to provide to DCH a comprehensive written description of their policies and procedures regarding the identification and quality procedures related to NICU claims submitted to the Department for the supplemental payment.

## Analysis Three

- *Perform a test of reasonableness of the charges reported on the claim to determine whether they appear consistent with charges for similar services at the same hospital and for peer hospitals.*

In order to analyze the reasonableness of charges reported on the NICU claims, a database was created containing the following items:

- The CMO encounters provided to DCH by the CMOs in the NICU supplemental payment request.
- CMO encounter claims incurred on or after 7/1/2009 and paid between 7/1/2009 and 3/31/2010 that were submitted to the FAC and met the criteria for the NICU supplemental payment but were not included in the supplemental payment request file above.
- Fee-for-service claims that met the criteria for the NICU supplemental payment.

In the event that the paid amount reflected on the NICU supplemental payment request differed from the payment amount reflected in the encounter, the encounter data paid amount was used for this analysis. The data was summarized by payor and DRG code in Tables 12 through 17 below. The results reflect claims and/or encounters with an admission date on or after 7/1/2009 and a paid date between 7/1/2009 and 3/31/2010. Adjusted claims, denied claims and claims with zero payment have been excluded. Outlier payments, as reported by the CMOs, have been included in the payment amount. It is important to note that the amounts paid by the CMOs to the providers are individually negotiated within the provider contracts and that any comparison between the reimbursement paid by each of the CMOs or by traditional Medicaid may not be of comparable reimbursement methodologies.

**Table 12: DRG Code 602**

	<b>AMERIGROUP</b>	<b>Peach State</b>	<b>WellCare</b>	<b>Traditional Medicaid</b>	<b>Cumulative</b>
<b>Number of Encounters</b>	14	26	34	24	98
<b>Number of Covered Days</b>	843	1,840	2,038	1,321	6,042
<b>Total Billed Amount</b>	\$3,877,579	\$9,795,740	\$10,424,051	\$6,067,077	\$30,164,448
<b>Total Paid Amount</b>	\$1,057,765	\$2,925,251	\$2,749,392	\$2,100,413	\$8,832,822
<b>Minimum Length of Stay</b>	3	6	1	1	1
<b>Maximum Length of Stay</b>	139	150	198	108	198
<b>Average Length of Stay</b>	60	70	59	55	62
<b>Minimum Billed Amount</b>	\$1,423	\$56,646	\$1,339	\$1,865	\$1,339
<b>Maximum Billed Amount</b>	\$479,103	\$806,829	\$1,040,122	\$817,389	\$1,040,122
<b>Average Billed Amount</b>	\$276,970	\$376,759	\$306,590	\$252,795	\$307,800
<b>Minimum Paid Amount</b>	\$1,463	\$30,123	\$643	\$2,237	\$643
<b>Maximum Paid Amount</b>	\$105,809	\$281,130	\$252,293	\$101,150	\$281,130
<b>Average Paid Amount</b>	\$75,555	\$112,510	\$80,864	\$87,517	\$90,131
<b>Average Billed Amount Per Day</b>	\$4,600	\$5,324	\$5,115	\$4,593	\$4,992
<b>Average Paid Amount Per Day</b>	\$1,255	\$1,590	\$1,349	\$1,590	\$1,462

**Table 13: DRG Code 604**

	<b>AMERIGROUP</b>	<b>Peach State</b>	<b>WellCare</b>	<b>Traditional Medicaid</b>	<b>Cumulative</b>
<b>Number of Encounters</b>	28	38	39	41	146
<b>Number of Covered Days</b>	1,671	2,571	2,242	2,333	8,817
<b>Total Billed Amount</b>	\$6,310,134	\$10,526,704	\$10,258,326	\$10,186,545	\$37,281,709
<b>Total Paid Amount</b>	\$1,864,943	\$3,507,237	\$2,798,852	\$2,621,014	\$10,792,046
<b>Minimum Length of Stay</b>	2	1	1	1	1
<b>Maximum Length of Stay</b>	119	119	137	125	137
<b>Average Length of Stay</b>	59	67	57	56	60
<b>Minimum Billed Amount</b>	\$6,154	\$7,754	\$1,889	\$16,629	\$1,889
<b>Maximum Billed Amount</b>	\$538,531	\$869,426	\$1,048,221	\$863,803	\$1,048,221
<b>Average Billed Amount</b>	\$225,362	\$277,019	\$263,034	\$248,452	\$255,354
<b>Minimum Paid Amount</b>	\$4,219	\$5,149	\$944	\$9,136	\$944
<b>Maximum Paid Amount</b>	\$92,251	\$318,740	\$389,701	\$80,035	\$389,701
<b>Average Paid Amount</b>	\$66,605	\$92,296	\$71,765	\$63,927	\$73,918
<b>Average Billed Amount Per Day</b>	\$3,776	\$4,094	\$4,576	\$4,366	\$4,228
<b>Average Paid Amount Per Day</b>	\$1,116	\$1,364	\$1,248	\$1,123	\$1,224

**Table 14: DRG Code 606**

	<b>AMERIGROUP</b>	<b>Peach State</b>	<b>WellCare</b>	<b>Traditional Medicaid</b>	<b>Cumulative</b>
<b>Number of Encounters</b>	1	0	3	5	9
<b>Number of Covered Days</b>	27	0	341	284	652
<b>Total Billed Amount</b>	\$116,475	\$0	\$1,508,599	\$1,686,493	\$3,311,567
<b>Total Paid Amount</b>	\$34,892	\$0	\$486,087	\$528,694	\$1,049,673
<b>Minimum Length of Stay</b>	27	0	83	3	3
<b>Maximum Length of Stay</b>	27	0	146	105	146
<b>Average Length of Stay</b>	27	0	113	56	72
<b>Minimum Billed Amount</b>	\$116,475	\$0	\$362,680	\$32,979	\$32,979
<b>Maximum Billed Amount</b>	\$116,475	\$0	\$601,130	\$695,182	\$695,182
<b>Average Billed Amount</b>	\$116,475	\$0	\$502,866	\$337,299	\$367,952
<b>Minimum Paid Amount</b>	\$34,892	\$0	\$117,087	\$3,589	\$3,589
<b>Maximum Paid Amount</b>	\$34,892	\$0	\$193,531	\$225,483	\$225,483
<b>Average Paid Amount</b>	\$34,892	\$0	\$162,029	\$105,739	\$116,630
<b>Average Billed Amount Per Day</b>	\$4,314	\$0	\$4,424	\$5,938	\$5,079
<b>Average Paid Amount Per Day</b>	\$1,292	\$0	\$1,425	\$1,862	\$1,610

Table 15: DRG Code 609

	AMERIGROUP	Peach State	WellCare	Traditional Medicaid	Cumulative
Number of Encounters	2	0	7	2	11
Number of Covered Days	29	0	327	47	403
Total Billed Amount	\$163,421	\$0	\$1,654,150	\$246,772	\$2,064,343
Total Paid Amount	\$57,731	\$0	\$641,072	\$55,160	\$753,963
Minimum Length of Stay	2	0	1	20	1
Maximum Length of Stay	27	0	94	27	94
Average Length of Stay	14	0	46	23	37
Minimum Billed Amount	\$22,345	\$0	\$102,321	\$111,616	\$22,345
Maximum Billed Amount	\$141,076	\$0	\$406,172	\$135,156	\$406,172
Average Billed Amount	\$81,711	\$0	\$236,307	\$123,386	\$187,668
Minimum Paid Amount	\$3,367	\$0	\$2,087	\$2,592	\$2,087
Maximum Paid Amount	\$54,364	\$0	\$191,459	\$52,568	\$191,459
Average Paid Amount	\$28,866	\$0	\$91,582	\$27,580	\$68,542
Average Billed Amount Per Day	\$5,635	\$0	\$5,059	\$5,250	\$5,122
Average Paid Amount Per Day	\$1,991	\$0	\$1,960	\$1,174	\$1,871

**Table 16: DRG Code 615**

	<b>AMERIGROUP</b>	<b>Peach State</b>	<b>WellCare</b>	<b>Traditional Medicaid</b>	<b>Cumulative</b>
<b>Number of Encounters</b>	4	1	8	4	17
<b>Number of Covered Days</b>	87	36	323	108	554
<b>Total Billed Amount</b>	\$1,390,375	\$12,039	\$1,513,563	\$488,274	\$3,404,251
<b>Total Paid Amount</b>	\$339,574	\$4,358	\$546,891	\$117,698	\$1,008,521
<b>Minimum Length of Stay</b>	10	36	12	13	10
<b>Maximum Length of Stay</b>	36	36	64	48	64
<b>Average Length of Stay</b>	21	36	40	27	33
<b>Minimum Billed Amount</b>	\$114,811	\$12,039	\$92,127	\$57,294	\$12,039
<b>Maximum Billed Amount</b>	\$872,957	\$12,039	\$298,292	\$198,998	\$872,957
<b>Average Billed Amount</b>	\$347,594	\$12,039	\$189,195	\$122,068	\$200,250
<b>Minimum Paid Amount</b>	\$2,321	\$4,358	\$2,277	\$1,980	\$1,980
<b>Maximum Paid Amount</b>	\$330,519	\$4,358	\$141,277	\$65,671	\$330,519
<b>Average Paid Amount</b>	\$84,893	\$4,358	\$68,361	\$29,424	\$59,325
<b>Average Billed Amount Per Day</b>	\$15,981	\$334	\$4,686	\$4,521	\$6,145
<b>Average Paid Amount Per Day</b>	\$3,903	\$121	\$1,693	\$1,090	\$1,820

**Table 17: DRG Code 622**

	AMERIGROUP	Peach State	WellCare	Traditional Medicaid	Cumulative
<b>Number of Encounters</b>	28	21	48	44	141
<b>Number of Covered Days</b>	745	543	1,102	1,235	3,625
<b>Total Billed Amount</b>	\$5,060,960	\$6,046,806	\$8,533,432	\$8,299,796	\$27,940,994
<b>Total Paid Amount</b>	\$1,994,022	\$1,806,099	\$3,394,300	\$2,910,603	\$10,105,024
<b>Minimum Length of Stay</b>	4	6	6	7	4
<b>Maximum Length of Stay</b>	90	113	68	100	113
<b>Average Length of Stay</b>	26	25	22	28	26
<b>Minimum Billed Amount</b>	\$3,774	\$3,872	\$4,546	\$32,548	\$3,774
<b>Maximum Billed Amount</b>	\$573,610	\$1,805,828	\$713,077	\$624,074	\$1,805,828
<b>Average Billed Amount</b>	\$180,749	\$287,943	\$177,780	\$188,632	\$198,163
<b>Minimum Paid Amount</b>	\$26,860	\$2,119	\$1,517	\$58,368	\$1,517
<b>Maximum Paid Amount</b>	\$78,764	\$423,163	\$339,027	\$68,374	\$423,163
<b>Average Paid Amount</b>	\$71,215	\$86,005	\$70,715	\$66,150	\$71,667
<b>Average Billed Amount Per Day</b>	\$6,793	\$11,136	\$7,744	\$6,720	\$7,708
<b>Average Paid Amount Per Day</b>	\$2,677	\$3,326	\$3,080	\$2,357	\$2,788

**Summary of Comparison of Charges**

In reviewing the comparisons included in the Tables 12 through 17, we noted the following:

- WellCare had two claims, one with a DRG 604 and one with a DRG 609, in which the provider billed and was reimbursed significantly more than peer claims. For the claim coded with a DRG 604, the average billed and paid amounts per day for this claim were \$14,559 and \$5,413, respectively. For the claim coded with a DRG of 609, the average billed and paid amounts were \$5,641 and \$2,659 respectively, comparable to the peer claims.
- AMERIGROUP had one claim for DRG 615 in which the provider billed and was reimbursed significantly more than peer claims. The average billed and paid amounts day for this single claim were \$6,466 and \$2,448, respectively.
- PSHP had one claim with a DRG of 622 in which the provider billed and was paid significantly more than peer claims. The average billed and paid amounts day for this single claim were \$44,045 and \$10,321, respectively.

Of the four claims identified above, three of the claims were submitted by the same provider. DCH may wish for the CMOs to perform a more extensive review of these claims and the billing practices of these providers. The specific claims and provider information can be provided directly to DCH and the CMOs.

## Analysis Four

- *Verify that the NICU claim for which the CMO is requesting supplemental payment is accurately reflected in the encounter data submitted by the CMO to the Department's fiscal agent contractor.*

NICU claims submitted by the CMOs to DCH for supplemental NICU payments were compared to the encounter data. The claim records were matched to the encounter data based on a combination of the CMO claim number, member identification number, provider identification number and date of service. The DRG code provided in the encounter data was calculated by ACS and not necessarily reflective of the DRG used by the CMO during the payment process. Therefore, our comparison does not include the DRG code. Our analysis verified that an encounter record was submitted for the corresponding NICU claim identified in the request for supplemental NICU payment. The paid amounts provided in the supplemental NICU payment request were compared to the paid amounts reflected in the encounter record and 44 instances were noted where there was a variance in the paid amounts. These variances range from a low of \$38 to a high of more than \$369,000. Without conducting further analysis, we are unable to provide additional details to DCH regarding the source of these variances.

In addition, we identified 138 additional encounter records for NICU services incurred on or after 7/1/2009 and paid between 7/1/2009 and 3/31/2010 for which the CMOs had not requested a supplemental payment as of the date of this report. The additional records were reviewed to determine if they appeared to meet the NICU supplemental payment criteria outlined in DCH memorandum dated 1/7/2010:

- The date of birth must be during fiscal year 2010 (July 1, 2009 to June 30, 2010) and the newborn must be an eligible Medicaid or PeachCare member for their entire hospital stay with their enrollment date in the CMO the same as their date

of birth. Please note that in cases where a member is transferred out of a CMO and into fee-for-service while hospitalized (such as with an SSI case) but the CMO is still responsible for paying for the entire hospital stay, the CMO will still be eligible for the NICU supplemental payment for that member.

- The newborn must have been discharged from the hospital and a payment must have been paid to the hospital based on one of the following DRGs: 602, 604, 606 (only if costs exceed the outlier threshold), 609 (only if costs exceed the outlier threshold), 615 (only if costs exceed the outlier threshold) and 622.
- The NICU supplemental payment rate was developed assuming that inpatient claims payments would be made using TRICARE DRG Grouper Version 24. If claims are paid under a different arrangement (such as DRG Grouper Version 16) the DRG and the outlier threshold amount will still be based on version 24.
- There has been no previous NICU supplemental payment made by DCH on this member. There will be only one (1) supplemental payment per individual regardless of the number of qualifying DRGs.
- The CMO's Encounter data submitted to DCH must accurately reflect the newborn's hospital claim payment.
- Medicaid or PeachCare must be the primary payor for the member. If the member has primary coverage through another payor, the case does not qualify for a NICU supplemental payment.

Although it appears that these claims were eligible for the supplemental payment, the Department may wish to have the CMOs confirm that the correct criteria for identifying qualifying claims is being utilized by the CMOs.

## Analysis Five

- *Analyze the members' CMO enrollment status after discharge for at least a three month period.*

Out of 156 NICU claims submitted to DCH by the CMOs for the supplemental payment, 50 or approximately 32 percent of newborns' enrollment had changed to either traditional Medicaid or to one of the other two CMOs within the first three months after the date of discharge. This change in enrollment is as follows:

- 44 members (28 percent) went from being enrolled with a CMO at birth to being enrolled in traditional Medicaid by the end of month three.
- Two newborns (1 percent) enrolled with AMERIGROUP at birth changed to traditional Medicaid and then back to AMERIGROUP by the end of month three.
- One newborn (.6 percent) enrolled with PSHP at birth changed to traditional Medicaid and then back to PSHP by the end of month three.
- One newborn (.6 percent) enrolled with AMERIGROUP at birth and one newborn enrolled with WellCare (.6 percent) changed to PSHP by the end of month three.

- One newborn (.6 percent) enrolled with AMERIGROUP at birth switched to WellCare by the end of month three.

Upon review of the members who's enrollment changed, we noted that many changes were a function of changes in eligibility or the relocation of the member outside of the CMO's service region. No questionable trends in enrollment were noted.

# RECOMMENDATIONS

## DCH Recommendations

- DCH may wish to recoup the two claims confirmed as inaccurate by WellCare identified in Table 2.
- The Department may wish to consider requiring the CMOs to perform a more comprehensive review, including a review of the supporting medical records, of the NICU supplemental claim prior to submission for request for NICU supplemental payment. In doing so, the Department may wish to also consider:
  - Changing the current submission guidelines for the NICU supplemental payment to account for the additional time required for analyzing medical records for each claim.
  - Requiring a synopsis of each medical review, including the birth weight of the newborn, to be included with each submission.
  - Requiring that a signed attestation stating that a medical review has been completed be submitted with each request.
- DCH may wish to consider that if a claim submitted by the CMO for the supplemental payment contains missing or inaccurate data such as an invalid code (e.g. missing required decimal point or digit) that the claim be rejected and returned to the CMO for correction and resubmission.
- For the two claims identified in Table 10 where Myers and Stauffer, using data provided by the RHIT consultant, grouped claims to DRG 615 instead of DRG 622, the Department may wish to require WellCare to confirm with the provider that the claim was coded correctly including a statement as to the rationale behind this determination. WellCare should provide this confirmation and supporting rationale to DCH.
- The Department may wish to require Peach State Health Plan and WellCare provide further documentation to support the claims identified as potential issues in the narrative following Table 11.
- The Department may wish to review one out-of-state hospital identified during our analysis as having unusual coding and utilization patterns. Detailed information regarding this provider can be provided directly to DCH and the CMO.
- DCH may wish to require the CMOs to conduct provider education regarding the correct coding of NICU claims.

## CMO Recommendations

- We recommend that each CMO confirm that the correct criteria for identifying NICU claims eligible for the supplemental payment are being utilized.
- We recommend that each CMO thoroughly document in writing the policies and procedures used to determine that a NICU claim is adequately supported by

medical records, is coded and billed properly by the provider and that any outlier required has been appropriately calculated and paid.

- We recommend that each CMO review their periodic submission of NICU claims to DCH to ensure that the required data elements are included that would allow the Department to confirm the accuracy of the claim prior to submitting the claim to DCH.