Audit of Acute Care FFS Inpatient Claims for Non-Payable Services: Medicaid Billing Policy

Report Number A2022-03

June 30, 2023

Utah Office of
Inspector General

Gene Cottrell
Inspector General

June 30, 2023

To: Utah Department of Health and Human Services

Please see the attached report, **Audit of Acute Care FFS Inpatient Claims for Non-Payable Services: Medicaid Billing Policy**, (A2022-03). An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 5 of this report.

Sincerely,

Gene D. Cottrell
Gene Cottrell
Inspector General
Utah Office of Inspector General

cc: Jon Pierpont, Chief of Staff, Office of Governor Spencer Cox
J. Stuart Adams, President of the Utah Senate
Brad Wilson, Speaker of the Utah House of Representatives
Sen. Jacob L. Anderegg, Senate Chair, Social Services Appropriations Subcommittee
Rep. Raymond P. Ward, House Chair Social Services Appropriations Subcommittee
Tracy Gruber, Executive Director Utah Department of Health and Human Services (DHHS)
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TABLE OF CONTENTS

Executive Summary....................1

Introduction....................2

Background....................2

Objectives and Scope....................5

Methodology....................5

Conclusion....................5

Finding: Medicaid policy for FFS acute care inpatient hospital claims of non-covered or non-payable services cause incomplete and incorrect reporting... 6

Recommendations....................9

Glossary of Terms....................10

Management Response....................12

Evaluation of Management Response....................15

Contact and Staff Acknowledgement....................16

EXECUTIVE SUMMARY

The Utah Office of Inspector General (UOIG) regularly reviews the fee-for-service (FFS) inpatient paid claims for reasonableness and program compliance. One of the tests performed by UOIG for inpatient claims was to review payment of claims lacking prior authorization (PA) for services normally requiring PA. Through the process of reviewing claims lacking PA, the UOIG identified non-covered or non-payable services that were performed but excluded from Medicaid claim visibility by removing codes for these services prior to claim submission.

Utah Medicaid (Medicaid) authorization prior to performance of certain procedures protects Medicaid funds from being used for medically unnecessary procedures and verifies compliance with federal and state laws. Medicaid provides retro-authorization for emergent and other situations as specified in policy up to 180 days after performance of the procedure.[1]

Audit Objective:

Determine if Medicaid policy for billing of inpatient hospital services is consistent with generally accepted practices for complete and accurate health claims.

Audit Finding:

Utah Medicaid policy for hospital services acknowledges all delivered services should be included on a claim, but then directs hospitals to *not include* services delivered lacking a PA, non-covered or non-payable when coding inpatient claims.[2] Medicaid indicates in their policy the reason for not following the industry standard of including all services delivered on the claim was due to a legacy Medicaid Management Information System (MMIS) limitation.[3] Medicaid stated they evaluated options to modify MMIS programming at different intervals and determined that it required a substantial amount of effort and cost to rebuild the system edits therefore did not correct the MMIS programming but instead required providers to not include services lacking prior authorization so that current programming would pay covered charges.

Medicaid policy for FFS acute care inpatient hospital claims of non-covered or non-payable services cause incomplete and incorrect reporting.

Medicaid policy requiring providers to not claim services that lack prior authorization effectively removed Medicaid's ability to monitor for performance of medically unnecessary procedures. Medicaid policy requirement for hospitals to not include non-covered and non-payable services on claims for recipients diminishes Program Integrity oversight for review and hinders identification of fraud, waste and abuse since non-covered or non-payable services are removed from the claim.

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[1] Medicaid provider manual Section I, Article 10-3 Retroactive Authorization: https://medicaid-manuals.dhhs.utah.gov/#t=Section_1_General_Information%2Fsection_I_general_information.htm%2310_Prior_Authorization&rhtocid=_0_9. Accessed 11/21/2022

[2] Medicaid Provider Manual, Hospital Services, Updated January 2022 and forward. Article 11-7. See current, https://medicaid-manuals.dhhs.utah.gov/#t=Hospital_Services%2Fhospital_services.htm%2311-7_Reporting_and_Billing_Covered&rhtocid=_14_10_6. Accessed 11/21/2022

[3] See Medicaid Provider Manual Hospital Services: Updated January 2022 *Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims.* (Article 11-7)

INTRODUCTION

BACKGROUND

The UOIG regularly reviews FFS inpatient paid claims for reasonableness and program compliance. One of the tests performed by UOIG for inpatient claims was to review payment of claims lacking PA for services normally requiring PA. Through the process of reviewing claims lacking PA, the UOIG identified non-covered or non-payable services that were performed but excluded from Medicaid's visibility by removing codes for these services prior to claim submission.

Conceptually, Medicaid requires prior authorization of certain procedures as a method of utilization control. Medicaid prior authorization of certain procedures protects Medicaid funds from being used for medically unnecessary procedures and verifies compliance with federal and state laws protecting recipients from potentially unethical practices, for example reproductive sterilization without legally obtained consent from the Medicaid recipient. The audit initially focused on inpatient FFS paid claims that included procedures that lacked the required PA. The audit did not inspect prior authorization forms or documents since our purpose was to determine the implications of not including all services delivered on the claim.[4]

Medicaid directs physicians and other healthcare professionals to determine whether the treatment and procedures require prior authorization. Medicaid will not reimburse hospitals for hospital services that lack a required PA.

The physician directing the patient care contacts the responsible hospital representative and reserves the operating room or other hospital service for the Medicaid recipient. Medicaid specifies certain exceptions to obtaining authorization prior to performing the procedure, for example emergent situations may be approved up to 180 days after the procedure.[5]

The hospital and the physician each file separate claims directly to Medicaid for recipients on the FFS plan. The hospital files claims for reimbursement of hospital services for example the cost of nursing and other staff, operating room equipment and supplies, and inpatient recovery support. The physician files a claim for professional services. Medicaid's Management Information System (MMIS) applies a series of edits during adjudication and suspends claims lacking a required prior authorization and notifies the provider. One of the MMIS edits that rejects inpatient FFS claims lacking the required PA is called edit 596.

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[4] Federal law regarding Sterilization, Date accessed 11/16/2022 CFR Part 441 Subpart F – Sterilizations. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-F. Federal law requires providers obtain informed patient consent 30 days or more prior to performing sterilizations in order for the state to obtain the Federal Financial Participation (federal match) for a reimbursable claim. An individual may consent to sterilization at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization.

[5] Retroactive PA Medicaid Provider Manual Section I: General Information Chapter 10 All Providers Accessed 11/21/2022 https://medicaid-manuals.dhhs.utah.gov/#t=Section_1_General_Information%2Fsection_I_general_information.htm%2310_Prior_Authorization&rhtocid=_0_9.

A UOIG nurse investigator reviewed the FFS inpatient paid claims that initially failed the edit 596 due to lack of PA. The nurse investigator noticed a pattern of claims denied for payment then refiled without the codes requiring PA and the claims paid. In other situations, providers obtained PA retroactively and resubmitted the claims for payment. Medicaid's requirement for hospitals to not include non-covered services on claims for recipients diminishes UOIG Program Integrity's ability to review, identify fraud, waste and abuse since non-covered or non-payable services are removed from the claim.

See Medicaid policy, Federal, and State law below:

1. **Medicaid Provider Manual Hospital Services: Updated January 2022**
   A. **Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims.** ("Article 11-7" Reference)

> Correct coding guidelines encourage providers to include all delivered services on their claim submissions. Therefore, providers should include covered and non-covered services when submitting an acute inpatient hospital claim.
>
> Due to the limitations of Utah's current Medicaid claims processing system, there are instances when an entire claim will deny as a result of a single denied line. For example, a claim is denied when a single line is a non-covered service. This can occur when a claim is submitted for a service requiring prior authorization, but the hospital or other provider did not obtain prior authorization.
>
> To allow payment for covered services, when non-covered services have also been delivered, Medicaid requires acute inpatient hospitals to submit claims that include covered services and exclude non-covered services that would otherwise result in denial of the entire claim. In addition, when a claim is submitted that excludes non-covered services, providers must not include any ICD-10-PCS, [6] CPT, HCPCS, [7] or revenue [8] codes related to the non-covered services.
>
> For example, a member is admitted to an acute care hospital for labor and delivery and elects to have a sterilization procedure performed during the same episode of care. However, the provider does not have prior authorization for the sterilization. In this instance, the sterilization, and the associated services, are non-covered. The facility must exclude the non-

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[6] ICD-10-Procedure Classification System (PCS) classifies procedures performed for inpatient health care only and does not include healthcare delivery to outpatients, or physician services to inpatients. Accessed 11/21/2022 https://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm

[7] HCPCS level 1 is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies. Accessed 11/21/2022 https://www.cms.gov/medicare/coding/medhcpcsgeninfo

[8] Revenue Codes are descriptions and dollar amounts charged for hospital services provided to a patient. The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department. Accessed 11/16/2022 https://valuehealthcareservices.com/education/understanding-hospital-revenue-codes/

covered services from the claim. Note: Providers must be familiar with and adhere to all federal regulations regarding sterilization requirements.[9]

B. Reimbursement for Inpatient Hospital Services.

Medicaid policy states non-covered charges included on a claim for hospital services will not cause an overpayment since only covered charges will be included in the calculation of reimbursement and denied or non-covered charges reported on the claim will be excluded from the reimbursement:

- Only covered charges will be included in the calculation of the hospital's reimbursement.
- Denied or non-covered charges will be excluded. [10]

2. Medicaid Provider Agreement requires accuracy and completeness

The Medicaid Providers Agreement requires that the information submitted by or on behalf of the provider will constitute a certification (whether or not such certification is reproduced on the claim form) that the information "submitted in, with, or in support of the claim is true, accurate, and complete." [11]

3. HHS Center for Medicare and Medicaid Services (CMS) states the following regarding completeness and accuracy for coding of hospital claims

> These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-PCS itself. They are intended to provide direction that is applicable in most circumstances. However, there may be unique circumstances where exceptions are applied. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tables, Index and Definitions of ICD-10-PCS, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-PCS procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The procedure codes have been adopted under HIPAA for hospital inpatient healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those procedures that are to be reported. The importance of consistent, complete

[9] Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims;
Issued January 2022 Provider Manual, Announced in the January 2022 MIB paragraph 16-24, and continues in the current provider manual: date accessed 11/16/2022 https://medicaid-manuals.dhhs.utah.gov/#t=Hospital_Services%2Fhospital_services.htm

[10]Reimbursement for Inpatient Hospital Services https://medicaid.utah.gov/utah-medicaid-official-publications/ Article 13 Date accessed 11/16

[11] Medicaid requires completeness and accuracy: Medicaid Provider Manual Section 1, Accessed 11/16/2022. https://medicaid.utah.gov/ Documents/pdfs/ SECTION1.pdf

documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.[12]

OBJECTIVES AND SCOPE

Audit Objective:

Determine if Medicaid policy for billing of inpatient hospital services is consistent with generally accepted practices for complete and accurate health claims.

Audit Scope:

The scope of this audit focuses on the billing and processing of acute care inpatient hospital services requiring prior authorization for dates of service January 2020 through June 2022. The scope includes federal and state laws, policies, administrative codes and rules, and medical records.

METHODOLOGY

The audit relies on research conducted by UOIG nurse investigators, supplemented with additional research and analysis by the UOIG audit section. UOIG nurse investigators obtained data analysis from the UOIG Data Scientists, performed MMIS research and in many instances obtained medical records and pathology reports to verify the performance of procedures not claimed.

CONCLUSION

Medicaid Provider Manual Article 11-7 for hospital inpatient claims requiring providers to not claim non-payable delivered services, cause incorrect reporting with potential compliance issues. The Medicaid policy requirement for hospitals to not include non-covered and non-payable services on claims for recipients diminish the UOIG Program Integrity section's ability to review, identify fraud, waste and abuse since the non-covered or non-payable services are taken off the claim.

[12] Federal law completeness, Accessed 11/16/2022 https://www.cms.gov/Medicare/Coding/ICD10/ Downloads/2020-ICD-10-PCS-Guidelines.pdf

FINDING	Medicaid policy for FFS acute care inpatient hospital claims of non-covered or non-payable services cause incomplete and incorrect reporting.

CMS and Medicaid require claims to be complete and accurate.[13] [14] Medicaid acknowledged all delivered services should be included on a claim, but then directs hospitals to not include non-payable services delivered, or services lacking a PA.[15] Medicaid's reason for not including non-covered service is listed below.

Section 1 below discusses six different effects of not reporting all services delivered to Medicaid recipients. Section 2 discusses the X12 EDI methodology required by CMS.

1. Effects of delivered services not claimed for Medicaid recipients on the FFS Plan:

a. Removes Medicaid's ability to monitor non-payable:
Medicaid's instruction to providers to not include on the claim non-covered services delivered to Medicaid recipients removes Medicaid's ability to receive record of non-payable procedures.

b. Reports a different Diagnosis Related Group (DRG) for services provided:
Hospital services are reimbursed based on the DRG reported and not including services delivered but not payable due to lack of PA will report as a very different DRG. For example, unreported sterilization following childbirth due to lack of PA reports a non-sterilization DRG.

c. Raises potential implications as to false claims.
Claims that lack services delivered to Medicaid recipients result in incomplete claims reported or sometimes misreports claims as stated above. For example, reporting claims as non-sterilization DRGs when sterilization to a Medicaid recipient was performed is neither accurate nor complete.

d. Overpays
Overpayments can result since Medicaid Policy stated in Article 11-7 did not instruct the provider to remove costs associated with the non-payable codes. UOIG nurse investigators observe costs remaining on the claim despite removal of codes and causing in these instances the use of federal match for sterilization in violation of the federal law.

e. Reports an incomplete history
Unreported services delivered to Medicaid recipients results in an incomplete history within MMIS for subsequent review by Medicaid.

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[13] CMS complete and accurate claims: Accessed 11/16/2022 https://www.cms.gov/Medicare/Coding /ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf
[14] Medicaid complete and accurate claims: Accessed 11/16/2022 https://medicaid-manuals.dhhs.utah.gov /#t=Section _1_General_Information%2Fsection_I_general_information.htm%231_General_Information&rhtocid=_0_0
[15] Medicaid Provider Manual, Hospital Services, Updated January 2022 and forward. Article 11-7. See current, https://medicaid-manuals.dhhs.utah.gov/#t=Hospital_Services%2Fhospital_services.htm%2311-7_Reporting_and_Billing_Covered&rhtocid=_14_10_6. Accessed 11/21/2022.

If a patient following labor and delivery received a procedure resulting in sterilization, for example a hysterectomy without a prior authorization and using official Medicaid policy Article 11-7, the sterilization procedure was not included on the claim. A Medicaid reviewer observing the client's history in MMIS prior to approving a subsequent treatment (for example, claims for a subsequent labor and delivery) would not see the unclaimed sterilization procedure and may approve a treatment that, had the sterilization been known would have been cause for disapproval.

Audit Note:
Medicaid provides retroactive authorization for certain procedures or circumstances up to 180 days after the date of service when deemed appropriate.[16]

2. HIPAA Compliant Methodology for Non-Covered and Non-Payable Services

The US Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requiring the Secretary of HHS to adopt for certain electronic health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. HIPAA required HHS to select standards from among standards already approved by private organizations. The HHS adopted the American National Standards Institute (ANSI) the Accredited Standards Committee (ASC) standards referred to as the X12N.[17]

CMS and Utah Medicaid require version 5010 of the X12 for all electronic transmission of healthcare information.

The 5010 includes and fully supports syntax for coding of non-covered and non-payable healthcare claims including multiple adjustment reason codes for non-covered services.[18]

Summary:

Medicaid's policy requiring hospitals to not claim the non-covered or non-payable services removes Medicaid's ability to receive records of non-payable services and ensure compliance with federal and state laws and regulations. Not including all services delivered to Medicaid recipients on the FFS claims also diminishes Program Integrity's ability to review claims for fraud, waste and abuse.

Medicaid indicates in their policy the reason for not following the industry standard of including all services delivered on the claim was due to a legacy MMIS limitation.[19] Medicaid stated they evaluated options to modify MMIS programming at different intervals and determined that it required a substantial amount of effort and cost to rebuild the system edits therefore did not correct

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[16] Retroactive PA Medicaid Provider Manual Section I: General Information Chapter 10 All Providers
Date accessed 11/21/2022 https://medicaid-manuals.dhhs.utah.gov/#t=Section_1_General_Information%2Fsection_I_general_information.htm%2310_Prior_Authorization&rhtocid=_0_9

[17] 'https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Transactions/Transactions Overview'. Date Accessed 02/02/2023

[18] X12 List of adjustment reason codes Accessed 11/16/2022 https://x12.org/codes/claim-adjustment-reason-codes. The X12 Standard includes multiple adjustment reason codes (ARC) for non-covered services, for example ARC 49-52, 78, 96, 202, and B1

[19] See Medicaid Provider Manual Hospital Services: Updated January 2022
Reporting and Billing Covered and Non-Covered Services for Acute Inpatient Hospital Claims. (Article 11-7)

the MMIS programming but instead required providers to not include services lacking prior authorization so that current programming would pay covered charges.

Medicaid indicated that a modification could be added in the future to the Provider Reimbursement Information System for Medicaid (PRISM) System to process claims reporting covered and non-covered or non-payable procedures.

During the audit UOIG and Medicaid discussed how to ensure accurate billing and reimbursement for hospital claims submitted to Utah Medicaid that include non-covered procedures; the following policy is proposed by Medicaid:

1. When a billing hospital submits a claim containing both covered and non-covered surgical procedures, the hospital must include all relevant ICD-10-PCS codes on the claim form, indicating all performed procedures.
2. In addition to reporting all ICD-10-PCS codes, billing hospitals are required to designate charges related to non-covered surgical procedures as non-covered charges on the UB-04 claim form, or its electronic equivalent (837I). This indicates that specific services within the claim are not covered and not expected to be paid.
3. Upon receiving the claim, Utah Medicaid will review all submitted ICD-10-PCS codes for procedures that require Prior Authorization (PA) or documented consent. If a PA or consent form is required but not found for a specific procedure, Utah Medicaid will determine the appropriate Diagnosis-Related Group (DRG) payment by excluding the non-covered procedure code(s) from the DRG calculation.

Medicaid stated that this policy proposal aims to streamline the billing process for claims with non-covered procedures, ensuring accurate reimbursement for providers and promoting transparency in the claim submission process.

The UOIG recommends the below for policy and claim coding methodology correction.

Recommendations

We recommend Medicaid:

1.1 Adopt a policy for billing hospitals to submit claims that accurately represent both covered and non-covered procedures, in line with the HIPAA X12 837 methodology. This policy should require hospitals to report all relevant ICD-10-PCS codes for performed procedures, including non-covered or non-payable services. The policy should make clear that any charges associated with the non-covered ICD-10-PCS codes, reported under revenue codes, should be reported as non-covered.

1.2 Update the PRISM system to adjudicate inpatient hospital claims containing both covered and non-covered procedures. This includes identifying ICD-10-PCS codes that require Prior Authorization (PA) and adjusting the Diagnosis-Related Group (DRG) payment calculation by excluding non-covered ICD-10-PCS codes. When a PA is required but not found, the system should adjust payment calculations by excluding both non-covered charges and non-authorized ICD-10-PCS codes. The system should also ensure that the non-covered charges are captured and available in the data warehouse.

1.3 In coordination with recommendation 1.1, communicate the changes to providers through a Medicaid Information Bulletin (MIB) announcement, emphasizing the importance of submitting complete and accurate claims with all services delivered, including covered and non-covered procedures. The MIB announcement should also provide clear guidance on the appropriate methodology for reporting non-covered services and any related non-covered charges, ensuring providers are well-informed and able to comply with the updated policy requirements.

GLOSSARY OF TERMS

Term	Description
Article 11-7	Refers to the Medicaid Provider Manual for hospital services policy article 11-7 updated January 2022 and forward. Date accessed 11/16/2022 https://medicaid-manuals.dhhs.utah.gov/#t=Hospital _Services%2Fhospital_services.htm
CMS	Centers for Medicare & Medicaid Services.
CPT	The Current Procedural Terminology (CPT) code set is a procedural code set developed by the American Medical Association (AMA). The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. Physician claims for services rendered to inpatients use CPT codes.
DHHS	Utah Department of Health and Human Services
DRG	Diagnosis Related Group. Prospective payment rates based on Diagnosis Related Groups (DRGs) are the basis of Medicare's hospital reimbursement system. The DRGs are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. The design and development of the DRGs began in the late sixties at Yale University.[20]
FFS	Fee for services rendered and claimed resulting in direct payment reimbursement by Medicaid to the provider.
HIPAA	US Congress Health Insurance Portability and Accountability Act of 1996
HHS	United States Department of Health and Human Services
ICD-10-CM	ICD-10 refers to the tenth edition of the International Classification of Diseases, which is a medical coding system chiefly designed by the World Health Organization (WHO) to catalog health conditions by categories of similar diseases under which more specific conditions are listed, thus mapping nuanced diseases to broader morbidities. The US version of ICD-10, created by the CMS and the National Center for Health Statistics (NCHS), consists of two medical code sets—ICD-10-CM and ICD-10-PCS. CM

[20] https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf

	stands for *clinical modification* are codes used by physicians and other healthcare professionals to classify specific diseases.
ICD-10-PCS	ICD-10-PCS stands for the International Classification of Diseases Tenth Revision Procedure Coding System. ICD-10-PCS is a procedural classification system of medical codes used in hospital settings to report inpatient procedures. Inpatient claims for hospital services use PCS codes.
Medicaid	Utah DHHS Division of Integrated Healthcare, the Single State Agency responsible for all of the State of Medicaid Program.
MMIS legacy	Refers to the mainframe Medicaid Management Information System that was Medicaid's primary system for adjudicating healthcare claims and other health information. Medicaid stopped adjudicating healthcare claims in the MMIS legacy system in mid-March 2023.
PA	Prior Authorization of services.
PCS	ICD-10-PCS
PRISM	Provider Reimbursement Information System for Medicaid. Medicaid went Go-live with PRISM on April 3, 2023 for adjudicating healthcare claims and other health information.
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

June 30, 2023

Gene Cottrell
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Cottrell:

On behalf of the Department of Health and Human Services, thank you for the opportunity to respond to the audit titled *Audit of Acute Care FFS Inpatient Claims for Non-Payable Services: Medicaid Billing Policy (A2022-03)*. I appreciate the effort and professionalism of you and your staff in this review. The final product reflects a significant effort and time of the DHHS staff collecting information for OIG review, answering questions, and planning changes to improve the program. This audit and its responses will result in a better, more efficient program.

DHHS agrees with the recommendations in this report. DHHS is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Jennifer Strohecker (Jul 3, 2023 10:55 MDT)

Jennifer Strohecker, PharmD, BCPS
Medicaid Director
Director, Division of Integrated Healthcare

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Finding: Medicaid policy for FFS acute care inpatient hospital claims of non-covered or non-payable services cause incomplete and incorrect reporting.

Recommendation 1.1

We recommend Medicaid adopt a policy for billing hospitals to submit claims that accurately represent both covered and non-covered procedures, in line with the HIPAA X12 837 methodology. This policy should require hospitals to report all relevant ICD-10-PCS codes for performed procedures, including non-covered or non-payable services. The policy should make clear that any charges associated with the non-covered ICD-10-PCS codes, reported under revenue codes, should be reported as non-covered.

Department Response:

DHHS agrees with this recommendation.

What: The Office of Health Policy and Authorization (OHPA) will update the policy to align with the recommendation once system programming in PRISM can occur.

When: July 2024 (Due to release prioritization in PRISM system)

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 1.2

We recommend Medicaid update the PRISM system to adjudicate inpatient hospital claims containing both covered and non-covered procedures. This includes identifying ICD-10-PCS codes that require Prior Authorization (PA) and adjusting the Diagnosis-Related Group (DRG) payment calculation by excluding non-covered ICD-10-PCS codes. When a PA is required but not found, the system should adjust payment calculations by excluding both non-covered charges and non-authorized ICD-10-PCS codes. The system should also ensure that the non-covered charges are captured and available in the data warehouse.

Department Response:

DHHS agrees with this recommendation.

What: OHPA will submit a Change Request (CR) to align with the recommendation. The CR will request that PRISM adjudicate claims correctly and still capture non-payable surgical codes.

When: July 2024 (Due to release prioritization in PRISM system)

Contact: James Stamos, Director, Office of Health Policy and Authorization

Recommendation 1.3

We recommend Medicaid, in coordination with recommendation 1.1, communicate the changes to providers through a Medicaid Information Bulletin (MIB) announcement, emphasizing the

importance of submitting complete and accurate claims with all services delivered, including covered and non-covered procedures. The MIB announcement should also provide clear guidance on the appropriate methodology for reporting non-covered services and any related non-covered charges, ensuring providers are well-informed and able to comply with the updated policy requirements.

Department Response:

DHHS agrees with this recommendation.

What: OHPA will publish a MIB article detailing the change once the change is implemented in PRISM and the policy is updated.

When: July 2024 (Due to release prioritization in PRISM system)

Contact: James Stamos, Director, Office of Health Policy and Authorization

EVALUATION OF MANAGEMENT RESPONSE

Utah OIG appreciates the response DHHS provided to this audit. The response states DHHS full agreement and commitment to the implementation of all the recommendations by July 2024.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

Ron Sufficool
Auditor

Neil Erickson
Audit Manager

UTAH OIG MISSION STATEMENT

The Utah Office of Inspector General of Medicaid Services, on behalf of the Utah Taxpayer, will comprehensively review Medicaid policies, programs, contracts and services in order to identify root problems contributing to fraud, waste, and abuse within the system and make recommendations for improvement to Medicaid management and the provider community.

ADDRESS

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OTHER

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