DEPARTMENT OF COMMUNITY HEALTH
GEORGIA FAMILIES PROGRAM

REPORT 22:
ANALYSIS OF NEONATAL INTENSIVE CARE UNIT (NICU) SUPPLEMENTAL PAYMENTS

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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, which 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 administration of 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.
- ***Certified Coding Associate (CCA)*** - A medical coder for both hospital and physician settings who has fulfilled the American Health Information Management Association's (AHIMA) education and examination requirements.
- ***Department of Community Health (DCH or Department)*** - The Department within the state of Georgia which oversees and administers the Medicaid and PeachCare for Kids® programs.
- ***Diagnostic Related Group (DRG)*** - Any of the payment categories which 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. The fee is based on the principal diagnosis, surgical procedure, the age of the patient, and expected length of stay in the hospital.
- ***Discharge*** - Point at which a 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.
- ***Encounter*** - A distinct set of health care services provided to a Medicaid or PeachCare for Kids® Member enrolled with a Contractor on the dates the services were delivered.
- ***Encounter Data*** - Health Care Encounter Data includes: 1) All data captured during the course of a single Health Care encounter which specifies the diagnoses, co morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices, and equipment associated with the Member receiving services during the Encounter; 2) The identification of the Member receiving and the Provider(s) delivering the Health Care services during the single Encounter; and, 3) A unique or 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® claims 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.
- ***Hewlett-Packard (HP)*** - State of Georgia fiscal agent claims processor beginning on November 1, 2010.
- ***ICD-9-CM (ICD-9) Codes*** - The International Classification of Diseases, Clinical Modification, 9th 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 medical assistance program 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 which 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 which 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 which 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 which 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*** - A 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[1], 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

The Department of Community Health has developed criteria to determine which NICU claims qualify for the supplemental payment. Those criteria are as follows:

- The date of birth must be on or after fiscal year 2010 (July 1, 2009 and forward) and the newborn must be an eligible Medicaid or PeachCare for Kids® member for the duration of the hospital stay and the member's CMO enrollment date must be equal to the member's 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 case) but the CMO remains 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 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.

[1] The Department began making supplemental NICU payments to the CMOs in February 2010.

- The NICU supplemental payment rate was developed assuming 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 supplemental payment per individual regardless of the number of qualifying DRGs.
- The Encounter data submitted to DCH must accurately reflect the newborn's hospital claim payment.
- Medicaid or PeachCare for Kids® 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.

Previously, the CMOs posted a monthly list to the Department's web portal of NICU claims which they believed qualified for the supplemental payment. This process was automated in 2011, with the CMOs uploading a file to the Department's fiscal agent contractor, Hewlett-Packard (HP), no later than the fifth day of the month. With the automated process, if the fifth day falls on a weekend or state holiday, the deadline for submission to HP is extended to the next business day. We noted that several data elements such as diagnosis codes, procedures codes, and discharge status are not required to be reported by the CMOs to DCH. The claims in this file are not adjudicated or adjusted by HP, with the exception of performing the following edits and audits:

1. **Missing Data Elements**
   The state will reject service lines with missing, incomplete, or invalidly formatted data elements.
2. **Member Verification**
   The State will validate the submitted NICU files against the member eligibility file. The Member Medicaid/PCK ID data element will be utilized for member verification. The verification will consider all merged IDs.
3. **Participation in Georgia Families**
   This will validate plan affiliation for the enrolled member. On the date of admission, the member must be enrolled in Georgia Families and be enrolled with the CMO making the request. This will also validate that the Care Management Organization code submitted in the provider master file.
4. **Admission Date Verifications**
   The Admission date must be on or after the July 1, 2009 implementation date. The Admission date must be on or after the Member's date of birth. The Admission date must be equal to or prior to the Discharge date.
5. **Diagnosis Related Group (DRG) Code & Outlier Requirement**
   This will check that the DRG code submitted is a valid NICU related diagnosis code which qualifies for issuance of the Supplemental Payment. In addition, DRGs 606, 609, and 615 require an outlier. The outlier flag must contain a "Y" for these codes. There should only be one record submitted regardless of the number of valid diagnosis codes submitted on the claim.
   Note that Rule #5, "Diagnosis Related Group (DRG) Code & Outlier Requirement," is subject to override logic. If records are rejected due to this rule and deemed valid, the CMO should follow the procedure to request an override review. Upon review of the documentation, if the

Department agrees with the request, the record will be released for payment and processed in the next payment cycle.

6. **Payment Date Edits**
   This will check to see if the payment has a paid date. In addition, the payment date must be greater than or equal to the discharge date and less than the file submission date.
7. **Payment Amount Edit**
   The payment amount must be greater than or equal to $10,000. Payments less than this amount will be rejected for review.
   Note that Rule #7, "Payment Amount less than $10, 000," is subject to override logic. If records are rejected with this code and deemed valid, the CMO should follow the procedure to request an override review. Upon review of the documentation, if the Department agrees with the request, the record will be released for payment and processed in the next payment cycle.
8. **Discharge Date Validations**
   The discharge date should be prior to date of death, if there is a date of death.
9. **Duplicate Checking**
   Duplicate checking logic will verify that the Member ID on the incoming file is unique. The member should only be listed once regardless of the number of qualified DRG codes. This will involve the comparison of the member Medicaid ID for all incoming records within the same request file.
10. **Age Validations**
    This will validate the member's age as being less than one year old as of the Admission Date.
11. **Lifetime Payment**
    There is a one-time payment limit per member per lifetime; any request received for a member who has previously received a supplemental NICU payment will be rejected.

If a claim passes all the edits and audits, then a supplemental payment is made by HP to the CMO. Claims that do not pass these edits and audits are sent back to the CMO by HP with an explanation as to why the claim did not qualify for a supplemental payment. The CMO is given the opportunity to correct the information on the rejected claims and resubmit the claims. Each CMO is also required to submit the encounter claim within 90 days of the date the claim was paid. HP provides the Department with a listing of the claims for which a supplemental payment was made. The Department also audits the encounter data in an effort to validate the CMO-submitted data on a regular basis.

The Department requested that Myers and Stauffer LC (MSLC) perform several analyses to confirm claims for which the CMO received a supplemental payment met the criteria outlined above. Specifically, the analytical objectives of this initiative were 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 included a review of the medical record documents which contain clinical data on diagnoses, treatments, and outcomes, as well as other required documentation for services provided to the patient 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 claim elements were supported by the items in #1, above.
3. Perform a test of reasonableness of the charges reported on the claim to determine whether they appeared consistent with charges for similar services at the same hospital and for peer hospitals.
4. Verify that the NICU claim for which a supplemental payment was made was 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 SUMMARY

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 which 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 issues identified prior to the issuance of this report. Each CMO was given an opportunity to review the initial draft of this report. CMO responses can be found throughout the Findings Summary and Detailed Analyses sections of the report as applicable. Additionally, each CMO's complete response after review of the initial draft of this report can be found in Exhibits A-C.

- The analysis of Amerigroup NICU claims identified three claims for which the Department may wish to recoup the supplemental payments if the issues are not adequately addressed by the CMO.
    - Myers and Stauffer was unable to confirm the assigned DRG on two Amerigroup claims because the medical records were not received despite several requests to Amerigroup. Amerigroup is aware that the medical records have not been received to date by Myers and Stauffer. It should be noted that the hospital provider submitted medical records for one of these claims, but the records provided were for the wrong member. Amerigroup was advised of this issue. These two claims are listed in Table 2 below.

      Amerigroup response on August 1, 2012: "We acknowledge Myers and Stauffer's inability to confirm the assigned DRG on two Amerigroup claims due to the non-received medical records. Amerigroup made several attempts to obtain these medical records from the provider, yet we were unsuccessful in obtaining these records. If suggested, Amerigroup would be willing to perform a medical records review on the claims listed in Table 2 and report our findings."

    - There was one Amerigroup claim that, based on the medical records, Myers and Stauffer grouped to DRG 602; however, Amerigroup grouped the claim to DRG 622. This issue was sent to Amerigroup requesting they provide all data elements, including all diagnoses and procedure codes, used to group a claim to DRG. We requested the CMO confirm that the DRG assignment was correct and the CMO provided the following response:
        - "DRG 622 was based on CHAMPUS Grouper V24 Methodology." The response from Amerigroup included a screenshot showing the diagnosis codes utilized for the grouping of the claim, including diagnosis code 765.02 (Extreme fetal immaturity, 500-749 grams). Per our medical review, diagnosis code 765.02 was supported in the medical records. Myers and Stauffer included diagnosis code 765.02 in our grouping activities, which resulted in a calculated DRG of 602 (Neonate, birthwt <750g, discharged alive). A recommendation regarding this claim can be found in Table 4 below.

          Amerigroup response on August 1, 2012: "We acknowledge Myers and Stauffer's conclusion that this claim should have grouped to DRG 602. We recalculated the DRG in our system and still came up with a computed DRG of 622. While diagnosis code 765.02 was factored into our calculation, we are willing to reconfirm this calculation with the appropriate parties."

- Myers and Stauffer identified potential issues with two PSHP claims for which the Department paid a supplemental payment.
    - Myers and Stauffer calculated DRG 623 for one PSHP claim. According to the criteria as determined by the Department, DRG 623 is not one of the six DRG's which qualifies for the supplemental NICU payment. This claim was sent to PSHP for review.
        - PSHP confirmed that the claim grouped to DRG 623. They also stated they had received a supplemental payment for this claim. Claim detail and our recommendation are listed in Table 3 below.
          PSHP response on July 31, 2012: "The Plan agrees that the claim did not meet the criteria for the supplemental payment."

    - The medical records for one PSHP NICU claim indicated the member's birth weight fell within the 750-999 gram range. After consultation with a Myers and Stauffer Certified Coding Associate (CCA), it was determined that the diagnosis code 765.02 (Extreme fetal immaturity, 500-749 grams) billed on the UB-04 claim was incorrect. The provider should have billed diagnosis code 765.03 (Extreme fetal immaturity, 750-999 grams). Based on this corrected information, Myers and Stauffer grouped this claim to DRG 604 rather than DRG 602 included on the claim. We sent this issue to PSHP for review.
        - PSHP responded that: "DX billed: V30.00, 765.02, 769, 770.7, 774.2, 771.81, 276.1, 276.9, 765.23, 770.82, 458.8, 790.29, 362.23, 760.79, 747.83. Proc codes billed to determine DRG 602: 9604, 9672, 9983, 9904, 3891, 892. Discharge billed by provider is 01- Discharged to home. DRG assignment is correct". This claim is located in Table 4 below.
          PSHP response on July 31, 2012:
          Peach State will review the medical records associated with this claim.
          Please note that the claim was originally paid in June 2010. Pursuant to OCGA 33-20A-62, this claim would be outside of the 12 month look back period for recoupment of any applicable overpayment. However, if the Plan determines that this claim was incorrectly billed, it will review the provider's more recent filings and work to educate the provider regarding appropriate billing procedures.

TABLE 2: UNSUPPORTED AMERIGROUP NICU CLAIMS

NUMBER OF CLAIMS WITH ISSUE	SUMMARY OF ISSUE	NICU SUPPLEMENTAL PAYMENT RECOUPMENT AMOUNT
2	Despite multiple requests, the medical records were not provided for these two claims.	$165,760.24[1]

[1]- Total recoupment amount is comprised of two payments of $85,376.23 and $80,384.01.

The Department may wish to require Amerigroup to perform a medical records review of the claims listed in Table 2 and report their findings. If Amerigroup is unable to complete this request due to non-receipt of medical records, the Department may wish to consider these claims unsupported and require repayment of the supplemental payments for these two claims.

TABLE 3: CONFIRMED PSHP NICU CLAIM INELIGIBLE FOR SUPPLEMENTAL PAYMENT

SUMMARY OF ISSUE	CMO REPORTED DRG	MYERS AND STAUFFER CALCULATED DRG	NICU SUPPLEMENTAL PAYMENT RECOUPMENT AMOUNT
Claim grouped to DRG 623, which is not eligible for the supplemental payment	623	623	$85,376.23

The claim listed in Table 3 did not appear on the list provided by the Department of NICU supplemental payments paid from July 2009 to November 2011; therefore it is not clear if this claim has already been recouped by the Department. If this claim issue remains outstanding, we recommend that the Department recoup the supplemental NICU payment for this claim as it does not qualify for the NICU supplemental payment.

TABLE 4: NICU CLAIMS WITH INCORRECT DRG ASSIGNMENT BASED ON BIRTH WEIGHT

CMO	NUMBER OF CLAIMS WITH ISSUE	BIRTH WEIGHT RANGE DOCUMENTED IN MEDICAL RECORD	CMO REPORTED DRG	DRG DESCRIPTION	MYERS AND STAUFFER CALCULATED DRG
AMGP	1	Neonate, birthwt <750g, discharged alive	622	Neonate, birthwt >2499g, w signif or proc, w mult major prob	602
PSHP	1	Neonate, birthwt <750g, discharged alive	602	Neonate, birthwt 750-999g, discharged alive	604

Myers and Stauffer recommends the Department require Amerigroup confirm that diagnosis code 765.02 was included in their grouping of the claim listed on Table 4 and if so, explain why they arrived at a different DRG assignment.

The Department may wish to require PSHP to perform a medical record review of the claim listed in Table 4 and report their findings to the Department. If an incorrect DRG assignment is determined, the CMO should work with the provider to ensure proper payment of the claim is made. Once the final DRG assignment is determined and the payment to the provider is adjusted as appropriate, PSHP should report their findings to the Department.

The Department provided Myers and Stauffer with the files the CMOs submitted to HP requesting the NICU supplemental payment. Upon analysis of these files, Myers and Stauffer found the following concerns:

- One Member included in the data had two separate Medicaid ID numbers, and it appears the CMO received two supplemental payments. Only one of the Member Medicaid ID numbers appears on the comprehensive Excel document containing NICU payments for paid dates of July

2009 to November 2011 provided by the Department. Therefore, it is not clear if this issue has already been identified and addressed by the Department. This issue is listed in Table 5 below.

- One NICU claim from PSHP contained a date of birth for the member that was 27 days later than the admission date indicated in the medical records. One of the required data verification checks performed when the claim is submitted to HP for the supplemental payment is to verify that the admission date must be on or after the member's date of birth. It Is not clear to Myers and Stauffer if the incorrect date of birth was reported by the CMO Admission Date edit failed or was not yet in place, or if the date of birth changed when reported to DCH.

TABLE 5: POTENTIAL DUPLICATE NICU SUPPLEMENTAL PAYMENT

SUMMARY OF ISSUE	NICU SUPPLEMENTAL PAYMENT RECOUPMENT AMOUNT
Appears WellCare received two NICU supplemental claim payments for one member.	$85,376.23

If the Department confirms WellCare received two supplemental NICU payments for one member, we recommend recoupment of the additional payment.

WellCare response on August 1, 2012: "While it appears on the surface that the state issued two Medicaid ID #s to WellCare, in actuality, only one ID received payment."

The Department may wish to include additional edits and audits to their current pre-payment process to determine if claims submitted by the CMOs qualify for a supplemental payment. Myers and Stauffer recommends the following additional edits:

- Require the CMOs to include the member's discharge status when submitting claims for the NICU supplemental payment. HP should test the discharge status for all claims assigned a DRG of 602, 604, or 606 to ensure the member discharge status is not '20'- "Expired".
- Expand duplicate checking logic to also check for a combination of duplicated date of birth with admission date and discharge date.
- Update the Discharge Date Validation to state discharge date should be prior to or equal to the date of death, if there is a date of death.
- Update the Age Validation edit to only include member's 28 days old or less as of the Admission Date. Member's 29 days of age or older will not group to one of the six DRGs that qualifies for the NICU supplemental payment.
- Require the CMOs to provide the member's birth weight in grams as part of their NICU submission. Logic should be added to confirm the assigned DRG on the claim to the member's birth weight.
- Require a signed attestation from the CMO, submitted with each NICU supplemental payment request file, stating quality assurance measures have been completed.
- After analysis of the sample claims with DRGs where the costs must exceed the outlier, it was found that while PSHP provided a detailed account of the outlier calculation, there is no encounter claim showing the payment of the outlier to the provider. Myers and Stauffer recommends the Department consider requiring the CMO to pay the appropriate outlier payment before receiving a supplemental payment for DRGs 606, 609, or 615.

METHODOLOGY

ANALYSES ONE AND TWO

The Department provided a comprehensive listing of all NICU claims for which a supplemental payment was paid as of November 12, 2011. Myers and Stauffer received files where NICU supplemental payments were paid directly to the CMOs by the Department for the period January 2010 through April 2011 for WellCare and for January 2010 through May 2011 for both Amerigroup and PSHP. NICU supplemental payments paid after April 2011 for WellCare and May 2011 for Amerigroup and PSHP respectively were paid using an automated system process. The automated process is described in greater detail below. The manual and automated files were combined by CMO and reviewed for quality assurance. Any NICU claims analyzed as part of our first NICU report were excluded.

Myers and Stauffer sampled and analyzed a total of 93 claims. These claims represent at least 10 percent of claims from each CMO's universe of NICU claims for which the Department paid a supplemental payment. The universe of claims for each CMO was sorted into three separate categories, and the sample claims selected in the following manner:

1. The difference between the supplemental NICU payment paid by the Department and the CMO payment to the provider was calculated. The claims with the largest difference were analyzed.
2. Claims billed by specific hospital providers as requested by the Department were selected. We randomly selected claims from each CMO's universe of remaining claims. Randomly selected claims were chosen to ensure that at least one claim for each of the DRGs was selected.

Each CMO was responsible for requesting from the provider and submitting to Myers and Stauffer the medical records and/or other documentation required for this analysis by March 16th, 2012. Upon receipt of the medical records, 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.

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

- 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
  - History and Physical Admission Note
  - 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), including Itemization of all charges on the claim
  - Other items as required, depending on the circumstances required by the claim

Assumptions, Limitations and Notes Relevant to Analyses One and Two

- Myers and Stauffer utilized the UB-04 claim form submitted by the hospital provider to the CMO for reimbursement of NICU services when performing the medical records analysis.
- Data listed on the UB-04 claim form found to be unsupported by the medical record was not included in the grouping activities performed by Myers and Stauffer.
- Myers and Stauffer utilized our CCA for any questions regarding the coding of a claim that required further analysis.
- If the grouping results 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.
- 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 can be provided directly to the CMOs as requested by the Department.

Analyses Three through Five

In addition to performing a medical records analysis for a sample of NICU claims where the Department paid a NICU supplemental payment, the Department requested Myers and Stauffer perform additional analyses designed to identify relevant trends or other concerns. Analyses were performed on member enrollment, comparison of the NICU claims data submitted to HP by the CMOs with the encounter data, and a test of reasonableness of claim charges to determine if they appear consistent with charges for similar services at the same hospital and for peer hospitals.

Myers and Stauffer maintains a data warehouse which includes encounter data from each CMO, as well as traditional Medicaid and PeachCare for Kids® 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

- Listing of NICU claims included in this analysis
- 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 May 11, 2012, the reconciliation indicated that Amerigroup and PSHP had submitted approximately 98 percent of their encounter claims. WellCare had submitted approximately 93 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.

Myers and Stauffer also performed an analysis of the data submitted by HP 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. This analysis was only applicable to the data elements of member's name, member's date of birth, admission date, and discharge date as these are the only data elements relating to the member that are received by the Department from HP.

ANALYSIS ONE: FINDINGS AND RECOMMENDATIONS

The tables on the following page 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 6: MEMBER DATA FINDINGS SUMMARY

CMO	AMERIGROUP	PSHP	WELLCARE
Data Element Tested	Member First and Last Name[1]	Member First and Last Name[1]	Member First and Last Name[1]
Variances Between Medical Record and UB-04 Identified	None	None	None
Variances Between Medical Record and Data Reported to DCH by CMO Identified	None	None	None
Data Element Tested	Member Date of Birth	Member Date of Birth	Member Date of Birth
Variances Between Medical Record and UB-04 Identified	None	None	None
Variances Between Medical Record and Data Reported to DCH by CMO Identified	None	One[2]	None
Data Element Tested	Member Less Than 28 Days Old	Member Less Than 28 Days Old	Member Less Than 28 Days Old
Variances Between Medical Record and UB-04 Identified	None	None	None
Variances Between Medical Record and Data Reported to DCH by CMO Identified	None	None	None

NOTES TO TABLE 6

Note 1: It was noted on several charts that the first and last name had changed. Since this is not an uncommon occurrence on newborn claims, Myers and Stauffer only considered the change a variance if the member name and medical record number did not match.

Note 2: One NICU claim for PSHP contained a date of birth for the member that was 27 days later than the admission date. Per review of the medical records, the date of birth was equal to the admission date. Upon review of the encounter data, the date of birth was listed as the same date as the admission date. It is not clear if this is how the date of birth was received

from the CMO to HP or if the date of birth became altered somehow when submitted to the Department. This finding did not appear to impact the payment of the claim.

TABLE 7: ADMISSION AND DISCHARGE DATA FINDINGS SUMMARY

CMO	AMERIGROUP	PSHP	WELLCARE
Data Element Tested	Admission Date	Admission Date	Admission Date
Variances Between Medical Record and UB-04 Identified	None	None	One[4]
Variances Between Medical Record and Data Reported to DCH by HP Identified	None	One[3]	One[4]
Data Element Tested	No Admission Date Prior to 7/1/09	No Admission Date Prior to 7/1/09	No Admission Date Prior to 7/1/09
Variances Between Medical Record and UB-04 Identified	None	None	None
Variances Between Medical Record and Data Reported to DCH by HP Identified	None	None	None
Data Element Tested	Discharge Date	Discharge Date	Discharge Date
Variances Between Medical Record and UB-04 Identified	None	None	None
Variances Between Medical Record and Data Reported to DCH by HP Identified	Six[5]	None	Two[6]
Data Element Tested	Discharge Status	Discharge Status	Discharge Status
Variances Between Medical Record and UB-04 Identified	Two[7]	None	One[8]
Variances Between Medical Record and Data Reported to DCH by HP Identified	N/A[9]	N/A[9]	N/A[9]

NOTES TO TABLE 7

Note 3: One NICU claim for PSHP contained an admission date that was one day later than the admission date indicated in the medical records. This finding did not impact the payment of the claim.

Note 4: One WellCare NICU claim submitted to HP had an admission date that was one day earlier than the admission date indicated in the medical record. Additionally, the NICU claim data submitted by HP to DCH for the supplemental payment also contained the later date rather than the correct admission date shown in the medical record. This finding did not impact the payment of the claim.

Note 5: Six Amerigroup NICU claims submitted to the Department had a discharge date that differed from the discharge date found in the medical record. The difference in days ranged from five days to 126 days. In each of these cases, the discharge date matched what the provider submitted on the UB-04 claim form.

Note 6: Two NICU claims submitted by WellCare to HP and subsequently submitted to DCH for supplemental payment had a variance where the discharge date in the medical record was not the same as the discharge date indicated on the claim submitted for payment. Of the two claims, one had a discharge date that was one day later, while the other had a discharge date that was 40 days later. This finding did not impact the payment of these claims.

Note 7: Myers and Stauffer identified two Amerigroup claims where the medical record indicated the member was discharged home, but the provider submitted UB-04 claim stated the member was transferred to another hospital. This finding did not impact the payment of these claims.

Note 8: One WellCare claim had a patient discharge status indicating member transferred to another hospital, however the medical records indicated that that member was discharged to home. This finding did not impact the payment of this claim.

Note 9: Discharge status is not a data element that is required by the State when the CMOs request a supplemental payment.

TABLE 8: DIAGNOSIS AND REVENUE CODE FINDINGS SUMMARY

CMO	AMERIGROUP	PSHP	WELLCARE
Data Element Tested	ICD-9-CM Diagnosis Codes[10,11]	ICD-9-CM Diagnosis Codes[10,11]	ICD-9-CM Diagnosis Codes[10,11]
Variances Between Medical Record and UB-04 Identified	None	One[12]	None
Variances Between Medical Record and Data Reported to DCH by CMO Identified	N/A[13]	N/A[13]	N/A[13]
Data Element Tested	Revenue Codes	Revenue Codes	Revenue Codes
Variances Between Medical Record and UB-04 Identified	None	None	None
Variances Between Medical Record and Data Reported to DCH by CMO Identified	N/A[13]	N/A[13]	N/A[13]

NOTES TO TABLE 8

Note 10: Myers and Stauffer analyzed the first nine diagnosis codes listed on the provider-submitted UB-04 claim form. Only diagnosis code variances which impacted the manner in which a claim grouped are listed on Table 8 above as variances.

Note 11: Myers and Stauffer identified instances where invalid diagnosis codes were included on the claim submitted to DCH. Examples include diagnosis codes which require a fourth or fifth digit but those digits were not found on the claim. Myers and Stauffer found one invalid diagnosis code on an Amerigroup claim and another on a WellCare claim.

Note 12: One UB-04 claim for a PSHP member included a diagnosis code where the medical record supported a different diagnosis code than the one billed on the provider claim form. The member's birth weight was within the 750-999 gram range. The diagnosis code denoted an incorrect birth weight range which impacted the claim as the claim grouped to a DRG of 602 "Neonate, birthwt <750g, discharged alive." Based on TRICARE Version 24 Grouper, we determined that the claim should be grouped to DRG 604 (Neonate, birthwt 750-999g, discharged alive). Myers and Stauffer sent this claim to PSHP for review on May 31, 2012, requesting the CMO provide all data elements, including all diagnoses and procedure codes, billed on the UB-04 claim used to group this claim. We also requested the CMO confirm the accuracy of the DRG assignment on the claim. Myers and Stauffer provided PSHP the member's birth weight found in the medical records. PSHP responded the following "DX billed: V30.00, 765.02, 769, 770.7, 774.2, 771.81, 276.1, 276.9, 765.23, 770.82, 458.8, 790.29, 362.23, 760.79, 747.83 Proc codes billed to determine DRG 602: 9604, 9672, 9983,

9904, 3891, 3892. Discharge billed by provider is 01- Discharged to home. DRG assignment is correct."

Note 13: The Department only requires certain data elements to be provided upon submission of claims in which they are requesting a supplemental payment. Diagnosis codes and revenue codes are not required data elements and, therefore, were not analyzed by Myers and Stauffer.

TABLE 9: PSHP CLAIM WITH UNSUPPORTED DIAGNOSIS CODE IMPACTING DRG ASSIGNMENT

UB-04 SUBMITTED DIAGNOSIS CODE	DIAGNOSIS CODE DESCRIPTION	MEDICAL RECORD BIRTH WEIGHT RANGE	CMO REPORTED DRG	M&S CALCULATED DRG
765.03	Extreme fetal immaturity, 500-749 grams	750-999 grams	602	604

Based on the findings for the PSHP claim listed in Table 9, Myers and Stauffer recommends the Department require Peach State Health Plan to perform a review of the medical records for this claim and report their findings and any subsequent actions to the Department.

TABLE 10: PROCEDURE CODES SUMMARY

CMO	AMERIGROUP	PSHP	WELLCARE
Data Element Tested	ICD-9-CM Procedure Codes[14]	ICD-9-CM Procedure Codes[14]	ICD-9-CM Procedure Codes[14]
Variances Between Medical Record and UB-04 Identified	None[15]	None[15]	None[15]
Variances Between Medical Record and Data Reported to DCH by CMO Identified	N/A[16]	N/A[16]	N/A[16]

NOTES TO TABLE 10

Note 14: 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 15: Myers and Stauffer found one procedure code on an Amerigroup claim that was invalid. We also indentified a number of procedure codes we were not able to locate in the medical records provided by the hospital. We found four unsupported procedure codes for Amerigroup, two for PSHP, and three for WellCare. The omission of these procedure codes did not affect the grouping of these claims in the instances identified and, therefore, were not included on Table 10.

Note 16: According to the Revised Supplemental Neonatal Intensive Care Payment Process, the procedure code is not a required data element.

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. Diagnosis codes or procedure codes which were not supported in the medical records were excluded from grouping activities performed by Myers and Stauffer. The results of this analysis can be found in Table 11.

TABLE 11: 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 MEDICAL RECORDS NOT RECEIVED
Amerigroup	32	31	One[17]	Two[19]
PSHP	22	21	One[18]	0
WellCare	37	37	0	0

The completed grouping activities resulted in the identification of four claims where Myers and Stauffer was not able to group the claim to the DRG reported by the CMO.

NOTES TO TABLE 11

Note 17: There was one Amerigroup claim where it appears that Amerigroup did not use all the diagnosis codes submitted by the provider to determine the grouping of the claim. Myers and Stauffer requested Amerigroup provide all data elements, including all diagnoses and procedure codes, billed on the UB-04 claim that Amerigroup used to group this claim to DRG 622. We also requested the CMO confirm the appropriateness of the DRG assignment on the claim. Amerigroup responded "DRG 622 was based on CHAMPUS Grouper V24 Methodology" and provided several screenshots from their claims processing system. One screenshot showed the diagnosis codes utilized for the grouping of the claim which included diagnosis code 765.02 (Extreme fetal immaturity, 500-749 grams). Myers and Stauffer found this diagnosis code in the medical records and included this code in our grouping activities for a calculated DRG of 602. Myers and Stauffer recommends the Department require Amerigroup to confirm that the diagnosis code 765.02 was included in their grouping of this

claim and if so, explain why they arrived at a different DRG assignment. Claim is listed on Table 12 below.

Note 18: Myers and Stauffer identified one PSHP claim where the diagnosis code denoted an incorrect birth weight range and the claim grouped to a DRG of 602 "Neonate, birthwt <750g, discharged alive" rather than DRG 604 "Neonate, birthwt 750-999g, discharged alive." According to the medical record, the member's birth weight was within the 750-999 gram range. This claim is discussed in greater detail in Note 12 above and is also included on Table 9.

Note 19: Myers and Stauffer was unable to confirm the assigned DRG on two Amerigroup claims because the medical records were not received despite several requests to Amerigroup.

TABLE 12: DIAGNOSIS CODE DENOTING BIRTH WEIGHT DOES NOT MATCH CMO CALCULATED DRG

CMO	MEDICAL RECORD BIRTH WEIGHT RANGE	CMO REPORTED DRG	DRG 622 DESCRIPTION
Amerigroup	<750 grams	622	Neonate, birthwt >2499g, w signif or proc, w mult major prob

OUTLIER PAYMENTS

From the sample, the claims with an assigned DRG of either 606, 609, or 615 which qualify for an outlier payment were identified. Additional required data for repricing and calculation of the outlier payment were obtained. This included the CMO/provider contracts, along with the Georgia Medicaid base rates. The encounter data was analyzed to determine if a claim was received and paid with an outlier payment. If the claim with the outlier payment was missing or the initial claim had a zero payment, the claim was sent to the CMO to request the payment methodology and confirmation that an outlier was paid.

In the sample, there were a total of 21 claims identified that would qualify for an outlier payment. Of the 21, 11 were Amerigroup claims, seven of the claims were related to WellCare members, and three were PSHP claims. There were a total of three claims, one claim from each CMO, which Myers and Stauffer sent to the respective CMO for clarification of their outlier payment calculation.

CMO POLICIES FOR THE PROCESSING OF NICU CLAIMS

On February 10, 2012, 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 by March 18, 2012. Myers and Stauffer did not receive any policies and procedures from Amerigroup, PSHP, or WellCare relating to the processing of NICU claims prior to the issuance of the first draft of this report to the Department on July 5, 2012.

ANALYSIS TWO: FINDINGS AND RECOMMENDATIONS

OUTLIER PAYMENTS

- Information received from Amerigroup showed both an inlier and outlier payment was made. All seven of the AMGP claims identified as requiring an outlier payment were paid as required.
- While PSHP provided a detailed account of the outlier calculation, there is no encounter claim which shows the outlier amount was paid to the provider.
- The encounter claims data shows an outlier payment was paid for the WellCare claim in question; however the encounter data does not appear to include the claim that includes the inlier payment. The documentation which WellCare provided does not show an inlier payment was made to the provider.

NICU CLAIMS POLICIES AND PROCEDURES

Upon receipt and review of this report, the Department required each CMO respond to our findings. Myers and Stauffer received copies of policies and procedures effective for services beginning on or after July 1, 2009 related to the processing of NICU claims from Amerigroup, Peach State Health Plan and WellCare. A summary of our findings for each CMO are listed below.

Amerigroup
The majority of the documentation provided by Amerigroup was in relation to how a claim examiner should process a claim. It was noted the Amerigroup employs some of the same edits the Department has in place upon receipt of the NICU claim into the HP system.

Peach State Health Plan (PSHP)
PSHP provided one policy that appears to be solely related to their payment of outlier claims. Policy did not seem to address specifically how a NICU claim was processed in their claims system.

WellCare
Myers and Stauffer did not receive any policies and procedures from WellCare. In a letter dated August 1, 2012 WellCare stated the following:

> *In late 2011, WellCare employed an internal Quality Assurance (QA) step of NICU supplemental payment requests prior to file submission to Hewlett-Packard (HP). This process ensured an accepted encounter was on record and assigned an ICN by HP prior to WellCare submission of a NICU supplemental payment request. With the implementation of this process, DCH may notice a decrease in volume of our NICU payment requests when compared to historical trends.*

On August 8, 2012 Myers and Stauffer requested WellCare provide their written policies and procedures for the processing of NICU claims. On August 9, 2012 we received one policy from WellCare regarding

the payment for inpatient claims. The only language specific to newborns was related to eligibility. It was noted that WellCare performs a retrospective reviews for claims where an outlier payment is requested.

Other findings noted upon analysis of the procedures and policies:

- One CMO policy stated for claims where the member age is 28 days or less a birth weight is required. It appears if the provider does not include the birth weight on the claim form the claims examiner will enter a specified birth weight per policy.

We recommend that the Department require each of the CMOs provide 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:

- CMO encounter claims incurred on or after 7/1/2009 and were paid by the CMO between 04/01/2010 to 11/30/2011 and were submitted to the state agent fiscal contractor with a DRG of 602, 604, 606, 609, 615, or 622.
- Fee-for-service claims that met the same criteria listed above for the encounter data.
- The encounter data paid amount was used for this analysis. The data was summarized by payor and DRG code in Tables 13 through 18 below. Adjusted claims, denied claims, and claims with zero payment have been excluded. Outlier payments, if applicable, 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 13: DRG CODE 602

	AMERIGROUP	PSHP	WELLCARE	TRADITIONAL MEDICAID	GRAND TOTAL
Number of Encounters	73	69	131	64	337
Number of Covered Days	5,562	5,609	10,490	4,871	26,532
Total Paid Amount	$8,204,413	$9,265,269	$16,111,640	$6,533,892	$40,115,215
Minimum Length of Stay	1	1	1	1	1
Maximum Length of Stay	226	304	197	210	304
Average Length of Stay	76	81	80	76	79
Minimum Paid Amount	$116	$2,631	$612	$1,171	$116
Maximum Paid Amount	$705,059	$474,428	$600,794	$130,753	$705,059
Average Paid Amount	$112,389	$134,279	$122,990	$102,092	$119,036
Average Paid Amount Per Day	$1,475	$1,652	$1,536	$1,341	$1,512

TABLE 14: DRG CODE 604

	AMERIGROUP	PSHP	WELLCARE	TRADITIONAL MEDICAID	GRAND TOTAL
Number of Encounters	103	90	160	97	450
Number of Covered Days	6,094	5,689	10,510	6,091	28,384
Total Paid Amount	$7,547,798	$8,992,613	$14,539,139	$6,716,091	$37,795,640
Minimum Length of Stay	4	1	1	1	1
Maximum Length of Stay	118	118	165	229	229
Average Length of Stay	59	63	66	63	63
Minimum Paid Amount	$25,125	$3,691	$500	$3,288	$500
Maximum Paid Amount	$103,210	$313,558	$461,008	$89,159	$461,008
Average Paid Amount	$73,280	$99,918	$90,870	$69,238	$83,990
Average Paid Amount Per Day	$1,239	$1,581	$1,383	$1,103	$1,332

TABLE 15: DRG CODE 606

	AMERIGROUP	PSHP	WELLCARE	TRADITIONAL MEDICAID	GRAND TOTAL
Number of Encounters	10	11	21	13	55
Number of Covered Days	613	1,168	1,688	1,112	4,581
Total Paid Amount	$975,706	$1,839,874	$2,522,031	$462,493	$5,800,103
Minimum Length of Stay	31	10	7	15	7
Maximum Length of Stay	99	229	217	152	229
Average Length of Stay	61	106	80	86	83
Minimum Paid Amount	$2,087	$2,381	$1,980	$2,251	$1,980
Maximum Paid Amount	$265,402	$529,755	$559,525	$170,455	$559,525
Average Paid Amount	$97,571	$167,261	$120,097	$35,576	$105,456
Average Paid Amount Per Day	$1,592	$1,575	$1,494	$416	$1,266

TABLE 16: DRG CODE 609

	AMERIGROUP	PSHP	WELLCARE	TRADITIONAL MEDICAID	GRAND TOTAL
Number of Encounters	9	19	14	6	48
Number of Covered Days	373	1,087	527	416	2,403
Total Paid Amount	$507,825	$2,297,235	$634,088	$278,778	$3,717,926
Minimum Length of Stay	16	16	3	26	3
Maximum Length of Stay	101	160	77	145	160
Average Length of Stay	41	57	38	69	50
Minimum Paid Amount	$2,087	$2,087	$2,380	$2,592	$2,087
Maximum Paid Amount	$223,248	$415,533	$126,546	$164,204	$415,533
Average Paid Amount	$56,425	$120,908	$45,292	$46,463	$77,457
Average Paid Amount Per Day	$1,361	$2,113	$1,203	$670	$1,547

TABLE 17: DRG CODE 615

	AMERIGROUP	PSHP	WELLCARE	TRADITIONAL MEDICAID	GRAND TOTAL
Number of Encounters	12	20	29	11	72
Number of Covered Days	401	1,067	1,465	529	3,462
Total Paid Amount	$604,147	$2,057,364	$3,019,613	$427,813	$6,183,118
Minimum Length of Stay	3	6	11	4	3
Maximum Length of Stay	93	150	172	152	172
Average Length of Stay	33	53	51	48	48
Minimum Paid Amount	$723	$2,087	$1,980	$1,980	$723
Maximum Paid Amount	$206,102	$448,551	$660,133	$253,050	$660,133
Average Paid Amount	$50,346	$102,868	$104,125	$38,892	$85,877
Average Paid Amount Per Day	$1,507	$1,928	$2,061	$809	$1,786

TABLE 18: DRG CODE 622

	AMERIGROUP	PSHP	WELLCARE	TRADITIONAL MEDICAID	GRAND TOTAL
Number of Encounters	97	93	141	94	425
Number of Covered Days	2,830	3,181	3,763	3,728	13,502
Total Paid Amount	$9,700,797	$7,435,694	$12,431,675	$8,060,647	$37,628,812
Minimum Length of Stay	1	1	1	1	1
Maximum Length of Stay	250	171	172	192	250
Average Length of Stay	29	34	27	40	32
Minimum Paid Amount	$1,012	$5,548	$2,662	$47,970	$1,012
Maximum Paid Amount	$819,498	$405,261	$654,910	$629,792	$819,498
Average Paid Amount	$100,008	$79,954	$88,168	$85,752	$88,538
Average Paid Amount Per Day	$3,428	$2,338	$3,304	$2,162	$2,787

ANALYSIS THREE: FINDINGS AND RECOMMENDATIONS

In analyzing Tables 13 through 18, Myers and Stauffer noted the following:

- WellCare had the largest number claims for five of the six DRGs analyzed. This finding was consistent as they also have the largest PeachCare for Kids® membership among the three CMOs.
- Across all six DRGs analyzed, Medicaid consistently had the lowest average paid amount per day.
- Although DRG 602 did not have the largest number of total encounters, it did have the largest total amount paid. Between Amerigroup, PSHP, WellCare, and Tradtional Medicaid, a total of approximately $40 million was paid to the hospital providers for the sample claims reviewed. This is likely due to the high acuity nature of this population as DRG 602 are neonates with a birth weight of 749 grams or less.

- DRG 604, Neonate, birthwt 750-999g, discharged alive, had the highest total number of encounters at 450, which represented a total of 28,384 covered inpatient days with a total paid of approximately $38 million between the three CMOs and traditional Medicaid.
- For DRG 606, Neonate, birthwt 1000-1499g, w signif or proc, discharged alive, there were a total of 55 encounters during the period analyzed. The average cost per day for all CMO's and Traditional Medicaid was $1,266, which was the lowest among the DRGs analyzed in this report. Traditional Medicaid had the lowest average daily cost at $416 while Amerigroup was the highest and paid on average $1,592 per day.
- The lowest number of encounters included DRG 609, Neonate, Birthwt 1500-1999G, W Signif OR, with a total of 48 encounters for the period analyzed. Peach State Health Plan had the most encounters with 19 encounters, representing 1,087 covered inpatient days and total payments of approximately $2 million.
- There were a total of 72 encounters in the sample with DRG 615, Neonate, birthwt 2000-2499g, w signif or proc, w mult major prob. The average cost per day for all CMOs and Traditional Medicaid was $1,786. Traditional Medicaid had the lowest average daily cost of $809 while WellCare had the highest average daily cost of $2,061.
- DRG 622, Neonate, birthwt >2499g, w signif or proc, w mult major prob, represented 425 encounters during the period analyzed, including a total of 13,502 days with a total paid of approximately $38 million. The average cost per day for all CMO's and Traditional Medicaid was $2,787. Amerigroup had the highest average paid per day of $3,428.

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. A DRG code comparison is not included in this analysis as encounter claims processed by ACS, the Department's fiscal agent contractor until November 1, 2010, are not necessarily reflective of the DRG used by the CMO during the payment process. The purpose of our analysis was to verify that an encounter record was submitted for the corresponding NICU claim identified in the request for supplemental NICU payment. Data elements compared were member Medicaid ID, member date of birth, admission date, and discharge date.

ANALYSIS FOUR: FINDINGS AND RECOMMENDATIONS

Our findings are as follows:

- Myers and Stauffer found that of the 93 claims reviewed, 91 Member Medicaid identification numbers matched what the CMOs reported to what was found in the encounter data. For the two members whose identification numbers did not match, it was determined these members had merged member ID's.

- Only one date of birth did not match between the CMO submitted data and the encounter data. The member's date of birth is 27 days earlier in the encounter data. This finding is described in greater detail in Note 2 above.
- A total of seven discharge dates supplied by Amerigroup did not match the corresponding encounter claims. The discharge date differences ranged from five to 66 days.
- Myers and Stauffer found discharge dates on two WellCare claims which do not match the submitted dates in the encounter data. One date was four days later, while the other discharge date was 40 days earlier than the discharge date submitted in the encounter data.

Based on the findings above, the majority of the issues found by Myers and Stauffer were related to discharge dates. Each CMO should ensure through and complete quality assurance procedures are performed before data is submitted to the Department to request a NICU supplemental payment.

ANALYSIS FIVE

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

The purpose of this analysis is to identify any changes or trends in member enrollment using eligibility data for all members found in the NICU sample for the time period specified above and report findings.

Out of 93 NICU claims submitted to DCH by the CMOs for the supplemental payment, 53 or about 57.1% of the newborn members remained at the CMO with which they were initially enrolled for at least the three month period analyzed and 31, or approximately 33% of newborns' enrollment had changed to traditional Medicaid within the three month period. There were no enrollments which changed to one of the other two CMOs within the first three months after the date of discharge. The above changes in enrollment are detailed by CMO below:

- **Amerigroup**
  - 17 members (50.0 percent) remained with AMGP at the end of 90 days
  - 15 members (44.1 percent) went from being enrolled with a CMO at birth to being enrolled in traditional Medicaid by the end of month three
  - One member (2.9 percent) passed away before day 90
  - One member was disenrolled from AMGP with no disenrollment reason given
- **PSHP**
  - 13 members (59.1 percent)) were PSHP members at the end of month three
  - Five members (22.7 percent)) were enrolled in traditional Medicaid at the end of 90 days
  - Four members passed away before the end of the third month
- **WellCare**
  - 23 members (62.2 percent) remained with WellCare at the end of 90 days.
  - 11 members (29.7 percent) were enrolled in traditional Medicaid by the end of month three.
  - One member was disenrolled from Medicaid and the CMO before the end of 90 days.
  - Two members were disenrolled from WellCare with an "Other Disenrollment Reason."

We noted that many enrollment changes were a function of the relocation of the member outside of the CMO's service region. There were three members which were disenrolled with a disenrollment reason which was not clear or no diesenrollment reason.

RECOMMENDATIONS

DCH RECOMMENDATIONS

- The Department should consider requiring Amerigroup to perform a medical records review of the claims listed on Table 2 and report their findings. If Amerigroup is unable to complete this request due to non-receipt of medical records, the Department may wish to consider these claims unsupported and require repayment of the supplemental payments for these two claims.
- DCH may wish to recoup the supplemental payment made for the PSHP claim confirmed as grouping to DRG 623 on Table 3.
- Myers and Stauffer recommends the Department require Amerigroup to confirm that the diagnosis code 765.02 was included in their grouping of the claim listed on Table 4 and if so, explain why they arrived at a different DRG assignment.
- Myers and Stauffer recommends the Department require PSHP to perform a medical record review of the claim listed in Table 4 and report their findings to the Department. If an incorrect DRG assignment is determined, the CMO should work with the provider to assure proper payment of the claim is made. Once the final DRG assignment is determined and payment is completed, PSHP must report their findings to the Department.
- Determine if WellCare received two supplemental payments for one member with two distinct Medicaid ID numbers. If it is determined that two payments were received by WellCare, Myer and Stauffer recommends recoup of one of those payments. Issue is listed on Table 5 in the Findings Snapshot portion of the report.
- Verify that the Claim Admission Date check, one of the required data verification checks performed when the claim is submitted to HP for the supplemental payment, is functioning correctly.
- The Department should consider requiring the CMO to pay the appropriate outlier payment before receiving a supplemental payment for DRG 606, 609, or 615.
- Include additional edits and audits to the Department's current pre-payment process as performed in the HP system for determination of claims submitted by the CMOs requesting a supplemental payment. Myers and Stauffer recommends the additional edits and/or audits:
    - Require the CMOs to include the member's discharge status when submitting claims for the NICU supplemental payment. HP should test the discharge status for all claims assigned a DRG of 602, 604, or 606 to ensure the member discharge status is not '20'-"Expired".
    - Expand Duplicate Checking logic to also check for a combination of duplicated date of birth with admission date and discharge date.
    - Update the Discharge Date Validation to state discharge date should be prior to or equal to the date of death, if there is a date of death.
    - Update the Age Validation edit to only include member's 28 days old or less as of the Admission Date. Member's 29 days of age or older will not group to one of the six DRGs that qualifies for the NICU supplemental payment.
    - Require the CMOs to provide the member's birth weight in grams as part of their NICU submission. Logic should be added to confirm the assigned DRG on the claim to the member's birth weight.

- Require a signed attestation from the CMO, submitted with each NICU supplemental payment request file, stating quality assurance measures have been completed.

CMO RECOMMENDATIONS

- We recommend that each CMO thoroughly document in writing the policies and procedures used to determine that a NICU claim is coded and billed properly by the provider and that any outlier required has been appropriately calculated and paid. Specifically,
  - Update their provider contracts to state a birth weight must be supplied on the claim for members 28 days of age or less.
    - If a birth weight is not provided, the CMO should deny the claim for missing birth weight.
- We recommend that each CMO review their monthly submission of NICU claims where they are requesting a NICU supplemental payment to ensure that the required data elements are included and confirm the accuracy of the claim prior to submitting the claim to DCH.

EXHIBITS

Exhibit A

August 1, 2012

Savombi Fields, CFE
Manager
Myers and Stauffer LC
133 Peachtree Street NE, Suite 3150
Atlanta, Georgia 30303

RE: Report #22 DCH NICU Analysis

Dear Savombi:

Please find this letter as our acknowledgement of the NICU analysis published by Myers and Stauffer. After reviewing the report, we wanted to take the opportunity to speak to a few of the findings published in this report.

AGP Finding 1 (Page 10, ¶3): Medical Records Requests

We acknowledge Myers and Stauffer's inability to confirm the assigned DRG on two Amerigroup claims due to the non- received medical records. Amerigroup made several attempts to obtain these medical records from the provider, yet we were unsuccessful in obtaining these records. If suggested, Amerigroup would be willing to perform a medical records review on the claims listed in Table 2 and report our findings.

AGP Finding 2 (Page 10, ¶4): DRG Grouping

We acknowledge Myers and Stauffer's conclusion that this claim should have grouped to DRG 602. We recalculated the DRG in our system and still came up with a computed DRG of 622. While diagnosis code 765.02 was factored into our calculation, we are willing to reconfirm this calculation with the appropriate parties.

AGP Finding 3 (Page 25, ¶5): NICU Policies

To date, all Amerigroup claims policies and procedures have been supplied to Myers and Stauffer.

303 Perimeter Center North
Suite 400
Atlanta, Georgia 30346
678.587.4840

www.amerigroupcorp.com

Amerigroup RealSolutions in healthcare

Thank you for allowing us the opportunity to review your findings. We take great strides to ensure the payment accuracy of our claims is consistent with the parameters of the State and provider contracts. We'll take the observations and recommendations put forth by this report and ensure we incorporate them into our internal processes.

Sincerely,

Aaron

Aaron Lambert
Associate Vice President, Operations
Amerigroup Community Care

4425 Corporation Lane
Virginia Beach, Virginia 23462
757.490.6900

www.amerigroupcorp.com

Exhibit B

PEACH STATE HEALTH PLAN RESPONSE TO MYERS AND STAUFFER REPORT NO. 22

M&S Report pg. 10	
Area of Concern	**CMO Response**
• Myers and Stauffer calculated DRG 623 for one PSHP claim. According to the criteria as determined by the Department, DRG 623 is not one of the six DRG's that qualifies for the supplemental NICU payment. This claim was sent to PSHP for review. o PSHP confirmed that the claim grouped to DRG 623. The Plan also stated we received a supplemental payment for this claim. • This claim (see table 3- pg 11) did not appear on the list provided by the Department of NICU supplemental payments paid from July 2009 to November 2011; therefore it is not clear if this claim has already been recouped by the Department. If this claim issue remains outstanding, M&S recommends that the Department recoup the supplemental NICU payment for this claim as it does not qualify for the NICU supplemental payment	The Plan agrees that the claim did not meet the criteria for the supplemental payment

M&S Report pg. 11	
Area of Concern	**CMO Response**
• The medical records for another PSHP NICU claim indicated the member's birth weight fell within the 750-999 gram range. After consultation with a Myers and Stauffer Certified Coding Associate, it was determined that the diagnosis code 765.02 (Extreme fetal immaturity, 500- 749 grams) billed on the UB-04 claim was incorrect. The provider should have billed diagnosis code 765.03 (Extreme fetal immaturity, 750-999 grams). Based on this corrected information, Myers and Stauffer grouped this claim to DRG 604 rather than DRG 602 included on the claim. This claim was sent to PSHP for review. o PSHP responded that: "DX billed: V30.00, 765.02, 769, 770.7, 774.2, 771.81, 276.1, 276.9, 765.23, 770.82, 458.8, 790.29, 362.23, 760.79, 747.83. Proc codes billed to determine DRG 602: 9604, 9672, 9983, 9904, 3891, 892. Discharge billed by provider is 01- Discharged to home. DRG assignment is correct". • (See table 4-pg.12) for this claim. The Department may wish to require PSHP to perform a medical record review of the claim listed in Table 4 and report their findings to the Department. If an incorrect DRG assignment is determined, Peach State should work with the provider to ensure proper payment of the claim is made. Once the final DRG assignment is determined and the payment to the provider is adjusted as appropriate, PSHP should report their findings to the Department.	Peach State will review the medical records associated with this claim. Please note that the claim was originally paid in June 2010. Pursuant to OCGA 33-20A-62, this claim would be outside of the 12 month look back period for recoupment of any applicable overpayment. However, if the Plan determines that this claim was incorrectly billed, it will review the provider's more recent filings and work to educate the provider regarding appropriate billing procedures.

M&S Report pg. 25	
Area of Concern	**CMO Response**
Policies were not submitted by Amerigroup, PSHP or WellCare	Peach State's policies are enclosed with this response.

Exhibit C

Annette Zerbe, CHC
Senior Director, Regulatory Affairs

August 1, 2012

Kathy Haley, MPL, CFE
Myers & Stauffer LC
9265 Counselors Row, Suite 200
Indianapolis, IN 46240

RE: Draft Report #22: Analysis of NICU Supplemental Payments

Dear Ms. Haley,

This letter is in response to Draft Report #22: Analysis of NICU Supplemental Payments. WellCare values your feedback and we remain committed to remedial action on matters recognized as areas for improvement. In the spirit of offering feedback, there are two sections of this report that we would like to respond to.

Potential Duplicate NICU Supplemental Payment –
We welcome the opportunity to assist DCH in investigating any potential duplicate payment disbursed to our plan. WellCare currently has a thorough process of reconciling NICU supplemental payments received. Upon discovery of any payment discrepancy, our Revenue Reconciliation department communicates with DCH representatives to bring awareness of the payment discrepancy for prompt resolution. In the case of the potential duplicate claim identified in this report, our research reflects only one NICU supplemental payment has been received by WellCare.

Discharge Date	Billing Provider Medicaid ID	Billing Provider Name	Check Number	CMO Paid Date	CMO TCN	DRG Code	DRG Code and Description	Outlier Flag	Payment Received Date	Capitation Paid Amount
[redacted]					[redacted]7222	622	622 - NEONATE, BIRTHWT >2499G, W SIGNIF OR PR	N	[redacted]	$85,376.23
					[redacted]7222	622		N		85,376.23

WellCare received one submission under claim #[redacted]7222 and paid that claim only once. While it appears on the surface that the state issued two Medicaid ID #s to WellCare, in actuality, only one ID received payment. A total payment of $53,759.58 was issued.

Quality Assurance Process –
In late 2011, WellCare employed an internal Quality Assurance (QA) step of NICU supplemental payment requests prior to file submission to Hewlett-Packard (HP).

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Annette Zerbe, CHC
Senior Director, Regulatory Affairs

This process ensured an accepted encounter was on record and assigned an ICN by HP prior to WellCare submission of a NICU supplemental payment request. With the implementation of this process, DCH may notice a decrease in volume of our NICU payment requests when compared to historical trends.

We appreciate your analysis concerning the accuracy of WellCare's NICU supplemental payments and the opportunity to respond accordingly. WellCare of Georgia remains committed to working with DCH as partners in administering the Georgia Families program.

Sincerely,

Annette Zerbe, CHC
Senior Director, Regulatory Affairs
WellCare of Georgia, Inc.

cc: David McNichols, Georgia State President
Kathy Ryland, Georgia Chief Operating Officer
Joshua Luft, Senior Manager Reporting & Analytics
Claudette Bazile, Deputy Director of Operations, Medicaid Division

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