HEALTHSYSTEMS OF ILLINOIS

QUESTIONS AND ANSWERS

Responses to provider questions presented to HSI and IDPA in August and September 2002 and Implementation Regional Meetings

Please direct IDPA billing questions to IDPA Billing Consultants at: 217-782-5565

QUESTION	RESPONSE
Admission Orders and Observation Services	
Can an admit order be changed to an order for Observation prior to billing? If not, where is the regulation cited that states an admit order cannot be changed to an Observation order prior to billing? Can a physician retroactively change or clarify admission orders prior to submitting the initial claim to IDPA?	Yes. If an admission is denied and the admitting/attending physician agrees that the services could have been rendered in Observation, the hospital can bill for the Observation stay as long as there is an order to admit to Observation. Yes, the physician is able to retroactively change or clarify orders prior to submitting the initial claim to IDPA.
Appeals	
If an expedited appeal is done and upholds the initial denial, what is the next step in the appeal process?	If the hospital or physician disagrees with HSI adverse determination, the hospital or physician may submit a written request for review by IDPA to ensure that due process was followed.
What is the appeal process? Will this occur during hospitalization or through chart review after discharge?	The reconsideration (appeal) process provides any hospital or physician who receives a utilization review denial notice and disagrees with the determination an opportunity to request and receive a reconsideration of the denial determination. There are **Expedited Reconsiderations** that can be requested (in writing) and completed while the patient is in the hospital. There is also **Standard Reconsideration** that can be requested after the patient is discharged. The request must be submitted in writing within 60 days of HSI's denial notification letter. HSI will complete the reconsideration review within 30 days of receipt of the request.
Billing and Payment:	
If a DRG reimbursed facility admits a patient and then transfers the patient to another facility, the receiving hospital is reimbursed the full DRG payment. How is the transferring hospital to be reimbursed? What is the formula? By percentage of ELOS?	The transferring hospital's reimbursement is prorated, based on the length of stay. The receiving hospital receives a full DRG reimbursement.
Who is going to process our claims? Who can hospitals contact to discuss pending claims?	Claims are processed by IDPA. Hospitals may contact their IDPA Billing consultant at **217-782-5565.**
How is payment affected if an admission is certified, but continued stay reviews were not done?	Payment will be made only when the total covered days are equal to or less than the total days certified by HSI. If the billed days are greater than the days approved, the claim will reject.
What is the daily Medicaid reimbursement rate for inpatient treatment? Inpatient mental health?	The daily (per diem) rate is hospital specific. Contact the IDPA Billing Consultant at **217-782-5565** to determine the hospital's reimbursement rate.
What is the daily Medicaid physician reimbursement rate?	There is no daily physician reimbursement rate. The rate paid depends on what CPT code was billed.
What is the expected timeframe for payment after discharge has occurred when all days have been certified?	The timeframe for payment depends on IDPA's current adjudication and payment cycle.

Would the referral hospital be required to use the same admitting diagnosis code as the referring facility?	No. At the time that the patient is transferred the admitting diagnosis may be different than at the time of initial admission to the hospital. The referral hospital needs to call for concurrent review if the admitting diagnosis is on Attachment A, B, or C. The list of these codes are attached to IDPA's Informational Notice and is available on the IDPA's website at www.state.il.us/dpa/provider_release_bulletins.htm or HSI website at www.HSofI.org
If a patient is discharged AMA, how is payment to the hospital influenced?	The Patient Status Code should be coded as "07." This may change the DRG reimbursement.
When a review is cancelled because "chart not available" and subsequently the medical record is located should the provider rebill IDPA electronically or hard copy with a copy of HSI's Notice of Cancelled Review?	When a review has been cancelled for "chart not available", the claim needs to be re-billed to IDPA and the claim will then suspend again for review. The cancelled review notice should not be submitted with the claim. The claim can be billed electronically as long as there are not other attachments required.
Are PHP and IOP going to be covered for chemical dependency treatment? Does IDPA cover Psychiatric Intensive Outpatient Programs (20 hours a week or more)? Is PHP considered inpatient or outpatient? What are the conditions for review on psychiatric PHP and IOP Programs? Do PHP or IOPs need to do this UR if the diagnosis is on the sheet?	These are outpatient services and will not be subject to these reviews. Coverage for outpatient psychiatric services has not changed. Reference in Hospital Handbook – Psychiatric Clinic Services (A & B) H-201.18 and 262 may be found on IDPA's web site.
How are Pass Days handled with the new concurrent review requirement?	Only days that are medically necessary will be approved. Pass Days should be recorded as non-covered days on the request for Concurrent/Continued Stay Review Form. The non-covered days need to be reflected on the UB-92. The DOS on the claim must be equal to or less than the LOS approved or the claim will reject.
How will Office of Mental Health (OMH) and IDPA reconcile reimbursement?	In general, OMH and DPA reimbursement will be distinct because each agency is purchasing services for a different population. However, reconciliation will be necessary for treatment events for which both agencies have made payment. This could occur for clients who become Medicaid eligible retroactively. Periodically, OMH will match its payment files with those of DPA to determine if duplicate payments have been made. In those instances, payment by OMH will be voided and the funds recovered or credited against the future purchase of services.
Since the HSI Review Request Form and UB-92 requires both the hospital's and physician's Medicaid provider number, what do hospitals do if the physician is not enrolled in Medicaid?	The physician's provider number is necessary. If the physician is not enrolled in Medicaid, enter the first ten digits of the AMA medical education Number, the nine digit SSN, State License Number, or UPIN.
Coding, Diagnoses and DRGs:	
Please explain the theory behind continued stay review when the hospital is paid based on DRG. What should the hospital do when days are denied?	The admission and entire LOS must be medically necessary and appropriate. HSI performs admission and continued stay review on DRG reimbursed cases to identify medically unnecessary inpatient hospital days. IDPA will reimburse the hospital as usual when the admission is certified. Non-certified days are reported to IDPA on the UB-92 as non-covered days.

	If the hospital is designated as a Disproportionate Share Hospital (DSH) or receives additional quarterly payments, non-covered days are not applied to the hospital's DSH days or other additional quarterly payments the hospital may be entitled to receive. If a hospital is seeking to be designated as a DSH hospital or apply for additional quarterly payments, every medical necessary inpatient day is used in the determination.
If a facility receives payment based on the DRG reimbursed methodology, is it still necessary to request a continued stay review?	Yes.
What grouper is Medicaid using?	IDPA utilities the HCFA V12.0 Medicare grouper as developed by 3M Corporation. This grouper was placed in effect with Medicare on 10-1-1994, and per Illinois Administrative rules the Department began utilizing it for claims pricing on 1-1-1995. Current law requiring the continued use of all weights and rates in effect on 7-1-1995 require the Department to continue using this version until such time as a revision in the law allows the Department to update.
DRGs 434 and 435 are no longer valid per Medicare's grouper?	IDPA continues to recognize and pay these DRGs even though Medicare may not. In 1995 the Department paid for DRG s 434 & 435 associated with alcohol and substance abuse detoxification. Since the current law requires the Department to utilize the same weights and rates in effect on 7-1-1995, the Department is bound to continue to pay for these services. In response to all revisions in DRGs, diagnosis and procedure codes that have occurred since 10-1-1994, the Department annually acquires an updated version of the 3M Diagnosis and Procedure Code Mapper. This software allows the Department to map backward all current diagnosis code, procedure codes and DRG codes, to corresponding codes that existed in the HCFA V12.0 grouper software.
When is the Public Aid grouper going to be updated?	The Department has no immediate plans to update the grouper. As previously stated, the Department is bound by current law requiring continued use of the rates and weights in effect on 7-1-1995.
Is Medicaid still scheduled to go to DRGs in October 2002 for psychiatric diagnoses?	This policy has not changed. Inpatient psychiatric services are billed with the appropriate diagnosis codes. The DRG assigned is based on the codes submitted on the UB-92 claim form.
Our psychiatric facility doesn't submit claims per DRG. Will IDPA group ICD-9/DSM IV codes?	IDPA groups all claims prior to selection of the pre-payment review cases regardless of the payment method. DRGs are assigned based on the codes submitted on the UB-92 claim form.
Do hospitals have to hire additional coding staff or can UR nurses apply the codes?	HSI defers to each hospital's administration to make that determination.
The hospital is being asked to provide ICD-9-CM codes other than the reason for admission. How important is this? The UR staff are not coders and do not have access to codes.	HSI uses this information to assess the clinical condition of the patient and to determine the number of days certified and therefore, the next review point. The complete clinical picture is required to ensure that complications and co-morbid conditions are considered in the review determination. Providing the ICD-9 codes will assist the appropriate assignment of LOS since co-morbidities are considered.

At the workshop, the speaker indicated that if the RN doesn't know the diagnosis code, the HSI reviewer could provide it. What happens if the HSI reviewer makes an error, and the final billing code doesn't match?	While HSI may assist the hospital in identifying the possible admitting diagnosis code, it is ultimately the provider's responsibility to assign and provide the admitting diagnosis code to HSI. In the case that the HSI reviewer enters an incorrect diagnosis code into the review system, it can be corrected by the hospital by contacting HSI with the correct admitting diagnosis code. The admitting diagnosis code will be recorded on the HSI Certification of Admission Notice that is transmitted to the hospital.
What is the difference between Chest Pain (143) on Attachment D, Chest Pain, Unspecified (786.50) on Attachment C, and Chest Pain, Other (786.59) on Attachment C?	Chest Pain (143) on Attachment D: The "143" refers a DRG assignment and Title. Many ICD-9-CM codes may group to this DRG. Chest Pain, Unspecified (786.50): This ICD-9-CM code is assigned when the type/cause of chest pain is unspecified by the physician. Chest Pain, Other (786.59): This ICD-9-CM code is assigned when pain is described as chest discomfort, pressure or tightness. The Hospital's Health Information Management (Medical Record) Department may be the appropriate source for additional information on coding and DRG assignments.
What happens when the admission code assigned for review differs from the diagnosis code submitted on the UB-92? The admitting diagnosis might not be the same as the final diagnosis. What if the diagnosis on the UB doesn't match the diagnosis called in?	Each claim submitted to IDPA is subjected to MMIS edits. The system identifies those admitting diagnosis codes that require HSI's certification. If the admitting diagnosis submitted on the claim form is on IDPA's Attachment A, B, or C, the edit systems "checks" the certification information to ensure that the total "covered days" have been certified by HSI. • If the HSI certified days are equal to or greater than the days billed, the claim will pay as long as it clears all other MMIS edits. • If the admitting diagnosis is subject to Concurrent Review and no such review has occurred, the claim will suspend for Retrospective Prepayment Review. • If the admitting diagnosis is subject to Concurrent Review and differs from the admitting diagnosis on the HSI review information, the claim will reject. • If the code on Attachment A, B, or C is not submitted as the admitting diagnosis on the claim, the claim continues through the payment process. Each claim (per-diem or DRG reimbursed) is grouped by IDPA's MMIS system to determine the DRG. If the case groups to a DRG that is listed on IDPA's Attachment D, and the case has not been certified by HSI, the claim will suspect for Retrospective Prepayment Review. HSI sends the hospital a *Notice of Review Approval* that contains the admitting diagnosis as provided by the time of admission. If the admitting diagnosis is different than the one the hospital will use on the UB-92, the hospital should contact HSI within 30 days of discharge (and before submitting the claim) to clarify the discrepancy (provide the correct admitting diagnosis).
For dual diagnosis patients, is only the primary diagnosis the determiner for certification? If a patient has 2 diagnoses on admission, do both get certified or does the hospital wait until one is ruled out?	Certification should be obtained when the **admitting diagnosis** as defined in the UB-92 Billing Manual is listed on IDPA's Attachment A, B, or C. No. The admitting diagnosis is the primary reason the patient was admitted as an inpatient as documented by the physician.

If a patient is admitted with the diagnosis of chest pain AND angina, are hospitals still required to call in the chest pain, even though it is known to be related to the angina?	Certification should be obtained when the admitting diagnosis as defined in the UB-92 Billing Manual is listed on IDPA's Attachment A, B, or C.
Are coding reviews and DRG validation done by the RN Reviewer or by and RHIA/RHIT/CCS?	Coding reviews and DRG validation is performed by HSI's Utilization Review Coordinators (URCs) who are Registered Nurses. These URCs are trained in the principles of ICD-9-CM coding and DRG validation. Final coding on all DRG referral cases is performed by an RHIA/CCS.
If a patient is admitted with a diagnosis on Attachment C, but the final diagnosis is NOT on the list, e.g. abdominal pain turned cholecystectomy or chest pain turned MI, is admission (concurrent) review still required?	The definition of admitting diagnosis as defined in the UB-92 Billing Manual should be applied. If the code for the diagnosis that meets the definition is on Attachment C, admission (concurrent) review is required.
Is inpatient substance abuse treatment covered by admission certification concurrent review?	If the code for the admitting diagnosis is listed on Attachment A, B, or C, concurrent review is required.
Is there a focus list of particular DRGs that are being review?	Attachment D contains the DRGs that are subjected to retrospective prepayment review.
Certification and Concurrent Review:	
What advantages are offered by admission/concurrent review for Public Aid patients?	By conducting concurrent review, a provider would at time of admission contact via FAX or telephone the HSI reviewers and present the patient's specific medical condition. Concurrent review is not required prior to admission, but instead, after the physician admits the patient, during the patient's hospitalization. The nurse reviewer will render a decision either at that time of the request or a decision will be made within two business days if referral to a Physician Peer Reviewer is required. Continued Stay reviews are completed within one business day of receipt of all required information. If the reviewer needs additional information, the provider will be able to gather that information while the patient is still in the hospital. The hospital may request a continued stay review, if additional inpatient days beyond the initial number of approved days are needed. Concurrent review is time sensitive. If the case is referred for physician review, concurrent review allows the admitting or attending physician to dialogue with the Physician Peer Reviewer on the patient's condition and care needs during the patient's hospital stay. It offers less risk to the hospitals than experienced with the retrospective prepayment review process, often occurring months after the patient has been discharged. It provides an opportunity for hospitals to experience more expeditious payment after the clean claim has been submitted to IDPA.
Is there a penalty for failing to comply with IDPA's concurrent review requirement? Will there be in the future.	There is no penalty at this time. IDPA believes the concurrent review process will result in less risk to the hospital. If hospitals do not comply, prepayment review will occur. It has the advantages as indicated above.
What if hospitals don't have the staffing/manpower to participate in concurrent review?	As described in the Hospital's Utilization Manual, each hospital is required to perform utilization review for admissions. IDPA is aware that all hospitals may not be prepared to make the transition to the new system that became effective September 16, 2002. IDPA offered hospitals the opportunity to continue with retrospective prepayment review process while making the transition to concurrent review. Hospitals will not be penalized.

Do other states currently participate in a concurrent review process? If so, how is it working? Do facilities like concurrent review?	Yes, Medicaid programs in other states do require concurrent review, e.g. Missouri, Mississippi, and Indiana. Concurrent review has been well received. In some states, 100% of all hospital admissions as well as other services require prospective and/or concurrent certification. This process is common in the private sector and was recommended to IDPA by the psychiatric community.
Is an admission certification necessary when a Participant has Medicare Part A or other primary payer?	Reviews are performed on secondary claims except when Medicare Part A is primary and the hospital is billing for the Medicare deductible/co-insurance.
Do children enrolled under the DSCC waiver require their hospitalizations to be certified?	No. But if the claims are not submitted in hard copy as special handling and the hospitals send them through normal processing, they will be rejected.
Are out-of-state hospitals required to do concurrent review?	Yes, if the patient is an IDPA Program Participant and if the admitting diagnosis is subject to concurrent review.
Will a disproportionate share of psychiatric hospitals be subject to admission certification and concurrent reviews or remain with retrospective onsite reviews? If so, why?	Yes. The admission certification and concurrent review process applies to all hospitals. IDPA requires that 100% of psychiatric inpatient admissions require review at this time.
Will Mental Health professionals be doing the admission certifications for psychiatric admissions to an inpatient unit? Will HSI RN reviewers be knowledgeable about psychiatric treatment?	The concurrent and retrospective prepayment reviews will be performed by Registered Nurses using screening criteria as appropriate. Some are trained primarily as psychiatric nurses, others as medical/surgical nurses. All URC will be trained to appropriately apply behavioral health review criteria for initial review. There are additional UR staff (i.e. psychiatrists) who are available to provide ongoing training and consultation when necessary.
What will Medicaid cover in terms of substance abuse? What resources are available for substance abuse services?	Services subject to either concurrent or retrospective prepayment review that are medically necessary and the diagnosis code is on Attachment A, B or C or DRG on Attachment D. Contact the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse (OASA) at **1-866-213-0548** or **217-785-7754** for information on resources for substance abuse treatment programs.
What is the procedure when a patient is admitted for a medical condition that does not require admission certification, but during the stay, the patient's primary diagnosis changes to a psychiatric diagnosis?	The hospital must discharge the patient from the medical service and admit the patient to the psychiatric service, using the appropriate admitting diagnosis. This is a change in the Category of Service for the inpatient stay. The hospital must submit separate claims, if there is a change in the Category of Service. If the admitting diagnosis is subject to concurrent review for the inpatient stay, a Certification of Admission should be requested. In this case, the clinical information on the psychiatric condition would need to be provided to HSI within 24 hours of the admission to psychiatric inpatient acute care.
What data analysis reports will be provided to hospitals and in what timeframes?	The hospital will receive: • Daily lists of cases requiring further concurrent review, and • the Monthly Report of Coding Changes. When web-based review request submission becomes available, hospital-specific reports will be available. HSI will work with IDPA and the hospital community to identify additional reports that may be provided.

What is the process for authorizing inpatient admissions to any level of care?	Only diagnosis codes on Attachment A, B, and C require certification, and if necessary, continued stay review(s). **This is <u>after</u> admission. This is not a pre-certification and it is not a pre-admission approval process.** Hospital staff or physicians should submit requests for certification, within 24 hours of admission or shortly thereafter, while the patient is still in the hospital. The request may be submitted to HSI via fax, mail, telephone or (electronic [web] submission, when available). The request will be reviewed by a URC to evaluate the medical necessity, reasonableness and appropriateness of the hospital admission using clinical information provided. Based on the information provided, if the hospitalization meets the screening criteria for admission, the facility will be informed of the certification decision immediately if telephonic; or within one business day of receipt of complete information, if fax or direct mail. If the initial clinical information provided do not meet screening criteria, the case will be referred to a physician reviewer and a certification decision will be communicated to the facility within two business days of receipt of complete information.
The list of medical diagnoses is ambiguous (e.g., seizures – is this convulsions, epilepsy, asthma, shortness of breath, fluid overload, acidosis?) Sometimes the reason the patient is admitted does not exactly fit with the list; should the case be reviewed or not?	The hospital should seek certification when the admitting diagnosis is on IDPA's Attachment A, B, or C. "Admitting Diagnosis" is defined in IDPA's UB-92 Billing Manual for Illinois (Form Locator 76). When a patient is admitted the medical diagnoses may be ambiguous and the admitting diagnosis may differ from the principal diagnosis. To the degree possible, efforts should be made to determine the code for the admitting diagnosis based on the information in the medical record to the time the review is requested. It is the ICD-9-CM code for the medical diagnosis that determines whether review is required, not the narrative description. If the admitting diagnosis on the *Notice of Review Approval* is different than the one the hospital is using on the UB-92, the hospital should contact HSI within 30 days of discharge (and before <u>submitting the claim</u>) to provide the correct admitting diagnosis.
Will an authorization number be given when an inpatient stay is approved? What is the TAN?	Yes. HSI will issue a Treatment Authorization Number (TAN) specific to certified admission for tracking purposes only. The TAN should not be recorded on the claim submitted to IDPA. HSI will transmit the admission and number of days approved to IDPA. The TAN allows HSI to quickly access the patient's record to facilitate the review process.
Will HSI's certification include the date that it was sent?	Yes. HSI's written Notice of Review Approval or Notice of Denial will be dated. The date of submission of the hospital's or physician's request for certification is also included.
If a hospital is not paid for the diagnosis, does the physician get paid?	HSI's review determination applies only to the hospitalization. The <u>physician is reimbursed for services rendered by him or her</u>.
How does the reviewer determine the number of days that are certified before a continuing stay review is necessary?	HSI's URC utilizes Solucient's Length of Stay Norms as a guide along with the clinical information submitted to determine the next review point. For requests referred to Physician Peer Reviewers (PRs), the PRs determine the number of days certified based on the patient's clinical condition and the estimated Length of Stay supplied at the time of the request for review.
Do the ICD-9-CM diagnostic codes listed on Attachment C apply to all ages, i.e., adult and pediatric?	Yes.

What if there is not sufficient clinical information at the time of admission to complete certification? If hospitals call in incomplete information, can hospitals call back with additional information to the considered later?	If the URC lacks the clinical information necessary to perform review, the information will be requested. If the information is not submitted within 30 days of discharge, the review will be cancelled. When the hospital submits a claim, the claim will suspend and the case will be forwarded to HSI for retrospective prepayment review.
If admission certification is obtained, will failure to obtain continued stay cause a payment denial?	If the admission is <u>not</u> certified during the hospitalization and the case was subject to admission review, the case will be selected for retrospective prepayment review based on the admitting diagnosis according to Attachments A, B, and C. If the admission <u>is</u> certified and continued stay review is requested more than 30 days after the patient's discharge, HSI will issue an Administrative Denial – Failure to Obtain Continued Stay Review. The hospital may ask for a standard reconsideration of this administrative denial.
Once a concurrent review is approved, will the same case ever be selected for post-payment review? Please clarify: Does failure to receive admission certification cause a case to be reviewed on a retrospective prepaymant basis?	Yes. The case may be selected as part of a retrospective post-payment review sample to review for quality of care and to validate the information provided during concurrent review. If the admission is <u>not</u> certified during the hospitalization and the case was subject to admission review, the case will be selected for retrospective prepayment review based on the admitting diagnosis according to Attachments A, B, and C.
If an admission and/or continuing stay days have been approved telephonically, can payment still be denied via a retro-review?	No. The case will not be selected for retrospective prepayment review if it was certified by HSI during concurrent review.
If a patient requiring a psychiatric admission presents to the ER, is the ER staff required to call for pre-certification before transferring the patient to the psychiatric unit?	No. **This is not a pre-certification or pre-approval process**. Hospital staff or physicians should submit requests for certification after admission (within 24 hours), or shortly thereafter, while the patient is still in the hospital. The hospital determines the staff responsible for requesting the certification based on their resources, needs, etc.
If a patient is transferred from a general hospital to an inpatient psychiatric facility, who is responsible for obtaining admission certification? Referring or receiving facility?	The hospital to which the patient is being admitted should seek the certification, in each case.
What should be done about patients who are already in the hospital on 9/16/02? What if they don't meet the new admission criteria? What happens to patients who are inhouse prior to 9/16/02?	Hospitals may seek certification for those patients currently hospitalized with an admitting diagnosis (as defined in the UB-92 Manual) on Attachment A, B, or C. If criteria are not met, the request will be referred to an HSI Physician Peer Reviewer.
Who at the hospital is expected to call in the clinical information for an admission certification? Clinical (UR) staff or non-clinical (registration) staff? Can a clinical person call in demographic information?	The hospital is to determine the staff to perform this function. The certification process does involve the submission and discussion of clinical information; therefore, careful consideration should be given regarding assignment of this responsibility. The review requires submission of clinical as well as demographic information. HSI will accept the review request and necessary information from any reliable person considered appropriate by the hospital.

If the admission is certified, but we miss the continuing stay review, will an administrative denial be issued? Can hospitals still call in continuing stay information even if the patient has already been discharged?	HSI will conduct a continued stay review when a request is received while the patient is hospitalized or within 30-days of discharge of the patient. An administrative denial will be issued when a continued stay review request is received by HSI more than 30-days post-discharge. Administrative denials are subject to reconsideration if requested by the provider. The LOS reported on the UB-92 must match what was approved by HSI.
Is continued stay review required on all admissions?	Continued stay review is required on all cases with admitting diagnosis (as defined in the UB-92 Billing Manual) on IDPA's Attachments A, B, or C. The list of these codes are attached to the IDPA's Informational Notice and is available on the IDPA's web site at www.state.il.us/dpa/provider_release_bulletins.htm or HSI web site at www.HSofI.org.
When are hospitals supposed to call in clinical information for continuing stay reviews?	Request for concurrent review for continued LOS should be submitted to HSI the day prior to expiration of the certification (last day certified) if needed. The last day certified is provided during telephonic review and is noted within HSI's certification approval letter.
Is continuing stay criteria for concurrent review based on SI/IS criteria or Discharge Screens?	When InterQual Criteria is applied to the review, IS and Discharge Screens are applied. Both SI and IS are applied when psychiatric or detoxification cases are reviewed in conjunction with the discharge screens.
How can hospitals submit information for concurrent review on short weekend admissions? Can hospitals still call in the admission information on Monday even if the patient has already been discharged?	No. If the patient is admitted and discharged and a request for certification was not submitted while the patient was hospitalized, the case will be selected as a retrospective prepayment review.
What are HSI's hours of operation? Is HSI staffed 24 hours a day, 7 day a week, for concurrent review certification?	**Normal business hours** are **8:00 a.m. – 5:00 p.m., Monday – Friday**, except for designated Federal and State holidays. The **review request telephone lines** are available **7:00 a.m. – 5:00 p.m., Monday – Saturday**, except for designated Federal and State holidays. Review request may also be **submitted by fax, 24-hours per day, 365 days per year** or a request may be submitted in writing by overnight mail.
Given the high volume of psychiatric admissions how will concurrent reviews be handled? How frequent?	All psychiatric admissions require admission certification/concurrent/continued stay review at the time of admission or within 24 hours of admission. The number of days certified will depend on the clinical information provided by the hospital. The facility will be informed of the next review date at the time of the telephone contact or within one day of the receipt of complete clinical information via fax or overnight mail. Each hospital will also receive the daily summary listing of all cases due for concurrent review.
When can suicide precautions be discontinued prior to discharge without denying days?	There is no pre-set number of days allowed for discontinuation of suicide precautions. Certification of days will be based on whether or not the patient continues to meet the psychiatric inpatient criteria.
Confidentiality, Privacy and Patient Rights	
Is HSI considered to be a "HIPAA business associate?" If so, is a contract required?	Once HIPAA is implemented, HSI will have a Business Associate Agreement that will be available for execution.

If hospitals fax patient information at this time, are hospitals faxing to a secure site?	Yes.
When on-line review request are possible, will patient names be included on certification put on the website OR will a number or other identifiers be used to ensure confidentiality?	Information submitted as part of the on-line review request process will be encrypted to ensure confidentiality.
Do hospitals, as a healthcare facility, need to obtain consent to release information prior to calling in clinical information for concurrent review?	No. Since IDPA is reimbursing for the care being provided to the Program Participant, IDPA or HSI, as its designated PRO/QIO, has the authority to perform federally required utilization review of care.
If a patient refuses to sign consent to release information, is a pre-certification call still required? If so, would the patient be responsible for the bill?	Consent for release of information for certification review is not required since the IDPA is reimbursing for the care being provided to the IDPA Program Participants. IDPA or HSI, as its designated PRO/QIO, has the authority to perform federally required utilization review of care.
Court Ordered Admissions	
How will HSI deal with patients whose admissions are court ordered, especially when HSI assigns a specific length of stay?	HSI approves admissions and continued stays when medical necessity and appropriateness of the inpatient setting are established. This applies to all admissions, including those that are court ordered. IDPA only reimburses medically necessary and appropriate inpatient care.
Criteria:	
What criteria are used to determine appropriateness of inpatient admission and continued stay?	Depending on the diagnosis, for medical/surgical the latest available version of InterQual is used (currently 2001). For psychiatric diagnoses, IDPA Adult and Child/Adolescent Psychiatric Inpatient Criteria and IDPA Detoxification Review Criteria are used.
What criteria are used to determine appropriate admission to the Observation level of care?	Observation services are not subject to the concurrent review process. The review requirements are only for patients admitted for inpatient hospitalizations. Quality of care reviews will be conducted on patients admitted to Observation, through sampling, based on a retrospective postpayment review process.
Can facilities obtain copies of the criteria used? What is non-proprietary criteria?	InterQual is copyrighted and hospitals may purchase the criteria by contacting InterQual. The IDPA's criteria may be obtained from IDPA web site at www.state.il.us/dpa/ IDPA's criteria is non-proprietary which means it is not "owned" by the user and may be shared with anyone who requests it.
What criteria will be used for psychiatric hospitalizations and continued care for adults, children and adolescents?	Revised Adult and Child Adolescent Psychiatric Criteria release by IDPA in Provider Bulletin August 14, 2002 (No H200-02-3). In HSI's Training Packet and IDPA's web site www.state.il.us/dpa/
What InterQual criteria will be used for long-term inpatient care vs. acute inpatient care?	The acute inpatient criteria has been adopted for use on all inpatient hospital care. Hospitals may make recommendations to IDPA for consideration of other appropriate criteria.
What if a patient needs a procedure that InterQual criteria indicate requires an inpatient level of care, but Ambulatory Payment Categories (APC) list the level of care as "OBS"? Which criteria should hospitals use?	If the InterQual criteria for inpatient admission are met, the request will be approved. HSI may approve medically necessary admission and services only. The APC list is for Medicare patients. The most current IDPA list of Ambulatory Procedures can be found on the IDPA website at www.state.il.us/dpa/provider_release_bulletins.htm
Critical Access Hospitals:	
How does all this affect Critical Access Hospitals under cost-based reimbursement as of October 1, 2002 for DRG validation, etc.? Do "all hospitals" include "Critical Access Hospitals"?	Critical Access Hospitals are subject to review. Yes.

Denials:	
If a denial is issued, who notifies the recipient and how is this done? Who informs the patient when a continued stay is no longer medically necessary?	HSI does not provide notification of denial to the IDPA Program Participants. The hospital or the physician may notify the patient in accordance with their policies and procedures.
What types of cases are likely to be denied for admission? For continuing stay?	If medical necessity of the admission and/or continued hospitalization cannot be established with the clinical information provided, the admission and/or continued stay will be denied by the physician peer reviewer. The hospital and/or physician may request a reconsideration.
Will an addictionologist be used for physician review at the first of review instead of when the case go to the reconsideration level of appeal?	A specialist will not be consulted at the first level of review.
Discharges and Case Management:	
Is any consideration being offered to assist facilities faced with challenging discharges?	HSI may approve medically necessary days only.
What will happen in cases when a patient is stable for discharge but appropriate placement cannot be found? Examples: an aggressive geriatric patient with MI dx; Dual Diagnosis patient who cannot return to group home and we have to wait for DHS to place.	Every hospital social worker/discharge planner should have contact information (telephone numbers) for all screening entities (i.e., DHS ORS, DHS Office of Mental Health (OMH), DoA etc). It is through the respective screening entities that hospital staff are to identify placement options for persons being discharged from hospitals; including persons with psychiatric needs. There is no one telephone number, since the screening entities throughout the state work for the various agencies; regarding persons of specific age with specific needs e.g. psychiatric would be handled through a screening agent for DHS OMH. Neither OMH nor IDPA guarantees discharge placement for any client, even when payment has been authorized for the inpatient treatment event. For OMH-reimbursed care, community mental health agencies are expected to manage post-discharge treatment, provided they have the capacity and have been sufficiently involved in the inpatient treatment event (admission screening, discharge planing). To facilitate post-discharge linkage with community mental health agencies, hospitals are urged to coordinate with the community agency early and continuously through the inpatient treatment episode. This contact can be facilitated through the OMH network office, if necessary. If a patient/hospital needs information about discharge placement for a client with alcohol and/or substance abuse problems contact the OASA Hotline at **1-866-213-0548.**

For a patient who has been discharged without transportation resources, what resources are available?	All non-emergency transportation for covered medical services requires prior approval. IDPA has contracted with DynTek Services, Inc. to administer the Non-Emergency Transportation Services Prior Approval Program in Illinois. DynTek began operating in Cook County on June 1, 2001. DynTek expanded to Region 3 on August 1, 2002. (Region 3 includes: Bureau, Champaign, Ford, Fulton, Henderson, Iroquois, Knox, LaSalle, Livingston, Marshall, Mason, McDonough, McLean, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Vermilion, Warren, and Woodford.) DynTek expanded to Region 4 on October 1, 2002. (Region 4 includes: Adams, Brown, Calhoun, Cass, Christian, Clark, Coles, Cumberland, Dewitt, Douglas, Edgar, Effingham, Greene, Hancock, Jersey, Logan, Macon, Macoupin, Menard, Montgomery, Morgan, Moultrie, Piatt, Pike, Sangamon, Schuyler, Scott, and Shelby.) Participants living in these geographic areas must have all non-emergency transportation prior approved by DynTek Services Inc. for the transportation provider to be paid. Participants living in areas where DynTek is not operating must have all non-emergency transportation prior approved by the Illinois Department of Human Services local office. In regions administered by DynTek, any interested person may call DynTek to request prior approval for a single trip, such as a hospital discharge. If the requesting person knows which transportation provider the patient wishes to use, DynTek will approve the transportation, providing the transportation provider is an enrolled provider and is enrolled to provide the level of transportation appropriate for the patient's medical needs. If the requesting person does not have a preferred transportation provider, DynTek will randomly select three enrolled transportation providers that are appropriate for the Participant's needs. The requesting person will select the transportation provider from the three offered by DynTek. It is the responsibility of the requesting person to contact the transportation provider to schedule the trip. If none of the three originally offered by DynTek are available, DynTek will randomly select three more transportation providers for the Participant to choose from. In regions not yet administered by DynTek, designated staff at the Participant's DHS local office will provide assistance in locating a transportation provider if the Participant does not have a preferred transportation provider.

Who are the contacts for Participants in the four Home and Community Based Services (HCBS) waiver?	Case Management services are provided to Participants in the HCBS waivers. Contacts follow: HCBS Waiver for persons with Disabilities, Brain Injury and HIV/AIDS: **217-782-2722** HCBS Waiver for Persons with Developmental Disabilities Age 18 and over: **217-524-2515** HCBS Waiver for Persons over 60 years of age: **1-800-252-8966** HCBS for Technologically Dependent and Medically Fragile Children under 21: **1-800-322-3722**
Would "no available nursing home bed" that is documented in the discharge planning by social services validate a continued stay, i.e., non-avoidable day?	No. The continued stay must be medically necessary and appropriate. Days awaiting placement are not paid for by IDPA if inpatient acute care is not medically necessary and appropriate.
Eligibility:	
If a patient is admitted under OMH funds, but later becomes Medicaid eligible, how should the facility proceed? Is review necessary? Is there a special form that should be used to notify HSI of the change in funding?	Hospitals should proceed with concurrent review with OMH at the time the patient is admitted under OMH funds. Concurrent review with HSI at the time the patient becomes Medicaid eligible. HSI will receive the review findings from OMH and honor those findings for prior eligibility**.**
If a patient has Medicare Part A as primary, but all Medicare days have been exhausted, and therefore Medicaid becomes primary, is concurrent review required? How about Medicare Part B?	Hospitals must fax documentation that the patient has exhausted **all** Medicare Part A benefits at the time of certification of admission request. Concurrent stay review will occur if the admitting diagnosis is on Attachment A, B, or C. Admission of patients with Medicare Part B only should be certified if the admitting diagnosis is on Attachment A, B, or C.
Will HSI do concurrent reviews on patients who are "Medicaid pending" status?	No.
How can hospitals obtain information about Medicaid eligibility after hours, on weekends, and/or holidays?	IDPA has established the **Automated Voice Response System (AVRS)** for client eligibility inquiries. The toll-free telephone number **1-800-842-1461** is available 23 1/2 hours a day to allow providers to access client eligibility information through the use of any telephone. To utilize the AVRS, the provider must have the Participant's recipient identification number (RIN). Eligibility information consists of whether the Participant is eligible for one of IDPA's programs, and in which program the Participant is eligible specific to the date of service in question. Public Act 88-554 mandated the IDPA create a statewide electronic **Recipient Eligibility Verification (REV)** system. The REV system is available to enrolled providers throughout the state. The REV system utilizes various clearinghouses, known as REV vendors that have direct telecommunication line access into IDPA's databases. Additional information on REV system and vendors is available at www.state.il.us/il/dpa/html/medical_rev.htm

Will all "pending Medicaid" status admissions that become active be reimbursed if inpatient criteria are met? Will reviews be concurrent or retrospective?	If the patient's Medicaid eligibility becomes active while the patient is hospitalized, the certification review should be obtained. If criteria are met, reimbursement will be made for medically necessary days occurring during the eligibility timeframe. If certification is not obtained, the case will be selected for retrospective prepayment review if the admitting diagnosis is on Attachment A, B, or C.
Exclusions:	
What patients are considered to be enrolled in State Chronic Renal Programs?	For a person to participate in the State Chronic Renal Programs, the individual **cannot** be eligible for benefits with IDPA Medical Assistance Program.
"Renal Dialysis Patient" is listed as an exclusion, but "Chronic Renal Failure" is listed as one of the Attachment C diagnoses. Isn't this a contradiction?	No. Patients who experience chronic renal failure may not be enrolled in the State Chronic Renal Program. These are not the same population groups.
Is there a requirement to certify OB patients?	No. Delivery of a child is not an admitting diagnosis subject to concurrent review at this time. Only if the patient's admitting diagnosis code is listed on Attachment A, B, or C is concurrent review is required.
Faxed Review Requests:	
How are faxed requests for concurrent review being handled? Are the same reviewers doing telephonic review handling faxed requests?	HSI's Registered Nurse URC perform both telephonic and fax reviews.
Is there a back-up fax to handle requests if the usual fax machine isn't working?	HSI utilizes a fax server to receive requests. A back-up server is in place in the event that the primary server is down.
If a review is requested by fax, how will the facility liaison get information regarding the certification decision?	Verbal notification is provided on the day of the determination. Written notice of all certification decisions is provided to the facility liaison by auto-fax (if supported by the hospital's fax machine) or by mail within one business day of the review determination. Admission review determinations are made within one business day of receipt of the request (and all required information) if the nurse reviewer is able to certify the request. If Physician Peer Reviewer referral is made, the determination is made within two business days of receipt of all required information. Review determinations are made within one business day on continued stay review request.
HSI Implementation:	
The telephone reviews are taking 20-30 minutes or longer. This is about twice as long as phone reviews for other payers (generally about 15 minutes).	HSI monitors phone activity (volume and performance) real time and historically. During the first three weeks of HSI's review activity**,** the computer-generated data reflects an average per call "talk time" of approximately 10.5 minutes. (This "talk time average" includes calls in which multiple reviews are requested on the same call.) Average wait time on the Pre-certification Line has been less than 1 minute. During the initial weeks of implementation, hospitals have been calling to request reviews for patients who were hospitalized prior to September 16, in cases, patients who were hospitalized for considerable lengths of time. These reviews generally take longer than the average to conduct, particularly if the case was not reviewed at any point during the stay. HSI does not anticipate long phone calls once all hospitals have requested certification for admissions prior to September 16.

Review sheets have repetitive information on them and the same information is asked on the second pages and on the concurrent sheets. Completing these sheets is labor intensive and the information does not flow well. There is no place to document additional information that is not listed on the review sheet. The hospital needs to be able to list the medications the psychiatric patients are taking. Can these sheets be streamlined?	HSI's review request forms are designed to ensure that faxed request are correctly identified and linked to the correct patient. The forms are designed to provide the clinical information required for the review process. On the Psychiatric Admission Review Work Sheet (page 4 of 5), there is a section that states IV,IM, Sub-q Meds, this section can be used to list all PO psychiatric medications, the same is true on the Concurrent Review Work Sheet (page 2 of 3). If there is pertinent additional medical information, please use the worksheet to provide detail information in another section.
Why would the turnaround for faxes be more than 24 hours? The concurrent review list contains patient names that have previously been identified as discharged. Please explain.	Requests received after 5:00 p.m. are considered received the next business day. Discharge dates recorded on the review list are entered into our computer system throughout the day until 5:00 p.m. The concurrent review list is faxed to the hospital beginning at 4:00 a.m. If the hospital returns the list to HSI late in the business day (after 3:30 p.m.), it is possible the data will not be recorded until the following business day. Upon completion of the review, the outcome of the review is immediately provided to the hospital via telephone.
Please explain why the hospital cannot send concurrent review information until an authorization is received.	The hospital is notified telephonically of all certifications of admission approvals and provided with the initial LOS. Hospitals do not need to call back offering additional information, until they have received determination from the prior review period. It may be possible no further medical information will be required due to the number of days initially certified. If concurrent review is needed, providing the TAN number will expedite the review.
Is there a list of HSI contact people for situations where the Helpline cannot answer the question or call back?	It is our intent to be responsive to the hospitals. We are working on a process to ensure calls are returned in a timely manner. The Project Manager is available when needed.
Physician Reviewers:	
For physician-to-physician review will there be a child psychiatrist available to review the cases?	Child psychiatrists have been recruited as physician peer reviewers. Every effort will be made to match the physician peer reviewers experience with that of the patient's attending physician.
Profiling:	
If facilities are profiled, will the hospital be viewed negatively when it fails to discharge patients who no longer meet medical necessity, even when it is due to circumstances beyond its conrol, i.e. placement problems?	HSI's profiles will indicate the extent of known placement problems. The hospital will not be viewed negatively for placement problems. Educational interventions appropriate to the situation will be considered.
Retrospective Prepayment and Retrospective Postpayment Review:	
Will there continue to be a focus on one day stays?	Reviews of one-day hospitalizations are currently eliminated as retrospective prepayment review. One-day stays will be reviewed based on a postpayment sample methodology.
How will old cases be handled, i.e., reviews that were sent to be reviewed by IDPA's previous PRO contractor?	On 10/01/2002, IDPA will facilitate the transition of incomplete retrospective prepayment reviews and Quality Improvement Plans to HSI for completion.
What will the process be for record requests?	The process will remain the same.
How will chart reviews be done and where will they take place?	The process will remain the same.
How will the QIP change?	There will be no changes in the QIP process.