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The prior grand jury noted, among other things, the following:

A. For many years, each hospital within DHS has had its own version of a patient-following and patient-billing system and did not communicate patient information to the other hospitals. DHS solved this issue by replacing these systems with one centralized system across the six hospitals and their agencies, known as the ORCHID system.<sup>2</sup> ORCHID's implementation is expected to be completed in 2016.

B. All payors—including government and private entity reimbursors—limit the time allowed for a submission for reimbursement. Once that time is exceeded, the invoice is denied. DHS exceeded these time limits because:

(1) DHS was understaffed and could not meet deadlines to process denials of DHS's requests for payment from organizations it was billing.

(2) The staff at DHS didn't understand the payors' codes and took too long to inquire of the payor.

C. Prior to treating a patient, physicians must register their National Provider Identifier (NPI) codes with the hospital (via a form 855R). But if patients are treated before an NPI code is entered into the system, those treatments cannot be billed.

D. When outpatients check in to a county hospital or clinic, they should be logged in at an admissions desk. Sometimes admissions fails to verify methods of payment and/or insurance coverage. The hospital or clinic thus may provide the service but may not be reimbursed for the service.

The prior jury's report and recommendations can be found in the 2013–2014 Final Report, pages 23–73.

## **FINDINGS**

1. The Department of Health Services responded to all 16 questions put to it by the committee. Its responding document is reproduced in full as Attachment A to this report. The questions are listed and DHS's responses are summarized on the following table.

2. The table lists the committee's questions on the left and categorizes the DHS responses as either implemented, in progress, no progress, or decline to implement. Of the 16

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<sup>2</sup> Online Real-Time Centralized Health Information Database.

recommendations made by the prior jury, six have been implemented, nine are in progress, and one is delayed because of technical difficulties.

3. With 15 out of 16 recommendations either completed or underway, clearly a good faith effort is being made by DHS. The department is to be complimented on its rapid progress.

**Summary of Responses to Civil Grand Jury questions  
by the Department of Health Services**

<b>Questions to DHS</b>	<b>Implemented</b>	<b>In Progress</b>	<b>No Progress</b>	<b>Decline</b>	<b>Comments</b>
<b>2.1</b> Have both the new ORCHID system and the current system incorporated codes on all accounts for classifying and explaining reasons for denial?	X				
<b>2.2</b> Has DHS updated the procedure to include new Reason for denial codes?	X				
<b>2.3</b> Has the availability of Patient Financial Services worker staff been increased at all hospitals?		X			
<b>2.4</b> What method, if any, has DHS implemented to replace the discontinued method of identifying write-offs for denied or late claims that are billed by the DHS Consolidated Business Office?		X			Replaced with new process (see Attachment A)
<b>2.5</b> Has DHS determined the staffing required to review Medi-Cal fee-for-service accounts for patients still in DHS hospitals?	X				
<b>2.6</b> Has DHS conducted a staffing analysis to determine if additional staffing will reduce backlogs and reduce billing time?		X			
<b>2.7</b> What is the projected date by which DHS expects to fully implement the original recommendation to require DHS physicians to report their NPI number and complete the 855R form linking the NPI number to DHS prior to commencing work at a DHS facility?		X			Target date is July 1, 2015
<b>2.8</b> Is DHS monitoring the processing of Medicare claims by the new ORCHID system?			X		Technical Problems
<b>2.9</b> Has DHS standardized Health Information Reports to monitor coding backlogs?	X				

<b>Questions to DHS</b>	<b>Implemented</b>	<b>In Progress</b>	<b>No Progress</b>	<b>Decline</b>	<b>Comments</b>
<b>2.10</b> Has DHS conducted a staff analysis to determine if additional staff will decrease the HIM backlogs and delays in coding?	X				
<b>2.11</b> What is the method by which DHS will ensure that a patient is identified as requiring third party authorization for follow-up services prior to such services being provided; and when will that method be fully implemented?		X			Refer to detailed implementation schedule shown on 03/20/2015 Response (see Attachment A)
<b>2.12</b> Please identify the classifications or groupings of staff who will receive training on the electronic notification system. What is the status of the training on the electronic notification system and what is the target date for full implementation of the training?		X			Training will be within 60 days of their scheduled ORCHID implementation date
<b>2.13</b> Has DHS evaluated how to pre-screen outpatient appointments to ensure authorization has been obtained?		X			
<b>2.14</b> Has DHS selected a staffing model to expedite service authorization from third-party payers?	X				
<b>2.15</b> Has DHS selected an electronic tool to expedite service authorization from third-party payers?		X			
<b>2.16</b> Has DHS ensured that the new ORCHID system facilitates online processing of health care plan treatment authorizations?		X			
<b>TOTALS:</b>	<b>6</b>	<b>9</b>	<b>1</b>	<b>0</b>	

## **ACRONYMS**

**CGJ** Los Angeles County 2014–2015 Civil Grand Jury

**DHS** Department of Health Services

**FY** Fiscal Year

**HIM** Health Information Management

**HPE** Hospital Presumptive Eligibility

**IQRs** InterQual Reviews

**NPI** National Provider Identifier

**ORCHID** Online Real-Time Centralized Health Information Database

**PFSW** Patient Financial Services Worker

**PRW** Patient Resources Worker

**RM** Revenue Management

**S&S** Services and Supplies

**TAR** Treatment Authorization Requests

## **COMMITTEE MEMBERS**

Virgil L. Greer Jr., chair

Steve Yi, secretary

John Acevedo

Ben Cowitt

## ATTACHMENT A

RESPONSE TO THE CIVIL GRAND JURY FINAL REPORT  
COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES (DHS)  
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SUBJECT: **FY 2013-2014 CIVIL GRAND JURY RECOMMENDATIONS FOR A  
TIMELY AND CLEAN “BILL” OF HEALTH MAY SAVE \$285 MILLION**

### **RECOMMENDATION No. 2.1**

Utilize DHS's Electronic billing system, Affinity Adjustment Codes on all accounts for classifying and better explaining the reasons for all write-offs.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. Currently all account write-offs utilize an Affinity adjustment code and a reason code subset to provide more specific detail for each write-off adjustment. DHS will work with facility staff (i.e., meeting with facility management, issue guidelines, conduct trainings, etc.) to facilitate and reinforce the appropriate use of these codes by October 31, 2014.

### **CGJ QUESTION 2.1**

Have both the new ORCHID system and the current system incorporated codes on all accounts for classifying and explaining reasons for denial?

### **1/30/15 RESPONSE**

Implemented - On August 20, 2014, Revenue Management (RM) staff conducted a meeting and training with facility billing managers and staff to bring their attention to inconsistencies and coding errors identified on write-off reports. Clarification and Instructions were provided on the appropriate use of write-off codes. Based on staff feedbacks, RM staff has revised the standardized code listing to more accurately reflect write-off descriptions. Additional instructions will be provided to facility management and staff on the appropriate use of the revised write-off codes.

### **RECOMMENDATION No. 2.2**

Update the DHS write-off procedure to include all Reason Codes, including new Codes, as they are developed.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. DHS will revise the write-off procedures to include all applicable Reason Codes and provide guidelines for facility staff to request new reason codes when necessary. DHS will work with the facilities to monitor and update the reason codes listing.

## **CGJ QUESTION 2.2**

Has DHS updated the procedure to include new Reason [Codes] for denial codes?

### **1/30/15 RESPONSE**

Implemented - DHS updated the write-off procedure on 10/15/14. The revised procedure includes additional write-off codes and provides guidelines for requesting new codes in the future if necessary.

## **RECOMMENDATION No. 2.3**

Expand the scheduled availability of Patient Financial Services Worker staff at all hospitals.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. DHS will evaluate expanding the use of Patient Financial Services Workers (PFSWs) and Patient Resources Workers (PRWs) at DHS facilities for Medi-Cal and Hospital Presumptive Eligibility (HPE) application intakes. The evaluation may include options such as additional staff, added work shifts and/or shift rotation to increase worker availability during off hours. If necessary, DHS will submit a budget request for additional staffing needed to fully implement this recommendation. Completion of the evaluation is anticipated by December 31, 2014.

## **CGJ QUESTION 2.3**

Has the availability of Patient Financial Services worker staff been increased at all hospitals?

### **1/30/15 RESPONSE**

Implemented - DHS staff worked with Human Resources to expedite PFSW and PRW examinations and certification lists in order to fill all available positions. As of 12/31/14, 78 candidates have been selected to fill 90 vacant PFSW positions and 49 candidates have been selected to fill 64 vacant PRW positions. DHS will continue to identify candidates to fill the remaining vacant positions.

## **RECOMMENDATION No. 2.4**

Develop and track a Reason Code Classifying write-offs for denied or late claims that are billed by the DHS Consolidated Business Office without Treatment Authorization Requests (TARs) or InterQual Reviews (IQRs) demonstrating the medical necessity of the services provided.

### **7/18/14 RESPONSE**

DHS disagrees with this recommendation. This billing practice has been discontinued.

### **CGJ QUESTION 2.4**

How does DHS classify and track write-offs for denied or late claims without treatment billed by DHS (What is in place of suggested procedure)?

### **1/30/15 RESPONSE**

Not Applicable – DHS has discontinued billing of accounts without TARs or IQRs.

### **CGJ Question 2.4 as of 02/19/2015**

What method, if any, has DHS implemented to replace the discontinued method of identifying write-offs for denied or late claims that are billed by the DHS Consolidated Business Office?

### **3/20/2015 Response**

DHS has significantly reduced the TAR inventories as referenced in Recommendation 2.5 below; as a result, the Utilization Review Units in the hospitals have been able to timely review accounts to enable timely billing. Also, DHS has developed an inventory status report to identify and prioritize accounts that need a TAR in order to be billed for stronger control. DHS does not bill any accounts that do not have a TAR.

### **RECOMMENDATION No. 2.5**

Formalize the point at which Medi-Cal fee-for-service accounts are retrospectively reviewed for patients still in the Department hospitals.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. An assessment will be conducted to determine the staffing needs to perform the concurrent reviews recommended. If necessary, DHS will submit a budget request for additional staffing needed to fully implement this recommendation. Completion of the assessment is anticipated by December 31, 2014.

### **CGJ QUESTION 2.5**

Has DHS determined the staffing required to review Medi-Cal fee-for-service accounts for patients still in DHS hospitals?

### **1/30/15 RESPONSE**

Implemented - Currently Medi-Cal Fee-for-Service patients are reviewed on a daily basis when receiving acute care. DHS utilizes a State approved evidence based proprietary software program (InterQual) for determination of medical necessity. A second level review of the account is completed by a physician to evaluate the medical necessity if InterQual criteria are not met. DHS Utilization Review (UR) Committee has implemented an action plan; where UR nurses are reassigned from other County hospitals should a backlog develop at a DHS facility, to assist in the reviews using approved overtime. Also, additional Physician Advisors are recruited to complete second level reviews. Based on this strategy and assessment, DHS has been able to mitigate the effect of staff shortage at its facilities.

### **RECOMMENDATION No. 2.6**

Conduct a Utilization Review staffing analysis at county hospitals as an increase in staff may substantially increase Department cash flow by decreasing backlogs and increasing the timeliness of billings.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. DHS will conduct a staffing analysis to determine if additional staffing will decrease backlogs and increase billing timeliness. If necessary, DHS will submit a budget request for additional staffing needed to fully implement this recommendation. Completion of the evaluation is anticipated by December 31, 2014.

### **CGJ QUESTION 2.6**

Has DHS conducted a staffing analysis to determine if additional staffing will reduce backlogs and reduce billing time?

### **1/30/15 RESPONSE**

Implemented - In the spring of 2014, DHS performed a comprehensive assessment of staffing needs within inpatient Utilization Review departments with the goal of ensuring sufficient staff are available to complete all inpatient UR related duties which would decrease backlogs and increase billing timeliness. DHS calculated the additional staff needed for each hospital to achieve full staffing levels. These items were included in DHS' 2014-15 supplemental budget request, approved by the Board of Supervisors on September 30, 2014. Approximately half of the newly added items have been filled to date, with interviews ongoing.

### **RECOMMENDATION No. 2.7**

Utilize available systems and tools, and require DHS physicians to report their National Provider Identifier (NPI) number and complete the 855R form linking the NPI number to DHS, as required for Medicare billing purposes, prior to commencing work at a DHS facility.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. DHS will assess available systems, tools, and processes to determine how best to implement this recommendation. Completion of the assessment is anticipated by December 31, 2014.

### **CGJ QUESTION 2.7**

Does DHS require physicians to report their National Provider Identifier (NPI) number and enter it into the system prior to commencing work at a DHS site?

### **1/30/15 RESPONSE**

Partially Implemented - DHS is evaluating the licensed practitioner credentialing process and the utilization of the new Cactus credentialing software to enable improved accountability and control. In the interim, Medical Administration and Finance are working together to initiate enrollment applications for practitioners who provide care to Medicare members.

### **CGJ Question 2.7 as of 02/19/2015**

What is the projected date by which DHS expects to fully implement the original recommendation to require DHS physicians to report their NPI number and complete the 855R form linking the NPI number to DHS prior to commencing work at a DHS facility?

### **3/20/2015 Response**

The target date is July 1, 2015. On this date, the credentialing process will include initiation of NPIs and enrollment of physicians into the Medicare program for the facilities where it is a requirement (Comprehensive Health Centers and Health Centers).

### **RECOMMENDATION No. 2.8**

Monitor the processing of Medicare claims to ensure that the implementation of ORCHID, the Department's new electronic health record system is aiding and providing Medicare itemized claims.

### **7/18/14 RESPONSE**

DHS agrees with this recommendation. DHS will monitor the processing of Medicare claims and ensure itemized billing is accommodated within the Online Real-Time Centralized Health Information Database (ORCHID), Affinity Patient Accounting, Billing Clearinghouse, etc., as each DHS facility implements ORCHID. ORCHID implementation and associated interfaces for billing is anticipated to be completed prior to December 31, 2014.