

In the Policies and Procedures, Section IV. REQUESTS FOR INFORMATION, it is noted that hospitals will transmit to BCBSKS on a monthly basis (45 days from the end of each month) abstract information for claims meeting the stated specifications below. Failure to transmit this information could result in a decision to place a provider on prepay review.

There are a number of facilities that are delinquent in sending their abstracting files to us. The KHDS staff has contacted Provider Relations to assist them in obtaining the needed files as quickly as possible. We will be contacting those providers in the near future to determine if there are problems that prevent the transmission of the abstract information and work with you to get the necessary files.

Abstracting is one of those processes that I believe is taken too lightly....following are some examples that resulted in additional payments to a facility which might not have happened if the abstracting information was not received and reviewed. Now obviously, the opposite could occur and the hospital could be asked to refund an inappropriate payment. But either way, the chances of catching these errors are greater when the hospitals transmit their abstracting files timely.

1. *DRG validation – Business office switched diagnosis codes so the claim would pay as an accident. Claim will be reprocessed with correct diagnosis codes for DRG 0049 and will be forced to pay as an accident with \$12,170.49 additional payment to the hospital. DRG validation – Claim missing procedure code 51.23. DRG will change from 0204 to 0493 with \$1,310 additional payment to the hospital*
2. *DRG validation – claim forced to the abstract. The diagnosis code on the claim was changed from 278.1 (obesity) to 729.30 (panniculitis – which (pathologically) the patient did not have. This claim was paid due a predetermination that the surgery was medically necessary. The hospital was paid approximately \$2,909 less as a result.*
3. *DRG validation – FEP case. The DRG on the claim was 0774. Correct DRG is 0765. Claim adjusted with \$1,139.70 additional payment to the hospital*

AGAIN I would like to remind you there is a 45 day time guideline - and when you don't follow this time line, you are risking pre-pay review on BCBSKS patients The Kansas Hospital Association is getting strict about their dates as well. If we don't receive the data timely, you also risk your data not getting supplied to KHA for those of you that we handle this activity for. We have approximately 70% of the hospitals across the state that rely on KHDS to submit to KHA. It's a state mandate that this data go into KHA - timely each quarter.

KHDS always responds back regarding the condition of the file. Is your staff reading the response from us? These re some examples of what you might see...

- A. Does it say your file went to production?
- B. Does it say that it was for the wrong month?

- C. Does it say that it's for the wrong hospital (yes, one hospital managed to put the wrong hospital number in - choosing a number that belonged to someone else).
- D. Does it tell you that the file was too error heavy and that you will be required to resubmit?
- E. Does it have a notice that there are corrections required?

The responses we send are very clear and concise - and not lengthy. We also send most of these responses through secure e-mail, so we have record of who read or pick them up vs those who do not.

Following is the portion from the Policies and Procedures concerning this portion of our agreement with contracting hospitals.

**Abstract
Information**

Severity/Intensity elements, Hospital Code Number, Medical Record Number, Patient's Account Number, Abstract Record Counter, Admission Class, Admission Hour, Admission Date, Principal Procedure Date, Discharge Date, Birth Date, Gender, Race, Referral Source, Primary Payment Status, Discharge Status, Discharge Hour, Transfer Destination, Special Units, Primary Service, Attending Physician's Number, Principal Surgeon's Number, Other Physician or Surgeon's Number, Accommodation on Admission and Discharge, Member ID Number, Primary Diagnosis, Admitting Diagnosis, up to 24 Secondary Diagnoses with Dates, Principal Procedure, up to 24 Secondary Procedures with Surgeons and Dates, Zip Code, Transfer Location, Patient Last Name, Patient First Name, Social Security

Number, Patient Status, Batch Year, Batch Month, Batch Number, Hemoglobin Low, Hemoglobin Drop, and Blue Cross Provider Number. Abstract information is to be transmitted to BCBSKS as needed or on a monthly basis (45 days from the end of each month) on files meeting the above specifications. Failure to submit medical abstract information within the time frame specified above shall result in the Contracting Provider being placed on prepayment utilization review.