CLAIMS RECOVERY PROCESSING - FISCAL AGENT PROCEDURE

BACKGROUND FOR CLAIMS RECOVERY PROCESSING

The contractor performs Third-Party Liability (TPL) recovery of claims submitted to the fiscal agent and its Medicaid Management Information System (MMIS). It involves the identification of claims that had other coverage and were inappropriately paid by the State and the recovery of the payments for those claims.

The contractor shall accomplish the recoveries via the submission of HIPAA-compliant standard transactions: Accredited Standards Committee (ASC) X12N[1] (standards for the insurance and health care industries) 837 version 5010 electronic claims for voids or adjustments per 45 C.F.R. §162.925. The contractor's TPL transactions must be submitted via the NJMMIS website located at: www.njmmis.com. The receipt and validation of all submissions will result in the generation of all standard HIPAA responses (e.g., TA1 Interchange Acknowledgement Segment, 999 Functional Acknowledgement Transaction Set, etc.).

APPROACH

The contractor is to include all claim types, except pharmacy, in the HIPAA ASC X12N 837 Institutional, Professional, and Dental transaction submissions. The contractor shall use HIPAA National Council for Prescription Drug Programs (NCPDP) D.0 transaction submissions for pharmaceutical claims.

The transactions will undergo all standard edits/ audits within the MMIS.

The results of the adjudication of all of the contractor's recovery voids and adjustments will be reported to the billing providers via HIPAA ASC X12N 835 electronic remittance advice (RA) transactions.

New MMIS adjustment reason codes[2] submitted on Notes and Comments (NTE) segments will be used exclusively by the contractor when submitting adjustments/ voids for recoveries. All of the contractor's recovery programs will be identified by new adjustment reason codes. Edits on the NTE segments will identify services to be locked for providers' re-adjustments. The new edit code will be created to deny provider-initiated adjustments to the previously adjusted contractor's claims. State users and the contractor will be able to adjust these claims.

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[1] The X12N subcommittee has documented the specific details of each HIPAA standard transaction in an implementation guide. The current HIPAA-mandated standard transactions for health care are the 5010 version of the ASC X12 standard transactions.

[2] The fiscal agent is permitted to provide companion guidance to communicate their collection of implementation information. The ASC X12 companion guides allow flexibility in terms of data elements and situational codes that can be used.

REQUIREMENTS/ CONSTRAINTS/ ASSUMPTIONS

a. In order to submit HIPAA 837/ 5010 electronic claims, the contractor shall demonstrate the ability to create HIPAA standard ASC X12N 837 Institutional, Professional, and Dental transactions;

b. The contractor does not have to obtain formal certification as a HIPAA claims submitter. The fiscal agent will assign a submitter number and add the contractor to the MMIS's Provider database as a 5010 Institutional, Professional and Dental transactions submitter;

c. The ICN of the claim to be adjusted shall be reported in the standard loop/ segment/ field and will be stored in the former ICN field in the MMIS claim activity record;

d. The contractor shall submit adjustment reason codes and edit codes on the NTE segment for each adjustment/ void transaction to specify a reason for the transaction and subsequent adjustments restrictions for providers. The fiscal agent will create an NTE values validation process and create an appropriate adjustment/ void transaction based on the information submitted on the NTE segment by the contractor;

e. The contractor may retroactively recover for the prior ten (10) years. It is expected that a Provider's National Provider Identification (NPI) number may not always be available. As such, the contractor shall submit the Medicaid Provider ID in the secondary provider identification loop for each Provider ID required;

f. All denied adjustments/ voids will be transferred from the fiscal agent to the contractor via network data mover (NDM) processing within the end of a week's claims file date. The contractor shall build an extract of TPL recovery project-related claims and re-submit corrected transactions with the next ASC X12N 837's file processing;

g. Explanation of Benefits (EOB) codes will be created in order to display the contractor's contact information on the remittance advices (RAs) to inform providers how to address questions/ issues related to adjustments/ voids;

h. Use the "TPL Paid" amount from the claim activity data for the claim to be adjusted as the claim-level TPL amount in the corresponding TPL adjustment; and

i. The processing by the NTE segment types are described as follows:

INSTITUTIONAL 2300 NTE SEGMENT

Position	End Position	Field Name	Claim Field Name
39	40	ADJUSTMENT REASON CODE	A-ADJUSTMENT-REASON (3:4)
41	44	EOB EDIT CODE	A-CLM-ERROR [1]

PROFESSIONAL 2300 NTE SEGMENT

Position	End Position	Field Name	Claim Field Name
52	53	ADJUSTMENT REASON CODE	A-ADJUSTMENT-REASON (3:4)
54	57	EOB EDIT CODE	A-CLM-ERROR [1]

DENTAL 2400 NTE SEGMENT

Position	End Position	Field Name	Claim Field Name
5	6	ADJUSTMENT REASON CODE	A-ADJUSTMENT-REASON (3:4)
7	10	EOB EDIT CODE	A-CLM-ERROR [1]

j. The processing by the transaction types are described as follows:

INSTITUTIONAL TRANSACTION 005010X223 IG.

REF/ BILLING PROVIDER SECONDARY IDENTIFICATION
Loop: 2010BB — PAYER NAME
REF02 when REF01 'G2'

REF - ATTENDING PROVIDER SECONDARY IDENTIFICATION
Loop: 2310A — ATTENDING PROVIDER NAME
REF02 when REF01 'G2'

REF - OPERATING PHYSICIAN SECONDARY IDENTIFICATION
Loop: 2310B — OPERATING PHYSICIAN NAME
REF02 when REF01 'G2'

REF - OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION
Loop: 2310C — OTHER OPERATING PHYSICIAN NAME
REF02 when REF01 'G2'

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION
Loop: 2310D — RENDERING PROVIDER NAME
REF02 when REF01 'G2'

REF - REFERRING PROVIDER SECONDARY IDENTIFICATION
2310F — REFERRING PROVIDER NAME
REF02 when REF01 'G2'

PROFESSIONAL TRANSACTION 005010X222 IG.

REF/ BILLING PROVIDER SECONDARY IDENTIFICATION
Loop: 2010BB — PAYER NAME
REF02 when REF01 'G2'

REF - REFERRING PROVIDER SECONDARYIDENTIFICATION
2310A — REFERRING PROVIDER NAME
REF02 when REF01 'G2'

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION
Loop: 2310B — RENDERING PROVIDER NAME
REF02 when REF01 'G2'

DENTAL TRANSACTION 005010X224 IG.

REF/ BILLING PROVIDER SECONDARY IDENTIFICATION
Loop: 2010BB — PAYER NAME
REF02 when REF01 'G2'

REF - REFERRING PROVIDER SECONDARYIDENTIFICATION
2310A — REFERRING PROVIDER NAME
REF02 when REF01 'G2'

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION
Loop: 2310B — RENDERING PROVIDER NAME
REF02 when REF01 'G2'

HARDWARE REQUIREMENTS

No additional hardware requirements have been identified.

TYPES OF SUBMISSIONS

COB – Commercial Insurance Coverage;

Credit Balance – Excess pay;

Credit Balance – Deceased recipient;

Credit Balance – Re-admission;

Credit Balance – Transfer;

Credit Balance – Duplicate Payment;

COB – Medicare Part A and Part B Coverage; and

Credit Balance – On-site Financial Review.