MEDICAID MANAGED CARE

Playing by New Jersey's Rules

JULY 2014

NEW JERSEY HOSPITAL ASSOCIATION
NJHA

UTILIZATION MANAGEMENT ▶

New Jersey State law defines as: A system for reviewing the appropriate and efficient allocation of healthcare services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a healthcare service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. *N.J.S.A 17B:30-50.*

The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization or ambulatory care procedures and retrospective review. *N.J.A.C. 11:24-1.2.*

- Medicaid Managed Care Organizations (MCOs) are required to have an automated system for prior authorizations that includes the ability to ensure enrollee is eligible, provider is eligible and the services are a covered benefit. *Section 3.5.1 of the Contract between the State of New Jersey Department of Human Services Division of Medical Assistance and Health Services and Medicaid Health Maintenance Organization.*[1]
- Medicaid MCOs must make notice of an approved utilization review determination by telephone or in writing to the provider within 14 business days of receipt of necessary information sufficient to make an informed decision. *Section 4.6.4(B)(1) of the State Contract.*
- Payers and hospitals shall have appropriate staff available between the hours of 9 a.m. and 5 p.m., seven days a week, to respond to authorization requests within the established time frames. *N.J.S.A. 17B:30-52(b).*
- Medicaid MCOs are required to make a determination for authorization on a timely basis, as required by the exigencies of the situation, but no later than:*
  - 24 hours for a person currently receiving inpatient hospital services or emergency department care ;
  - 15 days for a person who will receive inpatient hospital care; or
  - 15 days for a person who will be receiving outpatient services, including but not limited to: a clinic, rehabilitation facility or nursing home. *N.J.S.A. 17B:30-52(3) and Section 4.6.4(B)(1)(2)(5) of the State Contract.*

[1] *Contract between State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services and Medicaid Health Maintenance Organizations, http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf (accessed June 26, 2014) (hereinafter referred to as "State Contract")*

**Deadline extensions are applicable under certain situations and with appropriate notice.*

- In the event a payer is unable to make an authorization determination within the timeframes established due to the need for additional information, the payer shall have an additional period equal to the originally established timeframe in which to make a determination. *N.J.S.A. 17B:30-52(4).*
- Subscribers are to be held harmless from balance billing for medically necessary services that were authorized or covered by the MCO (excluding copayments, coinsurance and deductibles). *N.J.A.C. 11:24-9.1(d)(9).*
- If Medicaid MCOs fail to respond to authorization requests within the established timeframes the request is deemed approved. *N.J.S.A. 17B:30-52(c).*

MEDICAL NECESSITY DETERMINATIONS ▶

"Medical necessity" or "medically necessary" means or describes a healthcare service that a health care provider, exercising his/her prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms. *N.J.S.A. 17B:30-50.*

- Medicaid MCOs are required to post on their Web sites, in a clear and conspicuous manner, a description of the source of all commercially-produced clinical criteria guidelines and a copy of all internally-produced clinical criteria guidelines used by the payer or its agent to determine the medical necessity of healthcare services. *N.J.S.A. 17B:30-51(a)(1).*
- Medicaid MCOs are only allowed to change clinical criteria if participating healthcare providers are given at least 30 days prior notice of the change in the requirements. *N.J.S.A. 17B:30-51(a).*
- Medicaid MCOs shall not modify specific standards, criteria or procedures used to make a pre-authorization or pre-approval determination, pursuant to a retrospective review. *Section 4.6.4 of the State Contract.*
- Retrospective denials are not allowed if a provider received oral or written authorization. *N.J.A.C. 11:24-8.3.*
- Medicaid MCOs' decisions to deny, reduce or terminate a healthcare benefit,

or to deny payment for a healthcare service, based on medical necessity, must be made by a physician. *N.J.S.A. 17B:30-52(a) and N.J.A.C 11:24-8.3* and *11:24A-3.4(d)(1).*

- During the prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to review are medically necessary. In such cases, only the relevant sections of the records shall be required. *Section 4.6.4(A)(8) of the State Contract.*
- Medicaid MCOs may request complete or partial medical records for a retrospective review. Medicaid MCOs must ensure the medical records are reviewed by registered health information technicians, registered health information administrators or administrative personnel who have received appropriate training and will safeguard patient confidentiality. *Section 4.6.4(A)(8) of the State Contract.*

PAYMENT ISSUES ▶

- Medicaid MCOs must acknowledge receipt of all paper claims within 15 working days of receipt of the claim. Medicaid MCOs must acknowledge receipt of all electronic claims within 2 working days following receipt of the transmission. *N.J.S.A. 26:2J-8.1(d)(5*) and *N.J.A.C. 11:22-1.3(a).*
- Medicaid MCOs must pay, deny or contest claims within 30 calendar days for claims submitted electronically and 40 days for paper claims. *N.J.S.A. 26:2J-8.1(d)(1)* and *N.J.A.C 11:22-1.5.*
- Payment for a contested claim or contested portion of a claim that is subsequently corrected must be paid no later than 30 or 40 calendar days, as applicable, following the date that the Medicaid MCO receives all of the requested information. *N.J.S.A. 26:2J-8.1(d)(7)* and *N.J.A.C 11:22-1.5(b).*
- Medicaid MCOs are required to post information on the Internet providing a description of claims for which additional information is required in order to adjudicate the claim. *N.J.S.A. 17B:30-51(a)(3).*
- Medicaid MCOs are required to post the policy or procedure for reducing payment for duplicate or subsequent service provided by a healthcare provider on the same day of service. *N.J.S.A. 17B:30-51(a)(4).*

- Medicaid MCOs are required to pay interest on a claim when a determination against the provider is overturned following a provider's utilization of the ***appeal*** process established under Health Claims Authorization, Processing, and Payment Act (HCAPPA). If the claim is overturned upon appeal, the payer has 30 days following the date of the appeal determination to pay the claim and interest due. *N.J.S.A. 26:2J-8.1(e)(1).*
- If the claim is overturned after ***arbitration***, the payer has 10 business days following the date of the arbitrator's determination. In both instances, interest is calculated from the date the appeal was received by the payer. *N.J.S.A. 26:2J-8.1(e)(5).*
- Medicaid MCOs must pay interest on claims paid after 30/40 days, accrued at the rate of 12 percent per annum. Interest is due at the time the claim is paid. *N.J.S.A. 26:2J-8.1(d)(8)(c) and 26:2J-8.1(d)(9).*
- Medicaid MCOs cannot seek reimbursement for overpayment of a paid claim later than 18 months after the date the first payment on the claim was made, except for fraudulently submitted claims or claims submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits. *N.J.S.A. 26:2J-8.1(d)(10).*

COORDINATION OF BENEFITS ▶

Defined as: The process of determining the payment order and amounts each payer is responsible for in instances when an individual has more than one form of health insurance coverage.

- Medicaid payments must be last-dollar coverage and can only be utilized after all other sources of third party liability are exhausted; however, a Medicaid MCO must pay a claim, if at the time the claim is filed, information on health or casualty insurance coverage is not known or available. The State will then proceed with post-payment recovery, if necessary. *Section 8.7(A) of the State Contract.*

- Medicaid MCOs cannot deny payment on all or a portion of a claim while seeking coordination of benefits information unless good cause exists. Good cause only exists if a payer's records indicate that other coverage exists. Routine requests to determine if coordination of benefits exist do not constitute good cause. *N.J.S.A. 26:2J-8.1(d)(8)(b).*

CONTRACT TERMINATIONS ▶

- Hospitals whose Medicaid MCO contracts are not renewed, or are terminated by either party, must continue to provide services at the contract rate for a period of four months from a mutually agreed upon severance date. The Medicaid MCO must notify in writing all contracting providers and all members residing in the hospital's county or an adjacent county within the HMO's service area within the first 15 business days of the four-month extension. *N.J.A.C. 11:24-3.5(e).*
- Physicians and other healthcare professionals whose Medicaid MCO contracts are not renewed or are terminated must continue to provide services at the contract rate for up to four months when medically necessary. *N.J.A.C. 11:24-3.5(c).*
- Exceptions to the four-month rule, which require longer coverage periods, apply to pregnancy, post-operative care, oncology treatments and psychiatric services. *N.J.A.C 11:24-3.5(c)* and *N.J.A.C 11:24A-4.8(d).*
- Physicians and other healthcare professionals and providers whose contracts have been terminated by an Medicaid MCO must be provided 90-days written notice prior to the date of termination as well as notice of a right to a hearing to contest termination. *N.J.A.C. 11:24-3.5(a)* and *11:24A-4.8(a).*
- Medicaid MCOs must notify each member within 30 business days prior to the termination of a member's primary care physician from the MCO's provider network as well as any other physician or provider from which the covered person is currently receiving a course of treatment. *N.J.A.C. 11:24-3.5(b) and 11:24A-4.8(c).*

CONTINUITY OF CARE ▶

- Medicaid MCOs must ensure existing services in an enrollee's plan of care continue until the enrollee is evaluated by his/her primary care physician and a new plan of care is established with the MCO. *Section 4.1.1(E) of the State Contract.*
- Medicaid MCOs must honor and pay for plans of care for new enrollees or when a new benefit is added as a covered service. *Section 4.1.1(E) of the State Contract.*
- A Medicaid MCO must ensure that a utilization review agent making a determination involving continued or extended healthcare services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a healthcare provider and provide notice of such determination to the enrollee or the enrollee's designee and to the enrollee's healthcare provider, by telephone and in writing within one business day of receipt of the necessary information. *Section 4.6.4(B)(5) of the State Contract.*
- If a dispute arises concerning the provision of a service or the level of service, the service, if initiated, must continue to be covered by the Medicaid MCO until the dispute is resolved. *Section 4.6.4(C) of the State Contract.*


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