MCO TPL Come Behind Q& A

Q 1) Though it is understood that the MCO's will only be allowed a 12 month look back. Circumstances may occur where we identify information after 365 days that was not available at the time the claim was paid due to no fault of the MCO or their vendor.

A 1) Please see Business Rules #1, #9, #10, #11, #12, #13

Q 2) "Initiated" should be defined as the point at which the claim is identified by the MCO carrier or our TPL vendor. The actual recovery process varies based on whether the claim was ever filed with the other carrier previously.

A 2) Please see Business Rules #1, #9, #10, #11, #12, #13

Q 3) Duplicative language in the first paragraph. The first paragraph is more specific.

A 3) Language has been updated.

Q4) The MCO's will be sending the data to HSD to give to HMS.

A4) Encounter data requirements are to be submitted to HSD. The AR match off file submitted directly to HMS.

Q5) We understand that "previously billed" refers only to those claims billed to another carrier through our TPL vendor. The MCO's also has an internal recovery processes that would need to be reported on to have a true and accurate picture of the recovery efforts in place.

A5) See Business Rule #5.

Q 6) This is where claim tagging is critical for any previous activity begun but recovery not yet received. The right to recovery for overpayment identification should remain with the MCO as long as the identification was done in the 12 month period defined. Recovery could occur outside of the 12 months.

A6) Please see Business Rules #1, #5, #9, #10, #11, #12, #13

Q 7) The use of the terms "previously billed" refers to submission of claims data to the primary carrier for payment. In some cases this is typically done by the TPL vendor. This does not address the internal COB recovery process where overpayments are requested from providers. Both processes have to be addressed and lag time for recovery efforts considered.

1. Notification to Provider
2. Provider must pay in 60 days -Provider has up to Day 60, AGP still needs to reconcile overpayment after that.
3. Payment received by AGP
4. Claim needs to be adjusted to reflect recovery so ensure encounter data is accurate.
5. Encounter file to state for recovered claims.
6. Claims that are in the identification and recovery phase will need to be added to the AR list.
A7) See Business rule #5.

Q 8) Claims will be in a constant cycle of identification, notification, recovery. AR file as described here only addresses TPL vendor process. Using claims date older than 12 months as the only requirement may create duplicative efforts from the MCO’s and HMS and provider abrasion with multiple requests. Recommendation: Claim number “tagging” file regardless of status that is tagged at identification and sent to the state. MCO will provide 2 status categories
   1. In progress
   2. Non-recovered
The recovered claim will be in the Encounter file marked with the appropriate TPL recovery code for HMS to retrieve at the state.

Q 8) See Business Rule #5.

Q 9) The AR match-up only addresses claims from a TPL vendor. Internal processes follow a true recovery from the provider process. This should be addressed in this document.

A9) See Business Rule #5.

Q 10) The indication of denied status by the MCO TPL vendor does not mean the recovery process has stopped, it just means the other carrier has already paid for example. MCO will pursue with the provider.

A10) Please see Business Rules #1, #9, #10, #11, #12, #13

Q 11) The MCO’s request that once the claim identification is opened by the MCO for recovery that HMS not be able to pursue until the plan shows it has exhausted all means of recovery. Billing Medicare, recovering from providers, etc require careful research and understanding of the COB rules for that patient. Unlike the TPL vendor process this is not an automated process. With Medicare in particular if the member has ESRD but never applied for Medicare. The member can retro-enroll, waiting limits apply and then the claim can be filed with Medicare.

A11) Please see Business Rules #1, #9, #10, #11, #12, #13. In addition, HSD is not pursuing Medicare TPL at this time.

Q 12) The AR match-off file does not provide information on all claims in the identification phase. Duplication and abrasion could occur. We recommend that claim tagging be considered instead of the AR file. The AR file would just be one component.

A12) See Business Rule #5.

Q 13) Subrogation is the result of third party liability and not Coordination of Benefits. Subrogation is a legal process involving the courts and settlements that can take years. Subrogation is where the medical insurance originally paid the claim for medical expenses incurred that should have been covered under auto, home, business liability, home owners insurance policies Coordination of benefits does not apply for subrogation.

A13) If the questions is referring to casualty subrogation see business rule #14, but if it’s referring to commercial insurance billings and/or provider recoupment’s see business #1, #9, #10, #11, #12, #13
Q 14) The RAC Final rule does not provide a limit for look back to the MCO. Though it is understood that the MCO's will only be allowed a 12 month look back circumstances may occur where we identify information after 365 days that was not available at the time the claim was paid due to no fault of the MCO or our vendor. The MCO should have the right to recover or notify the state of that recovery action and be allowed to pursue unless the RAC is actively working. This would work similar to the MCO filing "claim tags" of active files being worked to be given to the RAC to prevent duplication. The same needs to be performed by the RAC.

A14) Please see Business Rules #1, #5, #9, #10, #11, #12, #13

Q 15) Please define initiate and attempt to recover
Recommendation:
Initiate is the point of identification
Attempt to Recover is the completion of the overpayment process. Identify, Notify, Recover from other carrier, and recover from provider, if no response recoups the overpayment from the provider from future claims.

A15) Please see "open status" in Business Rules document

Q 16) The only way to know if MCO has initiated a recovery whether through the vendor or internal processes is through claims tagging.

A16) Please see Business Rule #5.

Q 17) As the data template and memo are still being reviewed MCO would recommend resending the LOD for review after the final template is agreed upon.

A17) Approved Template accompanies the LOD.

Q 18) Recommend 2 categories of disposition 1) In progress 2) non-recovery.

A18) Please see Business Rule #5, 11, 12, 13. (Paid, Denied, and Open)

Q 19) Letter of Direction Requesting a file of claims billed to Third Party MCO would like at least 90 days from the date of the finalized letter to provide the monthly AR match off file. Like most of the MCOs, this will need to be coordinated with our subcontracted vendor for third party recoupment's.

A19) Agreed.

Q20) HMS Data Requirements File-The gap analysis provided on this file, i.e. the information fields that HMS is requesting that they believe are not included in our current encounter submission is incorrect. We are currently submitting much of this information in our encounter submissions that HMS believes we are not submitting. In addition, the additional information that HMS is requesting to be added to our encounters we send HSD may not be a valid field of information on the HIPAA compliance encounter format. HMS needs to verify that any additional information they are requesting has a corresponding valid field on the HIPAA compliant format.

A20) At this time the full claims data request will not be part of the current LOD.
Q21) Business Rules Relating to the New Mexico Human Services Department Third Party Liability Recovery Come Behind Program
On page 4 of the document, it states that:

Any claims that the Plan reports in an "Open" status will be subject to additional edits in order to help avoid duplication of effort, but to maximize recovery. HMS will review the Plan's "bill date" of the open claim, and only send out a come behind claim if the MCO has billed the suspect TPL claim within 12 months of payment and the claim has been in an open status for more than 4 months from the bill date.

But this is in conflict with the regulation NMAC 8.305.11.9g(2) cited at the beginning of the letter which includes the following excerpt:
The MCO shall have the sole right of subrogation, for 12 months, from when the MCO incurred the cost on behalf of the members, to initiate recovery or to attempt to recover any third-party resources available to Medicaid members....

A21) Please see Business Rules #1, #9, #10, #11, #12, #13
Q22) MCO believes we have the sole right of subrogation for these cases and does not lose that right if a TPL claims is in an open status more than 4 months. It is not at all unusual for some TPL claims to be open well beyond 4 months, especially for cases that are involved in litigation.

A22) If the questions is referring to casualty subrogation see business rule #14, but if it's referring to commercial insurance billings and/or provider recoupment's please see Business Rules #1, #9, #10, #11, #12, #13

Q 23) How are plans being addressed that do not have a reclamation process but rather auto recoup directly from providers and auto deny if the other insurance EOB is not provided?

A23) See Business Rule #5.

Q 24) How will different MCO's processes be accommodated in the AR Match-off file?
A24) There will be one standard process for all MCO's, see business rule #5

Q25) Should claims that are being recovered through a subrogation process be excluded as they are part of an ongoing legal process?
A25) If the questions is referring to casualty subrogation see business rule #14, but if it's referring to commercial insurance billings and/or provider recoupment's please see Business Rules #1, #9, #10, #11, #12, #13

Q 26) Is the intent of the AR Match-off File to reduce duplicate recovery efforts or to identify overpayments that are 13 months or older.
A26) Both.

Q27) What record layout should be used for the AR Match-Off file?
A27) Included with the LOD.
Q 28) How will recoveries be handled for MCO identified claims that have a paid date ranging between 13-36 months?

A28) See Business Rule #11

Q29) In situations when HMS directly recovers payment from the provider, how will encounters and financials be reconciled to balance accordingly?

A29) A communication methodology will be forthcoming.

Q30) Will a communication process be put into place between the MCO's and HMS prior to HMS initiating provider recoveries?

A30) TBD.

Q31) As offered in the last RAC meeting, MCO requests the opportunity to have a meeting with HMS to discuss their processes in relation to our system methodologies and capabilities in more detail.

A31) HMS can meet with the MCOs once the LODs are in place.

Q32) Advise against including Subrogation claims

A32) If the questions is referring to casualty subrogation, see business rule #14, but if it's referring to commercial insurance billings and/or provider recoupment's please see Business Rules #1, #9, #10, #11, #12, #13

Q33 ) Recommend that all Dental claims be audited through DentaQuest (as all MCO use them)

A33) While each MCO may or may not use a dental contractor, it is the responsibility of each MCO to be in compliance with the LOD. In acknowledgment of the fact that most MCO's use a subcontractor for this function, a separate claims encounter and AR match off file can be submitted for each.

Q34) For the "Letter Requesting a Full Claims file and a file of Claims Billed to a Third Party", need clarification under bullet 1 regarding the date of service: Should we really exclude 7/1/09 or should it be 'with a date of service greater than or equal to July 1, 2009'. Also should probably have an end date

A34) At this time the full claims file request will not be part of the current LOD.

Q35) Regarding the templates, need actual format requirements (are they fixed width or delimited, field data types, etc.)

A35) AR March off File:

Format: Text file
Q38) There appears to be some redundancy in the two Letters of Direction by having one LOD address both a full claims file and a TPL Recovery A/R Match file while the other LOD just focuses on the TPL Recovery A/R Match file. We would recommend either combining into a single LOD or breaking the full claims file and the TPL Recovery A/R Match file into separate Letters of Direction. As currently structured there could be confusion when referencing an LOD and the A/R Match file.

A36) At this time only one LOD will be issued for the AR match off file. The full claims data request will be issued at a future date.

Q37) The Letters of Direction and the data request files don’t give recognition that some recoveries will come back through the provider to the extent that the provider can bill the other carrier within timely filing requirements. It would be beneficial to have some ability to note when recoveries are being pursued through the provider channels rather than directly from another insurance carrier.

A37) See Business Rule #5

Q38) Third Party Liabilities can often be broken into two categories: Coordination of Benefits (COB) with other health insurance carriers and Subrogation. Due to the often long term nature of settlements in Subrogation cases going through the legal process it is not only that recoveries can be fully identified and pursued in a 12 month window. We recommend that the Letters of Direction be updated to clarify that the TPL Recovery activity being pursued in these cases is for COB activities and not Subrogation.

Q38) If the questions is referring to casualty subrogation see business rule #14, but if it’s referring to commercial insurance billings and/or provider recoupment’s please see Business Rules #1, #9, #10, #11, #12, #13

Q39) Due to a combination of the significant time frames being looked at for the full claims file, and the fact that the time frame crosses over the conversion of encounter file formats from 4010 to 5010 standards, the file production will require significant programming and will take a lot of time. We recommend that the LOD allow for leeway in coordination with HMS for file layouts and potential multiple file submissions to provide the best balance of timeliness and completeness of data.

A39) The initial file transfer of the AR match off file is to be received within 90 days of LOD, and monthly files thereafter. The full claims data request will not be part of the current LOD.

Q40) The full claims files will not have been subjected to all of the encounter submission editing that the monthly encounters have been going through over time. This will result in some variances between the full claims file and the encounter data that HMS will have from HSD.

A40) The full claims data request will not be part of the current LOD.
Q 41) The MCO may already have a working relationship with HMS and recognizes that the same may be true for the other MCO’s. We recommend that if a working relationship with HMS already exists, that direct file submission to HMS be allowed rather than using an HSU FTP site. This will be more efficient for all parties.

A41) Each MCO that has this working relationship will have to work with their HMS contact to establish an agreement/permission to share the data with HMS HSD directly.

Q42) The MCO does not bill third party liability.
   o Provider claims are denied if the claim does contain the COB information (OHNM system contains the TPL updates from the State).
   o Providers are instructed to bill the third party first and then re-submit their claim with the Explanation of Benefits (EOB) from the other carrier.
   o The amount billed to third party is not known until the provider sends the EOS.
   o The Provider Bills the Third party and then submits the claim and EOS to OH-NM.
Data requirements are already satisfied by the ANSI5010 encounter data submissions.

A42) See Business Rule #5.

Q 43 MCO additionally provides the State with a weekly data dump of all demographics and claims data for the HSD Data Warehouse.
   • MCO recommends that HSD/HMS leverage this data to populate the appropriate fields missing from the Xerox data.
   • MCO recommends that if any MCO has no gaps in the gap analysis that it is excluded from the requested complete claims file requirement

A43) See Business Rule #1 and refer to LOD.

Q44) MCO proposes to provide only those elements that are not already on the encounter file or on the Data Warehouse. Medicaid ID may be provided, of course, for matching purposes. Give us the list of elements from the GAP analysis and we will provide the missing elements.

A44) The full claims data request will not be part of the current LOD.

Q45) MCO would need to run some extensive queries and produce non-standard transactions. MCO Requests 120 days to comply with the file matching requirements.

A45) See answered A19

Q46) Subrogation processes are different from other TPL collection activities. For the following reasons, we feel that Subrogation should be excluded from the RAC process.

1. Claims subject to subrogation are not incorrect payments. These are correct payments for which the health plan has a right of reimbursement under the law.
2. Subrogation does not bill providers, nor do we request overpayments from providers. Subrogation seeks reimbursement from any possible coverage from auto, property liability or workers compensation carriers, or from the member’s personal injury settlement. All related claims are included in the subrogation interest at the time of settlement.
3. Subrogation activity is performed at the member level for all claims related to a specific injury and not at a claim specific level.

4. When a subrogation case is open, no party is "billed" for the accident related claims. The plaintiff attorney or P&C insurance company is notified of the health plan's right of subrogation and our intent to seek reimbursement out of any available coverage.

5. Subrogation cannot control when a personal injury case will settle. The patient and/or insurance company determine when the underlying personal injury claim will settle.

6. Subrogation cases take longer than 4 months to settle. These matters settle on average 12 – 18 months from the date the case is opened but could take many years to settle. There is no time frame in which a member and/or liability insurer must settle a claim; therefore, no time limit should apply to subrogation cases. We will pursue subrogation/reimbursement on open cases through resolution of the case, regardless of how long it takes.

A46) If the questions is referring to casualty subrogation see business rule #14, but if it's referring to commercial insurance billings and/or provider recoupment's please see Business Rules #1, #9, #10, #11, #12, #13

Q47) In cases where a recipient's eligibility is altered retroactively, we feel that the subrogation rights of HSD would not apply.

A47) Agreed, there is existing contract language to this affect.