Attachment D: CLAIMS ADMINISTRATION TASKS

General Notes for Contractor awareness:

- The Department will facilitate access to Medicaid rates where necessary and the Contractor will not be responsible for any licensing fees or other fees related to accessing those rates.
- As part of the Contractor's Claim Administration functions, Contractor staff are expected to be familiar with coordination of benefits rules between private insurers and identify whether other, collateral sources of coverage exist. Sources other than Medicaid and Medicare are the primary payers for claims.

Category	Item #	Activity/Task
Claims Receipt		
	1.	Support all Department-approved claim formats including paper, electronic, web-based, and batch transmission
	2.	Accept, process, and respond to electronic claims transactions received in HIPAA standard formats, including: • X12 837 Professional, Institutional and Dental (versions 4010 and 5010) • NCPDP Pharmacy (versions 5.1, D.0 and 1.1 – batch)
	3.	Develop and/or update claim forms in both manual and electronic formats as necessary, in consultation with the Department
	4.	Accept claim attachments via the following: • Hard copy • Fax • Electronic • Provider area of the website and/or vendor-supplied web portal
	5.	Accept or reject claim attachments based on standards established by the Department
	6.	Provide the capability to electronically associate claim attachments received to the appropriate claim
Claims Review		
	1.	Identify which claims may be replaced or indemnified from any collateral source in accordance with MIF regulations and statutory requirements
	2.	Provide the capability to confirm that a prior approval for claimed services exists when required by Department business rules
	3.	Provide the capability to route the claim attachments through the appropriate application or system in accordance with Department business rules

Claims Pricing		
	1.	Review claims and determine the appropriate rates of payment for the type of claim submitted, consistent with the program's statute and regulations
	2.	At the direction of the Department, the Contractor may be required, in limited circumstances, to negotiate with a provider for acceptable rates of payment
	3.	Price claims based on pricing information and reimbursement methodologies applicable for the claim's date of service
	4.	Provide the capability to price claims at both the document and line-levels. This includes the ability to pay for lines determined to be payable and not paying for lines that have been denied.
	5.	Determine pricing in accordance with MIF statutory and regulatory requirements and Department business rules using the billing code submitted on the claim and accounting forms
	6.	Accommodate variable pricing methodologies for identical procedure codes based on provider-specific data
	7.	Provide the capability to adjust pricing based on Department business rules for the grouping of procedures performed
	8.	Provide the capability to manually price pended claims and route through the appropriate application or system based on business rules defined by the Department via the website and/or vendor-supplied web-based application
	9.	Accept and process provider rate setting transactions in proprietary formats and industry standard formats (e.g., Excel spreadsheets) as specified by the Department
	10.	Provide the capability to manage various rate-based reimbursement methodologies, including, but not limited, to: • DRG reimbursement • APG reimbursement • Rate/location-based reimbursement
	11.	Accept and process at a frequency specified by the Department the DRG Code Interface Files including, but not limited, to: • CGS-APRDRG NY • CGS-ENAPGNY • CGS-NYEAPGSPT • CGS-NYPT
	12.	The weekly list must include, at a minimum, the following: • Check amount • Check number • Invoice number

		• Type of service • Payment type • Claim number • Name of Payee • Name of Enrollee • Enrollee Date of Birth • Enrollee identification number • Claim net amount • Claim received date • Pricing method • Date paid
	13.	Maintain grouper processes to support claims processing and pricing including, but not limited, to: • CGS-APRDRG NY • CGS-ENAPGNY • CGS-NYEAPGSPT • CGS-NYPT
	14.	Obtain and process, at a frequency specified by the Department, updates to the E-APG grouper
	15.	Accept or obtain and process, at a frequency specified by the Department, all other grouper interface files.
	16.	Process the quarterly and annual HCPCS and CPT Update files.
	17.	Process the Clinical Laboratory Fee Schedule files.
Claims Adjustments and Edits		
	1.	Provide the capability to perform adjustments or voids on previously adjudicated claims, including those processed within the same pay cycle, using the edit and pricing rules applicable to the original claim's dates of service and associate them with the original claim. Adjustments or voids can be submitted by the provider or Department
	2.	Adjust the claim document including all line items
	3.	Derive the edit payment status (pay, deny/reject, pend) for each edit failure based on the date of service and Department business rules
	4.	Provide the capability to selectively apply edits based on Department business rules including, but not limited to: • Claim transaction; • Claim type; and, • Entity or Provider level.
	5.	Edit claim transactions based on Department business rules for provider status and eligibility to provide claimed services, edit claim transaction including, but not limited to:

		• Diagnosis; • Procedures; and, • Revenue Code
	6.	Edit claim transactions based on Department business rules to identify the relationship between diagnoses and procedures; payable status for the procedure and/or diagnosis as specified by the Department and, for combinations of procedure codes at the entity-level, identify those requiring manual review and/or pricing for duplicate or near-duplicate services (e.g., an outpatient claim submitted for a date of service which was previously covered under an inpatient claim) based on Department business rules for duplicate editing.
	7.	Adjust payments based on pricing factors including, but not limited, to Third Party Liability (TPL) amounts
Claims Processing		
	1.	Review claims and determine whether such claims are eligible for payment as qualifying health care costs, including verification of provider licensure or certification where applicable. The Contractor shall contact the Department for assistance with questions concerning the eligibility of claims for payment
	2.	Process all eligible claims within forty-five (45) days of the date the claim is complete. Department might request a prioritization of claims. At least 95% of processed claims shall be accurate (correct in all details).
	3.	If a claim should be denied, the Contractor must deny the claim within forty-five (45) days from the date that a complete claim was received by the Contractor
	4.	Provide the capability to process and respond to all electronic claim transactions in real-time using HIPAA standard formats based on industry standards and Department requirements
	5.	Provide pharmacy benefit management services, including administering and processing pharmacy claims in accordance with applicable laws and regulations
	6.	Provide document-level processing with a disposition determination for every line. If any line on a claim pends, the entire document must be pended. Combinations of lines which pay or deny do not affect the disposition of the document.
	7.	Reject transactions that do not meet minimum standards based upon Department business rules
	8.	Derive the claim type and assign the appropriate claim type based upon Department business rules
	9.	Process claim transactions to meet minimum standards through all applicable edits. All edit failures must be recorded and included in the response transactions to the limit allowed by the transaction
	10.	The Contractor must produce a weekly list of claims approved to be paid (Check File) for Department review, with a corresponding payment file in a format and timeframe to be determined by the Department or Department designee • Errors must be addressed and corrected by the contractor in a timeframe determined by the Department • Various reviews, reports and/or analysis of weekly claims to be determined by the Department may

		be requested • The submission shall be certified by the Contractor • The submission shall be in a form acceptable to the Department
	11.	The weekly claims submission shall be accompanied by supporting documentation as required by the Department, including copies of invoices and approvals and show any adjustments to be billed, the amounts and reasons
	12.	Provide the capability to create the following transactions via the website and/or vendor-supplied web-based application based on Department business rules: • Hold/Release Check File and EFT Transactions • Stop Check File and EFT Transaction • Credit/Refund Check File and EFT Transactions
Claims Payment		
	1.	Assign a Claims Manager to verify claims for accuracy prior to submission to the Department for payment
	2.	Generate EFTs, Check Files and wire transfers in a format as required by the Department or Department designee
	3.	Have the capability to submit EFT payments as ACH (NACHA) files
	4.	Have the capability to submit Weekly Check Files as IPT files, with the required data fields/columns, using the naming convention as specified by the Department or Department designee
	5.	Upload files, in a format required by the Department, to the specified banking system for EFT (ACH), Check Files, and wire transfers. *Note: the Department prefers utilizing the EFT (ACH) process over check files (IPT).*
	6.	The Contractor will initiate all wire transfers within the required banking system, and the Department and/or Division of Treasury will review and approve the transactions
	7.	Produce an EFT payment file (ACH), based on approved provider or enrollee EFT agreements, for each payment cycle and transmit payment data for review and approval to the Department or Department Designee on a schedule approved by the Department
	8.	Provide the capability to track and correct any unsuccessful or incorrect Check File or EFT payments
	9.	Provide the capability to process foreign payments and prepare wire transfer documentation to be reviewed and approved by the Department or Department designee as required

Explanation of Benefits		
	1.	Provide the capability to produce Explanations of Benefits (EOBs) and instructions as required by Executive Order No. 26, in English and ten qualifying non-English languages
	2.	Produce EOBs based on criteria specified by the Department
	3.	Produce a file containing EOB information as requested by the Department
Reporting		
	1.	Notify the Department on a weekly basis of any overpayments, duplicate payments or payments that should have been denied, and make reasonable efforts to reclaim any overpayments or adjust future payments to such payees to the satisfaction of the Department
Data Capture & Retention Requirements		
	1.	Maintain all information related to claims adjudication including, but not limited, to: • Provider information (e.g., billing, servicing/rendering, pay to, ordering, prescribing, attending, supervising, operating); • Enrollee information (e.g., Enrollee ID, name, address, gender, date of birth); • Service information (e.g., all applicable procedure codes, modifiers, revenue code, rate codes, dates of service, admission/discharge dates, service units, diagnosis, total charges, non-covered charges, Co-Pay, third party payment); • Adjudication information (e.g., edit information, pricing, adjudication codes, pend tracking information); and, • Adjustment and void transaction information.
	2.	Capture the information contained in claims transactions based on Department business rules
	3.	Maintain all information related to payments including, but not limited, to: • Provider information (e.g., billing, servicing/rendering, pay to, ordering, prescribing, attending, supervising, operating); • Enrollee member information (e.g., member ID, name, address, gender, date of birth); • Service information (e.g., procedure codes, revenue code, rate codes, dates of service, admission/discharge dates, service units, diagnosis, total charges, non-covered charges, Co-Pay, third party payment); • Adjudication information (e.g., edit information, pricing, adjudication codes, pend tracking information); and • Adjustment and void transaction information.

	4.	Maintain all data required to support recoupments, including the following: • Recoupment amount; • Recoupment payment schedule or percentage; • Reason for recoupment (e.g., court orders, audits, retroactive rate adjustments, negative claim balances/overpayment); • Payment history (e.g., payment source and amount); • Current recoupment balance due; and, • Recoupment balance paid.