



State of New Jersey  
Department of Human Services  
Division of Medical Assistance & Health Services

# NEWSLETTER

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**TO:** Acute General Hospitals, Special Hospitals, Rehabilitative Hospitals and Private Psychiatric Hospitals

**SUBJECT:** Non-Delegated to Delegated Utilization Review (UR) Process for Inpatient Hospital Services for NJ FamilyCare Fee-For-Service Clients

**EFFECTIVE:** August 1, 2015

**PURPOSE:** To provide policy clarification of the hospital utilization review transition process from non-delegated to delegated designation status.

**BACKGROUND:** The Division of Medical Assistance and Health Services (DMAHS) contracts with a vendor to perform Utilization Review (UR), DRG validation, and quality of care audits for inpatient hospital services provided for NJ FamilyCare fee-for-service clients. The current vendor, Permedion, conducts utilization control audits for inpatient hospital services for approved acute care general hospitals and their excluded units, special hospitals, rehabilitative hospitals and private psychiatric hospitals per N.J.A.C. 10:52-1.15. DMAHS has established a 95% accuracy rate requirement as a provider performance measure for appropriate UR medical necessity determinations and billing practices. The Permedion audit process identifies adverse determinations and erroneous billing as errors. Providers with error rates that exceed the established 5% threshold for three consecutive months may be designated as a non-delegated facility. Non-delegated status requires Permedion to retain responsibility for performing all of the utilization review activities with binding authority. Delegated status authorizes in-house medical staff to conduct utilization reviews, with oversight by Permedion, for compliance and continued authority. In order for a non-delegated facility to become a delegated facility certain benchmarks must be met. There are four three-month steps in the process to become a delegated facility. If at any time during the process the facility's error rate exceeds the 5% threshold, the process starts over.

**ACTION:** Following analysis of the Permedion Review Cycle 5 Provider Performance audit findings, DMAHS will designate providers with error rates above the acceptable 5% threshold non-delegated UR status. The non-delegated UR designation will require provider submission of a corrective action plan (CAP) to DMAHS to correct deficient practices causing the elevated error rate. The non-delegated provider will also be subject to 100% Post Discharge Prepayment Review until the cumulative Permedion error rates are below the 5% threshold.

Beginning with Permedion Review Cycle 6 in November 2015, the process outlined below will be implemented. This process will only apply to those providers with non-delegated UR designation status.

## DMAHS Non-Delegated to Delegated UR Process:

### **Step One** (Nov-Dec-Jan)

- 100% Post Discharge Prepayment Review for all discharges occurring on or after November 1, 2015
- CAP submission to DMAHS to correct deficient practices causing unacceptable error rate
- DMAHS reviews CAP submission for approval or revision
- CAP implementation period **must** be completed by January 31, 2015
- Permedion monthly error rate posted on the Document Online Tracking System (DOTS)
- Providers **must** electronically submit the complete medical record, insurance eligibility form, UR certification and UB-04 (including any necessary attachments for claim adjudication) to **Permedion.NJUR@hms.com**

### **Step Two** (Feb-Mar-Apr)

- CAP effective February 1, 2016
- Permedion Biweekly error rate posted on DOTS
- In month 6 (April 2016), the post CAP provider performance is evaluated and the review process revised accordingly
  - Providers with cumulative Permedion Biweekly error rates greater than 5% are subject to additional CAP submissions and automatic referral to Medicaid Fraud Division
    - Effective May 1, 2016, the review process returns to Step One
  - Providers with cumulative Permedion Biweekly error rates less than 5%
    - Effective May 1, 2016, the review process moves on to Step Three

### **Step Three** (May-Jun-Jul)

- Providers with cumulative Permedion Biweekly error rates less than 5%
  - UB-04s (and any necessary attachments for claim adjudication) **ONLY** submitted electronically to Permedion
  - 50% of claims are randomly selected by Permedion for review
  - Remaining claims not selected are submitted to DMAHS for processing
  - Medical record request sent to provider for electronic submission of the 50% of claims randomly selected
  - Permedion monthly error rate posted on DOTS
- Providers with cumulative Permedion Biweekly error rates greater than 5% are subject to additional CAP submissions and automatic referral to Medicaid Fraud Division
  - Effective August 1, 2016, the review process returns to Step One
- Providers with cumulative Permedion Biweekly error rates less than 5%
  - Effective August 1, 2016, the review process moves on to Step Four

### **Step Four** (Aug-Sep-Oct)

- UB-04s (and any necessary attachments for claim adjudication) **ONLY** submitted electronically to Permedion
- 20% of claims are randomly selected by Permedion for review

- Remaining claims not selected are submitted to DMAHS for processing
- Medical record request sent to provider for electronic submission of the 20% of claims randomly selected
- Permedion monthly error rate posted on DOTS
- DMAHS reviews the cumulative Permedion Provider Performance UR data to determine the delegated vs. non-delegated UR status designation effective November 1, 2016
  - Providers with cumulative Permedion monthly error rates less than 5% receive delegation designation status for the next review cycle effective November 1, 2016
  - Providers with cumulative Permedion monthly error rates greater than 5% receive a non-delegation designation status for the next review cycle effective November 1, 2016 and the review process returns to Step One

**Any incomplete or untimely submission of requested medical information will result in a technical denial. This includes case specific submission of Explanation of Benefits (EOB) for insurance conversions and civil commitment orders. There are no appeals for technical denials.**

**For questions regarding this newsletter please contact the NJ Division of Medical Assistance and Health Services Office of Preventive Health Services at 609-588-2458.**

**DMAHS reserves the right to extend and/or modify the aforementioned review process at its discretion.**

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