



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

NEWSLETTER

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TO: Hospitals – **For Action**
Managed Care Organizations – **For Information Only**

SUBJECT: Contract Reprocurement to Permedion, for NJ FamilyCare Utilization Review Audits

EFFECTIVE: Immediately

PURPOSE: To notify providers and managed care organizations that effective immediately, Permedion will conduct Utilization Review (UR), Quality of Care, DRG Validation and Billing audits of inpatient hospital services for traditional fee-for-service (FFS) **and** managed care organization (MCO) NJ FamilyCare members.

BACKGROUND: In August 2010, The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) contracted with Permedion, an HMS subsidiary, to conduct UR, Quality of Care, DRG Validation and Billing audits of inpatient hospital services for traditional FFS NJ FamilyCare members. Permedion was tasked to safeguard against unnecessary or inappropriate services and assess the quality of those services provided. The scope of work was limited to traditional FFS inpatient claim review and did not include MCO encounter records. A new request for proposal (RFP) was posted for bid solicitation and Permedion was the successful bidder.

ACTION: Under the new Permedion contract, Permedion expanded the scope of the hospital UR audits to include MCO encounter records. Hospitals are required to respond to Permedion's request for documentation and/or findings concerning reviewed encounter claims within the specified time periods.

The Permedion UR audit process will remain unchanged for the traditional FFS NJ FamilyCare inpatient hospital services. The process involving MCO encounters, while similar, are as follows:

- Permedion will send the provider a random sample medical records request list.
- The provider will electronically submit the requested medical records, UR certifications and billing documentation, to include UB04 claim forms that represent a HIPAA 837(I) claim transaction, as submitted to and processed by the MCO, to Permedion for review.

- Permedion will review the documentation and determine if the services provided were medically necessary, were submitted correctly, have an encounter record transaction submitted by the MCO to the fiscal agent (FA), and if the documentation submitted is consistent with the services provided.
- Permedion will notify the provider and the MCO of all adverse determinations, to include a denial rationale.
- Adverse determinations that are not disputed by the provider must be adjusted or voided. The provider is responsible for adjusting the claim submitted to the MCO. The MCO is responsible for submission of the provider's adjusted or voided encounter record for processing by the FA. Instructions regarding the adjusted or voided claim/encounter process and response timeline are included in the adverse determination notification.
- Adverse determinations that are disputed by the provider can be appealed. The provider must submit a request for a first level of appeal to the UR Contractor. Instructions regarding the appeal process and response timeline are included in the Permedion adverse determination notification.
- Adverse determinations that are upheld by Permedion's 1st level appeal process can be appealed to DMAHS' Fair Hearing Unit as a second level appeal. Instructions regarding the Fair Hearing process and response timeline are included in the first level appeal decision notification.

It is the provider's responsibility to ensure outside vendors utilized for billing documentation and medical record requests are compliant with the Permedion UR audit response timeline. Any incomplete or untimely submission of medical information and/or billing documentation may result in recoupment of subject claims/encounters.

If you have any questions regarding this Newsletter, please contact Permedion at 609-632-1500.

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