REV - Disallowance Procedure

Purpose:

Revenue Collections conducts disallowance cycles to recover funds from providers where Medicaid paid the provider, but the member has access to Medicare or commercial insurance covering the services rendered. Department of Human Services (DHS), through Health Management Systems (HMS), instructs the provider to bill the correct insurer.

For the Iowa Medicaid Enterprise (IME), HMS pursues recoupment primarily for institutional acute care providers, hospitals, and rehabilitation centers where targeted commercial carriers or Medicare Part "A" or Medicare Part "B" are the liable payers. Medicare Part "A" services that are considered are home health, hospice and inpatient care. Medicare Part "B" services that are considered are clinical research, ambulance services, durable medical equipment, mental health and some limited outpatient prescription drugs. Medicare crossovers or exhausted Medicare benefits are carved out of the recoupment cycle.

Identification of Roles:

IME - Sends a copy of the Center for Medicare/Medicaid Services (CMS) Eligibility Database (EDB) response file each month, along with a copy of the BENDEX file. These files are used for the Medicare disallowance process. IME sends a copy of the eligibility, provider and paid claims file monthly. These files are used for the commercial carrier disallowance process.

IME Revenue Collections- Generates the Medicare Cycle using data-match files provided by IME for institutional claims. Matches recipients with Medicare coverage to claims paid by Medicaid over the past 36 months. Also, generates the Commercial carrier cycle for institutional claims. Matches recipients with verified commercial insurance coverage to claims paid by Medicaid over the past 36 months.

Performance Standards:

Five cycles per Fiscal Year

Path of Business Procedure:

Step 1: DHS sends a copy of the CMS Eligibility Database (EDB) response file each month, along with a copy of the BENDEX file to HMS Corporate.

Step 2: For Medicare, HMS Operations runs a series of programs that match the Iowa Medicaid eligibility information to the Medicare eligibility data to identify recipients with other coverage. Revenue Collections Project Manager performs commands that allow the data match to occur between the two data sets. The data match criteria is based on combinations of key field matches including: Social Security Number, Date of Birth, First Name and Last Name.

Step 3: For Commercial Insurance Verifications, HMS operations run a series of programs that match the Medicaid eligibility information to our commercial insurance repository. At this point the third party liability (TPL) is verified and TPL is updated in e-Care, which is an HMS database process. The verified TPL is loaded into the Data Match file and transmitted to the Core Unit for uploading to the Medicaid Management Information System (MMIS) TPL subsystem. At the beginning of a cycle, Revenue Collections receives a listing of the providers appearing on the Recovery Project Report detailing all claims that HMS has identified with primary coverage. Claims with the following attributes are removed:

a) Dates of service outside recipient's coverage period.
b) Medicare exhaust
c) Claims previously identified for recovery.
d) Medicare Crossovers

Claim data elements required by the provider to bill Medicare and the commercial carriers are included in the claim listing. These include:

a) Identification number of Subscriber
b) Name of Subscriber

Step 4: HMS Corporate Prints claims, then associates listings to the correct provider claim detail within the Provider Portal. Quality Assurance (QA) staff checks mailing label, packet accuracy, and scans listings, letters and instruction of each provider packet and associates the images to the correct provider claim detail within the Provider Portal. Upon completion of the QA approval process, HMS Corporate loads the claim detail information into Provider Portal for outreach tracking, payment posting, and reporting.

Step 5: Prior to release of the Disallowance Revenue Collections will e-mail our HMS corporate office at Irving, TX and request some random verifications be done. The purpose is to ensure that the eligibility data is correct on the outgoing project.

Step 6: Packets are mailed via 2nd Day Air to the Providers. Providers can also access their disallowance project online at http://dhs.iowa.gov/ime/providers/claims-and-billing and then selecting the link: Disallowance Project at the bottom of the page. From there it will take the provider into a secure web portal which will allow them to log on to obtain and work their data online.

Step 7: Revenue Collections notifies the listed providers that they have forty-five (45) days to send the IME documentation to refute Medicaid's claim and avoid recoupment of the disallowance amount, and to answer any questions that might arise from the Recovery Project.

Revenue Collections accepts the following documentation from providers as proof that Medicaid payments should not be recouped:

a) A copy of a current Medicare/Commercial Carrier denial
b) A current remittance from Medicare/Commercial Carrier stating that the patient or the service was not covered; or copy of a Medicaid remittance indicating prior DHS recoupment.
c) A print-out from the common working file for Medicare showing no coverage for service date
d) A print-out from the Commercial Carrier's Eligibility website showing no eligibility.

Step 8: If the provider agrees to the recoupment amount, they can document on the recovery project report and return the project listing, or the providers may submit checks for the balance due for the disallowance amount.

Step 9: IME Revenue Collections makes outbound calls to providers at mid-cycle that have more than 10 claims scheduled to recoup and no responses have been received. These are reminder calls or emails.

Step 10: Upon receipt of checks or denial documentation from providers, Revenue Collections updates Provider Portal (an HMS proprietary software program that manages disallowance cycles.)

a) Providers are instructed to send checks to Coordinated Disallowance, P.O. Box 310202, Des Moines, IA 50331. The checks are copied, deposited and forwarded to the IME by Wells Fargo Bank. The Core Unit scans the documents into OnBase.

b) Revenue Collections posts all checks to the Provider Portal system by referencing the OnBase image and are uploaded into MMIS at the end of the cycle.

Step 11: Provider claims that are refuted on the annotated listings are voided from the system. This is accomplished by keying in the correct reason code in Provider Portal so the claim will not recoup.

Step 12: At the close of the disallowance period, Revenue Collections ensures that all provider's payments and/or responses have been posted to the Provider Portal.

Step 13: **When the project closes: HMS Corporate will send an electronic file to CORE for uploading to MMIS. This file contains recoupment requests and check amounts.**

a) Once approved, Core uploads and creates a reject report in OnBase for each file. IAMT2200-R002 (HMS Error Report) (For Live & History Respectively) IAMC9000-R003 (Request Claims Count Report) Where Selected Count is '0' indicates error out (For Live & History Respectively).
b) Core completes the adjustments in MMIS.

Step 14: If the electronic file rejects or otherwise did not transfer to MMIS: IME Revenue Collections creates a manual credit adjustment or history request in OnBase. This request will generate a recoupment to be applied to the provider's account in MMIS, based on information from Provider Portal that indicates (at the claim level) the amount that needs to be recovered to Medicaid.

Step 15: If a provider discovers after the Recovery Project has closed that a member is not covered under the carrier indicated on our report, they can contact Revenue Collections, provide the refuting claim documentation along with the member's information and Revenue Collections will enter it into a spreadsheet that is sent to HMS at the end of every month for approval. Once approval is given, a credit adjustment request is sent to Core.

Step 16: If a provider indicates that payment was inappropriately recouped or a refund check was sent in error, Revenue Collection requests that the provider provide specific documentation before issuing a refund. If the provider states the primary payer denied the claim, Revenue Collections asks for a copy of the explanation of benefits (EOB) showing denial of the claim and reason for denial. Where the provider states that there is no coverage, proof of non-coverage is requested in the form of a Common Working File (for Medicare A or B) screen print or a denial due to lack of

coverage (Commercial) IME Revenue Collections may also review the eligibility page from the Commercial carrier's web site as well.

The following information is added to a spreadsheet and is submitted for adjustment at the end of the month and it becomes an attachment in the HMS invoice to DHS.

a) Patient Name
b) State Identification Number (ID)
c) Provider Number
d) Provider Name
e) Dollar amount of Refund
f) Refund Reason
g) Date of Request
h) Date of Processing
i) Date of Service
j) HMS Cycle Period

Step 17: Provider requests for assistance on claims that have been part of an HMS Recovery: Providers are informed that claims will not be adjusted for payment if timely follow-up does not occur with 1 year of the take back as long as the date of service is within 2 years per Provider Services' Informational letter 722 dated December 23, 2008. However, allowances will be made if the claim is 2 years old or older and the provider's attempts are shown to be prior to the claim becoming 2 years old.

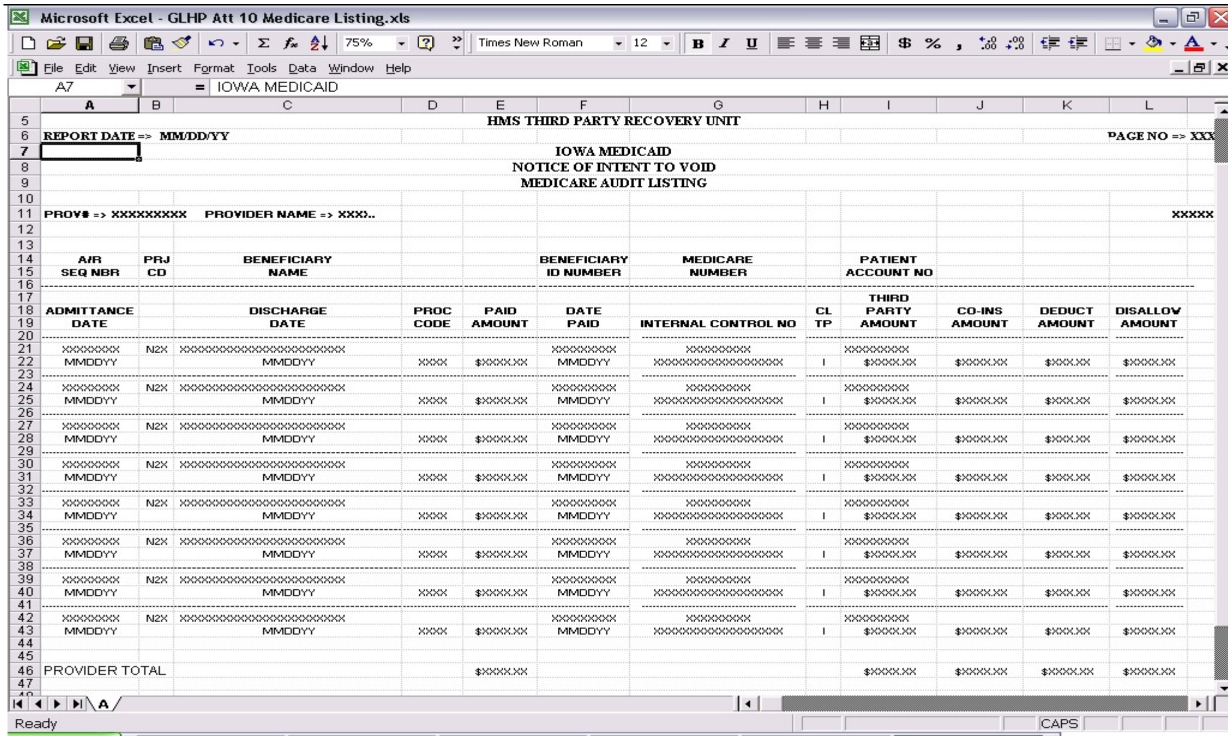
Step 18: Quality Assurance - The purpose of reviewing the provider disallowance process: To ensure that provider repayments are entered accurately and timely. The review steps are listed below:

a) Review a percentage of data received from provider and entered into Provider Portal to ensure provider disallowance is correct.
b) Review OnBase Queues to determine all checks for Disallowance Project have been indexed as Classification 35.
c) Validate recoupment and check totals with data sent from HMS.

Determine that CORE processes the electronic file timely.

Forms/Reports:

Disallowance Listing to Iowa Medicaid Enterprise



HMS THIRD PARTY RECOVERY UNIT

REPORT DATE => MM/DD/YY PAGE NO => XXX

IOWA MEDICAID
NOTICE OF INTENT TO VOID
MEDICARE AUDIT LISTING

PROV# => XXXXXXXX PROVIDER NAME => XXX).. XXXXX

A/R SEQ NBR	PRJ CD	BENEFICIARY NAME			BENEFICIARY ID NUMBER	MEDICARE NUMBER		PATIENT ACCOUNT NO			
ADMITTANCE DATE		DISCHARGE DATE	PROC CODE	PAID AMOUNT	DATE PAID	INTERNAL CONTROL NO	CL TP	THIRD PARTY AMOUNT	CO-INS AMOUNT	DEDUCT AMOUNT	DISALLOW AMOUNT
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
XXXXXXXX	N2X	XXXXXXXXXXXXXXXXXXXXXXX			XXXXXXXXX	XXXXXXXXX		XXXXXXXXX			
MMDDYY		MMDDYY	XXXX	$XXXX.XX	MMDDYY	XXXXXXXXXXXXXXXXXX	I	$XXXX.XX	$XXXX.XX	$XXX.XX	$XXXX.XX
PROVIDER TOTAL				$XXXX.XX				$XXXX.XX	$XXXX.XX	$XXXX.XX	$XXXX.XX

RFP References: N/A

Interfaces: N/A

Attachments: N/A
See next page

Disallowance Letter and Provider Instructions

Iowa Department of Human Services

Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

DATE

Dear Medicaid Provider:

To comply with recent federal and CMS mandates, the Department of Human Services (DHS) has had to intensify its efforts to ascertain if third party coverage (Medicare or Commercial Insurance) exists for services for which Medicaid has paid. In connection with this effort, DHS, through a contractor, Health Management Systems, Inc. (HMS), has recently completed a review of claims paid by the Medicaid Program for dates of service from MM/DD/YY through MM/DD/YY. **Retroactive Medicare, Wellmark BlueCross/BlueShield (BCBSIA) or the Federal Employee Plan (FEP) coverage** has been identified for a number of Medicaid recipients and their associated claims for which your facility received reimbursement from the Iowa Medicaid Program.

Federal Regulations require that Medicaid recover its payments when a liable third party is identified. If you have not billed the other insurance identified in the enclosed listing(s) yet, please do so now.

You have forty-five **(45) days** from the date of this notice to:

(1) Review your records;

(2) Bill the other insurer (if you have not already done so) on those claims so identified; and then either

(3) Send a full refund to HMS in the amount indicated on the listing under the column entitled “Disallow Amount”; or

(4) Forward documentation to Iowa Medicaid Enterprise, Revenue Collections to refute the refund request(s).

Please refer to Item 3 of the enclosed instructions for samples of acceptable documentation.

Enclosed is a copy of the claims listing describing details on those claims that appear to be eligible for other insurance coverage on the date of service. Use this listing as a resource document to identify the cases involved and to bill the indicated insurer. Please retain one copy of each listing for your records and return a copy to: **Iowa Medicaid Enterprise-Coordinated Disallowance Project, P.O. Box 310202, Des Moines, IA 50331-0202**.

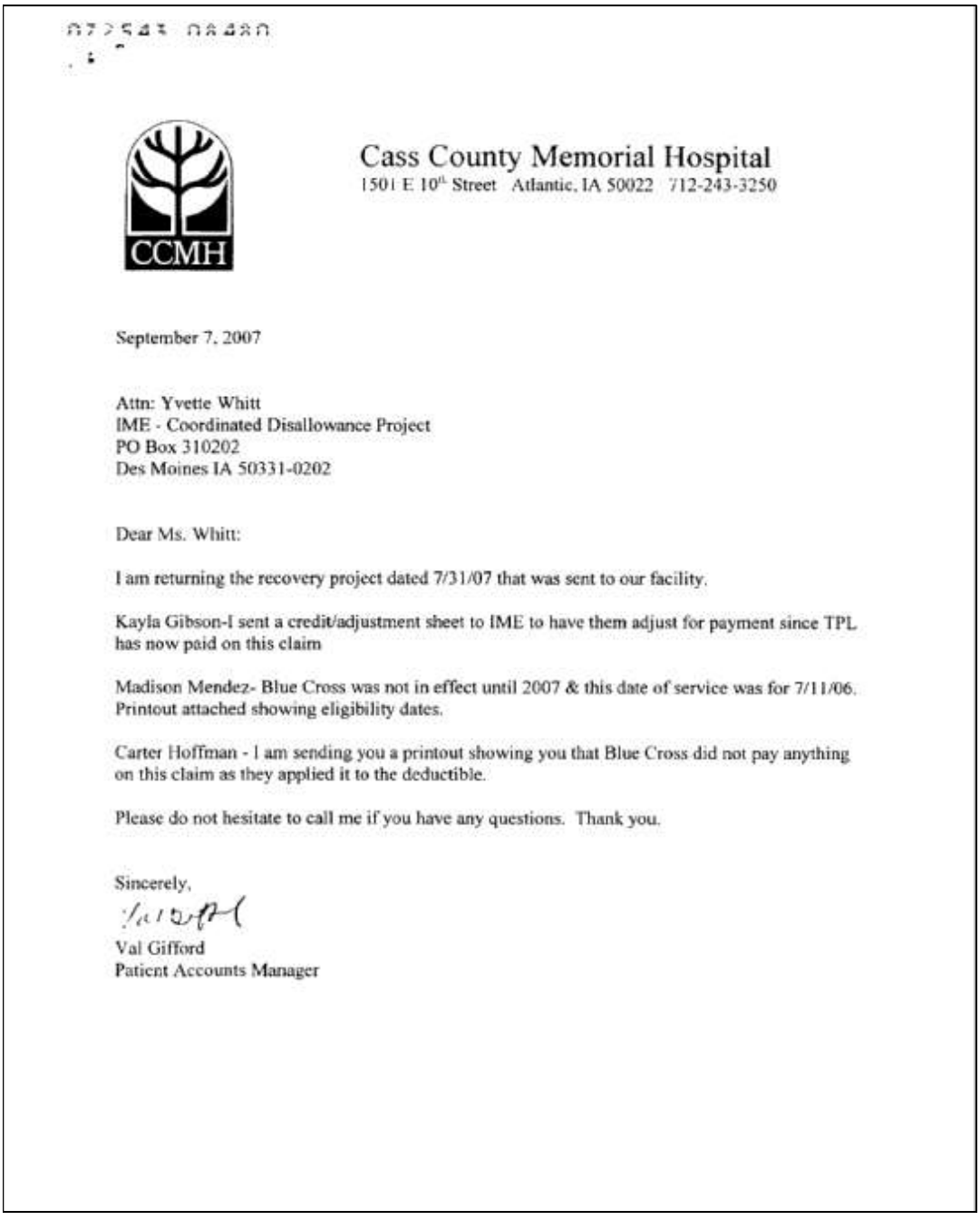
If there are any questions regarding this notice or the listing, please call Revenue Collections at 1-866-810-1206 (toll free) or 515-256-4619 (local Des Moines).

Thank you in advance for your cooperation and assistance in this recovery project.

Sincerely,

Robert Schlueter
Revenue Collections Unit Manager
Iowa Department of Human Services
Attachments

Example of Disputing Documentation



Cass County Memorial Hospital
1501 E 10th Street Atlantic, IA 50022 712-243-3250

CCMH

September 7, 2007

Attn: Yvette Whitt
IME - Coordinated Disallowance Project
PO Box 310202
Des Moines IA 50331-0202

Dear Ms. Whitt:

I am returning the recovery project dated 7/31/07 that was sent to our facility.

Kayla Gibson-I sent a credit/adjustment sheet to IME to have them adjust for payment since TPL has now paid on this claim

Madison Mendez- Blue Cross was not in effect until 2007 & this date of service was for 7/11/06. Printout attached showing eligibility dates.

Carter Hoffman - I am sending you a printout showing you that Blue Cross did not pay anything on this claim as they applied it to the deductible.

Please do not hesitate to call me if you have any questions. Thank you.

Sincerely,

Val Gifford
Patient Accounts Manager

Disallowance listing to Providers

STATE OF IOWA

DEPARTMENT OF HUMAN SERVICES

LISTING OF DHS PAID CLAIMS FOR BENEFICIARIES HAVING
PROJECT NAME: COB: COMMERCIAL INSURANCE

Tuesday, 31 July 2007

PAGE 1

FOR ASSISTANCE, PLEASE CALL
HMS PROVIDER RELATIONS
BETWEEN 7AM AND 7PM CST AT:

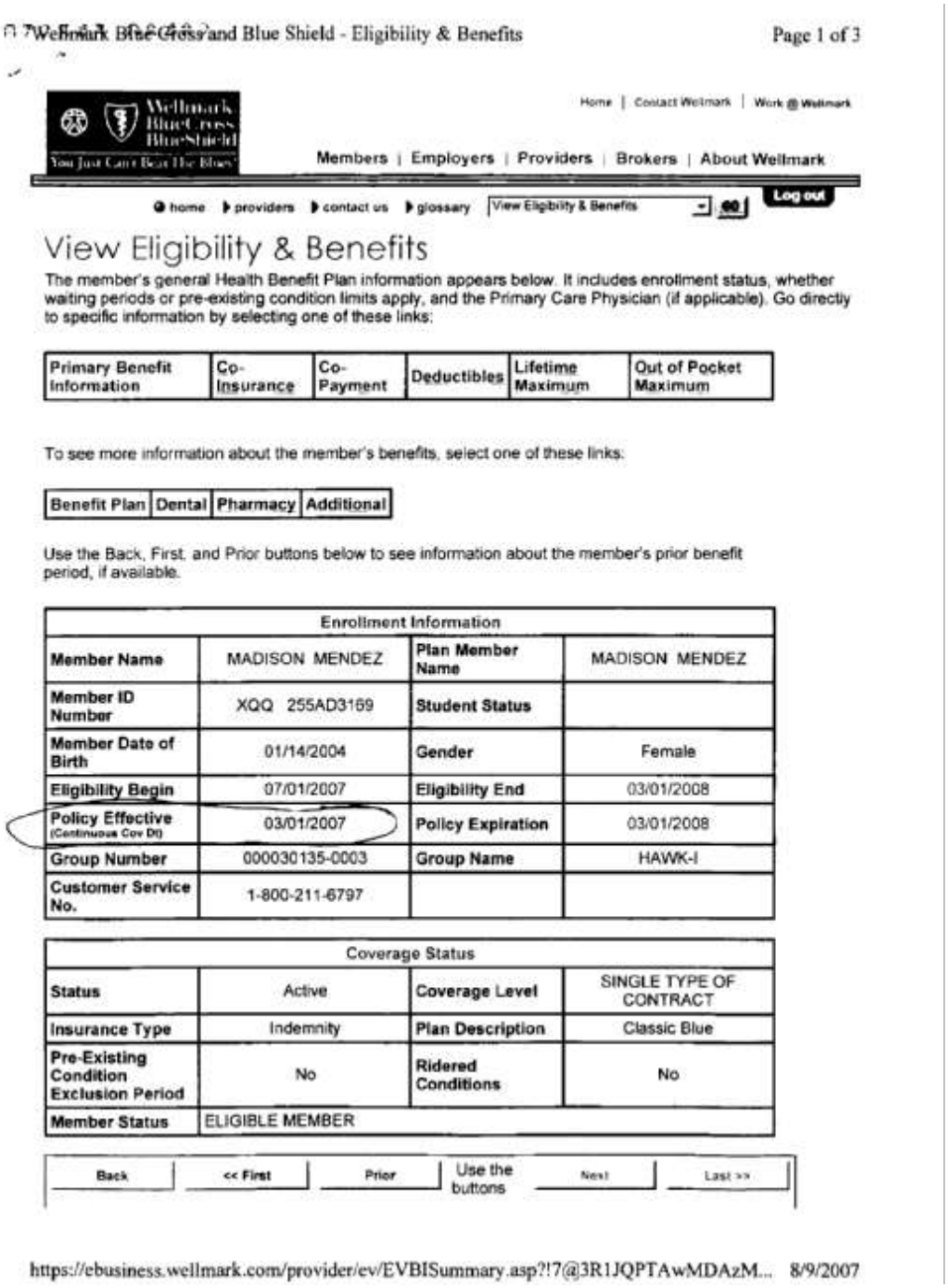
866) 810-1204

PROVIDER #=060039500 PROVIDER NAME=CASS COUNTY MEMORIAL HOSP NPI #=1093760944

MED/PAT ACCT NUM	PAYOR ID NUMBER	INSURED LN	INSURED FN	DHS ICN	DHS FROM DOS	DHS THRU DOS	DHS PAID AMOUNT	RECOUP AMOUNT	DHS REMIT DATE
CARRIER: BCBS IOWA ADDRESS:636 GRAND AVE DES MOINES IA 503092502 PHONE# : 5152829680 GROUP : 000030135-0006									
MEDICAID ID:		NAME:		DOB:					
YAA11441	XQQ268AD5970			30705900016098B000	02/10/2007	02/10/2007	170.02	170.02	02/28/2007
TOTALS FOR PATIENT =>							170.02	170.02	
CARRIER: BCBS IOWA ADDRESS:636 GRAND AVE DES MOINES IA 503092502 PHONE# : 5152829680 GROUP : 000030135O003									
MEDICAID ID:		NAME:		DOB:					
V2412054 1	XQQ255AD3169			306223000170529000	07/11/2006	07/11/2006	146.51	146.51	08/11/2006
TOTALS FOR PATIENT =>							146.51	146.51	
CARRIER: BCBS IOWA ADDRESS:636 GRAND AVE DES MOINES IA 503092502 PHONE# : 5152829680 GROUP : 000059999-2313									
MEDICAID ID:		NAME:		DOB:					
V2400392 1	XQH 267AD1061			406216007092583590	04/24/2006	04/24/2006	121.51	121.51	08/08/2006
TOTALS FOR PATIENT =>							121.51	121.51	
TOTALS FOR PROVIDER/PROJECT =>							438.04	438.04	

CD: 7/31/2007 31404003950008

Example of refuting documentation



Wellmark Blue Cross and Blue Shield - Eligibility & Benefits Page 1 of 3

Wellmark Blue Cross Blue Shield
You Just Care Beat The Blues

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View Eligibility & Benefits

The member's general Health Benefit Plan information appears below. It includes enrollment status, whether waiting periods or pre-existing condition limits apply, and the Primary Care Physician (if applicable). Go directly to specific information by selecting one of these links:

Primary Benefit Information	Co-Insurance	Co-Payment	Deductibles	Lifetime Maximum	Out of Pocket Maximum

To see more information about the member's benefits, select one of these links:

Benefit Plan	Dental	Pharmacy	Additional

Use the Back, First, and Prior buttons below to see information about the member's prior benefit period, if available.

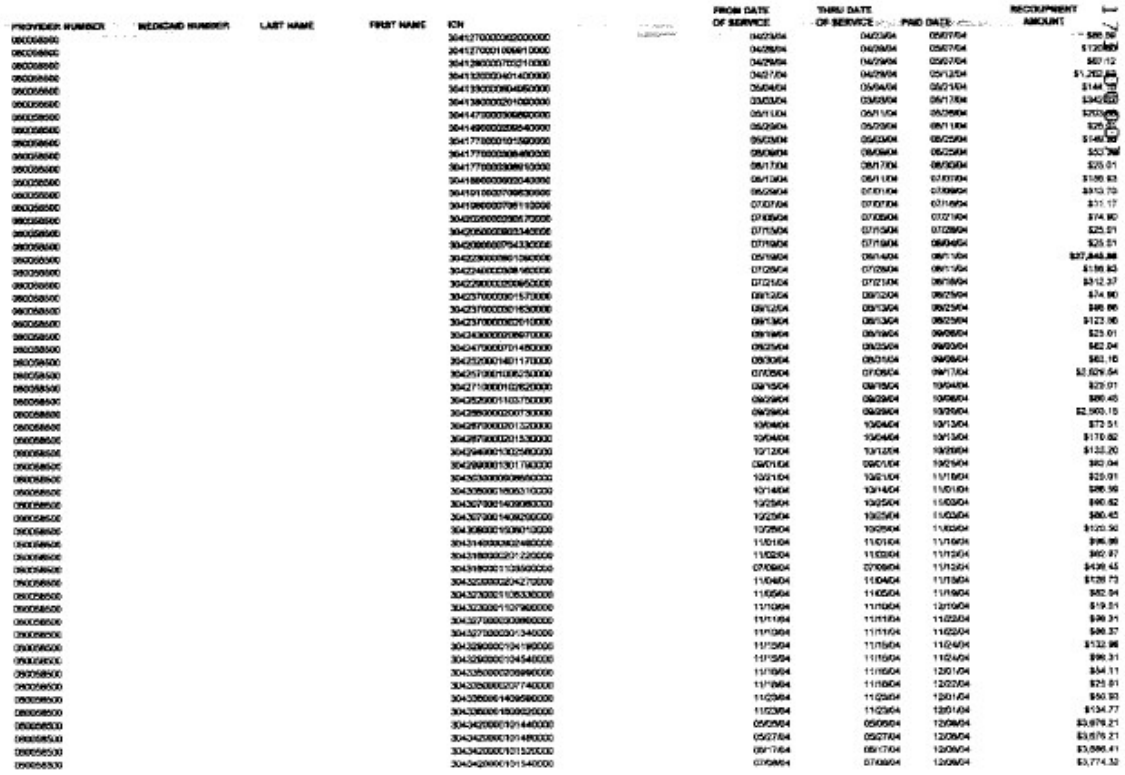
Enrollment Information			
Member Name	MADISON MENDEZ	**Plan Member Name**	MADISON MENDEZ
Member ID Number	XQQ 255AD3169	**Student Status**	
Member Date of Birth	01/14/2004	**Gender**	Female
Eligibility Begin	07/01/2007	**Eligibility End**	03/01/2008
Policy Effective (Continuous Cov Dt)	03/01/2007	**Policy Expiration**	03/01/2008
Group Number	000030135-0003	**Group Name**	HAWK-I
Customer Service No.	1-800-211-6797		

Coverage Status			
Status	Active	**Coverage Level**	SINGLE TYPE OF CONTRACT
Insurance Type	Indemnity	**Plan Description**	Classic Blue
Pre-Existing Condition Exclusion Period	No	**Ridered Conditions**	No
Member Status	ELIGIBLE MEMBER		

Back | << First | Prior | Use the buttons | Next | Last >>

https://ebusiness.wellmark.com/provider/ev/EVBISummary.asp?!7@3R1JQPTAwMDAzM... 8/9/2007

Disallowance “Close-of-Cycle” Spreadsheet



PROVIDER NUMBER	MEDICAID NUMBER	LAST NAME	FIRST NAME	ICN	FROM DATE OF SERVICE	THRU DATE OF SERVICE	PAID DATE	RECOUPMENT AMOUNT
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0800568000				30420000007543300000	07/19/04	07/19/04	08/06/04	$25.01
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0800568000				30429600001302580000	10/12/04	10/12/04	10/28/04	$123.20
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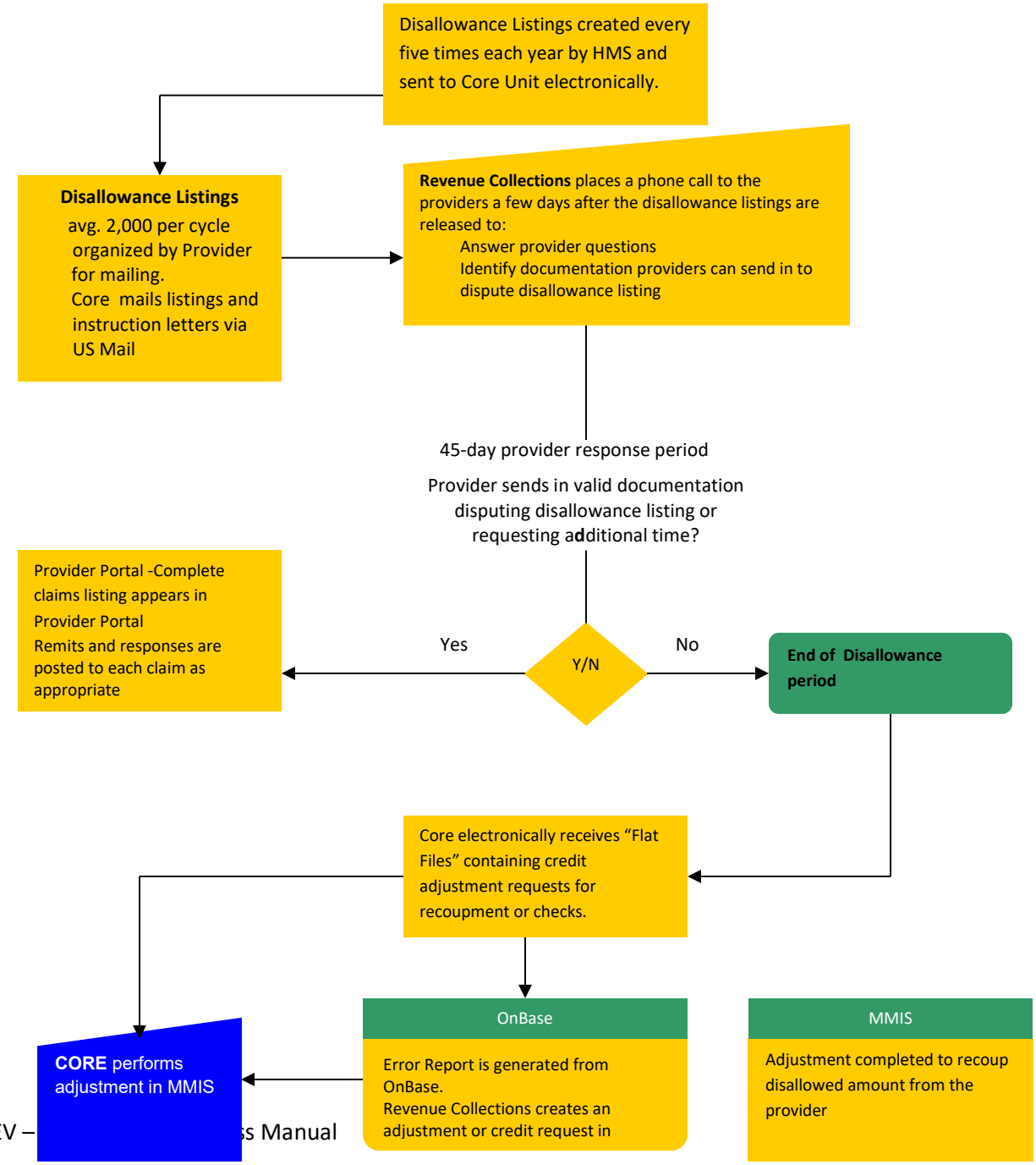
Disallowance Flowchart



Acronyms:

BCIA – Wellmark / Blue Cross of Iowa
DHS – Department of Human Services
HMS – Health Management Systems is a corporation is contracted by the Department of Human Services to perform revenue collections
IME – Iowa Medicaid Enterprises
MCR – Medicare
MCD – Medicaid
Q.A. – Quality Assurance
Recovery Project – When other insurance is identified by Revenue Collections for Medicaid paid claims, listings are sent out to notify providers of the discovery of other insurance and requesting that they bill the liable primary insurance and return what Medicaid has paid on those claims
Recoupment – Payment (money) that is taken back from a provider's Medicaid payment because of a claim payment error
Disallowances – The internal name HMS calls the recovery project
Provider Portal – An HMS proprietary web-based application used to track and post recovery project payments and responses