Administrative Policy Statement
GEORGIA MEDICARE DUAL ADVANTAGE

Policy Name	Policy Number	Effective Date
Program Integrity Provider Prepayment Review	AD-1114	09/01/2021 – 10/31/2022

Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource. and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Provider Prepayment Review

B. Background

CareSource Program Integrity (PI) operates a provider prepayment review program to detect, prevent and correct fraud, waste and abuse and to facilitate accurate claim payments. Physicians and other healthcare professionals may have the right to appeal results of reviews.

C. Definitions

- **Provider prepayment review-** reviews medical record documentation and compares it to billed services.
- **Program Integrity -** PI
- **Certified Professional Coder-**CPC
- **Registered Health Information Administrator-**RHIA
- **Registered Health Information Technician-**RHIT

D. Policy

I. A Provider prepayment review is the reviews of a provider's medical documentation prior to the payment of a claim. CareSource makes the decision to place agencies on prepayment including, but not limited to:
   A. Violation of policy or Conditions of Participation
   B. Inappropriate or aberrant billing practice; or
   C. Credible allegations of fraud

II. Placement on prepayment review will require the provider to submit medical records with each claim allowing CareSource to review the medical records in comparison to the billed services. CareSource will exercise discretion when determining if specific CPT codes, or all CPT codes will be placed on a prepayment review.
   A. CareSource will notify the provider that a determination has been made to place the provider on prepayment review by providing a written notification within 30 calendar days of the start date. At minimum, the notification will include documentation upload requirements, contact information and CPT codes being reviewed. In certain instances, it may be necessary to implement prepayment review immediately. In those cases providers will be notified subsequent to the action.
   B. Medical records MUST be submitted via paper format to the PO Box listed on the provider prepayment notification letter.
   C. All claims must be accompanied with medical records.
   D. Failure to submit medical records to CareSource in accordance with this provision will result in claim denial.
   E. CareSource will review with the documentation to determine whether the claim is appropriate for payment based on criteria including, but not limited to, provider documentation which establishes that:
      1. Services were provided according to CareSource policy requirements.
      2. Billed services were medically necessary, appropriate, and not in excess of the members need.

3. Members were eligible on the date the services were provided.
4. Prior authorization was obtained if required by policy.
5. Providers and their staff were qualified as required by policy; and
6. Providers possessed an active provider number, licenses, and certification at the time the services were provided to member (s).

III. CareSource will provide a monthly report to the provider/provider group regarding the outcome of the reviewed claims.

IV. The PI Provider Prepayment Review Team is made up of clinical review and coding specialists who maintain CPC, RHIA or RHIT designation.
   A. The team reviews provider documentation to determine whether the claim is appropriate for payment based on criteria including but not limited to, provider documentation which establishes that:
      1. Services were provided according to CareSource policy requirements.
      2. Billed services were medically necessary and appropriate, and not in excess of members need.
      3. Members were benefit eligible on the date the services were provided.
      4. Prior authorization was obtained if required by policy
      5. Providers and their staff were qualified as required by state and federal law.
      6. The provider possessed the proper license, state certification, or other accreditation requirements specific to the provider's scope of practice at the time the service was provided to the member.

V. Removal from Prepayment Review
   A. Providers must bill timely and accurate claims during the prepayment review period.
   B. Providers who demonstrate continued pattern of not billing timely and accurately during the prepayment review period may be terminated from CareSource pursuant to applicable policies and procedures.
   C. If appealing the termination action from CareSource, the provider should refer to the policy for requesting an appeal.
   D. Providers must bill the greater of 10 % of normal billing volume or a minimum of 40 claims for dates of service that occurred while on prepayment review to be considered for removal. The aggregate of claims reviewed must meet an 85% pass rate to be considered for removal
   E. Providers who have an error rate less than 15% (based on claim line items) for a period of at least three months will be considered for removal after they have fulfilled the requirements for all CPT codes under review. Providers will be notified in writing of the effective end day of review.

VI. Post Payment Review
   A. Providers who have been released from Prepayment Review will be subject to a post-review of claims billed, six to twelve months from release. Providers will be notified by CareSource prepayment review of the claims being reviewed, the documentation needed for the post review, and due date of the requested documents.
   B. If the provider does not comply with the request for documentation within the given timeframe, the provider will be placed back on prepayment review until CareSource determines is no longer necessary.
   C. If the Post Payment Review determines the provider has an error rate more than 15%, the provider may be placed back on prepayment review or be considered for termination from CareSource pursuant typo applicable policy and procedures. A provider may appeal their termination by following the provisions outlined in CareSource' s policy and procedures.

VII. Termination of providers on prepayment review:

A. CareSource may terminate provider/provider group agreement because of, but not limited to:
   1. Provider/Provider group has been on PPR for 16 months and there has been no billing activity during this time
   2. Documentation consistently fails to support services billed or medical records were not provided to support claims billed.
   3. Provider/Provider group currently on prepayment review may be terminated when entering a guilty plea or when a jury returns a guilty verdict in a federal or state prosecution involving healthcare fraud.

E. Conditions of Coverage-N/A

F. Related Policies/Rules-N/A

G. Review/Revision History

DATES		ACTION
Date Issued	06/09/2021	New Policy
Date Revised		
Date Effective	09/01/2021	
Date Achieved	10/31/2022	This policy is no longer active and has been archived. Please note that there could be other policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented policy.

H. References

N/A

The Administrative Policy Statement detailed above has received due consideration as defined in the Administrative Policy Statement Policy and is approved.