UTILIZATION REVIEW, CARE MANAGEMENT ORGANIZATIONS, AND ADVERSE ACTIONS

_____General

This chapter describes the method Care Management Organizations use to conduct utilization reviews and the role of the Program Integrity Unit of the Office of the Inspector General. Further, this chapter describes some of the types of adverse actions Care Management Organizations are authorized to take and the grounds for taking such actions.

_____ Prepayment Review

A) Prepayment review (PPR) is the review of a provider's medical documentation prior to payment of a claim. The Care Management Organizations (CMO) makes the decision to place agencies on prepayment review because of, but not limited to:

- Violation of Medicaid policy or Conditions of Participation;
- Inappropriate or aberrant billing practices; or
- Credible allegations of fraud.

The CMOs will evaluate decisions for PPR on a case by case basis. The CMOs will exercise discretion when determining if specific CPT codes, or all CPT codes will be placed on PPR. The CMOs will place providers on PPR for the same CPT codes across the enterprise to ensure consistency of the review.

The CMOs will notify the provider that a determination has been made to place the provider on PPR by providing a written notification within 30 calendar days of the start date. At a minimum, the notification will include documentation upload requirements, contact information, and CPT codes being reviewed. In certain instances, it may be necessary to implement PPR immediately. In those cases, providers will be notified subsequent to the action.

B) The CMOs or its representative reviews the provider's documentation to determine whether the claim is appropriate for Medicaid payment based on criteria including, but not limited to, provider documentation which establishes that:

1. Services were provided according to CMO policy requirements;
2. Billed services were medically necessary, appropriate, and not in excess of the member's need;
3. Members were Medicaid-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 Medicaid policy; and

6. Providers possessed an active Medicaid provider number, licenses, and certifications at the time the services were provided to the Medicaid member(s).

C) Providers may not appeal the CMO's decision to place the provider on Prepayment review. Prepayment review and the removal of a provider from Electronic Data Interchange (EDI) are not considered adverse actions. Providers may appeal the denial of any claim, reduction of reimbursement or the withholding of reimbursement, which occurred during the PPR process.

D) When the Office of Inspector General Program Integrity Unit (OIG-PI) notifies the CMO that a provider has been placed on PPR, the CMO will conduct a billing risk assessment to determine if they should take similar action. The CMO will notify the OIG-PI of the outcome of the risk assessment within 30 days.

The CMOs will provide a monthly report of all claims reviewed for providers on PPR to the OIG-PI. OIG-PI will review CMO monthly report and conduct a billing risk assessment, within 30 days, to determine if OIG-PI and other CMO payers should take similar action for claims billed to the Fee for Service (FFS) program and/or other CMOs for the same CPT codes. OIG-PI will also notify other CMOs by sending written notification if it is determined that OIG-PI or another CMO has placed a provider on PPR.

The CMOs will provide a monthly report to the provider regarding the outcome of the reviewed claims.

E) Removal from Prepayment Review:

Providers must bill timely and accurate claims during the prepayment review period. Providers who demonstrate a continued pattern of not billing timely and accurately during the prepayment review period may be terminated from the CMO program pursuant to applicable policies and procedures.

If appealing the termination action from a CMO, the provider should refer to the CMO's policy for requesting an appeal.

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 PPR to be considered for removal. The aggregate of claims reviewed must meet an 85% pass rate to be considered for removal.

Providers who have an error rate of 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.

The CMOs will notify OIG-PI when a provider is removed from PPR by providing a written notification.

F) Post Payment Review:

Providers who have been released from Prepayment Review will be subject to a post-review of claims billed, six (6) to 12 months from release. Providers will be notified by the CMO or its representative of the claims being reviewed, the documentation needed for the post review, and due date of the requested documents.

If the provider does not comply with the request for documentation within the given timeframe, the provider will be placed back on PPR until the CMO determines it is no longer necessary.

If the Post Payment Review determines the provider has an error rate of more than 15%, the provider may be placed back on PPR or be considered for termination from the CMO program pursuant to applicable policy and procedures. A provider may appeal their termination by following the provisions outlined in the CMO's policy and procedures.

G) Termination of Medicaid ID of providers on PPR

The CMOs may terminate the provider agreement because of, but not limited to:

- Provider/Provider group has been on PPR for 16 months and there has been no billing activity during this time;

- Documentation consistently fails to support services billed or medical records were not provided to support claims billed to Medicaid;

- Provider/Provider group currently on PPR 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.