ADMINISTRATIVE POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Program Integrity Provider Prepayment Review-WI MP-AD-1499	06/01/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract 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

Program Integrity 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 of medical record documentation and comparison billed services.
- **Program Integrity (PI)** – The proper management and functioning of a health insurance program to ensure it is providing quality and efficient care while using funds taxpayer dollars appropriately and with minimal waste.
- **Certified Professional Coder (CPC)** – The certified professional coder credential is offered through the American Academy of Professional Coders (AAPC). Professional coding is medical coding that is conducted in a professional environment, such as a physician's office, outpatient setting, or hospital.
- **Registered Health Information Administrator (RHIA)** – A professional who handles patient health information, requires certification, and must adhere to standards, such as the Health Insurance Portability and Accountability Act and other privacy and security rules.
- **Registered Health Information Technician (RHIT)** – A certified professional who stores and verifies the accuracy and completeness of electronic health records and analyzes patient data with the goal of controlling healthcare costs and improving patient care.
- **Soft Denial** – A denial applied to claims selected as part of the prepayment review audit. Soft denials do not require an appeal to resolve. Upload records to the CareSource Provider Portal for the denied claim. Soft denials are identified in the remittance advice by RARC code 127 “Missing patient medical record for this service”.

D. Policy

I. A provider prepay review involves reviewing medical records compared to services billed prior to claim adjudication. Providers are placed on prepay review to monitor for improper billing of medical claims including but not limited to the following reasons:
   A. overutilization of services
   B. billing for items or services not rendered
   C. selection of wrong CPT/HCPCS code or supplies
   D. lack of medical necessity
   E. billing/dispensing unnecessary services
   F. procedure repetition

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

G. upcoding
H. billing for services outside of provider specialty

II. CareSource will provide written notice within 30 days of the request or within the appropriate federal and/or state guidelines. In certain circumstances (eg, state directed reviews, suspected fraud), it may be necessary to implement prepayment review immediately. In those cases, providers will be notified subsequent to the action.

III. Placement on prepayment review will require the provider to submit medical records for all identified claims allowing CareSource to review the medical records in comparison to the billed services. CareSource will provide a written notice to the provider/provider group advising the effective date of prepayment review.
   A. Claims selected for prepayment review will be soft denied.
   B. Provider must upload medical records to the CareSource Provider Portal. It is not necessary to appeal a soft denial.
   C. Failure to submit medical records to CareSource in accordance with this provision will result in claim remaining denied.
   D. Failure to meet minimal documentation standards, such as member name and date of service on each page of the medical record, a signed dated order, and a valid provider signature, will result in claim denial.
   E. Providers must bill timely and accurate claims while under prepayment review.

IV. CareSource uses widely recognized sources to conduct reviews which includes, but is not limited to, the following:
   A. Centers for Medicare and Medicaid Services (CMS) guidelines, as stated in Medicare manuals
   B. Medicare local and national coverage determinations
   C. CareSource published policies (Administrative, Medical and Reimbursement), code-editing policies and provider manuals
   D. National Uniform Billing Guidelines from the National Billing Committee
   E. American Medical Association Current Procedural Terminology (CPT) guidelines
   F. current American Medical Association Healthcare Common Procedure Coding System (HCPCS) Level II
   G. ICD 10-CM official guidelines for coding and reporting
   H. American Association of Medical Audit Specialists national healthcare billing audit guidelines
   I. industry-standard utilization management criteria and/or care guidelines, such as MCG guidelines (current edition on date of service)
   J. Food and Drug Administration guidance
   K. national professional medical society's guidelines and consensus statements
   L. publication from specialty societies, such as the American Society for Parenteral and Enteral Nutrition, the Substance Abuse and Mental Health Service Administration, and the American Association of Neuromuscular & Mental Health

Services Administration

M. nationally recognized, evidence-based published literature including, but not limited to, sources, such as Medscape, the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG)

V. The Program Integrity Provider Prepayment Review Team is comprised of clinical review and coding specialists who maintain CPC, RHIA, or RHIT designations. 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 the following:
   A. Services were provided according to CareSource policy requirements.
   B. Members were benefit eligible on the date the services were provided.
   C. Prior authorization was obtained, if required by policy.
   D. Providers and staff were qualified, as required by state or federal law.
   E. The provider possessed the proper license, certification, or other accreditation requirements specific to the provider's scope of practice at the time the service was provided to the member.

VI. Providers whose claims (or claim lines) are determined not payable via coding review audit after medical records submission may dispute or appeal, whichever is appropriate, within timely filing limitations as outlined in the provider manual. Providers and/or billing managers may reach out directly to the program integrity prepayment review team to discuss specific claim denials.

VII. Release from prepayment review includes the following steps:
   A. CareSource will review provider accuracy monthly to determine if the provider is eligible for release from prepayment review. Eligibility is as follows:
      1. The provider has demonstrated a high accuracy rate on claim submissions for 3 consecutive months.
      2. The volume of claims submissions remained consistent with the volume before prepayment review.
      3. Provider maintains a high rate of records returned after soft denial.
   B. Once released from prepayment review, the provider/provider group will receive notification in writing as to the effective end date of review. Providers who demonstrate accurate billing practices and have been removed from prepayment review may be subject to future follow up reviews to ensure continued compliance with billing practices.
   C. If the provider fails to satisfy the requirements above, the following may be necessary:
      1. If after 12 months on prepayment review the provider fails to satisfy the requirements under subsection A, CareSource may do the one of following:
         a. outreach to provider to educate on claim accuracy issues
         b. require a corrective action plan

c. deny payment for services rendered during a specified period of time
d. terminate the provider agreement

2. If a provider has been on a prepayment review for 12 months, CareSource may terminate the provider agreement in the following conditions:
   a. no billing activity for 6 months
   b. claim submission volume during review period is not consistent with the volume before prepayment review

E. Conditions of Coverage

N/A

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATES	ACTION
Date Issued	08/14/2024	New Policy. Approved at Committee.
Date Revised	03/12/2025	Added written notice guidelines in section II
Date Effective	06/01/2025	
Date Archived		

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.