Administrative Policy Statement
WEST VIRGINIA MARKETPLACE

Policy Name		Policy Number	Effective Date
Provider Prepayment Review		AD-0774	04/01/2020
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

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A. Subject

Provider Prepayment Review

B. Background

CareSource Program Integrity and Investigation's Department (PII) 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 and Investigations-** PII
- **Certified Professional Coder-**CPC
- **Registered Health Information Administrator-**RHIA
- **Registered Health Information Technician-**RHIT

D. Policy

I. A Provider prepay review involves reviewing medical records compared to services billed prior to claim adjudication.
   A. Providers are placed on prepay review to monitor for improper billing of medical claims including but not limited to the following reasons:
      1. Overutilization of services
      2. Billing for items or services not rendered
      3. Selection of wrong CPT/HCPCS code or supplies
      4. Lack of medical necessity
      5. Billing/dispensing unnecessary services
      6. Procedure repetition
      7. Upcoding
      8. Billing for services outside of provider specialty

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.
   A. CareSource will provide a written 30 day notice to the provider/provider group advising them of the effective date of prepayment review.
      1. Beginning on this date and for the duration the provider is under prepayment review, all claims must be accompanied with medical records.
      2. Medical records MUST be submitted via paper format to the PO Box listed on the provider prepayment notification letter.
      3. Failure to submit medical records to CareSource in accordance with this provision will result in claim denial.
      4. 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.
      5. Providers must bill timely and accurate claims during the prepayment review period.

III. CareSource utilizes are published decision hierarchy to conduct our reviews, in addition we may use:
   A. CMS guidelines as stated in Medicare manuals.
   B. Medicare local coverage determinations and national coverage determination.

C. All CareSource published policies (Administrative, Medical and Reimbursement), Code-editing policies and CareSource provider manuals.
D. National Uniform Billing Guidelines from the National Billing Committee.
E. American Medical Association Current Procedural Terminology (CPT) guidelines.
F. American Medical Association Healthcare current 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, Substance Abuse and Mental Health Service Administration, and American Association of Neuromuscular & Mental Health Services Administration, etc.…
M. Nationally recognized, evidence-based published literature including, but not limited to, sources such as: Medscape, American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG).

IV. The PII 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 the 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 Medicaid policy.
        6. Providers possessed an active Medicaid Provider number, licenses and certification at the time the services were provided to the Medicaid member(s).

V. Providers whose claims are determined to be not payable may send in new/corrected claim, a dispute or an appeal, whichever is appropriate, within timely filing limitations as outlined in their provide manual.
    A. Providers and/or billing managers may reach out directly to the PII prepayment review team to discuss specific claim denials.
    B. The provider will remain subject to the prepayment review process until CareSource is satisfied that any inappropriate activity has been corrected.
    C. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from our Provider Network.
    D. Providers who are able to demonstrate accurate billing practices and are removed from prepayment review may be subject to future follow up reviews to ensure continued compliance with billing practices.
    E. Upon completion of the prepayment review period, the provider/provider group will be notified in writing the effective end day of the review.
    F. CareSource may choose to terminate the provider agreement or discontinue reimbursement for non-participating providers for the following but not limited to reasons:
        1. Provider/Provider group has been on prepayment review for six months and there has been no billing activity during this time.
        2. The volume of its claims submission during the review period was not with in ten percent of its volume before prepayment review.

3. Documentation consistently fails to support services billed or medical records are not provided.

VI. Providers are prohibited from billing covered individuals for services we have determined are not payable as a result of the prepayment review process, whether due to fraud, abuse, waste of any other billing issue, or for failure to submit medical records as set forth above.

E. Conditions of Coverage

F. Related Policies/Rules

N/A

G. Review/Revision History

DATES		ACTION
Date Issued	01/08/2020	New Policy
Date Revised		
Date Effective	04/01/2020	

H. References

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