REIMBURSEMENT POLICY STATEMENT
WEST VIRGINIA MARKETPLACE

Policy Name		Policy Number	Effective Date
Overpayment Recovery		PY-1117	08/01/2020-12/31/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy 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.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Table of Contents

A. Subject

Overpayment Recovery

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Retrospective review of claims paid to providers assist CareSource with ensuring accuracy in the payment process. CareSource will request voluntary repayment from providers when an overpayment is identified.

Fraud, waste and abuse investigations are an exception to this policy. In these investigations, the look back period may go beyond 2 years.

C. Definitions

- **Overpayment** - A payment that exceeds amounts properly payable to a provider. These commonly are discovered during a post-payment review. Examples include but are not limited to incorrect coding, non-covered services, and billing discrepancies.
- **Retroactive eligibility** - A payment for a member who was retroactively terminated. Member is not eligible for benefits.
- **Improper payment** - A payment that should not have been made or an overpayment was made. Examples include but are not limited to payment made for the ineligible member, ineligible service, payment made for a service not received, and duplicate payments.

D. Policy

I. Overpayment Recoveries
   A. Lookback period is 1 year from the original claim paid date when the recoupment is a result of:
      1. The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;
      2. The provider was not entitled to reimbursement;
      3. The service provided was not covered by the health benefit plan; or

4. The insured was not eligible for reimbursement.

B. There is no time limitation on the lookback period for when a recoupment is a result of:
   1. The claim was submitted fraudulently; or
   2. The claim contained material misrepresentations.

II. Initial Retroactive Denial Letter to the Provider
   A. CareSource will provide all the following information when initially seeking recovery of an overpayment made to a provider:
      1. The name and patient account number of the member to whom the service(s) were provided;
      2. The date(s) of services provided;
      3. The amount of overpayment; and
      4. A request that within 40 days from receipt of this letter, the provider pay CareSource the overpayment amount or demand the reason for the retroactive denial.

III. Receipt of Demand of Reason for Retroactive Denial from Provider
   A. Upon receipt of demand of retroactive denial reason from the provider, CareSource shall provide such reason within 30 days.
   B. Within 30 days of receipt of the reason for retroactive denial, the provider shall:
      1. Reimburse CareSource, allowing for offsets from future payments.
      2. Dispute the retroactive denial under the terms in the provider's contract with CareSource.
      3. Disputes shall be resolved within 30 days. At resolution, if that resolution is in CareSource's favor, the provider shall:
         a. Pay any amount due to CareSource; or
         b. Provide CareSource with written authorization for an offset against future payments.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

National Agreement, Article V. CLAIMS AND PAYMENTS, 5.11 (d).

G. Review/Revision History

	DATE	ACTION
Date Issued	04/29/2020	New policy
Date Revised		
Date Effective	08/01/2020	
Date Archived	12/31/2021	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

1. West Virginia Code. (n.d.). *§33-45-2. Minimum fair business standards contract provisions required; processing and payment of health care services; provider claims; commissioner's jurisdiction.* Retrieved January 28, 2020 from www.code.wvlegislature.gov
2. West Virginia Code. (n.d.). *§33-25A-23a. Civil penalty imposed by commissioner.* Retrieved January 28, 2020 from www.code.wvlegislature.gov
3. West Virginia Code. (n.d.). *§33-45-1. Definitions.* Retrieved April 23, 2020 from www.wvlegislature.gov

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