ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Program Integrity Provider Prepayment Review-IN MCD-AD-0781	12/01/2022-08/31/2023

Policy Type
ADMINISTRATIVE

Administrative Policy Statement 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 ma nagement 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 Sta tements, 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

Program Integrity Provider Prepayment Review

B. Background

This policy applies to participating (PAR) providers only.

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)** - The proper management and function of the 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 CPC 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. The RHIA role 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. An RHIT also analyzes patient data with the goal of controlling healthcare costs and improving patient care.

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 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.

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

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A. CareSource will provide a written 30-day notice to the provider/provider group advising them of the effective date of prepayment review.
   1. Prepayment review will be implemented for a period of 6 months
   2. The 6-month period begins upon the first successful adjudication of a claim submission under prepayment review.
   3. All claims must be submitted with medical records.
   4. Medical records may be submitted in one of the following ways:
      a. Electronically with a claim.
      b. Submitted via the provider portal.

      Note: CareSource will not accept medical records via fax.
   5. Failure to submit medical records to CareSource in accordance with this provision will result in claim denial.
   6. 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.
   7. Providers must bill timely and accurate claims during the prepayment review period.

III. CareSource utilizes our published decision hierarchy to conduct our reviews. In addition we may use:
   A. Centers for Medicare and Medicaid Services (CMS) guidelines as stated in Medicare manuals.
   B. Medicare local coverage determinations and national coverage determinations.
   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 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).

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.

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2. Billed services were medically necessary and appropriate, and not in excess of the member's 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 or federal law.
6. 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.

V. Providers whose claims are determined not payable may send in new corrected claims, a dispute, or an appeal, whichever is appropriate, within timely filing limitations as outlined in their provider manual.
   A. Providers and/or billing managers may reach out directly to the PI prepayment review team to discuss specific claim denials.

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

VII. On completion of the 6-month review period:
   A. CareSource will determine if the provider is eligible for release from prepayment review if:

1. The provider has achieved an 85% or more approval rate on claim submissions for 3 consecutive months and
2. The volume of its claims submissions remained within 10% of the volume before prepayment review.

   B. If the provider successfully completes both requirements under A above before the 6-month deadline the provider may be removed from the prepayment review process at the discretion of CareSource.
   C. If the provider fails to satisfy the requirements above they may be placed under an additional 6 month prepayment review period and be required to submit a corrective action plan.
      1. If after the second 6-month interval prescribed under subsection C the provider fails to satisfy the requirements under subsection A1 and A2, CareSource may do the following
         a. Deny payment for medical assistance services rendered during a specified period of time
         b. Terminate the provider agreement
         c. Require a corrective action plan
      2. Providers who are able to 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.
      3. If a provider has been on a prepayment review for 12 months CareSource may terminate the provider agreement if:
         a. There has been no billing activity for 6 months; or
         b. The volume of claim submissions during the review period is not within 10% of its volume before prepayment review.

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4. Upon completion of the prepayment review period, the provider/provider group will receive notification in writing as to the effective end date of the review.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATES	ACTION
Date Issued	01/08/2020	New Policy
Date Revised	08/19/2020 7/20/2022	Updated Section VII, updated title Removed requirement for paper format for submission; instead claims should be submitted electronically.
Date Effective	12/01/2022	
Date Archived	08/31/2023	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. Centers for Medicare and Medicaid Services. Medicare Program Integrity Manual (April 21, 2022). Retrieved July 11, 2022 from www.cms.gov.
2. Indiana General Assembly. 2022 Special Section: IAC 1-1.4-7. Retrieved July 12, 2022 from http://iga.in.gov/legislative/laws/2022.
3. Indiana General Assembly. 2022 Special Section: IA 4. Retrieved July 11, 2022 from http://iga.in.gov/legislative/laws/2022.
4. Indiana General Assembly. 2022 Special Section: IA 12-15. Retrieved July 11, 2022 from http://iga.in.gov/legislative/laws/2022.

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