



ADMINISTRATIVE POLICY STATEMENT

Ohio Medicaid

Policy Name & Number	Date Effective
Program Integrity Provider Prepayment Review-OH MCD-AD-0767	12/01/2022-11/30/2023
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 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 documents, Medical Policy Statements, 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 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. 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 and 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. 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
 - G. Upcoding
 - H. 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. CareSource will provide a written 30-day notice to the provider/provider group advising them of the effective date of prepayment review.
 - A. Prepayment review will be implemented for a period of 6 months.
 - B. The 6-month period begins upon the first successful adjudication of a claim submission under prepayment review.

- C. Medical records MUST be submitted via paper format to the P.O. Box listed on the provider prepayment notification letter.
 - D. All claims must be submitted with medical records.
 - E. Failure to submit medical records to CareSource in accordance with this provision will result in claim denial.
 - F. 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.
 - G. Providers must bill timely and accurate claims during the prepayment review period.
- III. CareSource utilizes a published decision hierarchy to conduct reviews. In addition, CareSource may use the following:
- A. Centers for Medicare and Medicaid Services (CMS) guidelines, as stated in Medicare manuals.
 - B. Medicare local 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. 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).
- IV. The Program Integrity Provider Prepayment Review Team is comprised of clinical review and coding specialists who maintain CPC, RHIA, or RHIT designations.
- 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 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 the provider manual.
- A. Providers and/or billing managers may reach out directly to the program integrity prepayment review team to discuss specific claim denials.

VI. Providers are prohibited from billing covered individuals for services determined 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.

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 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, an additional 6 month prepayment review period may be necessary, and the provider may 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 subsections 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 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 review period is not within 10% of the volume before prepayment review.
 4. Upon completion of the prepayment review period, the provider/provider group will receive notification in writing as to the effective end date of 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 07/20/2022	Updated Section VII, Editorial updates only.
Date Effective	12/01/2022	
Date Archived	11/30/2023	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.

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



H. References

N/A

Archived