Administrative Policy Statement
KENTUCKY MEDICARE ADVANTAGE

Policy Name	Policy Number	Effective Date
Program Integrity Provider Prepayment Review	AD-0891	01/01/2021

Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

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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

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 medical record documentation and compares it to billed services.
- **Program Integrity -** PI
- **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. Prepayment review will be implemented for a period of six (6 months)
      2. The six (6) month period begins upon the first successful adjudication of a claim submission under prepayment review.
      3. Medical records MUST be submitted via paper format to the PO Box listed on the provider prepayment notification letter.
      4. All claims must be accompanied with medical records.
      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. 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 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.
      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 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 we have 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 six month review period
   A. CareSource will determine if the provider is eligible for release from prepayment review if:
      1. The provider has achieved an eighty-five percent (85%) or more approval rate on claim submissions for three (3) consecutive months and
      2. The volume of its claims submissions remained within ten percent (10%) of the volume before prepayment review

B. If the provider successfully completes both requirements under A above before the six 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 subdivision (C) the provider fails to satisfy the requirements under subdivision (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 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 twelve (12) months CareSource may terminate the provider agreement if:
      a. There has been no billing activity for six (6) months; or
      b. The volume of claim submissions during review period is not within ten (10%) of its volume before prepayment review.
   4. Upon completion of the prepayment review period, the provider/provider group will receive notification in writings as to the effective end date of review.

E. Conditions of Coverage

F. Related Policies/Rules

N/A

G. Review/Revision History

DATES		ACTION
Date Issued	01/01/2021	New Policy
Date Revised		
Date Effective	01/01/2021	

H. References

NA

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