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Owner	Christy Donohue: Senior VP of Mountain Health Trust
Area	MHT Operations - Claims
Lines Of Business	Mountain Health Trust

Mountain Health Trust (Medicaid/CHIP) Prepayment Review Process

PURPOSE:

The Health Plan (THP) is committed to ensuring quality care for our members and proper payments to our providers. As a participant in federal and state funded healthcare programs, THP is obligated to have systems and procedures in place to guard against fraud, waste, and abuse. To that end, THP utilizes several program integrity tools. One such program integrity tool is prepayment review (PPR). PPR is part of THP's overall commitment to payment integrity and is used to satisfy THP's payment integrity oversight obligations and responsibilities. PPR's goals are to identify inappropriate billing patterns, educate providers on billing and medical record documentation in accordance with industry standards, and achieve appropriate billing and medical record documentation in the future.

POLICY:

PPR may be utilized when questionable or inappropriate billing patterns are identified or if a provider is suspected to be at high-risk of fraud, waste, and/or abuse. Providers may be referred to PPR via referrals from the West Virginia Bureau for Medical Services (BMS) and/or because of internal monitoring including, but not limited to, routine claims processing and data mining.

Examples of what might trigger a prepayment review include, but are not limited to, a history of:

- Billing errors
- Billing for services not rendered.
- Upcoding
- Billing for incongruent services

- Insufficient documentation
- Medically unnecessary services
- High utilization of a frequently abused code
- High utilization of any code, compared to peers.
- Complaints related to billing or services rendered.
- Modifying rendering physician when claims have been denied.
- Other billing or medical record documentation anomalies

PROCEDURE:

NOTIFICATION TO PROVIDER (PPR Begins)

A provider subject to PPR will be notified in writing ten (10) days prior to the PPR effective date.

The PPR notification will include:

- The reason(s) for PPR
- The effective date of PPR
- The PPR review term (up to 120 calendar) begins when the first documentation is received by THP.
- The specific claim codes or types of claims subject to PPR
- The requirement that all claims subject to PPR must be accompanied by required documentation, otherwise the claim will be denied.
- Instructions on how to submit the required documentation.
- Notice that failure to submit medical records will result in claim denial.
- Notice that failure to meet minimal documentation standards including, but not necessarily limited to, member name, date of service, and provider signature will result in claim denial.
- Notice that PPR is separate and distinct from other prior authorization and/or pre-adjudication requirements.
- The provider's right to appeal any claims denied because of the review.
- Notice that provider cannot bill members for denied claims as a result of PPR.
- Connection to the provider's Practice Management Consultant (PMC). THP's PMC is a resource available to support the provider through PPR and other THP educational and operational matters.

HOW RECORDS WILL BE SUBMITTED/RESUBMITTED

During PPR, the provider must submit medical records and/or other information, such as staff listings and/or treatment plans to support the charges billed.

PPR providers have two options to submit required documentation to THP:

- Dedicated fax line 855-525-6214
- Secure SharePoint site (only used for medical records)

    - Instructions will be provided via email following the initial notification.

THP expects providers to follow industry standard medical record documentation guidelines, as defined in THP's Provider Manual.

EVALUATE AND ADJUDICATE OF PPR CLAIMS

PPR claims must be submitted with documents required to substantiate the nature and extent and appropriateness of the services billed.

PPR claims subject to prepayment review will be evaluated using various relevant authorities as applicable including, but not necessarily limited to:

- THP policies
- WV Mountain Health Trust (MHT) guidelines
- Bureau for Medical Services' (BMS)WV Medicaid Provider Manual
- American Society of Addiction Medicine (ASAM) guidelines
- Centers for Medicare and Medicaid (CMS) guidelines
- Medicare Local Coverage Determinations and national coverage determinations (NCDs)
- National Correct Coding Initiative (NCCI)
- American Medical Association's CPT guidelines
- American Medical Association's HCPCS guidelines
- ICD-10 Official Guidelines for Coding and Reporting
- National professional medical societies
- State or national professional associations
- Other nationally recognized, evidence-based published literature

PPR will be conducted by a team consisting of experienced claim analysts, certified medical coders, and nurses, in collaboration with other subject matter experts, as applicable. At any time during PPR, if THP suspects a quality of care concern a referral will be made to THP's Quality team. This referral will be managed separately outside of PPR in accordance with THP's Medical Record Review policy outlined in THP's Provider Manual.

For a PPR claim to successfully adjudicate and the provider to receive payment, documentation must clearly establish that:

- Billed services were provided in accordance with all relevant policies, regulations, and laws;
- Billed services were supported by appropriate documentation.
- Members were benefit eligible on the date of service.
- Any required prior authorizations were obtained; and
- The rendering provider was qualified to provide the service(s) and bill for same, including but not limited to, holding the required licensure, certification, enrollment status, accreditation, or other prerequisites.

To substantiate the documentation within the medical record, THP may conduct member service verification calls pursuant to the requirements in 42 CFR § 438.608.

THP's PMC along with applicable PPR team members will contact the provider and applicable staff to schedule educational meetings to share identified issues and results. To ensure clear communication, this information will also be shared after the meeting, via email, with the provider and applicable staff.

PROVIDER NON-COMPLIANCE WITH PPR

If a provider fails to participate, the affected claims will be denied.

Examples of non-compliance include but not limited to:

- Failure to submit required documents, examples:
    - medical records
    - staff listing
    - treatment plans, etc.
- Failure to participate in educational meetings.
- Failure to modify billing behavior.
- Failure to submit claims during PPR period.

DENIED CLAIMS

For denied claims, the remedies available to the provider are the same under prepayment review as with any other denied claim, i.e., the provider may submit a corrected claim or file an appeal according to policy outlined in THP's Provider Manual.

Denial code "D248" will be utilized to track applicable claims. In addition, monthly reports will be generated to determine if there is a substantial decrease in claims volume. Providers may not bill covered members for services denied because of prepayment review.

NOTIFICATION TO PROVIDERS (PPR ENDS)

Upon PPR conclusion, the provider will be notified in writing that PPR has ended and that, accordingly, medical records are no longer required to be submitted with PPR claim.

The PPR team will complete its review of all applicable claims/medical records. Once all PPR claims have been reviewed, the provider will be notified in writing of any outstanding issues and next steps will be one of the following:

- Return to normal claims operations and no additional action is required.
- Monitor performance through a corrective action plan signed by provider and or provider representative
- Reinstate of PPR
- Terminate from THP's provider network

FUTURE ACTION

Providers who completed PPR and remain participating in THP's provider network may be subject to future follow up reviews to assure compliance with proper billing.

Follow up reviews may include, but are not limited to, one or more of the following:

- Focused analysis, review, and education process
- Site visit
- Readmittance to prepayment review process

All Revision Dates

8/15/2023, 3/9/2023, 12/29/2022, 12/27/2022, 10/27/2022, 10/11/2022, 9/12/2022, 8/2/2022, 7/18/2022, 6/16/2022, 6/15/2022, 4/26/2022, 4/12/2022, 4/1/2022, 3/29/2022, 11/4/2021

Approval Signatures

Step Description	Approver	Date
EMT Approval	Christy Donohue: Senior VP of Mountain Health Trust	8/15/2023
	Christy Donohue: Senior VP of Mountain Health Trust	8/15/2023