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 a number of program integrity tools. One such tool is prepayment review. Prepayment review is not punitive but instead is part of The Health Plan's overall commitment to payment integrity and is used to satisfy THP's oversight obligations and responsibilities. The goal of the prepayment review is to identify inappropriate billing patterns, educate providers on billing in accordance with industry standards, and prevent future inappropriate billing,

POLICY:

Prepayment review may be utilized when questionable billing patterns are identified or if a particular provider is deemed to be at high-risk of fraud, waste, and abuse. Providers may be identified via referrals from the Bureau for Medical Services or as a result of internal monitoring including, but not necessarily limited to, routine claims processing and targeted data mining.

Examples of what might trigger a prepayment review include, but are not necessarily 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

PROCEDURE:

NOTIFICATION TO PROVIDER

A provider subject to prepayment review will be notified in writing 10 days prior to the commencement of the review. The notification will include:

- The reason for the prepayment review
- The effective date of the review
- The term of the review (up to 120 days per term, which begins upon the first successful adjudication of a claim under prepayment review)
- The specific claim codes or types of claims subject to the additional review
- The requirement that all impacted claims must be accompanied by medical records
- Instructions on how to submit the required records
- Notice that failure to submit medical records in accordance with this policy 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 the prepayment review is separate and distinct from any other prior authorization or pre-adjudication requirements
- Notice that claims must not be delayed in order to avoid prepayment review; claims volume must remain within ten percent of the claims volume prior to implementation of prepayment review
- The provider's right to appeal any claims denied as a result of the review

HOW RECORDS WILL BE SUBMITTED/RESUBMITTED

During a prepayment review, the provider will be asked to provide medical records and/or other information to support the charges billed. The provider will be required to follow the record submission process outlined in the Provider Manual.

In addition to the submission processes outlined within the Provider Manual, THP has created two additional options for providers.

- Dedicated fax line
- Secure SharePoint site

EVALUATION AND ADJUDICATION OF CLAIMS

Claims subject to a prepayment review must be submitted with documents required to substantiate the nature, extent, and medical necessity of the services billed. 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 guidelines
- Bureau for Medical Services Provider Manual
- American Society of Addiction Medicine (ASAM) guidelines
- CMS guidelines
- Medicare local coverage determinations and national coverage determinations
- National Correct Coding Initiative
- American Medical Association's CPT guidelines
- American Medical Association's HCPCS guidelines
- ICD-10 Official Guidelines for Coding and Reporting
- Industry standard utilization management criteria and/or standards of care guidelines
- Licensing boards
- National professional medical societies
- State or national professional associations
- Other nationally recognized, evidence-based published literature

The prepayment review will be conducted by a team consisting of experienced claims analyst, certified medical coders, and nurses, in collaboration with subject matter experts.

For a claim to successfully pass prepayment review, documentation must clearly establish that:

- Services were provided in accordance with all relevant policies, regulations, and laws;
- Billed services were supported by appropriate documentation;
- Billed services were not in excess of the member's needs;
- Members were benefit eligible on the date of service;
- Any required prior authorizations were properly 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.

PROVIDER NON-COMPLIANCE

If a provider fails to submit medical records or other documentation as outlined herein, the affected claims will be denied. Non-compliance will be taken into account in the recommendation at the conclusion of prepayment review. In addition, monthly reports will be run to determine if there is a delay in claims submission to avoid prepayment review.

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.

Providers may not bill covered members for services denied as a result of prepayment review.

DURATION OF PREPAYMENT REVIEW

Prepayment review may last for up to 120 days. Claims received within the term are subject to the review regardless of the date of service. Prepayment review may be discontinued earlier than the set term if:

- The provider has achieved a 90% or more approval rate on claims submissions for 30 consecutive days, and
- The volume of claims submissions remained within ten percent of the claims volume prior to the implementation of prepayment review.

PROVIDER EDUCATION

During the prepayment review process, THP's Practice Management Consultant (PMC) will contact the provider and billing manager to schedule meetings to share findings and claim submission volumes from the prepayment review. This will allow the provider to review and respond to any concerns that have been identified.

PROVIDER NOTIFICATION OF CONCLUSION

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

THP REVIEW OF PROVIDER'S PRACTICES DURING PREPAYMENT

At the conclusion of the prepayment review process and after all the applicable claims have been reviewed, the provider will be notified in writing of the findings of the prepayment review team. Issues identified throughout the prepayment review process will be categorized as resolved, improved, or open. Open indicates there has been no substantial improvement in the identified issue. This notification will also include a determination as to the provider's participation status along with any applicable appeal rights.

FUTURE ACTION

Providers who are removed from prepayment review but remain in the network may be subject to future follow up reviews including unscheduled site visits to assure continued compliance with proper billing.