Modifiers not Applicable for:

- ☑ Kentucky
- ☑ Hawaii
- ☑ Arizona

Readmissions not Applicable for:

- ☑ Florida
- ☑ Illinois
- ☑ Missouri
- ☑ Kentucky
- ☑ Arizona

Claims & Payment Policy: Pre-Payment and Post-Payment Review

Policy Number: CPP - 102

Original Effective Date: 7/3/2018 Revised Date(s): N/A

BACKGROUND

In a recent Medicare Learning Network (MLN) bulletin, The Centers for Medicare & Medicaid Services (CMS) reported that about 12.1% of all Medicare Fee-For-Service (FFS) claim payments are improper. CMS began several initiatives to prevent or identify improper payments before CMS processes a claim, and to identify and recover improper payments after paying a claim. The overall goal was to reduce improper payments by identifying and addressing coverage and coding billing errors for all provider types.

As defined by CMS, medical review is the collection of information and clinical review of medical records by The Health Plan to ensure that payments are made only for services that meet all Medicare coverage, coding, and medical necessity requirements. This definition may differ across state Medicaid programs, but the intent is similar. The goal of The Health Plan's medical review program is to increase the payment accuracy of Medicare and Medicaid claims. The policy is outlined in general terms below. State-specific definitions and requirements may vary.

Key Terms:

- Pre-payment Review: Review of claims prior to payment. A pre-payment review results in an initial determination.
- Post-payment Review: Review of claims after adjudication. A post-payment review may result in either no change to the initial determination or a revised determination, indicating an underpayment or overpayment.

- Underpayment: Reimbursement by the plan that is less than the amount due for covered services
- Overpayment: Reimbursement over the amount due for covered services. Common reasons for overpayment are:
    - Billing for excessive or non-covered services
    - Duplicate submission and subsequent payment of the same service or claim
    - Payment for excluded or medically unnecessary services
    - Payment for services that were furnished in a setting that was not appropriate to the patient's medical needs and condition
    - Payment to an incorrect payee

- Administrative Denial – An administrative denial is an unfavorable decision related to a payment, policies, or procedures and/or is a denial that is not based on a review of medical necessity.

- Technical Denial – A technical denial is a denial of the entire paid amount of a claim in instances when the care provided to a member cannot be substantiated due to a provider's non-response to The Health Plan's requests for medical records, itemized bills, documents, etc.

POSITION STATEMENT

The first page of this document lists any state-specific addenda. Each addendum notes any state requirements, and these may supplement and/or differ from the information listed in the body of the policy. In the event of a conflict between the policy and the applicable state addendum, the state addendum governs.

In accordance with CMS policies and procedures, and applicable state and federal regulations, The Health Plan's reserves the right to perform pre-payment and post-payment reviews to ensure payment integrity. Criteria for payment include, but are not limited to, services that:

- Are covered;
- Are medically necessary or not excluded;
- Are rendered in a setting appropriate to the member's condition and medical needs;
- Are correctly coded and billed;
- Have not already been reimbursed; and
- Are reimbursed to the correct payee.

The Health Plan members, as part of their enrollment documents, sign an authorization for release of medical records. Additionally, the HIPAA Privacy Rule [45 CFR 164.506] allows for the sharing of protected health information between the provider and health plan without copy of a signed client release for "Treatment, Payment and Health Care Operations" which includes the review of medical records for medical necessity and coding accuracy.

Pre-Pay Review Process

The Health Plan (or its designee) may conduct a pre-payment review of a provider's services rendered to The Health Plan members. The Health Plan may also conduct pre-payment reviews of claims as required or allowed by applicable law, and may request medical records, itemized bills, invoices or other substantiating documentation to support payment of the claim.

As determined by The Health Plan, when additional documentation is needed for The Health Plan to accurately adjudicate a claim, the claim will be denied. Providers will have dispute rights allowing the submission of medical records to support payment of the claim.

Record request: The provider will receive the request via an explanation of payment (EOP) for a claim denial. Dispute rights commence from the date of the EOP receipt. Providers may send records for The Health Plan to review the justification for the dispute reversal. Dispute time frames vary according to Medicare or state Medicaid agency rules.

Lack of response: If the requested records or dispute are not received within dispute time frames from the original date of claim denial, the claim will remain denied. Providers may receive a notice and/or may have the right to re-dispute the claim denial per applicable contractual, state or federal guidelines.

Upon receipt of medical records, if The Health Plan (or its designee) determines that a coding and/or payment adjustment is applicable, the provider will receive the appropriate claim adjudication, an EOP, and/or a findings letter.

Post-Payment Review and Technical Denials

The Health Plan (or its designee) conducts post-payment reviews of provider's records related to services rendered to The Health Plan members. During such reviews, the provider should allow The Health Plan access to, or provide, the medical record and billing documents requested that support the charges billed.

For post-payment reviews, medical records and/or related documentation will be reviewed as per the specific reason the records were requested. Upon completion of the medical record review, either the payment will stand or The Health Plan will issue a Recovery letter. The timeline for the requests of records is as follows:

Initial request: A letter will be mailed to the provider asking that records be provided within 30 days from the date of the letter.

Second reminder: If the requested records are not received within 30 days of the initial letter, a second letter may be mailed or outbound calls may be made to the provider, allowing the provider an additional 30 days to respond. If the records are not received by the 60th day after the initial request, The Health Plan will issue a technical denial with a request for repayment, and the recoupment

process will begin directly following the 60-day period for the amount stated in the letter, or per state Medicaid rules as applicable.

If the requested documentation is received after a technical denial has been issued, but within the dispute period outlined as per applicable contractual, state or federal guidelines, the records will be reviewed. If the records submitted support payment of the original claim, the review will be closed. If the records submitted do not justify payment, a findings letters with a request for payment, with appeal rights, if applicable, will be issued to the provider.

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration of a Medicare Advantage plan denial determination. Requests for reconsideration must be submitted within 60 days of the date on the remittance advice and a signed waiver of liability (WOL) statement will be required.

CODING & BILLING

NA

REFERENCES

1. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf
2. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare & Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs;
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP. The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business to which they apply. CPPs are available at www.wellcare.com. Select the *Provider* tab, then *Tools* and then *Payment Guidelines*.

Easy Choice Health Plan ~ Missouri Care ~ 'Ohana Health Plan, ~ Staywell of Florida ~ WellCare Prescription Insurance
WellCare (Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

RULES PRICING AND PAYMENT COMMITTEE

Date	Action
06/12/2018	Approved by RPPC.