IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT202360 JUNE 8, 2023

Program Integrity reminds providers about the prepayment review process and requirements

Under *Indiana Administrative Code 405 IAC 1-1.4-7*, prepayment review (PPR) is a manual claim review process that allows for review of claims for appropriate coding and documentation, and education on appropriate billing practices. PPR is an important educational tool that ensures reimbursement for services that are reasonable, medically necessary, and of optimum quality and quantity by reviewing claims and documentation prior to reimbursement.

Providers are placed on PPR due to a review of their claim submissions, or other ways they may come to the attention of the Office of Medicaid Policy and Planning (OMPP), and it was decided they need manual review of their claims. Being placed on PPR is not a sanction; instead, it allows for providers to have their claims reviewed and specific feedback given on their billing practices.

PPR process

Providers will receive a letter informing them that they have been placed on PPR and the start date for their placement. The letter will also include what claim types or billing codes will be placed on PPR. The OMPP Program Integrity (PI) staff has developed an option where selected claim types of a provider may be placed on PPR instead of every claim placed on PPR as has been done in the past. Included with this letter are detailed instructions on claim and document submission. PPR shall be implemented for a period of six months. As discussed in this bulletin, there is an opportunity for providers to be removed from PPR in as little as three months.

The actual timeline for PPR starts upon the first adjudicated claim after a provider is placed on PPR. While on PPR, providers will receive educational letters, which include a review of the claims, an identification of errors and educational resources for the provider. Providers will also receive Remittance Advices (RAs) with specific explanations of benefits (EOBs) for the claims reviewed by the PPR staff. Providers are highly encouraged to review their RAs while on PPR.

It is important for providers to remember that while on PPR they must submit all supporting documentation with each claim billed during this period. See the *IHCP Quick Reference Guide* for contact information to submit claims. Claims and documentation submitted by providers are reviewed to ensure that services being billed were provided according to Medicaid policy requirements, medically necessary given the patient's diagnosis and circumstances, and compliant with all applicable Indiana Health Coverage Programs (IHCP) and medical guidelines.

Providers should all remember that denied claim determinations are appealable through administrative review. PPR staff will review the following:

- Services were provided according to Medicaid policy requirements.
- The billed services were medically necessary, appropriate, and not in excess of the member's need pursuant to a physician order as documented in policy or services standards.
- The number of visits and services delivered are logically consistent with the member's characteristics and circumstances, such as type of illness, age, gender and service location.
- The provider and member were Medicaid-eligible on the date the service was provided.
- Prior authorization was obtained, if required by policy.
- The provider's staff was qualified as required by state or federal law.
- The provider possessed the proper license, certification or other accreditation requirements specific to the provider's scope of practice and Medicaid policy at the time the service was provided to the member.
- The claim does not duplicate or conflict with one reviewed previously or currently being reviewed.
- The payment does not exceed any reimbursement rates or limits in the Indiana State Medicaid Plan.

For more information about the Indiana statue, code and regulations for PPR, see *405 IAC 1-1.4-7* and the IHCP *Provider and Member Utilization Review* provider reference module at in.gov/medicaid/providers.

Removal from PPR

To be removed from PPR, providers must:

- Achieve a minimum 85% approval rate over a consecutive three-month period (see the *Compliance calculation* section below).
- Maintain a claim volume within 10% of its claim volume prior to being selected for PPR (see the *Volume calculation* section on next page).

If providers meet these two requirements, they can be removed from PPR before the expiration of the six-month period. If providers do not meet these two requirements within the first six months, they will remain on PPR for an additional six-month time period and may be required to submit a corrective action plan. After being on PPR for 12 months, the OMPP may take additional steps, including termination of the provider's agreement or other remedial actions.

Compliance calculation

At least every three months while on PPR, a provider's compliance rate will be calculated to determine if the provider is eligible for release or if a continuation or other actions are warranted. Because PPR does not start until the provider's first adjudicated claim and the time needed to gather all appropriate data, it could take up to four months before the first compliance review is done. To review a provider's compliance, the compliance rate is calculated by dividing the number of denied claims by the total number of claims submitted by the provider, then subtracting that amount from 100%.

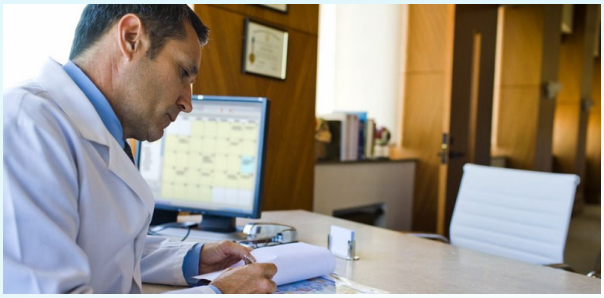
Because PPR is an educational tool, this calculation gives a specific and accurate number of denied claims. This calculation includes both detail lines denied by the PPR staff and other system denials. As some claims may deny after the PPR staff has reviewed, it is important for providers to regularly check their RAs. PPR staff will compile the most common reasons for errors and provide those at each six-month report for providers.

Volume calculation

A provider's volume requirement is calculated by taking the total claims from the current months under review and comparing it to the total from the same number of months prior to being on PPR. As an example, when reviewing claims for January 2020 through March 2020, the total claims from those three months would be compared to the total amount of claims from October 2019 through December 2019.

PPR goal and more information

The goal of PPR is to educate providers on appropriate coding and billing practices. This process is not a sanction and being placed on PPR is not an appealable action. However, providers are reminded that claims denied under the PPR process may be appealed like other claim determinations.



If providers have any questions while on PPR, please contact the IHCP Program Integrity Hotline at 855-878-8362 or send email to prepayment.review@fssa.in.gov.

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

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