Provider Payment Review Tool

Review Type	Justification	Facilitator	Products	Publication	Process	Contact
Pre-Payment Review						
Readmissions	Pre-pay claim reviews provide procedural and financial accuracy assurance prior to claim finalization. Focusing on reviewing the claim in a pre-pay status allows for reduced Provider abrasion and inefficiencies caused when claims are reworked and adjusted through post-pay reviews. There are some types of reviews that may only be performed in a post-pay setting. Those that can be edited against and/or verified manually prior to releasing the claim are conducted in pre-pay status.	CareSource	Medicaid	https://www.caresource.com/documents/medicaid-oh-policy-reimburse-py-0724-20190328/	• Potential readmission inpatient claims that are different facility/different TIN (tax identification number) will process as billed without prepay readmission review These claims will be reviewed by the Payment Integrity vendor during a post-pay audit (described in detail below) • Potential readmission inpatient claims that are same facility / same TIN (tax identification number) will follow the below process: o Readmission claim received without Medical Records will deny requiring medical records with the below codes: □ Internal EX CareSource Code(s); • XVT – Disallow submit medical record for review • XVU – Readmit - Disallow submit Med Records □ External Remit Remark Code (visible on 835/EOP) – M127 “Missing patient medical record for this service” □ Claim Adjustment Reason Code – 249 “This claim has been identified as a readmission” □ Provider will need to submit a corrected claim (paper) with the pertinent medical records to both inpatient claims (original and potential readmission claim) to the address below: CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401 o Claims (corrected or original) received with Medical Records will pend for clinical review □ Claim will pay or claim will deny based on Clinical Review. **Hospital Claims Attachments** A hospital/facility can now upload large files (up to100MB) on the Provider Portal in conjunction with Re-admission, Re-Admit Original Discharge, or Unlisted Code claim submissions. This is available in all state and plans.	CareSource Provider Services 800-488-1034
			Medicare Advantage	https://www.caresource.com/documents/medicare-oh-policy-reimburse-py-0774-20190123/		
Inpatient Hospital Claims with DRG	Pre-pay claim reviews provide procedural and financial accuracy assurance prior to claim finalization. Focusing on reviewing the claim in a pre-pay status allows for reduced Provider abrasion and inefficiencies caused when claims are reworked and adjusted through post-pay reviews. There are some types of reviews that may only be performed in a post-pay setting. Those that can be edited against and/or verified manually prior to releasing the claim are conducted in pre-pay status.	Equian	All	https://www.caresource.com/documents/cs_p-0438-equian-intro-letter-for-inpatient-hospital-wdrg-network-notification/	• Inpatient Hospital Claims with total payable =>$25,000 and with DRG outliers =>$2,500 • All markets except KY Medicaid; Date received => 8/1/2019 for all except GA => 9/13/2019 o Claim is adjudicated to a final payable state (status 01 in Facets) □ Provider Portal will reflect “waiting to be paid” o Claim is sent to Equian for itemized bill review □ If CareSource has the itemized bill (submitted with the claim or via Fax or email), itemized bill is sent to Equian □ If no itemized bill included with the claim, Equian sends a letter to Provider requesting the itemized bill to be submitted within 30 days (samples above) □ If no itemized bill is received within 30 days of Equian’s outreach, claim will deny; • Internal EX CareSource Code – 299 “Claim denied itemized statement required” (Note – this will soon be updated to differentiate from the high dollar itemized bill denials. The new Ex code will be communicated once created. The below provider facing HIPAA codes below will not change with the new CareSource ex code creation.) • External Remit Remark Code (visible on the 835/EOP) – N26 “Attachment/other documentation referenced on the claim was not received” • Claim Adjustment Reason Code (visible on 835/EOP) – Missing itemized bill/statement” o Equian conducts their review of the itemized bill and sends; □ feedback report to the provider that details their review and adjustments □ payment recommendations to CareSource o Applicable line level adjustments are made to the claim and the claim is released within 30 days of CareSource or Equian receipt of the itemized bill. • If Providers disagree or have questions, they are to contact Equian • If no change in Equian decision and the provider still disagrees, an appeal can be filed via the normal CareSource appeal process.	Equian Claims Resolution Team 888-895-2254
High Dollar Claims	Pre-pay claim reviews provide procedural and financial accuracy assurance prior to claim finalization. Focusing on reviewing the claim in a pre-pay status allows for reduced Provider abrasion and inefficiencies caused when claims are reworked and adjusted through post-pay reviews. There are some types of reviews that may only be performed in a post-pay setting. Those that can be edited against and/or verified manually prior to releasing the claim are conducted in pre-pay status.	CareSource	All	https://www.caresource.com/documents/cs-p-0386-high-dollar-claims-cover-sheet-netwrok-notification/	• All claims with billed charges > $500,000 require itemized bill for payment o Claims submitted without an itemized bill are denied □ Internal EX CareSource Code – 299 Claim denied itemized statement required □ External Remit Remark Code (visible on the 835/EOP) – N26 “Attachment/other documentation referenced on the claim was not received” □ Claim Adjustment Reason Code (visible on 835/EOP) – Missing itemized bill/statement” o To submit itemized bills, Providers may attach the itemized bill to their claim via paper, address below: CareSource Attn: Claims Department P.O. Box 8730 Dayton, OH 45401 o They may also bill the claim electronically and complete the following cover sheet – https://www.caresource.com/documents/cs-p-0449_itemized-bill-cover-sheet/ o Submit the cover sheet and itemized statement by email: claimsitemizedbills@caresource.com or by sending a fax to 1-937-396-3173 or toll free at 1-844-794-1579. • CareSource will review the itemized bill and adjust the denied claim accordingly within 30 days of receipt of the itemized bill.	CareSource Provider Services 800-488-0134

Post-Payment Review						
Place of Service Validation	CareSource is paying for claims when the level of care doesn't match the documentation provided in the medical record. This is a review of targeted inpatient claims to validate the level of care matches the documentation provided in the medical record. Review is Not a Determination of Medical Necessity.	HMS	All	N/A	Inpatient claim submitted and paid • HMS Clinical reviewers will verify that the documentation in the medical record supported an inpatient setting or whether the claim should have been billed as observation or outpatient level of care. o Letter sent to provider requesting Medical Records o Medical Records should be submitted to HMS per instructions in letter □ Can be uploaded to HMS Portal o Upon review, Medical Records do not support inpatient place of stay, provider will be notified via letter that the claim will be recovered in 30 days (unless contract states different time frame for recoveries) and they may contact HMS to dispute o Claim will be recovered in 30 days with the below Remit Code □ M77 – Missing or invalid POS (Place of Service) o ***Provider may appeal through normal CareSource Appeal Process***	HMS Provider Relations 866-875-1749
DRG	CareSource is paying for claims that have been inappropriately billed based on coding guidelines, or when documentation in the medical record does not support all the diagnosis and procedures that are billed. Review of targeted inpatient claims to validate proper coding of all diagnosis and procedure codes, and all elements affecting DRG reassignment to ensure proper reimbursement.	HMS	All	https://www.caresource.com/documents/oh-p-1563-cs-hms-intro-letter-for-drg-validations-network-notification/ https://www.caresource.com/documents/oh-sp-0226-post-payment-audit-update-network-notification_final/	• Inpatient claim submitted and paid • HMS Clinical reviewers will verify that the documentation in the medical record supported the DRG submitted on the claim. o Letter sent to provider requesting Medical Records o Medical Records should be submitted to HMS per instructions in letter □ ***Can be uploaded to HMS Portal*** o Upon review, Medical Records do not support the submitted DRG, provider will be notified via letter that partial amounts on the claim will be recovered in 30 days (unless contract states different time frame for recoveries) and they may contact HMS to dispute o Claim will be recovered in 30 days with the below Remit Code □ M208 – Missing or invalid DRG (Diagnosis Related Group) o ***Provider may appeal through normal CareSource Appeal***	HMS Provider Relations 866-875-1749