Applicable To:
☑ KY Medicaid

Claims and Payment Policy: Comprehensive Payment Integrity (CPI) KY Only

Policy Number: CPP-160

BACKGROUND

According to the National Conference of State Legislatures (NCHL), fraud, abuse and waste cost healthcare programs billions of dollars every year, diverting funds that could otherwise be used for legitimate health care services. Not only do fraudulent and abusive practices increase the cost of federal and state healthcare programs without adding value – they increase risk and potential harm to patients who are exposed to unnecessary procedures. In 2015, improper payments alone—which include things like payment for non-covered services or for services that were billed but not provided—totaled more than $29 billion according to the Government Accountability Office.

While fraud involves knowingly misrepresenting the truth to obtain unauthorized benefit, abuse includes any practice that is inconsistent with acceptable fiscal, business or medical practices that unnecessarily increase costs. Waste encompasses overutilization of resources and inaccurate payments for services, such as unintentional duplicate payments. As federal and state programs look for innovative ways to contain burgeoning Medicare and Medicaid costs and promote the program's integrity, fighting fraud and abuse offers one approach that everyone can support.

POSITION STATEMENT

WellCare has partnered with Optum to use algorithms and best practices to capture opportunities related to FWAE (Fraud, Waste, Abuse, and Error). Optum's Comprehensive Payment Integrity (CPI) program may refer any aberrant billing patterns or behavior that may be potentially fraudulent to the Special Investigations Unit (SIU). SUI will then pursue an internal investigation using current processes.

PROGRAM DESCRIPTION

Wellcare's Comprehensive Payment Solution ensures that claims process and pay accurately. Wellcare may deny a claim and request medical records (or coordinate request through a third-party vendor) from the provider or supplier who submitted the claim to support the services submitted on the claim. Providers should submit adequate medical record documentation that supports the services billed.

Once medical records are received by Optum, trained coding professionals will examine the documentation to determine if the services billed are supported (or not supported) as submitted and pay (or deny) the claim accordingly. Optum decides to pay or deny the claim based upon whether or not the records support how the claim is billed (not whether the services are medically necessary). The provider's submission of medical records is not a guarantee of payment.

WellCare uses claims editing software programs to assist in determining proper coding for provider claims payment. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule (NPFS) database, the American Medical Association (AMA), the Specialty Society correct coding guidelines, and state-specific regulations. These claim edits are also appoved by the Kentucky Department for Medicaid Services prior to implementation.

These software programs may result in claim edits for specific procedure code combinations. These claim edits may also result in adjustments to the provider's claims payment or a request for review of medical records prior to or subsequent to payment. Providers may request reconsideration of any adjustments produced by the claims editing software programs by submitting a timely request to WellCare or another contracted third party vendor. A reduction in payment as a result of claim policies and/or processing procedures is not an indication that the service provided is a non-covered service, and thus providers must not bill or collect payment from members for such reductions in payment.

Optum CPI Claims Process

WellCare receives notification from Optum indicating which claims are tagged for review. Depending on the review type, Optum may or may not require medical records to complete the claim review. If the review requires medical records, Optum sends communication directly to WellCare providers.

WellCare sends an electronic Explanation of Payment (EOP) to providers with a message indicating the reason codes CPIMR or CPISI. CPIMR indicates a claim has been tagged for medical record review. CPISI indicates a claim has been tagged at the request of WellCare's Special Investigation Unit (SIU).

The provider's submission of medical records is not a guarantee of payment. Optum reviews the medical records within 12 business days of receipt and may conclude that the billed code(s) will be denied. Optum will then communicate to the provider the reason(s) for the denial in the Optum initial review findings letter. WellCare sends the denial to the provider via EOP. If Optum does not receive the requested records, they will make a determination on the claim based upon the available information which may result in the denial being upheld.

Letters

Optum will auto-generate a medical records request (MRR) letter and will send the letter directly to providers. WellCare requires Optum to use the Vendor ID mailing address. The MRR will include directions on how or where to submit the records.

Optum sends the initial letter to the provider that requests medical records. If more than one claim is tagged in a day, the provider will receive one letter with a list of claims.

Provider has 120 days to submit medical records. If a provider does not respond within 30 days, the provider may receive one followup letter and one final letter, informing the provider that the claim will remain denied due to lack of response.

Once records are reviewed by Optum, decisions to overturn the denial will be rendered. If at least one line on a claim is denied, the provider will receive a denial letter explaining the rationale for the denial and instructions for submitting an appeal should the provider disagree.

All communications sent by Optum are shared with WellCare for record retention.

Medical Record Review

Timely Submissions

Providers are expected to respond promptly. If records have not been received 30 calendar days after the initial medical record request, the provider will receive a follow-up medical record request letter.

If records have not been received within 120 calendar days after the Initial medical record request, the provider will receive a denial letter indicating records have not been received.

If the provider does NOT submit the requested medical records, Optum would not be able to make a reasonable determination and the claim will remain denied/upheld. This denial is referred to as a technical denial.

Document submission options include electronically via secured internet upload, fax, or US Mail

1. Within Q1 2020, providers will also have the option to upload medical records via secure Internet upload. Using a web browser, go to the following URL: https://sftp.databankimx.com/form/RecordUploadService?ID=0012
2. **FAX:** 267-687-0994
3. **HARD COPY** (i.e. paper copy) using one of the following addresses:

By Mail (US Postal Service):	or	By Delivery Services (FedEx, UPS):
OPTUM P.O. Box 52846 Philadelphia, PA 19115		OPTUM 458 Pike Road Huntingdon Valley, PA 19006

Appeal Process

If a provider does not agree with Optum's decision, he/she may appeal. Appeals may be submitted in the following ways: URL upload, fax, mail. See section below **Medical Record Review, Timely Submissions** for details.

Optum will perform the appeal on behalf of WellCare. If the provider submits an appeal, the provider will receive a letter acknowledging the appeal request. Once an appeal is received, Optum will render a final decision within 30 days. If a provider does not agree with the final appeal decision, he/she may file for independent external review. The appeal response letter will provide instructions on how to submit a **Kentucky Independent External Review Request** See section below.

Kentucky Independent External Review Requests

In accordance with 907 KAR 17:035, if a provider receives an adverse final decision of a denial, in whole or in part of a health service or claim for reimbursement related to this service, a provider may request an external independent third-party review. Providers may only do so after first completing an internal appeal process with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

Providers must submit their request for external independent third-party review within 60 days from the date of receipt of the notice. Providers may submit their request to WellCare of Kentucky via one of the following methods:

1) Email: kyexternalreview@wellcare.com
2) Fax: 1-800-509-8203
3) Mail: WellCare Health Plans
   Attention: External Independent Third-Party Review
   13551 Triton Park Blvd. Suite 1800 Louisville, KY 40223

Provider Inquiries/Support

Optum's Provider Inquiry Response Team (PIRT) is dedicated specifically to answering questions.

Optum's provider inquiry team is equipped to educate providers on submitting medical records for initial review or if the provider has an appeals question.

The PIRT contact number is 1-844-458-6739. Operational hours are Monday thru Friday 8:00 a.m. to 6:30 p.m., Central Standard Time, excluding holidays.

CODING & BILLING

All ICD-10 CM, CPT, HCPCs, ICD-10 PCS and DRG codes are eligible.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

Algorithm	A process or set of rules to be followed in calculations or other problem-solving operations, especially by a computer.
CPI Claims Process	Optum applies a systematic algorithm to identify aberrant (waste and error) billing patterns at the line level. Optum may deny and request medical records from the provider or supplier who submitted the claim to support the services submitted on the claim.
Explanation of Payment (EOP)	Provides details on claims that have been paid, denied or adjusted. • CPIXX reason codes: o CPIMR/ CPISI - MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Fraud, Waste, and Abuse	**Fraud** • Any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee or other person(s). • Fraud also includes knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. **Waste**

	• The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program, Medicaid program, or Affinity. Waste is generally the misuse of resources. **Abuse** • Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee. • Abuse also includes enrollee practices that result in unnecessary cost to the state or federal government, MCO, contractor, subcontractor or provider.
Predictive Score Models	Predictive score modeling uses statistics to predict outcomes. Predictive modelling can be applied to any type of unknown event, regardless of when it occurred. CPI examines multiple factors simultaneously to calculate a risk score representing the likelihood of overpayment. Examples can be seen in global patient activity, modifier abuse, and peer group anomalies.
Provider Flags	Stops claims for review based upon past review of provider's billings and will target specific overpayment issues such as up-coding or unbundling.
Turnaround Times (TAT)	Turnaround time (TAT) is the time interval from the time of submission of a process to the time of the completion of the process. PROVIDER: • Once a provider's claim hits a concept, the concept may not trigger a denial/hold immediately. • The provider can take 5, 20, 45, or 60 days. If Optum does not receive records 30 days after the original request, they will send a follow-up letter. • At 120 days, if records are not received, the claim is denied (technical denial) with a reason code, CPIxx that explains requested medical documentation not received from provider within timeframe. OPTUM (per Service Level Agreements (SLA): • HOLD analytics- 48 hours • PEND analytics- 12 days o Once Optum receives medical records from the provider, Optum is contractually held to a 12-day turnaround SLA. o Optum's clinical case reviewers will review the records and make the determination within 12 days, at which point the provider will receive either payment or a denial letter explaining reason for denial.

Specialized Medical Reviews	Claims reviewed by Board Certified physicians for accuracy of claims coding.

REFERENCES

1. Comprehensive Health Management Inc. Optum Contract. Accessed 10/28/2019.
2. "Definition of Fraud, Waste, and Abuse". Affinity Health Plans. Website: affinityplan.org/Contact-Us/Reach-Out-to-Us/Fraud,-Waste-and-Abuse/Fraud,-Waste-and-Abuse/. Accessed October 28, 2019.
3. National Conference of State Legislatures. Medicaid Fraud and Abuse. Retreived from : https://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx Accessed January 14, 2020.
4. Wellcare PrePay CPI Overview ppt. Accessed 10/28/2019.
5. Wellcare CPI FAQ document. Accessed 10/28/2019.

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 and 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 and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- 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 for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

Care1st Health Plan Arizona, Inc. ~ Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) ~ 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 & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
03/23/2020	• Approved by RGC