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ForwardHealth UPDATE

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NEW PAYMENT INTEGRITY REVIEW PROGRAM

The Wisconsin Department of Health Services (DHS) Office of the Inspector General (OIG) is implementing a new Payment Integrity Review (PIR) program for ForwardHealth providers for claims submitted on and after April 1, 2023. This program:

- Allows the OIG to review claims prior to payment.
- Requires providers to submit all required documentation to support approval and payment of PIR-selected claims.

The goal of the PIR program is to further safeguard the integrity of DHS-administered public assistance programs, such as BadgerCare Plus and Wisconsin Medicaid, from fraud, waste, and abuse by:

- Proactively reviewing claims prior to payment to ensure federal and state requirements are met.
- Providing enhanced, compliance-based technical assistance to meet the specific needs of providers.
- Increasing the monitoring of benefit and service areas that are at high risk for fraud, waste, and abuse.

AFFECTED PROGRAMS
BadgerCare Plus, Medicaid

TO
All Providers, HMOs and Other Managed Care Programs

The information provided in this ForwardHealth Update is published in accordance with Wis. Admin. Code §§ DHS 106.08(3)(d), 106.11, and 107.02(2).

WISCONSIN DEPARTMENT of HEALTH SERVICES

Fraud, waste, and abuse includes the potential overutilization of services or other practices that directly or indirectly result in unnecessary program costs, such as:

- Billing for items or services that were not rendered.
- Incorrect or excessive billing of Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure codes.
- Unit errors, duplicate charges, and redundant charges.
- Billing for services outside of the provider specialty.
- Insufficient documentation in the medical record to support the charges billed.
- Lack of medical necessity or noncovered services.

Note: Review of claims in the PIR process does not preclude claims from future post-payment audits or review.

Payment Integrity Review Program Overview

When a provider submits a claim electronically via the ForwardHealth Portal, the system will display a message if the claim is subject to PIR. The message will instruct providers to submit supporting documentation with the claim. Providers have seven days to attach documentation to claims. The claim will automatically be denied if documentation is not attached within seven days.

Claims that meet PIR requirements may be eligible for payment once they are accurate and complete. Claims that do not meet PIR requirements may be denied or repriced. In these cases, providers are encouraged to:

- Review the Explanation of Benefits (EOB) for billing errors.
- Refer to the ForwardHealth Online Handbook for claims documentation and program policy requirements.
- Correct the PIR billing errors and resubmit the claim.

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Types of Payment Integrity Review

There are three types of review in the PIR program:

- Claims Review
- Pre-Payment Review
- Intermediate Sanctions

The information provided in this ForwardHealth Update is published in accordance with Wis. Admin. Code §§ DHS 106.08(3)(d), 106.11, and 107.02(2).

For each type of review, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

Claims Review

In accordance with Wis. Admin. Code § DHS 107.02(2), the OIG may identify providers, provider types, benefit areas, or procedure codes, and based on those criteria, choose a sampling of claims to review prior to payment. When a claim submitted through the Portal that meets one of these criteria is selected for review, a message will appear on the Portal to notify the provider that the claim must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

Pre-Payment Review

In accordance with Wis. Admin Code § DHS 106.11, if the OIG has cause to suspect that a provider is prescribing or providing services that are not necessary for members, are in excess of the medical needs of members, or do not conform to applicable professional practice standards, the provider's claims may be subject to review prior to payment. Providers who are subject to this type of review will receive a Pre-Payment Review Initial Notice letter, explaining that the OIG has identified billing practice or program integrity concerns in the provider's claims that warrant the review. This notice details the steps the provider must follow to substantiate their claims and the length of time their claims will be subject to review. Additionally, a message will appear on the Portal when the provider submits claims to notify the provider that certain claims must be submitted with all necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from pre-payment review, both of the following conditions must be met:

- Seventy-five percent of the provider's reviewed claims over a three-month period are approved to be paid.
- The number of claims the provider submits during that three-month period may not drop more than 10 percent from their submitted claim amount prior to pre-payment review.

The OIG reserves the right to adjust these thresholds according to the facts of the case.

CALL TO ACTION

For each type of PIR, providers must submit supporting documentation that substantiates the CPT and/or HCPCS procedure codes on the claim.

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Intermediate Sanction Review

In accordance with Wis. Admin. Code § DHS 106.08(3)(d), if the OIG has established cause that a provider is violating program rules, the OIG may impose an intermediate sanction that requires the provider's claims to be reviewed prior to payment. Providers who are subject to this type of review will be sent an official Intermediate Sanction Notice letter from the OIG that details the program integrity concerns that warrant the sanction, the length of time the sanction will apply, and the provider's right to appeal the sanction. The provider also will receive a message on the Portal when submitting claims that indicates certain claims must be submitted with the necessary supporting documentation within seven calendar days. The claim will automatically be denied if documentation is not attached within seven days.

For a provider to be considered for removal from an intermediate sanction, the provider must meet the parameters set during the sanction process.

To better understand these review type differences, refer to the Attachment to this ForwardHealth Update.

Supporting Documentation

Providers are notified that an individual claim is subject to PIR through a message on the Portal when submitting claims. When this occurs, providers have seven calendar days to submit the supporting documentation that must be retained in the member's record for the specific service billed. This documentation must be attached to the claim. The following are examples of documentation providers may attach to the claim; however, this list is not exhaustive, and providers may submit any documentation available to substantiate payment:

- Case management or consultation notes
- Durable medical equipment or supply delivery receipts or proof of delivery and itemized invoices or bills
- Face-to-face encounter documentation
- Individualized plans of care and updates
- Initial or program assessments and questionnaires to indicate the start date of service (DOS)
- Office visit documentation
- Operative reports
- Prescriptions or test orders
- Session or service notice for each DOS

NEVER MISS A MESSAGE

Stay current on policies and procedures by signing up for Portal text messages or email alerts! These alerts let providers know when there is a new secure Portal message. Go to the **Message Center** on the secure Portal and click **Notification Preferences**. Section 12.4 of the ForwardHealth Provider Portal Account User Guide has detailed instructions.

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- Testing and lab results
- Transportation logs
- Treatment notes

Providers must attach this documentation to the claim at the time of, or up to seven days following, submission of the claim. A claim may be denied if the supporting documentation is not submitted. If a claim is denied, providers may submit a new claim with the required documentation for reconsideration. To reduce provider impact, claims reviewed by the OIG will be processed as quickly as possible, with an expected average adjudication of 30 days.

The PIR program does not change any ForwardHealth policies on how to submit a claim or attach documentation to a claim. Providers are encouraged to refer to the Online Handbook for information about:

- How to submit a claim (Submission chapter).
- How to attach documentation to a claim (Uploading Claim Attachments Via the Portal topic [#11677]).
- Claim status and decisions (Claim Status topic [#535]).
- EOB codes (Explanation of Benefit Codes in the Claim Header and in the Detail Lines topic [#4822]).
- Claim adjustments (Adjustment Requests chapter).

Per the Accuracy of Claims topic (#516), providers are reminded that they are responsible for the accuracy, truthfulness, and completeness of all claims submitted whether prepared or submitted by the provider or by an outside billing service or clearinghouse. Providers may submit claims only **after** the service is provided.

Provider Resources

Training Videos

To better understand the current claim submission process and the PIR program, providers may watch the following videos on the Trainings page of the Portal:

- Module 1: Introduction to Options for Electronic Claims Submission under the Options for Electronic Claims Submission Training link
- Payment Integrity Review Program

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User Guides and Instruction Sheet

The following user guides and instruction sheet on the User Guides page of the Portal contain information about submitting claims and claim attachments:

- ForwardHealth Provider Portal Institutional Claims User Guide
- ForwardHealth Provider Portal Professional Claims User Guide
- ForwardHealth Provider Portal Dental Claims User Guide
- ForwardHealth Portal Uploading Claim Attachments Instruction Sheet

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § DHS 106.02(9). Providers are required to produce or submit documentation, or both, to DHS upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

Information Regarding Managed Care Organizations

This Update applies to services that members receive on a fee-for-service basis and through BadgerCare Plus, Medicaid SSI, and other managed care programs. For information about managed care implementation of the updated policy, contact the appropriate managed care organization (MCO). MCOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

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This Update was issued on 03/01/2023 and information contained in this Update was incorporated into the Online Handbook on 04/03/2023.

ATTACHMENT
Types of Payment Integrity Review

	CLAIMS REVIEW	PRE-PAYMENT REVIEW	INTERMEDIATE SANCTION
How claims are selected for review	A sampling of claims is selected from providers, provider types, benefit areas, or service codes identified by the Office of the Inspector General (OIG).	The OIG has reasonable suspicion that a provider is violating program rules.	The OIG has established cause that a provider is violating program rules.
How providers are notified that selected claims are under review	The provider receives a message on the ForwardHealth Portal.	The provider receives a Provider Notification letter and message on the Portal.	The provider receives a Notice of Intermediate Sanction letter and message on the Portal.
How to successfully exit the review	Claims are selected for review based on a pre-determined percentage of claim submissions of specific criteria. All providers who bill the service codes that are part of this criteria are subject to review, regardless of their compliance rates.	Seventy-five percent of a provider's reviewed claims over a three-month period must be paid as submitted. The number of claims submitted during the three-month period may not drop more than 10 percent of the provider's volume of submitted claims prior to pre-payment review.	The provider must meet parameters set during the sanction process.

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