§ 108C-7. Prepayment claims review.

(a) In order to ensure that claims presented by a provider for payment by the Department meet the requirements of federal and State laws and regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review by the Department. Grounds for being placed on prepayment claims review shall include, but shall not be limited to, receipt by the Department of credible allegations of fraud, identification of aberrant billing practices as a result of investigations, data analysis performed by the Department, the failure of the provider to timely respond to a request for documentation made by the Department or one of its authorized representatives, or other grounds as defined by the Department in rule.

(b) Providers shall not be entitled to payment prior to claims review by the Department. The Department shall notify the provider in writing of the decision and the process for submitting claims for prepayment claims review. The written notice shall be deposited, first-class postage prepaid, in the United States mail and addressed to the most recent address given by the provider to the Department. The prepayment claims review shall be instituted no less than 20 calendar days from the date of the mailing of written notification. The notice shall contain all of the following:

(1) An explanation of the Department's decision to place the provider on prepayment claims review.
(2) A description of the review process and claims processing times.
(3) A description of the claims subject to prepayment claims review.
(4) A specific list of all supporting documentation that the provider will need to submit to the prepayment review vendor for all claims that are subject to the prepayment claims review.
(5) The process for submitting claims and supporting documentation.
(6) The standard of evaluation used by the Department to determine when a provider's claims will no longer be subject to prepayment claims review.

(c) For any claims in which the Department has given prior authorization, prepayment review shall not include review of the medical necessity for the approved services.

(d) The Department shall process all clean claims submitted for prepayment review within 20 calendar days of receipt of the supporting documentation for each claim by the prepayment review vendor. To be considered by the Department, the documentation submitted must be complete, legible, and clearly identify the provider to which the documentation applies. If the provider failed to provide any of the specifically requested supporting documentation necessary to process a claim pursuant to this section, the Department shall send to the provider written notification of the lacking or deficient documentation within 15 calendar days of the due date of requested supporting documentation. The Department shall have an additional 20 days to process a claim upon receipt of the documentation.

(e) The provider shall remain subject to the prepayment claims review process until the provider achieves three consecutive months with a minimum seventy percent (70%) clean claims rate, provided that the number of claims submitted per month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. If a provider does not submit any claims following placement on prepayment review in any given month, then the claims accuracy rating shall be zero percent (0%) for each month in which no claims were submitted. If the provider does not meet the seventy percent (70%) clean claims rate minimum requirement for three consecutive months within six months of being placed on prepayment claims review, the Department may implement sanctions, including termination of the applicable Medicaid Administrative Participation Agreement, or continuation of prepayment

review. The Department shall give adequate advance notice of any modification, suspension, or termination of the Medicaid Administrative Participation Agreement.

Prepayment claims review shall not continue longer than 24 consecutive months unless the Department has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction. If the Department has initiated the termination or other sanction of the provider and the provider has appealed that termination or sanction, then the provider shall remain on prepayment review until the final disposition of the Department's termination or other sanction of the provider.

(e1) Failure of a provider to meet the seventy percent (70%) clean claims rate minimum requirement may result in a termination action. A termination action taken shall reflect the failure of the provider to meet the seventy percent (70%) clean claims rate minimum requirement and shall result in exclusion of the provider from future participation in the Medicaid program. If a provider fails to meet the seventy percent (70%) clean claims rate minimum requirement and subsequently requests a voluntary termination, the termination shall reflect the provider's failure to successfully complete prepayment claims review and shall result in exclusion of the provider from future participation in the Medicaid program.

(e2) A provider shall not withhold claims to avoid the claims review process. Any claims for services provided during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted and regardless of whether the provider has been taken off of prepayment review for any reason, including attaining a minimum of seventy percent (70%) clean claims rate for three consecutive months, the expiration of the 24-month time limit, or the termination of the provider.

(f) The decision to place or maintain a provider on prepayment claims review does not constitute a contested case under Chapter 150B of the General Statutes. A provider may not appeal or otherwise contest a decision of the Department to place or maintain a provider on prepayment review.

(g) If a provider elects to appeal the Department's decision to impose sanctions on the provider as a result of the prepayment review process to the Office of Administrative Hearings, then the provider shall have 45 days from the date that the appeal is filed to submit any documentation or records that address or challenge the findings of the prepayment review. The Department shall not review, and the administrative law judge shall not admit into evidence, any documentation or records submitted by the provider after the 45-day deadline. In order for a provider to meet its burden of proof under G.S. 108C-12(d) that a prior claim denial should be overturned, the provider must prove that (i) all required documentation was provided at the time the claim was submitted and was available for review by the prepayment review vendor and (ii) the claim should not have been denied at the time of the vendor's initial review. (2011-399, s. 1; 2017-57, s. 11H.19(a).)