

Policy: UM-PI 005028 Medicaid Provider Prepayment Review

Manual: Program Compliance

Original Date: 10/22/2026

Section: Program Integrity

Revision Date: N/A

LOB: Medicaid

Approved By: VP, Cost of Care, Sentara Health Plans

Process Owner: Directors, Utilization Management and Program Integrity

Revision Description (Most Recent): N/A

Policy Statement:

Sentara Health Plans (SHP) may conduct prepayment review of selected Virginia Medicaid claims. During prepayment review, SHP may pend a claim and request medical records or other documentation before releasing the claim for payment, partial payment, or denial. Review is based on the coverage, service authorization or registration, medical necessity, provider qualification, documentation, billing, and other program requirements applicable to the date of service.

This policy provides high-level notice of SHP's prepayment review process. It does not replace or modify federal or state law, the Virginia Department of Medical Assistance Services (DMAS) Cardinal Care Managed Care Contract, DMAS provider manuals, supplements, bulletins, billing guidance, the provider agreement, the SHP provider manual, or member appeal rights. If requirements differ, the controlling authority applicable to the date of service governs.

Purpose and Scope:

- Applies to Virginia Medicaid claims and services selected by SHP for prepayment review.
- Describes provider responsibilities, the general review process, potential outcomes, and available reconsideration or appeal pathways.
- Does not disclose confidential selection logic, fraud-detection methods, internal workflows, system controls, reviewer assignments, or service-specific audit tools.
- Does not create coverage, payment, or authorization rights beyond those established by applicable law, DMAS requirements, the member's benefit, the provider agreement, and SHP policy.

Definitions:

Administrative or Technical Review: Review of nonclinical requirements, including eligibility, benefit coverage, provider enrollment, authorization or registration, identifiers, timeliness, coding, modifiers, duplicate or overlapping services, billing requirements, and required records.

Clinical Review: Review by an appropriately qualified reviewer to determine whether submitted records support medical necessity, covered service components, amount, duration, scope, units billed, and other service-specific requirements.

Medical Record: Clinical and related documentation supporting the billed service, which may include assessments, evaluations, individualized plans, progress notes, service logs, signatures, credentials, supervision records, care coordination, and discharge or transition records.

Partial Payment Determination: A determination that only part of the billed service, units, dates, or claim lines is supported for payment.

Prepayment Review: A process in which payment of a selected claim is pended while SHP requests and reviews medical record documentation before releasing the claim for payment or denial.

Provider Reconsideration: A provider request for SHP to re-evaluate a processed claim determination in accordance with applicable SHP requirements.

Guidelines/Instructions:

1. SHP may select claims for prepayment review at the claim, service, provider, member, or program level based on factors determined appropriate by SHP and permitted under applicable law, contract, regulatory requirements, the provider agreement, and SHP policy. Selection may consider utilization or billing patterns, service risk, provider monitoring, concurrent or overlapping billing, complaints, prior findings, focused reviews, audits, corrective actions, or DMAS direction.
2. Selection for review is not, by itself, a determination that the provider, claim, or service is noncompliant or that fraud, waste, or abuse occurred.
3. SHP will apply requirements in effect for the date of service, including applicable DMAS manuals, appendices, supplements, billing guidance, service authorization or registration requirements, the executed provider agreement, and applicable SHP policies.
4. An authorization, registration, referral, or prior approval does not by itself guarantee claim payment. The claim and submitted records must support all applicable coverage, documentation, provider, coding, billing, and service-delivery requirements.
5. SHP will evaluate the documentation submitted and the totality of the record. A diagnosis, referral, template phrase, checklist entry, or automated output alone does not establish that all payment requirements are met.
6. Automation may support claim identification, routing, and status management, but required clinical judgment will be made by appropriately qualified personnel.
7. Potential fraud, waste, or abuse concerns may be referred for additional review or investigation and may be reported to DMAS or other authorities when required.

Medical Record Requests and Provider Responsibilities

1. SHP will identify the records or information requested, the submission method, and the response due date in the provider notice.
2. The provider must submit complete, accurate, readable, and timely documentation that supports the billed service and identifies the member, provider, rendering practitioner or staff, date of service, service delivered, and other elements required by the applicable authority.
3. The provider is responsible for maintaining, retaining, and producing records required by DMAS, applicable law, the provider agreement, and SHP requirements, including records maintained by employees, contractors, or other persons acting on the provider's behalf. Failure to maintain, retain, or produce documentation sufficient to support the billed service may result in denial of payment to the extent permitted by applicable requirements.
4. Submission of records does not guarantee payment. SHP may request clarification or additional documentation when permitted and reasonably necessary to complete the review.
5. Failure to submit requested records by the stated deadline, or submission of records that do not support the billed service, may result in partial or full claim denial, subject to applicable requirements and provider rights.
6. Providers must protect member confidentiality and use the secure submission method identified by SHP. Providers should retain proof of timely submission.

Review Categories

1. Clinical Review: medical necessity, clinical appropriateness, covered service components, treatment or service planning, service delivery, provider or staff qualifications, supervision, and clinical documentation.
2. Administrative or Technical Review: eligibility, benefit coverage, authorization or registration, provider enrollment, identifiers, timeliness, coding, modifiers, duplicate or overlapping services, and required records.
3. Program Integrity Review: billing or provider risk indicators, aberrant patterns, duplicate or overlapping billing, and potential fraud, waste, or abuse concerns.
4. Regulatory or Directed Review: review required by DMAS, contract, audit, corrective action, monitoring, or another applicable oversight requirement.

Review Standards and Service-Specific Requirements

1. For each service under review, SHP will use the service definition and requirements applicable to the date of service. Depending on the service, review may include medical necessity; covered and noncovered activities; amount, duration, scope, and units; authorization or registration; provider enrollment and qualifications; staffing and supervision; assessment and treatment or service planning; documentation; care coordination; utilization review; billing; and discharge or transition requirements.
2. SHP may conduct prepayment review for any Virginia Medicaid service subject to applicable federal requirements, Virginia Medicaid requirements, the Cardinal Care Managed Care Contract, the provider agreement, and SHP policies. Services may be added to or removed from prepayment review consistent with applicable authority and any applicable provider notice requirements.

Determinations and Claim Processing

1. Payment: the submitted claim and records support payment under applicable requirements.
2. Partial Payment: only a portion of the billed service, units, dates, or claim lines is supported. SHP may pay the supported portion and deny the unsupported portion.
3. Denial: the claim or record does not support payment, required documentation was not timely received, or another applicable payment requirement was not met.
4. Further Review: the claim may be referred for additional administrative, clinical, program integrity, or legal review when warranted.
5. SHP will provide claim or determination information consistent with applicable law, contract, provider agreement, and SHP notice requirements. Claim processing remains subject to coordination of benefits, third-party liability, member eligibility, benefit limits, claim edits, and other requirements that may apply after the prepayment review determination.

Provider Reconsideration Process

1. Providers may submit one (1) reconsideration request for a prepayment review determination, denial, partial denial, audit finding, or other adverse claim action in accordance with the instructions, submission requirements, and timelines identified in the determination notice, applicable provider manual, provider agreement, and SHP requirements.
2. The reconsideration request must clearly identify the disputed determination and include all facts, explanations, corrections, and supporting documentation the provider wishes SHP to consider.
3. SHP will review timely and complete reconsideration requests and issue a written reconsideration determination indicating whether the disputed finding or determination is upheld, modified, or overturned.

4. Providers are entitled to one (1) reconsideration review for each adverse determination. The reconsideration determination constitutes SHP's final reconsideration decision and exhausts SHP's internal reconsideration process.
5. The reconsideration process does not waive, replace, expand, or restrict rights available under applicable law, regulation, contract, provider agreement, employee benefit plan, or government program requirements. Providers must exhaust SHP's reconsideration process when required before pursuing an external appeal.
6. The reconsideration determination will include notice, when applicable, that the provider has exhausted SHP's reconsideration process and may pursue any available external appeal rights.

External Appeal Rights by Line of Business

Virginia Medicaid

1. After completion of SHP's reconsideration process, providers may pursue applicable Virginia Department of Medical Assistance Services (DMAS) provider appeal rights in accordance with the Cardinal Care Managed Care Contract, 12VAC30-20-500 et seq., and current DMAS appeal requirements.
2. SHP's reconsideration determination will identify applicable appeal rights and deadlines when required.

Medicare Advantage

1. Following completion of SHP's reconsideration process, providers may pursue any appeal rights available under applicable Centers for Medicare & Medicaid Services (CMS) regulations, Medicare guidance, provider contracts, and SHP Medicare policies and procedures.
2. Appeal rights, filing requirements, and applicable deadlines are governed by the Medicare program requirements in effect on the date of service and the applicable provider agreement.

Commercial and Exchange Products

1. Following completion of SHP's reconsideration process, providers may pursue any appeal, dispute resolution, arbitration, or other remedies available under the applicable provider agreement, member benefit plan, state or federal law, and SHP policies and procedures.
2. Applicable rights, filing requirements, and deadlines are governed by the provider agreement, benefit plan, and any controlling legal or regulatory requirements.

No Waiver; Reservation of Rights

1. Payment of a claim, prior payment of similar claims, or omission of an issue in one review does not waive SHP's right to apply applicable requirements to other claims or to conduct later review as permitted by law, contract, or provider agreement.
2. Prepayment review does not limit SHP's right or obligation to conduct post-payment review, recover overpayments, apply corrective action, refer a matter for investigation, or take other action permitted or required by applicable authority.
3. Nothing in this policy authorizes recoupment, denial, sanction, or other action beyond the authority available under applicable law, DMAS requirements, the provider agreement, and SHP policy.

Protective and Controlling Provisions

1. **Controlling Authority:** In the event of a conflict between this policy and applicable federal law, Virginia law, the Cardinal Care Managed Care Contract, DMAS manuals or guidance, the provider agreement, or other controlling regulatory requirements, the controlling authority applicable to the date of service governs.
2. **Future Amendments and Successor Guidance:** References in this policy to DMAS requirements include applicable amendments, replacements, supplements, Medicaid memos, bulletins, technical guidance, manual updates, and successor documents issued or adopted by DMAS. The requirement applicable to the date of service governs.
3. **No Reliance or Exhaustive Statement:** This policy is a high-level description of the prepayment review process and is not a complete statement of every coverage, payment, documentation, clinical, enrollment, authorization, registration, coding, billing, or program integrity requirement. Providers remain responsible for compliance with all requirements applicable to the billed service, whether or not each requirement is repeated in this policy.
4. **No Expansion of Authority:** Nothing in this policy creates a requirement, remedy, denial basis, sanction, or recovery right beyond what is permitted or required by applicable law, DMAS requirements, the Cardinal Care Managed Care Contract, the provider agreement, and SHP policy.

Exceptions:

Any exception must be required or permitted by applicable law, DMAS direction, the controlling contract, the provider agreement, or written SHP policy. An exception for one claim or circumstance does not establish a continuing exception.

Monitoring:

Outcomes Monitoring – Participating departments shall monitor review volume, inventory aging, medical record receipt, administrative and clinical outcomes, approvals, partial approvals, denials, claim release, notices, reconsiderations, appeals, overturns, provider and service trends, claims without an assigned owner, unresolved handoffs, claims awaiting correspondence or final disposition, threshold exceptions, quality findings, and identified operational or program integrity concerns. Monitoring may be stratified by Medicaid service, provider, review category, outcome, or other approved program dimension.

Document Management – The Directors of Utilization Management and Payment Integrity, in coordination with Claims and Compliance, shall be responsible for developing, communicating, and maintaining this policy and related procedures, service-specific review standards, control plans, and job aids. This policy shall be reviewed at least annually and when a material Medicaid service, regulatory, contractual, system, or workflow change occurs.

Related Documents:

<i>Policy</i>	UM-PI 005027 Prepayment Clinical Review and Audit Oversight
<i>Job Aids</i>	N/A
<i>Regulatory References</i>	Federal Statutes • Applicable federal Medicaid managed care requirements, including 42 CFR Part 438: Managed Care
	Code of Virginia and Virginia Administrative Code • Applicable Virginia statutes and Virginia Administrative Code requirements
	Virginia Department of Medical Assistance Services • Cardinal Care Managed Care Contract Section 18.2.2: Pre-Payment Review • Cardinal Care Technical Manual

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- Applicable DMAS provider manuals, appendices, supplements, Medicaid memos, bulletins, billing guidance, and fee schedules

Sentara Health Plans Provider Manual

- Applicable provider agreement
 - Applicable claim, medical-record request, determination, reconsideration, and appeal notices
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