Prepayment Review FAQ's

Q: How can documentation be submitted?

A. Providers can fax documentation to THP's dedicated fax line at 855.525.6214 or preferably use THP's secure SharePoint site to upload records electronically. To request access to SharePoint, providers will need to follow instructions provided in the initial Prepayment Review letter.

- Please note: If a provider chooses to use SharePoint to submit medical records, claims will still need to be submitted via traditional routes. Paper claims submitted to SharePoint are not able to be processed.

Q: What does the effective date on the Initial Prepayment Review letter entail?

A. The effective date listed on the Initial Prepayment Review letter is the beginning date upon which providers will be required to submit medical records/documentation.

- Prepayment Review period of 120 days begins upon the first successful adjudication of a claim under prepayment review.
- The Effective Date identified in the letter is based on claim submission date, not date of service.

Example: Provider is placed on Prepayment Review effective January 1st, 2022.

Provider submits a claim with a Date of Service of 12/15/2021 on January 1st, 2022. Even though the Date of Service is before the effective date, the provider will still be required to submit records to support the claim since the claim was received by THP on the Effective Date of Prepayment Review.

Q: My claim was denied for missing documentation. What do I need to do to correct the issue?

A. The documentation to support the services billed must be submitted via fax or SharePoint and the claim must be resubmitted as a corrected claim for reprocessing.

- Please Note: If a claim was denied for missing documentation, then it must be submitted as a corrected claim in order for the claim to be reviewed. Resubmitting a claim as an original could result in a duplicate denial. You can indicate a corrected claim by putting a "7" in box 22 on the claim form.

Q: The remit received from THP shows claim was denied for "Payer deems the information submitted does not support this level of service". Can this be reprocessed?

A. When a claim is denied for "Payer deems the information submitted does not support this level of service", the documentation submitted didn't support the level of service provided and providers will need to refer to Section 5 and Section 15 of THP's Provider Manual as instructed in the initial letter. Provider has one level of appeal.

Q: What happens if a provider has a delay sending in documentation?

A. If a provider delays in sending in documentation, impacted claims will be denied. If a provider is experiencing issues, the provider should contact their PMC immediately to avoid any repercussions of delayed records.

Q: Where can I find the THP Provider Manual?

A. The THP Provider Manual can be found by going to healthplan.org and following the path below:

For Providers > Resources > Provider Manual

Q: Who can I contact at THP if I have any questions not addressed in the FAQ?

A. Contact your Practice Management Consultant. To identify your Practice Management Consultant, go to THP's website and follow the path below:

For Providers > Overview > Meet Your Practice Management Consultant

Q: What should my documentation/records contain?

A. The documentation should contain information that accurately reflects the services performed and/or items provided. Refer to THP's website and follow the path below to see THP's Medical Record Documentation Guidelines:

For Providers > Clinical Support > Documentation Guidelines.