PI Payment Policy 29
Optum Pause and Pay

All States & Lines of Business

Purpose

The purpose of this payment policy is to outline the Optum Pause & Pay payment accuracy solution process. This policy is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In the event of a conflict, federal and state guidelines, as well as the member's benefit plan document always supersede the information in a payment policy. Additionally, to the extent there are any conflicts between the payment policy and the provider contract language, the provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval.

Overview

Molina Healthcare is committed to continuously improving its overall payment integrity program and administers payment rules based on generally accepted principles of correct coding. Molina has partnered with Optum to implement best practices to reduce waste, abuse and error in medical claim billing through a pre-payment review. The intent of this payment integrity solution is to ensure that claims submitted to Molina Healthcare are coded and billed properly for accurate reimbursement. This program is designed to identify practices inconsistent with acceptable fiscal, business or medical practices that unnecessarily increase costs as well as overutilization of resources and inaccurate payments for service. Depending on the type of review, Optum may require medical records for review to support the services submitted on the claim and prior to payment determination. Medical records will be reviewed to verify the extent and nature of the services rendered for the patient's condition and that the claim is coded correctly for the services provided. This review does not include a determination of medical necessity. Referrals of aberrant billing patterns or behavior that may be potentially fraudulent may be made to the Special Investigations Unit (SIU). SIU may then pursue an internal investigation using established processes. This program will support Molina Healthcare's contractual obligations related to FWA contract language.

Process

The following outlines how Molina Healthcare will process claims in support of this correct coding and payment accuracy solution when medical records are required as part of pre-payment review.

Notification and Prepayment Review

Molina Healthcare receives notification from Optum indicating which claims are selected for pre-payment review and sends an Explanation of Payment (EOP) to providers with a message indicating that Optum is requesting Medical Records on Molina's behalf. The claim selection process is based on the submitted claim and is provider agnostic.

The EOP will contain the following Remit Remark Code and Message referencing each line:

Remit Remark Code: M127
Remit Message:

"Optum is requesting Medical Records on Molina's behalf. The allowed timeframe for Medical Record submission and any disputes is based on timely filing requirements. Please direct questions regarding this Medical Record request to Optum at (877) 244-0403."

Optum issues an initial medical record request letter to the provider with instructions for submitting documentation. A subsequent reminder letter is issued if applicable.

For each claim selected, the provider will be asked to submit

- Complete medical records to include history and physical, office/treatment records, consultation reports, operative reports, anesthesia and recovery room records and discharge summaries, if applicable
- Infusion flow sheets or medication administration logs, if applicable
- Orders and results of diagnostic tests, including pathology, radiology and laboratory, if applicable
- For DME, include a signed receipt from the member verifying receipt of any device/equipment/supplies, if applicable
- For all drug codes, as applicable, include the NDC information, drug name, units, provider HRSA grant number and information, along with invoice with the acquisition cost for the individual drugs

- Itemization of services billed for the above dates, if applicable

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

1 https://sftp.databankimx.com/form/RecordUploadService

2 FAX: 267-687-0994

3. HARD COPY (i.e. paper copy, CD, DVD) using the following address:

Mail:

Optum on behalf of Molina Healthcare

P.O. Box 51456

Philadelphia, PA 19115

Delivery Service:

Optum on behalf of Molina Healthcare

458 Pike Road

Huntingdon Valley, PA 19006

The submission of medical records is not a guarantee of payment, and Molina edits apply. Optum will review medical records within 10 business days of receipt.

If the claim is supported, a letter will be mailed and the claim will be reprocessed.

If the claim is partially supported, a letter will be mailed with the rationale for the denial and the claim will be reprocessed.

If the claim is unsupported, a letter will be mailed with the rationale for the denial.

If records are not received, the review is performed based on available information and a technical denial letter will be issued.

Instructions for submitting a reconsideration or a first level dispute are included in the letter.

Reconsiderations and First Level Disputes

If a provider disagrees with a denial, a reconsideration if applicable and/or a dispute may be submitted to Optum for review. The communication must include an explanation of the disagreement of the denial as well as supporting documentation such as additional medical records and source information within applicable timely filing guidelines. Upon review, if it is determined that a coding and/or payment adjustment is applicable, the healthcare provider will receive a letter from Optum with the review outcome and Molina will perform the appropriate claim adjudication.

Second Level Disputes

Instructions for submitting a second level dispute if applicable are included in the Optum first level dispute findings letter. Optum does not perform second level disputes.

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

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 review, case status, understanding review outcome, etc. Providers can contact the Optum PIRT team at **1-877-244-0403**.

Operational hours are Monday thru Friday 8:00 a.m. to 6:30 p.m., Central Standard Time, excluding holidays.

Coding

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

Approval History

TYPE	DATE	ACTION
Effective Date	01/01/2020	

References

1. 42 CFR § 455

Supplemental Information

Definitions

Appendix