Optum Pause and Pay
Pre-payment Review - Frequently Asked Questions (FAQs)

1. What is pre-pay review?

ConnectiCare, in partnership with Optum, will perform prepayment medical record reviews utilizing widely acknowledged national guidelines for billing practices and to support uniform billing for all payers. The prepayment claim reviews will look for overutilization and other inappropriate billing practices by reviewing state and federal policies sourced from Medicaid and Medicare rules utilized industry wide and then applying appropriate analytics.

The concepts utilized for the prepayment review are in alignment with correct coding practices and incorporate a review of medical records to determine if they support the services and codes billed.

2. How will claim payment change due to these reviews?

The difference will be the potential for a claim to be selected for review and would include a request for medical records prior to payment. A request will come directly from Optum on ConnectiCare's behalf. In these instances, ConnectiCare will deny the entire claim until notification has been received from Optum that medical records have been received and reviewed. Payment will be determined after the review of the medical records is complete, at which time you will receive a letter from Optum with the outcome of the review.

If your claim is identified for review, you will receive an Explanation of Payment (EOP) indicating medical records have been requested. 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* ConnectiCare*'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."*

Please note for Electronic Remittance Advices (ERAs), only the Remit Remark Code M127 will be visible in the 835 file. Providers can log into their Change Healthcare ProviderNet account to access the complete EOP and see the full verbiage and details of where to send their medical records should the request come from Optum.

The original determination may be upheld or overturned. In either case, you'll be notified of the decision. An adjustment claim will be created if the original decision is overturned for any or all lines. Additionally, Optum will also be handling Level 1 disputes/appeals for ConnectiCare. For questions regarding disputes/appeals, please refer to item #6 below.

3. *How do I submit my medical records and what should I include?*

The Optum medical record request letters will be sent within two business days of claim selection. The request letters will provide detailed instructions of how and where to submit your medical records and what to include with your submission. This includes:

- A list of impacted claims.
- An itemized list of required documents.
- A page of instructions to submit via secure internet, fax or mail, plus a cover sheet with a bar code to identify your case number and pertinent information for Optum.

Medical records are required to be submitted within 30 calendar days from receipt of the notice and should follow your Provider Manual guidelines for the method of submission. Once received, records will be reviewed within 10 business days, and an outcome letter will be sent to you.

If medical records are not received within 30 days, a second reminder letter will be sent by Optum. If no records are received within 90 days of the initial request, a technical denial letter will be sent as final communication and ConnectiCare will be notified that Optum has closed the case.

4. *Who do I contact at Optum for assistance with medical record submission?*

Should you need assistance with submitting your medical records or have any questions, you can contact the Optum Provider Inquiry Response Team (PIRT) team at **877-244-0403**.

5. *What Options do I have if I don't agree with a denial?*

Depending on your state agency's requirements, when Optum sends their initial findings denial letter, they will include information required should you request a reconsideration of their review. Your information should include:

- The cover sheet provided with the denial letter with a barcode.
- Explanation of why you do not agree with the denial.
- Supporting documentation such as additional medical records or source information.

Optum will conduct their review and send a resolution letter within 10 business days from date of receipt. **Timely filing rules will apply.**

6. *What options do I have if I don't agree with Optum's review of my request for reconsideration?*

If you submit a request for reconsideration for a denial and it is upheld, you will receive a letter with the outcome of the review which includes a summary for each claim line detailing the data that supports Optum's decision. If you disagree with the final determination, steps to submit your formal first-level dispute/appeal are included in the denial letter.

Your dispute/appeal submission will follow your state's timely filing rules and should include the following:

- The cover sheet provided with the denial letter with a barcode.
- Supporting documentation such as additional medical records and claim information.
- Detailed explanation as to the reason for your dispute/appeal and supporting documentation such as additional medical records or source information.

Once this information is received, Optum will send a Dispute Acknowledgement letter and start the review process.

7. How long do I have to submit records or an appeal?

ConnectiCare 's timely filing guidelines for submitting medical records or dispute/appeal submissions for your state apply.

8. What options do I have if I don't agree with Optum's review of my formal dispute/appeal request?

If you submit a formal dispute/appeal request and it's upheld, you will receive an Optum Dispute Response Letter with the outcome of the review and directions for submitting further correspondence to ConnectiCare. **Please note** your contract and state regulations apply regarding the availability of a second-level review.

You may submit a dispute/appeal letter and supporting documentation to ConnectiCare via one of the methods below. **Refer to your provider manual guidelines for required submission methods.** Documentation must include the following:

- A detailed explanation of why you disagree with the denial.
- Supporting documentation such as additional medical records or source information.
- A copy of the Optum dispute uphold letter.

Methods of correspondence submission to ConnectiCare **depending** on provider manual guidelines are:

1. PROVIDER PORTAL (*preferred method*) availity.com/providers
2. FAX
3. MAIL