Frequently asked questions (FAQs)
Pre-pay audit (post adjudication/pre-payment)

1. What is Pre-pay auditing?

Molina Healthcare of Nevada, Inc. ("Molina"), in partnership with Optum, will perform prepayment audits utilizing widely acknowledged national guidelines for billing practices and to support uniform billing for all payers. The pre-payment claim reviews will look for overutilization and other inappropriate billing practices by reviewing state and federal policies sourced from Medicaid rules utilized industry wide and then applying appropriate analytics.

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

Optum is currently applying a subset of professional analytics only, which could include those services billed by a facility. New analytics will be reviewed for future implementations after in-depth reviews are completed and with approval by Molina.

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

The main difference will be the potential tagging of claims for review which would trigger a request for medical records. A request will come directly from Optum on Molina's behalf. In these instances, Molina 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 EOP indicating medical records have been requested. The EOP will contain the following Remit Remark Code and Remit 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."

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 Explanation of Payment 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 appeals for Molina. For questions regarding disputes or 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 tagging. 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 hard copy, 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 SWH 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 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. Should you not agree with the final determination, steps to submit your formal 1st level dispute will be supplied.

Your dispute submission should follow your state's timely filing rules and 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.

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

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

Your timely filing guidelines for submitting medical records or dispute submissions follows: Nevada's regulatory requirements for physicians, refer to NRS-629,NRS 630, and NRS 633.

NRS 629.061 commands providers of health care make available for physical inspection health care records of a patient within 10 working days after the request by: 1) the patient or a representative with written authorization; 2) the personal representative of the estate of a deceased patient; 3) a trustee of a living trust created by the deceased patient; 4) the parent/guardian of a deceased patient; 5) an investigator for the Attorney General's office; and 6) an authorized representative or investigator of a state licensing board. Additionally, NRS 629.061 describes the allowed reimbursement for the costs of copying health care records and other records, such as Xrays.

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

If you submit a formal dispute 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 Molina. Please note, your contract & state regulations apply regarding the availability of a 2nd level review.

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

- Explanation of why you don't agree with the denial
- Supporting documentation such as additional medical records or source information
- A copy of the Optum dispute uphold letter.

Method of correspondence submission to Molina is:

1. PROVIDER PORTAL (*preferred method*)
   provider.molinahealthcare.com

2. HARD COPY
   Molina Healthcare of Nevada, Inc.
   8329 W. Sunset Road, Suite 100
   Las Vegas, Nevada 89113