Frequently Asked Questions (FAQs)

Pre-Pay Audit (Post Adjudication/Pre-Payment)

1. What is the purpose of conducting Pre-Pay Reviews?

Services must be billed in accordance with regulatory and health plan policies, including correct coding guidelines. The purpose of conducting Pre-Pay reviews is to ensure that services billed are consistent with medical record documentation

Molina, in partnership with Optum, will perform prepayment reviews to look for overutilization and other inappropriate billing practices.

Optum is currently applying a subset of analytics to only professional claims for Molina. 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?

If your claim is identified for review, you will receive an EOP indicating Medical Records have been requested; payment will be determined after the review of the Medical Records is complete, at which time you will receive a letter with the outcome of the review, along with steps to dispute a denial where applicable.

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

Remit Remark Code: M127
Remit Message:

"Optum 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."

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

If you receive a request for medical records from Optum, please follow the instructions in the letter. The letter will provide details of how and where to submit your medical records and what to include with your submission. Submission options vary, depending on market requirements. A URL Upload and Fax option are available for all markets.

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 Optum's Provider Inquiry Resolution Team at **1-877-244-0403**.

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

If your claim is identified for review, you will receive an EOP indicating Medical Records have been requested; payment will be determined after the review of the Medical Records is complete. You will receive a letter with the outcome of the review, along with steps to submit a request for a reconsideration for a denial where applicable. Please note, timely filing requirements 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, along with steps to submit your formal 1st level dispute where applicable. Please note, timely filing requirements apply.

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

Your timely filing guidelines for submitting medical records or dispute submissions should be followed, depending on state requirements.

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 is upheld, you will receive a 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.