Optum Pause and Pay and behavioral health services

Molina Healthcare of Nevada, Inc. partners with Optum to perform prepayment reviews using the medical record, and following the federal and Nevada Medicaid coding and billing guidelines. The documentation is reviewed to validate that it supports the services billed and aligns with coding and billing regulations. They are not medical necessity reviews.

Behavioral health providers may receive medical record requests from Optum on Molina's behalf. It is important to Molina that providers understand how this process will impact them to avoid delays or issues in reimbursement. The claim selection is centered around each individual claim and is impartial toward any specific health care provider.

Optum Pause and Pay process:

- When a claim is selected for review, a medical record notification request letter and Explanation of Payment (EOP) are mailed to the provider's mailing address.
  - Letters include impacted claim(s), an itemized list of required documents and instructions for records submission.
  - EOP will contain Remittance Advice Remark Code (RARC) M127 and the following statement:
    "Optum is requesting medical records on Molina's behalf. The allowed time frame 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**."
  - For the Electronic Remittance Advice (ERA), only the RARC M127 will be visible in the 835 file.
- Medical records must be submitted within 30 calendar days from receipt of notice.
  - If no records are received within 30 calendar days, a reminder letter is sent.
  - If no records are received at 90 days, the claim remains denied. A denial letter is mailed, and the case is closed by Optum.
- When Optum receives the medical records, they are reviewed within 10 business days. The provider, or in the case of a separate biller, is mailed a response letter with the outcome. The letter includes instructions on how to submit a reconsideration should the provider disagree with the findings.
- Reconsiderations are reviewed within 10 business days of receipt, and the provider, or in the case of a separate biller, is mailed a response letter with the outcome. The letter includes the steps to submit a first-level dispute/appeal should the provider disagree with the findings.

Important: Timely filing rules apply when submitting medical records and disputes/appeals.

Behavioral health and Optum Pause and Pay:

Psychotherapy codes and services may be selected for the Optum Pause and Pay review process. Behavioral health providers are encouraged to respond to the medical record request in a timely manner and ensure that all records meet the following requirements to avoid any reimbursement delays or issues.

Documentation requirements include, but are not limited to, the following:

1. Time element: For codes selected based on time, the documentation must include either the start and stop times or the total time as appropriate.
    a. If a separate evaluation and management (E/M) service is also performed during the encounter, the provider must differentiate the time spent on both services. The E/M code level must be selected based on medical decision making (MDM), not selected based on time. The time spent performing E/M services cannot be counted toward the time requirement for psychotherapy services. For more details, refer to the CPT Section guidelines.
2. Treatment plan. Examples include modality, frequency and duration.
3. Clinical notes for each encounter include:
    a. Member's diagnosis, type of service, expectation of improvement in the member's disorder or condition, or maintenance of level of functioning.
    b. Periodic summary of goals, progress toward goals and treatment plan updates.
    c. Detailed summary of the session, including descriptive documentation of therapeutic interventions.
    d. Member's capacity to participate in psychotherapy.
    e. Indication of whether the service was provided in person or via telehealth (must document the mode of telehealth -- audio only or both audio and video). The documentation must support face-to-face service when that modality is utilized.
    f. Signature and credentials of the provider conducting the service.
4. Compliance with incident-to requirements: Services must be an integral part of service to the member's diagnosis or treatment and must be provided under direct physician supervision. For more details, refer to 42 CFR 410.26; **eCFR :: 42 CFR 410.26 — Services and supplies incident to a physician's professional services: Conditions**.
5. For psychotherapy, the providers must bill the appropriate CPT code based on the actual time spent performing the service, whether provided via telehealth or in person.
    a. If telehealth, use the appropriate place of service code indicators and modifiers.

For more information or to respond to a medical record review letter you have received, please contact the **Optum Provider Inquiry Response Team (PIRT)** at **(877) 244-0403**.

MOLINA® HEALTHCARE