Payment Policy: Optum Comprehensive Payment Integrity (CPI)

Reference Number: CPP-136
Product Types: ALL
Effective Date: 07/09/2018
Last Review Date: 10/25/2022

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
The purpose of this policy is to serve as a reference guide for the Optum Comprehensive Payment Integrity system, hereafter referred to as Optum CPI, that performs claim editing on both a pre-pay and post-pay basis as part of Centene's Fraud, Waste, and Abuse (FWA) program. Optum CPI may refer any aberrant billing patterns or behavior that may be potentially fraudulent to the Special Investigations Unit (SIU), which will then pursue an internal investigation.

Application
This policy applies to facility and professional claims.

Policy Description

Code Editing Overview

Centene uses claims editing software programs to assist in determining proper coding for provider claims payment. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative (NCCI) and the National Physician Fee Schedule (NPFS) database, the American Medical Association (AMA), Specialty Society correct coding guidelines, and state-specific regulations.

These software programs may result in claim edits for specific procedure code combinations. These claim edits may also result in adjustments (deny or pay) to the provider's claims payment or a request for review of medical records prior to or post payment. Providers may request reconsideration of any adjustments produced by the claims editing software programs by submitting a timely request to Centene or another contracted third party vendor. A reduction in payment as a result of claim policies and/or processing procedures is not an indication that the service provided is a non-covered service, and thus providers must not bill or collect payment from members for such reductions in payment.

All ICD-10 CM, CPT, HCPCS, and DRG codes are eligible for this claim editing as described.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

Optum CPI System

Optum CPI ensures that claims process and pay accurately. This may result in a claim denial with a request for medical records from the provider or supplier who submitted the claim to support the services submitted on the claim. Providers should submit adequate medical record documentation that supports the services billed within 30 calendar days.

Once medical records are received by Optum, trained coding professionals will examine the documentation to determine if the services billed are supported (or not supported) as submitted. Optum makes a recommendation to pay or deny the claim based upon whether or the records support how the claim is billed (**not whether the services are medically necessary**). The provider's submission of medical records is not a guarantee of payment.

The Optum CPI program reviews claims for improper billing practices, including waste and error, inappropriate use, excessive use, mishandled services, improper or inaccurate billing, and/or other issues that may result in improper payments. Optum CPI will support Centene's contractual and regulatory obligations related to FWA contract language.

Reimbursement

Optum CPI Claims Process

Centene receives notification from Optum indicating which claims are flagged for pre-pay review. Depending on the review type, Optum may or may not require medical records to complete the claim review. If the review requires medical records, Optum sends communication directly to Centene providers.

Centene sends an electronic Explanation of Payment (EOP) to providers with a message indicating the reason codes CPIMR or CPISI. CPIMR indicates a claim has been flagged for medical record review. CPISI indicates a claim has been flagged at the request of Centene's Special Investigation Unit (SIU).

The provider's submission of medical records is not a guarantee of payment. Optum reviews the medical records within 7 business days of receipt and may conclude that the billed code(s) will be denied. Optum will then communicate to the provider the reason(s) for the denial in the Optum initial review findings letter. Centene also sends the denial to the provider via EOP. If Optum does not receive the requested records, Optum will make a determination on the claim based upon the available information which may result in the denial being upheld.

Medical Record Review

Letters

Optum will generate a medical records request (MRR) letter and will send the letter directly to providers. The MRR will include directions on how or where to submit the records.

Optum sends the initial letter to the provider to request medical records. If more than one claim is flagged in a day, the provider will receive one letter with a list of claims.

Providers are expected to respond promptly. If a provider does not respond within 30 days, the provider will receive a follow-up reminder letter.

If records have not been received within 120 calendar days after the initial medical record request, the provider will receive a denial letter indicating records have not been received. If the provider does NOT submit the requested medical records, Optum is not able to make a reasonable determination and the claim will remain denied/upheld. This is referred to as a technical denial. The provider may submit their records for review after receiving this notice.

Upon receipt and review of records, if at least one line on a claim is denied, the provider will receive a denial letter explaining the rationale for the denial and instructions for submitting a first level dispute should the provider disagree.

If the provider submits a dispute, the provider will receive a letter acknowledging the dispute request and a dispute response letter with the outcome. The dispute response letter will provide instructions on how to submit the second level dispute to Centene.

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

Instructions for Providing Required Documentation

The requested information can be provided by one of the methods listed below. Documents should be organized by placing all medical records for a recipient and date of service behind the enclosed barcoded cover sheet on which the recipient's name and the date of service are printed. Note: Secure Internet Upload does not require the cover sheet be included with the documentation submission.

Document submission options include electronically via secured internet upload, US Mail or CD/DVD

1. SECURE INTERNET UPLOAD Using a web browser, go to the following URL: https://sftp.databankimx.com/form/RecordUploadService?ID=0012

2. **HARD COPY** (i.e., paper copy) using one of the following addresses:

By Mail (US Postal Service):	or	By Delivery Services (FedEx, UPS):
OPTUM **P.O. Box 52846** **Philadelphia, PA 19115**		**OPTUM** **458 Pike Road Huntingdon Valley, PA 19006**

3. On a CD/DVD
   a. If submitting files on a CD/DVD, please use the following additional instructions:

i. Each claim must be in an individual file with the first page being the provided bar-coded cover sheet followed by the collection of records for that claim;
ii. Each individual file name must be the claim reference number shown on the enclosed list of claims;
iii. File type for the individual file must be PDF, JPG or GIF;
iv. All individual files should be combined into a single ZIP file on the CD/DVD with a file name in the following format: 364054_ 2365_00005126_21-JUL-18;
v. The CD/DVD contents must be password protected (WinZip 256bit encryption) zip file(s) with the following password (first four characters are uppercase <>and the remaining characters are the provider number): OPTU364054. Please do not password protect each individual file within the ZIP file. Only password protect the single ZIP file.
vi. IMPORTANT NOTE: If the contents of a received CD/DVD are inaccessible, review will not commence until contents are accessible.

Disputes
Providers have dispute rights on all claim denials. For the CPI program, Optum will perform the first level dispute. Second level disputes are handled by Centene. Please refer to your health plan's Quick Reference Guide (QRG) for additional instructions.

Provider Inquiries/Support
Optum's Provider Inquiry Response Team (PIRT) is dedicated specifically to answering questions for this program.

Optum's provider inquiry team is equipped to educate providers on submitting medical records for initial review or if the provider has a dispute question.

The PIRT contact number is 1-844-458-6739. Operational hours are Monday thru Friday 8:00 a.m. to 6:30 p.m. Central Standard Time, excluding holidays.

Definitions

Term	Description
Optum CPI Claims Process	Optum applies a systematic algorithm to identify aberrant (waste and error) billing patterns at the claim line level. Optum may deny and request medical records from the provider or supplier who submitted the claim to support the services submitted on the claim.
Explanation of Payment (EOP)	Informational letter sent to providers that gives details on claims that have been paid, denied, or adjusted. • Reason codes:

Term	Description
	CPIMR/ CPISI - MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Fraud, Waste, and Abuse (FWA)	**Fraud** • Any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee or other person(s). • Fraud also includes knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. **Waste** • The overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program, Medicaid program, or Centene. Waste is generally the misuse of resources. **Abuse** • Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the state or federal government or MCO, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care in a managed care setting, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee. • Abuse also includes enrollee practices that result in unnecessary cost to the state or federal government, MCO, contractor, subcontractor or provider. *For more information about FWA, please refer to the full description given in Centene's provider manual*
Turnaround Time (TAT)	The time interval from the time of submission of a claim to the time of the completion of the adjudication process

Term	Description
Specialized Medical Reviews	Claims reviewed by Board Certified physicians for coding accuracy. Reviewers have a broad and diverse range of clinical expertise to ensure thorough review of medical records and accurate decision making. Optum staff is required to maintain certain certifications/credentials depending upon their role and expertise.

References

1. National Conference of State Legislatures. Medicaid Fraud and Abuse. Retrieved from: https://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx Accessed January 14, 2020.
2. CPP 102 Prepay Review
3. CPP 166-CPI DRG
4. QRG

Revision History	
03/23/2020	Approved by RGC
10/25/2022	Reviewed and converted to Centene policy formatting

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.