# Behavioral Payment Integrity Overview

## General Overview:

Optum is committed to making health care better for everyone. Consumers, providers, and payers are all negatively affected when Fraud, Waste, Abuse, or Error (FWAE) occurs anywhere in the system. Fraud is the result of intentional misrepresentation to gain a benefit. Instances of Waste or Abuse may be unintentional. Waste is unnecessary consumption of heath care resources. Abuse is unsound business practice that results in undue payment. Errors are mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly. Everyone involved in health care can take steps to reduce the cost of fraud, waste, abuse and error.

Optum has a Program and Network Integrity (PNI) team within our organization. This team works with behavioral health providers to identify billing patterns and trends which may require education or modification. Together with providers, Optum is committed to identifying and remediating potential Fraud, Waste, Abuse and Error issues.

### Definition of Fraud, Waste, Abuse and Error

- Fraud is an intentional misrepresentation to gain a benefit
- Waste is any unnecessary consumption of health care resources
- Abuse is unsound business practice that results in undue payment
- Errors are mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly

### Definition of Payment Integrity

Optum proactively drives payment integrity to improve provider relationships and member experience. The solutions transform end-to-end claim processing performance by simplifying the payment system, improving accuracy and reducing costs.

With this holistic approach, we can help:

- Identify and recover inappropriate claim payments and overpayments
- Simplify and reduce the administrative cost of the payment cycle
- Avoid and prevent inappropriate claim payments and overpayments
- Drive out unnecessary and inappropriate medical costs
- Outsource payment cycle services, enabling plans to focus on core competencies

## Audit Overview:

Part of our responsibility is to determine whether the services billed in a claim accurately represent the services provided to the member. We're also responsible for determining whether the charges are payable according to the terms, conditions and exclusions of the member's benefit plan and our reimbursement policies.


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Continue to submit claims online or by mail as you normally do. For each claim submitted, you may receive a letter requesting medical records. Please return all requested information to us within 45 calendar days. If you do not respond as requested, your claim(s) may be denied.

Any request for documentation is used to verify the services billed are recorded in a manner consistent with industry guidelines. In line with HIPAA rules associated with Treatment, Payment and Operations, Progress Notes may be required to complete the audit. Progress notes should include but are not limited to: Medication prescription monitoring (if applicable), functional status, symptoms, session start and stop times, modalities and frequency of treatment furnished, clinical testing results (if applicable) and a summary of the following: diagnosis, treatment plan/goals, prognosis and progress to date.

## Frequently Asked Questions:

- **Why are we requesting medical records?**
  - The claim is being reviewed for accuracy: Once we receive the requested medical records, we'll review the claim with the records for compliance with coding guidelines and to determine whether all charges are properly documented and supported.

- **My previous claims have paid for this provider with no problem, why are you requesting these medical records now?**
  - We periodically review claims to determine whether they are properly payable as billed.

- **I need these services, why does Optum think I don't need them and will not pay unless I send in records?**
  - We request medical records to perform an administrative claim review and determine whether your provider's claims are properly billed and can be paid. This is not a review to determine whether services were medically necessary or appropriate.

- **What about HIPAA and doctor-patient confidentiality? Isn't it against the law to ask for these medical records?**
  - Correct, HIPAA specifically protects psychotherapy notes that are recorded by your clinician that document or analyze the contents of a conversation during your private counseling session. Optum is not requesting those private notes. HIPAA also allows a benefit plan to request, and a provider to supply, medical records for claim reviews and audits.

- **The letter requests so many things, what exactly is needed?**
  - Please refer to the Optum "Behavioral Health Services Documentation Requirements Reimbursement Policy" which can be found on www.providerexpress.com.

- **Has my claim been denied for requesting medical records? Do I need to submit an appeal?**
  - Your claim is on hold until the medical records are received. Please return the requested information to us within 45 days calendar days of the date of the request. Once the medical records are received, we will review for compliance with coding guidelines and to determine whether all charges are properly documented and supported. If you do not respond as requested, your claims may be denied.