Payment Policy: Optum Comprehensive Payment Integrity (CPI)

Reference Number: CC.PP.074
Product Types: ALL
Effective Date: 04/01/2023
Last Review Date: 11/06/2025 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 describe the Optum Comprehensive Payment Integrity system, hereafter referred to as Optum CPI, that performs claim editing on a pre-pay basis as part of Fraud, Waste, and Abuse (FWA) program for health plans affiliated with Centene. 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
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.

Optum CPI ensures that claims process and pay accurately. This may result in a claim denial or pend 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 to the address in the medical record request letter within 30 calendar days. 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 claim being denied. Specific provider contract timeframes may apply.

If 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 the Health Plan to pay or deny or replace the service(s) billed on the claim based upon whether or not the records support how the claim is billed. The Optum CPI program does not make a determination of medical necessity and may deny a claim for services which are not supported by the submitted medical records despite the provider having obtained a prior authorization for the service(s). The provider's submission of medical records is not a guarantee of payment. If payment of the claim line is denied, providers will receive a detailed letter from Optum with the rationale explaining why the services billed were not supported by the medical records.

Code Editing Overview
Health Plans affiliated with Centene use 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 after payment. Providers may request reconsideration of any adjustments produced by the claims editing software programs by submitting a timely request to the vendor on behalf of the Health Plan or another contracted third party vendor. A reduction or denial 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 according to State and/or CMS Guidelines.

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.

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 for the medical record request. CPIMR and explanation code 'bo' indicate a claim has been flagged for medical record coding review. CPISI indicates a claim has been flagged at the request of Centene's Special Investigation Unit (SIU).

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.

Dispute Process:
Providers have dispute rights on all claim denials. 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.

For the CPI program, Optum will perform the first level dispute. Second level disputes are handled by Centene. Should the provider not agree with the outcome of the second level review, please refer to your health plan's Quick Reference Guide (QRG) or Provider Manual for additional instructions on disputing or submitting an Appeal. 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://paymentintegrityportal.optum.com/upload Follow the directions outlined in the MRR for next steps, including the authorization code.

2. HARD COPY (i.e., paper copy) please use the address listed in the medical record request (MRR) **or (FedEx, UPS): OPTUM 458 Pike Road Huntingdon Valley, PA 19006**

3. CD/DVD If submitting files on a CD/DVD, please follow the instructions in the MRR.

4. Important: Always refer to the provider letter for next steps and where to send documentation. The address and location may vary based on state-specific or contracted guidelines.

Record Review

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. Because the process includes a comprehensive review, all billed services will be reviewed for billing accuracy against the medical records. Optum will communicate to the provider the reason(s) for the denial(s) in the Optum initial review findings letter. Centene also sends the denial explanation(s) 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.
The CPI review is a complete holistic review of all services billed by the provider on the claim form and is matched to the documentation in the medical records. The goal is not to medically code provider services, but to ensure the services billed are supported and present in the submitted medical documentation.
The holistic review will consist of a review of the following criteria which must be supported through documentation within the complete medical record (not all encompassing):
• Patient Demographics (name, DOB): Name and DOB match the patient submitted on the claim
• Date(s) of Service: Date of service matches the date of service submitted on the claim.
• Units: Units are supported by the documentation (not in scope for inpatient review)
• Modifiers: Modifiers supported, needed, missing, or etc. (review is dependent upon modifier and scenario) (not in scope for inpatient review)
• CPT Codes: Documentation supports the service billed, and the correct CPT/HCPCS code utilized (not in scope for inpatient review)
• Bundling/Unbundling of Services: Appropriate usage of NCCI edits for bundling/unbundling of procedure (not in scope for inpatient review)
• Place of Service (POS): POS matches the POS documented within the medical record
• Provider Signature/Attestation: Documentation contains an acceptable signature/attestation (not in scope for inpatient review)
• Date of Provider Signature: Documentation includes a signature date, and the date is within 30 days of the date of service.
Additional Inpatient criteria (not all encompassing):
• ICD-10-CM Codes: Documentation supports the DRG billed, and the correct diagnosis code(s) utilized
• ICD-10-PCS Codes: Documentation supports the procedure code(s) billed
• Additional DRG drivers: Documentation supports patient's sex and discharge status
Common reasons for claims to be denied due to incomplete medical records are as follows:

• Submitted or resubmitted records that are incomplete and missing pages, consequently the validity and accuracy of the billed charges cannot be verified.
• Medical records lacking sufficient detail to justify the billed charges such as missing E/M notes, absent treatment information, incomplete documentation for billed units, or missing time records and pages are considered incomplete.
• The absence of documentation for the specific date of service billed.
Please see the additional documentation section below for more types of documentation reviewed in the CPI program.

Additional Information

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.

Please refer to the medical record request (MMR) for information on how to contact PIRT.

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: • CPIMR/ CPISI - MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED • bo - DENY: MEDICAL RECORDS AND/OR OTHER SERVICE DOCUMENTATION REQUIRED
Turnaround Time (TAT) Dispute	The time interval from the time of submission of a claim to the time of the completion of the adjudication process General term used to describe reconsiderations and appeals. Please follow plan Quick Reference Guide (QRG) or provider manual for specific instructions, to include dispute timely filing guidelines, as applicable.

Types of medical records Optum CPI may require include, but are not limited to:

- Activities of daily living (ADL) sheet, including flow sheets and/or logs
- Admission assessments
- Anesthesia records (including time of anesthesia administration)
- Case management notes
- Change of therapy (COT) assessment
- Chat logs
- Chemotherapy orders
- Clinical trial information, including consents and treatment plans
- Consultation notes
- Diagnosis notes, including past medical history
- Discharge/transfer summaries
- Drawings and photos, when applicable
- Emergency department reports
- Evaluations: any evaluation related to the service provided
- Face sheets
- Face-to-face encounter documentation
- For durable medical equipment/home infusion/home health: delivery receipts or proof of delivery for supplies or drugs
- For inpatient rehabilitation: patient assessment instrument (PAI)
- For skilled nursing facilities: minimum data set (MDS)
- Hospice/end-of-life-care documentation
- Implant detail: sticker sheet and copies of invoices for implants or high cost drugs; implant logs with additional information on implants, screws and plates
- Laboratory and pathology reviews: Clinical reviews of pathology claims often require additional information to make determinations. Medical records from the ordering physician, as well as the requisition form and lab results, are necessary to complete a full and fair review of the pathology claim. Please note that this documentation will be requested from the entity that submitted the pathology claim.
- Laboratory reports and X-rays from ordering physician, along with written interpretations of X-rays, tests and/or laboratory results
- Medication records/medication administration records (MAR), including strength, National Drug Code (NDC) and waste, mixing logs, infusion medication sheet and transfusion/infusion logs
- Nurse or any other healthcare provider's progress, treatment, SOAP (subjective, objective, assessment, plan) notes, dietary notes and daily notes
- Obstetric/newborn services
- Operating reports and records
- Operative reports
- Patient history
- Physical exam
- Physician office records: complete records, including office visit documentation, demographic/face sheet, patient history, laboratory and procedure results and all correspondence with healthcare providers, including consultation requests and reports
- Physician orders

• Plans of care (POC), treatment plans (tried and failed conservative treatments) and any related evaluations and updates or recertifications for the time period during which the patient was treated. The POC and recertifications should be signed by a qualified healthcare provider.
• Preanesthetic evaluation
• Preoperative and postoperative notes
• Prescriptions
• Progress notes
• Psychiatric evaluation notes
• Physician query (if applicable): If the facility's coder requests additional information from the physician for clarification on documentation, he or she would submit a query to the physician.
• Skilled nursing, physical therapy, occupational therapy, speech therapy, respiratory therapy and medical social worker (MSW) documentation, including notes and therapy logs that detail the number of minutes each service was provided
• Test orders/results/reports including, but not limited to, pathology, radiology and laboratory (include results, when applicable)
• The Outcome and Assessment Information Set (OASIS) for home health claims, completed in its entirety. All six digits of the diagnosis code must exactly match between POC, OASIS and the claim. Any correction must be applied by the end of the episode. Fields cannot contain N/A, OASIS. Fields M2200 and M0110 cannot be blank or contain N/A.
• Toxicology reports
• Treatment notes
• Uniform billing form (UB-04)/Health Care Finance Administration Form (HCFA 1500)
• Wound care assessment

References

1. CC.PP.011, Payment Policy: Code Editing Overview

Revision History	
03/03/2020	Approved by RCG
10/25/2022	Reviewed and converted to Centene policy formatting
09/04/2024	Reviewed and combined with CPP-136 for increased transparency; Policy CPP-136 retired
11/07/2024	Updated policy formatting; Added CMS NCCI Policy Manual as reference.
03/12/2025	Reviewed and combined with CPP-136 for increased transparency, Policy CPP-136 retired and Medical Record Types added for increased transparency
11/06/2025	Annual Review completed; Validated policy content, references and links; Added revision date. Minor verbiage changes to bullet 14 under Record Review for clarity. In addition, the secure internet upload link has been updated to https://paymentintegrityportal.optum.com/upload.

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.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

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