Questions from Provider Training, 11/16/15, 1:00-2:30pm CST

<table>
<tr><th>Question</th><th>Response</th></tr>
<tr><td>1. Can we now bill same day services with the same provider but different CPT codes?</td><td>If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Regarding two different providers/same group/same specialty:

Q: If a patient is seen for more than one E/M or other medical service on a single date of service, and each service is performed by a physician with a different specialty designation, but in the same group practice, would each E/M or other medical service be separately reimbursable?

A: Yes. An E/M or other medical service provided on the same date by different physicians who are in a group practice but who have different specialty designations are separately reimbursable. No modifier is needed. The Same Day/Same Service policy applies when multiple E/M or other medical services are reported by physicians in the same group and specialty on the same date of service. In that case, only one E/M is separately reimbursable, unless the second service is for an unrelated problem and reported with modifier 25. This would not apply when one of the E/M services is a “per day” code.

(reference: CMS)</td></tr>
<tr><td>2. What is the timely filing for denials and appeals?</td><td>TBD; Response is forthcoming.</td></tr>
<tr><td>3. What is the timely filing for corrected claims and appeals?</td><td>The timeframe in which a participating provider can file a corrected claim is 365 day from date of service.</td></tr>
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4. Do the same rules apply for Optum as they do UHC for submitting a corrected claim? In other words, how should a corrected claim be submitted?	CMS 1500 – Box 19 must have "corrected claim" stamped and Box 22 should include the original claim # if available (found on the remit) UB – Bill Type 7 must be used to indicate correction of previous claim. Bill type 8 is used for adjustment. Provider express – refer to https://www.providerexpress.com/content/ope-provexpr/us/en/training.html for instructions.
5. What number do we use when billing: the 13 digit MCAID Number or the 9 digit UHC number on the card? (related Q: When entering guarantor information into our billing programs (for ex, we use claim track), do we use Medicaid or UHC number?)	The member ID on the member's card is preferable. However, if the member's card is unavailable, the Medicaid number can be used in those circumstances.
6. How to bill psychiatric consults in the emergency room?	Code 90791: Psychiatric Diagnostic Evaluation
7. If the member is on the medicine floor will a psychiatric inpatient consult, MRIs and cat scans require a separate authorization?	A psychiatric consultation will not require authorization.
8. Retro Medicaid Eligibility Members – Currently we service patient's that qualify for indigent care. A Medicaid application is taken and if they qualify for Medicaid we can submit those charges to Medicaid or Magellan. How can the hospital UM Department submit a request for a retro authorization for the inpatient services to Optum?	The Appeals and Grievances team takes retro requests: UnitedHealthcare Community Plan, Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364 Fax: 801-994-1082
9. We only provide PSR and CPST to children, so the LOCUS/ Independent Assessment does not apply to our clients. I assume we will just do our regular Assessment as we normally do, develop our treatment plan with the family, and then begin providing services ….without having to send or fax anything to United. Is that correct?	Yes, that is correct.

10. Can you explain more about the printed queries for controlled substances? Does this apply to children/adolescents? I f so, what is name of website we need to print queries from.	This applies only to prescribers. This program has been in place since 2006. It is a state program, so provider should review the state information since we do not manage the program. We only monitor charts for compliance with the process. Website is https://www.labppmp.com/Login.aspx?ReturnUrl=%2fdefault.aspx FAQs: http://www.pharmacy.la.gov/index.cfm?md=pagebuilder&tmp=home&pid=60
11. On the webinar, it indicated where to send PA's, but it does not indicate where assessments and LOCUS sheets should be submitted. Is there a fax number and/or option for online submission?	We do not yet have information on the RMO (system for submitting/tracking assessments), but it will be posted soon.
12. Can you elaborate on the requirement to coordinate services with treating medical providers (non-mental health)…..does this mean that we only need to collaborate with medical providers if the child is receiving treatment for a medical problem? Or are we required to show collaboration with assigned PCP even if child is not being treated for any medical illnesses?	Per the manual, we do expect (require) coordination of care to occur with other treating providers and document it in the record (or the member refusal to allow coordination of care to happen). If there are other treating providers, coordination of care should occur. The frequency of coordination of care will be guided by each case.
13. How will we know when EFT approved? I faxed over the application b/c I could not get the online application to submit properly.	Please refer to www.unitedhealthcareonline.com for information on EPS. A direct link is here: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/News/EPS_Community_Plan_Announcement.pdf