Optum

Provider Claims Intake (PCI) Process

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Optum Behavioral Health Process Update

Escalated Provider Claims Projects

Optum is committed to reviewing current processes and making improvements

To make it easier for participating providers to work with us, we are making the following changes to enhance the escalated provider claims project process for providers by:

1. **Standardizing** processes to enhance the quality of our outcomes and resolutions
2. **Reducing** rework and time it takes to identify and correct claims processed incorrectly
3. **Fast Tracking** escalated claims projects to our internal Claims Team
4. **Decreasing** patient confusion on what the financial out-of-pocket responsibility is
5. **Identifying** opportunities to educate providers on billing requirements to avoid claims issues in the future

How will this positively impact providers?

- An improved process for submitting Escalated Claims Projects to your Provider Relations Advocate (PRA)
- Real time tracking of where your Escalated Claims Project is in the process
- A reduction in claims project delays and a root cause analysis and solution to eliminate similar issues in the future
- Improved quality and accuracy and a reduction in turn-around-time to correct claims and identify billing requirements for claims to process correctly

Alongside this improvement we encourage providers to continue following the Claims Resolution and Dispute processes currently in the National Provider Manual and Provider Agreements: Optum Behavioral Health Solutions National Network Manual (providerexpress.com)

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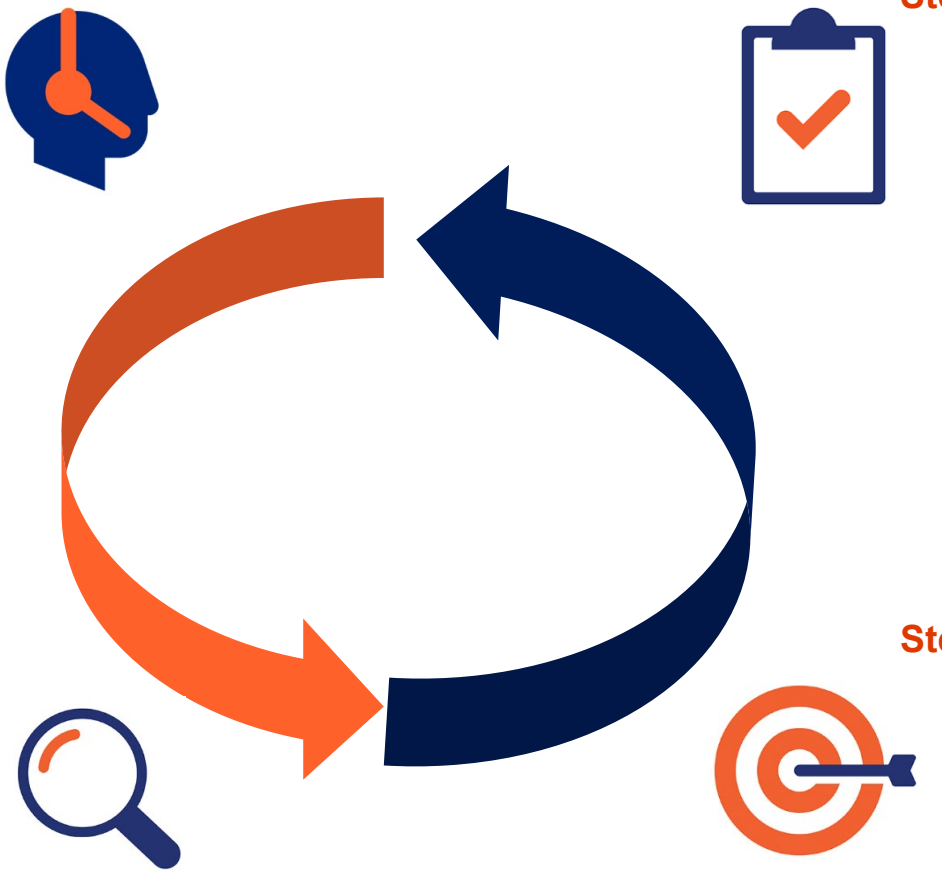
High-Level View of Improved Process to Submit Escalated Projects to Provider Claims Intake:

Step 1

- Provider emails or calls Provider Advocate (PRA) with escalated claims concern.
- PRA will supply the PCI Checklist and include the email address to submit the completed PCI checklist to.
- Provider can also submit the PCI checklist directly to their regional PCI inbox.

Step 2

- PCI team receives completed Pre-Submission Checklist and Required Claims Data Spreadsheet.
- PCI team verifies Checklist and Claim Issue Spreadsheet template are accurate and complete.
- Claims project is submitted generating a Claim ticket number which will be emailed back to the provider.



Step 3

- Claims processor will complete root cause analysis to determine if claims are processing incorrectly.
- Claims processor will review provider billing requirements which includes state specific mandates.
- Claims processor will submit appropriate claims for payment consideration.

Step 4

- PCI team communicates resolution summary to provider.
- Provider reviews spreadsheet and can request a meeting with the Claims team to dispute, if applicable through their PRA.

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How Do I Start The Process?

Upon receipt of an Escalated Claims Issue from the provider to the PRA, the PRA will email the provider a template that has two tabs:

- Provider Checklist
- Claims Issue Spreadsheet

If Provider has submitted a claims Reconsideration and/or contacted the Provider Service Line (PSL), please notate this on the Pre-Submission Checklist.

	Investigation Questions	Response
Question 1	State of service	
Question 2	Have you previously notified us of this claim dispute? How did you notify us? (Reconsideration? Appeal? Inquiry via Provider Express or Provider Service line?)	
Question 3	What was the date of previous notification?	

Example of Email Provider receives from a Provider Advocate:

Along with sending out the spreadsheet, PRAs will attach the following correspondence in the email attachments. This directs the provider to send the spreadsheet to the regional PCI inbox.

Dear Provider,

Thank you for contacting your Optum Provider Advocate regarding a claims dispute. Please insure you have submitted your request for claims review to one of the following self-service tools prior to an advocate review.

By mail:

Complete a reconsideration request form to outline the reason you disagree with our decision.

Then mail the form and supporting documentation to:

Optum Behavioral Health Solutions
P.O. Box 30757
Salt Lake City, UT 84123

Online via the *Provider Express* secure portal:

1. Go to **Providerexpress.com** and click Log In (located in the upper right corner). Then, sign in to the secure portal with your One Healthcare ID and password.
2. In the secure portal, click Appeals, then click Appeals Summary & Submission
3. In the Appeals Submission section of the page, select Submit Claim Appeal to start the process. Be sure to include:
   - The factual or legal basis for appeal
   - Any additional information, clinical records or documentation that will help in the review of your request

Provider Services Customer Service Line:
877-614-0484

Optum Provider Express:

https:www.providerexpress.com

If you have completed submission to one of the above self-service tools and would like to request an additional review by an Optum analyst, please complete the attached Provider Claims Intake Checklist and Claims submission template and submit to the PCI inbox.

Example of the Pre-Submission Checklist:

In order to expedite a resolution to claim issues it is critical that the questions below are answered thoroughly. Please note failure to do so may cause delay in the expediting of resolution.

Please verify member eligibility and outreach directly to the following Payers for the following lines of business: UMR, All Savers, Golden Rule, Surest, Student Services, GEHA

	Investigation Questions	Response	Specific Details
Question 1	State of service		
Question 2	Have you previously notified us of this claim dispute? How did you notify us? (Reconsideration? Appeal? Inquiry via Provider Express or Provider Service line?)		
Question 3	What was the date of previous notification?	*Please include first notification of dispute to Optum*	
Question 4	Please supply a provider's name (or other contact name) and phone number in the event additional outreach to obtain more information is required. Enter the contact name and phone number in column "D".		
Question 5	What is the approximate date the issue began? Indicate the date in column "D".		
Question 6	Does the issue continue to impact current dates of service? Select "Yes" or "No" in column "C".		
Question 7	Is the issue impacting a single provider, multiple providers or an entire group? Select the appropriate response in column "C".		

PLEASE BE ADVISED: ALL ABOVE QUESTIONS MUST BE ANSWERED. INCOMPLETE CHECKLISTS WILL BE RETURNED AND MUST BE RESUBMITTED WITH ALL REQUIRED FIELDS COMPLETE.

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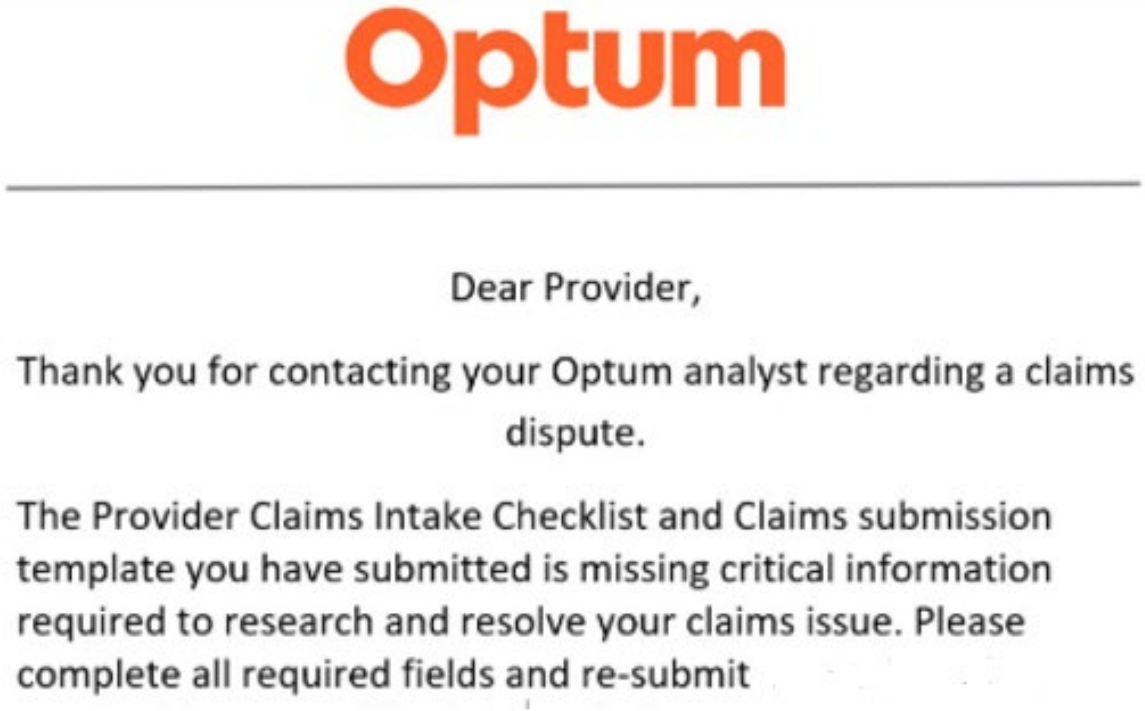
Example of the Required Claims Data Spreadsheet:

PROVIDER – All below fields are required, please see columns A-U.									
State of Service (Example: TX)	Line of Business	Claim ID	Member ID	Subscriber ID (if different from column D)	Member Last Name	Member First Name	Member DOB	Provider Tax ID	Group/Facility Name

Incomplete or Inaccurate Submissions:

If information is missing from the spreadsheet, the Provider Claims Intake Team will email the provider the following:

Example of Email:



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Dear Provider,

Thank you for contacting your Optum analyst regarding a claims dispute.

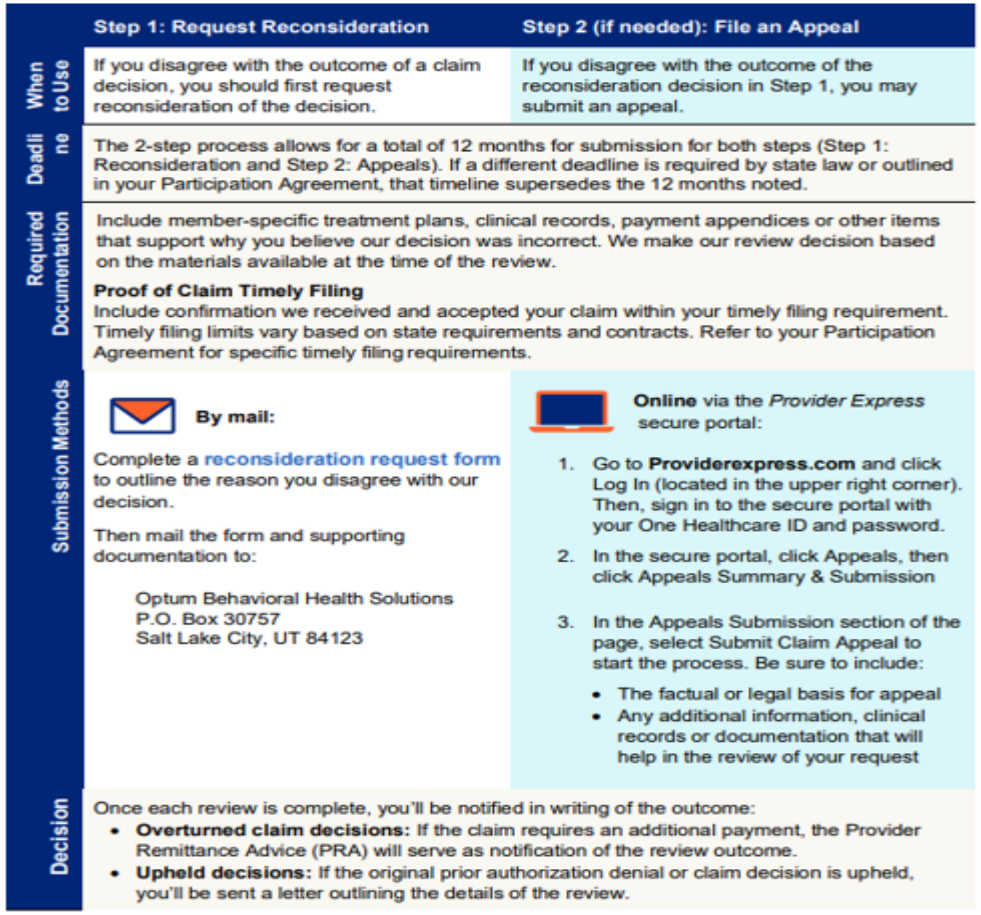
The Provider Claims Intake Checklist and Claims submission template you have submitted is missing critical information required to research and resolve your claims issue. Please complete all required fields and re-submit

Completed Claims Projects:

- Upon completion of the project, if corrections have been made, the provider will receive an outbound email with a spreadsheet attached, which will include detailed information on the outcome of each line item. This email will go to the address that was noted on the incoming email, used to submit the claim issues.
- The project will need to be reviewed in a timely fashion, by the provider's revenue cycle team.
  - Optum will be adhering to timely filing rules outlined in the provider's agreement. (It is imperative that review is completed timely to ensure that the contractual dispute process is followed).
  - Claim analysts will do a systemic sweep and may correct more claims then were original submitted.
- If there are questions or the provider believes the claims project review is not accurate, the Provider may contact their PRA to request a virtual meeting with the claims analyst that worked the project. At this time there will be a mutual conversation on the outcome of any claim in question. (Optum/UHC claims only)
- If the provider and the Claims team both agree that there was an error made in the claims process, the processor may take the claim back for reconsideration at that time.

Dispute Process

Along with the outbound spreadsheet upon completion, the provider will receive a link to the Network Manual Dispute Process for further insight and education.



	Step 1: Request Reconsideration	Step 2 (if needed): File an Appeal
When to Use	If you disagree with the outcome of a claim decision, you should first request reconsideration of the decision.	If you disagree with the outcome of the reconsideration decision in Step 1, you may submit an appeal.
Deadline	The 2-step process allows for a total of 12 months for submission for both steps (Step 1: Reconsideration and Step 2: Appeals). If a different deadline is required by state law or outlined in your Participation Agreement, that timeline supersedes the 12 months noted.	
Required Documentation	Include member-specific treatment plans, clinical records, payment appendices or other items that support why you believe our decision was incorrect. We make our review decision based on the materials available at the time of the review. **Proof of Claim Timely Filing** Include confirmation we received and accepted your claim within your timely filing requirement. Timely filing limits vary based on state requirements and contracts. Refer to your Participation Agreement for specific timely filing requirements.	
Submission Methods	**By mail:** Complete a reconsideration request form to outline the reason you disagree with our decision. Then mail the form and supporting documentation to: Optum Behavioral Health Solutions P.O. Box 30757 Salt Lake City, UT 84123	**Online** via the *Provider Express* secure portal: 1. Go to **Providerexpress.com** and click Log In (located in the upper right corner). Then, sign in to the secure portal with your One Healthcare ID and password. 2. In the secure portal, click Appeals, then click Appeals Summary & Submission 3. In the Appeals Submission section of the page, select Submit Claim Appeal to start the process. Be sure to include: • The factual or legal basis for appeal • Any additional information, clinical records or documentation that will help in the review of your request
Decision	Once each review is complete, you'll be notified in writing of the outcome: • **Overturned claim decisions:** If the claim requires an additional payment, the Provider Remittance Advice (PRA) will serve as notification of the review outcome. • **Upheld decisions:** If the original prior authorization denial or claim decision is upheld, you'll be sent a letter outlining the details of the review.	

**The reconsideration and appeal process applies to claim submissions for Commercial and Medicare Advantage benefit plans for dates of services July 5, 2023 or later. Your state rules and regulations, as well as the member's benefit plan, will govern whether reconsideration of claims decisions is available or whether claims decisions are to be resolved solely through the appeals process. The terms and conditions of your participation in a network administered by United Behavioral Health or its Affiliates and your reimbursement for covered services are determined by your Participation Agreement or the member's benefit plan. Should any item listed in this section conflict with your Participation Agreement or the member's benefit plan, the terms of your Participation Agreement or the member's benefit plan will control.*

Q&A