Optum

Provider Claims Intake Process (PCI)

Provider Relations (Northeast) 2025

Agenda

1. Introduction to Optum
2. Provider Claims Intake Process (PCI)

Optum

Introduction to Optum /Rhode Island Health Plan Partners

Who is Optum?

Optum is a leading health services organization dedicated to making the system work better for everyone

Our core values: **Integrity** • **Compassion** • **Inclusion** • **Relationships** • **Innovation** • **Performance**

What is PCI and what are the benefits?

Provider Claims Intake Process (PCI) is an effort to streamline communications with your Provider Relations Advocate and expedite the resolution of claim disputes.

- Benefit provider with faster turnaround times for claim disputes
- Improve root cause research and solutioning
- The ability for providers to speak directly to a claim's analyst

When will PCI Start?

The change will begin immediately, starting with providers familiarizing themselves with the use of the spreadsheet. Once the PCI email is established for the Northeast team, the Provider Relations team will instruct providers to submit their spreadsheets directly to the PCI email. This rollout is anticipated to begin in May 2025.

Fun Fact:

Guess what? Most of you amazing providers are already rocking those spreadsheets and sharing them with your Provider Relations team. 🎉

Completing the Claim Issue Submission Spreadsheet

Step 1: You will receive a claim issue spreadsheet from your Advocate or another Optum representative.

Step 2: The provider or provider biller should complete the PCI Spreadsheet with all required information.

Tab 1: Pre-Submission Checklist:

- Answer the 7 questions about your practice and the claim issues you are experiencing to the best of your knowledge.
- Use the "Specific Details" section to document extensive information about the issue.

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.			

Completing the Claim Issue Submission Spreadsheet

Tab 2: Required Claims Data

- Complete fields A-U as directed on the spreadsheet.
- **Field T**: Provide a description of the issue you are experiencing and/or why you believe the claim was not processed correctly.
- **Field U**: Detail any actions taken to date, such as calls to the Provider Service line, reference numbers, etc.
- Leave no blank spaces
  - **Note:** Revenue codes are used by facilities (hospitals).
  - Provide 3-5 examples for each line of business (Medicaid, Commercial, or Medicare, if applicable).
  - PDF EOB/Remits can be included as backup information for claims review (optional).

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
PROVIDER – All below fields are required, please see columns A-U.																				
State of Service (Example: TX)	Line of Business	UHC/Optum Claim ID	Member ID	UHC/Optum Subscriber ID (if different from column D)	Member Last Name	Member First Name	Member DOB	Provider Tax ID	Practitioner Name	Practitioner NPI	DOS	Revenue Code(s)	HCPC/CPT Code(s)	Submitted Charge Amount	Amount Paid	Total Amount Provider Believes Owed	Variance (Difference between columns O and N)	Denial on UHC/UBH Remit	Provider Comments/Reason why this claim was processed incorrectly	Provider Action Taken To Date
																	$0.00			
																	$0.00			

Completing the Claim Issue Submission Spreadsheet

Step 3: The provider or provider biller should send the completed spreadsheet to the PCI email providerclaimanalysis_newengland@optum.com

Step 4: If the spreadsheet is accepted (all fields are confirmed correct), the provider will receive an email confirming acceptance and providing the ticket number.

Step 5: Providers should save their ticket number for future reference in case they have any questions about their claim submission. Please include your ticket # when requesting a status update

Information: If the spreadsheet is not accepted, the provider or provider biller will be notified of the reasons for rejection and the specific fields that need correction. They should then update the spreadsheet accordingly and resubmit it with the corrected information.

Note: Please allow approximately 30 business days for review.

Helpful Hints:

Verify Spreadsheet Completion:

- Ensure all 7 questions on Tab 1 are answered.
- Confirm all fields on Tab 2 are filled with the required information.
- Leave no blank fields or blank lines between members

Email Submission:

- Include all stakeholders in your email who should receive the ticket number, this includes, revenue cycle team, billers, providers, etc.
- The PCI team will reply to all and share the ticket number with everyone included in your email.

Issue Examples:

- Provide 3-5 examples of each issue you are experiencing (examples only).
- A fully compiled list of claims is not necessary.

Disputed Claims:

- If you disagree with the outcome of your claims, inform your Provider Relations Advocate (PRA).
- Your PRA will document your concerns and discuss with the claims team to determine if the ticket should be reopened for further review or set up a meeting with a claims representative

Frequently Asked Questions:

Q. What if I receive a response that the claims I submitted are out of scope for the project?

A. UMR, All Savers, Golden Rule, Surest, Student Services, GEHA are third party vendors. Please refer to the member's card when determining if the claims should be analyzed by Optum.

Q. How can I obtain a list of my claim denials?

A. You can pull a list of claims back two years through your providerexpress.com secure portal and export to Excel. Please utilize this report by copying and pasting to complete the claims data tab on your PCI Checklist and Claim Submission template.

Q. Where is your network manual located which discusses the claims dispute process?

A. Optum Behavioral Health Solutions Network Manual March 2025

Q. How do I file a claim reconsideration on Provider Express?

A. Provider Express Training

Thank You