Optum | United Healthcare Community Plan

Wisconsin Provider Services Overview

Optum Provider Services

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Today's Agenda

1. Welcome
2. Claim Submission and Follow Up
3. Telemental Health
4. Website Resources
5. Provider Advocate Information

Claim Submission and Follow Up

Claims Submission Option 1

Online

Entry through UHC Provider website

- uhcprovider.com
- Submitting claims closely mirrors the process of manually completing a Form 1500.

  You must have a registered One Healthcare ID and password to gain access to the online claim submission function. To obtain a One Healthcare user ID, register online in upper right-hand corner or call 1-866-842-3278.

Entry through Provider Express

- Providerexpress.com
- Create a login in the upper right-hand corner
- The same One Healthcare ID you would use through the UHC portal on UHCprovider.com can be used for Providerexpress.com.

Claims Submission Option 2

EDI / Electronic submission

- Electronic Data Interchange (EDI)
- Electronic Claims Payer ID: 87726
- You may use any clearinghouse vendor to submit claims
- Additional information regarding EDI is available on our websites:

uhcprovider.com/en/resource-library/edi/edi-benefits.html

uhcprovider.com

Providerexpress.com

Claims Submission Option 3

U.S. Mail

There are several different Optum mailing addresses depending upon the Member's benefit plan. Find out where to submit your claim.

Please note: Claims submitted online or via EDI do not require a claim mailing address and typically result in faster processing

Reminders

Providers must bill on the appropriate claim form

- HCFA-1500: Used for CPT/HCPCS Codes
- UB-04: Used for Revenue Codes and/or Revenue + HCPCS Code combinations.

Providers must refer to their Fee Schedule/Payment Appendix for the appropriate codes/modifiers.

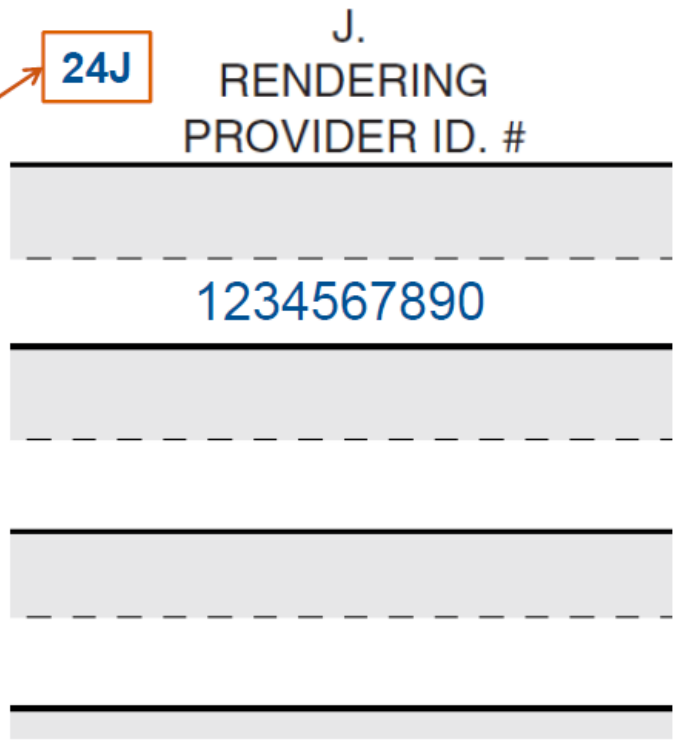
Providers are responsible to obtain Prior Authorizations for applicable services.

- As authorization requirements can vary by Member benefit plan and type of service, it is always important to verify when a preauthorization is required before those services are provided.
- We make it easy to verify what services need an authorization through our online tools on Provider Express.
- Hint: Start by looking up the Member's eligibility and benefits to see what services require an authorization. Check out our short video on Member Eligibility & Benefits

Placement of NPI Number on Form 1500

Behavioral Health Providers - The Rendering Clinician NPI, if a Licensed Clinician, should be placed in 24J.

Box 24J
In the **non-shaded field**, enter the **registered NPI number** (Rendering Clinician NPI, if a Licensed Clinician).



Placement of Billing vs Rendering Clinician Name on Form 1500

Box 31

- Enter the rendering provider's name and date
  - Provider should be registered under the NPI submitted in 24J
- If individual provider, name needs to match exactly with the name that is registered with NPPES (NPI Registry) and IME.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)

SIGNED *John Doe, MD* DATE 10/24/13

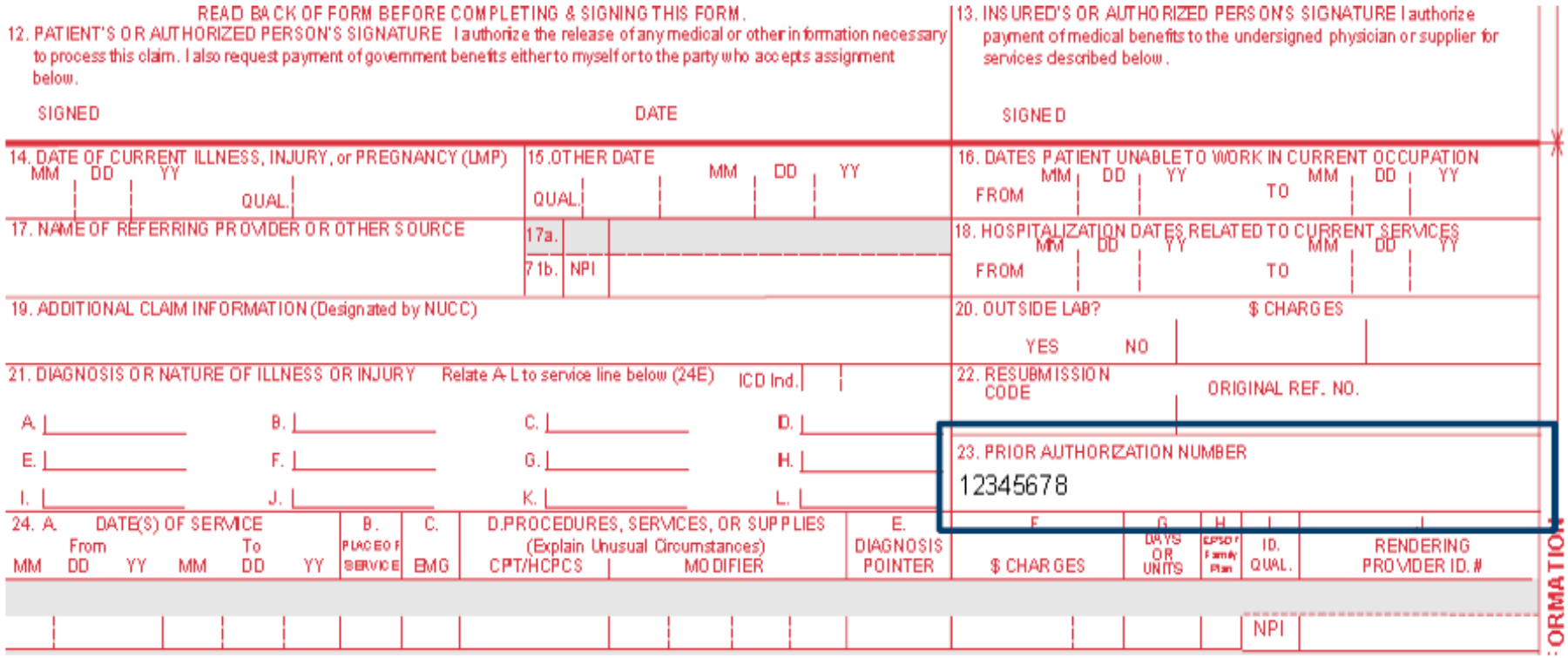
Placement of Billing Group/Agency on Form 1500

Box 33 - Provider/Group/BH Agency name, address and phone number

Box 33a - Provider/Group/BH Agency NPPES - registered NPI number

Prior Authorization Number Needed on Form 1500

Include the prior authorization number in box 23 of the CMS 1500 claim form. If you forget, our claim system will match the prior authorization number that's on file.


READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

12345678

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	RENDERING PROVIDER ID. #
										NPI	

FORMATION

Billing Requirements for both Electronic and Paper Claims

On all claims:

If the billing NPI number(33a) equals the Rendering NPI number, it's ok to leave out the rendering NPI in box 24J blank. If the billing NPI number does NOT equal the rendering NPI number, then you would need to submit a rendering clinician in box 24J, or if billing electronically, loop 2310B.

UnitedHealthcare/Optum follows NCCI edits:

For NCCI edits on which services are allowed only one per day, or cannot be billed with another service, or need an unbundling modifier, please refer to:

cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

NPI and Taxonomy Requirements for Medicaid Claims

Incorrectly billed claims are subject to denial

Applies to both **Billing and Rendering** NPIs submitted on claim on file.

Information submitted must match the current provider enrollment information with ForwardHealth:

- **National Provider Identifier (NPI)**
- **Taxonomy Code**
- **Address Information**

NPI and Taxonomy Requirements for Medicaid Claims (continued)

If the information you submit on your claim doesn't match what you have on file with ForwardHealth, we'll deny the claim. If this happens, you'll have the opportunity to correct your information and submit the corrected claim as needed.

Reminder: All NPIs and Taxonomy on the claim (Billing and Rendering) must be registered with ForwardHealth to bill and be paid for Medicaid Services

Click Here for more information on these requirements

Top Denial Patterns

Not Contracted

If a Medicaid claim is submitted without the required modifiers, the claim will deny as not contracted. If you are a contracted provider and receive this denial, verify that you have submitted the required modifier(s) and submit a corrected claim as needed.

Duplicate Claims

Please note that the average claim turnaround time is 30 business days for claims that need adjusted. This time can vary depending on the volume of the claims being reviewed. It is critical to allow initial claim submissions to fully process before attempting to resubmit. If you bill claims that are still in process, this can potentially cause delays in your claim processing due to volume.

Note: Corrected claims that are not correctly marked as corrected may deny as duplicate and would require resubmission to allow payment.

Billing Limitations and Common Codes

Some services may not be billed on the same day as other covered services and most codes have a daily or annual limit to the amount of services that may be provided.

Example:

- **Max Frequency Per Day Policy**: The maximum allowed amount of units for individual services.
- **CCI Editing Policy**: Services that will not be reimbursed if billed on the same day by the same health care provider.

Codes may also have maximum unit, age or gender limits that flag a claim for additional review.

Maximum Frequency Per Day Reimbursement Policy found on Provider Express.

Billing Tips

Claim Billing Tips for WI Medicaid flyer

Ensure the codes you are billing are covered and check for any prior authorization requirements

Attach the correct modifiers

Check the Member's eligibility prior to billing

Provide clear definition as to why you are disputing a claim

The Provider Service Line (PSL) should be your first point of contact

Always ensure you obtain a reference number from the PSL line prior to escalating to your Advocate

Housekeeping Reminders

- Clean claims are considered claims that were billed correctly the first time
- The Member cannot be balance billed for behavioral services covered under the contractual agreement
- **The Provider is responsible to verify member eligibility**
- UnitedHealthcare follows the CMS National Correct Coding Initiative
- (NCCI edits/methodologies) when processing claims
- Reimbursement policy guidelines: providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/reimbursement-policies.html

Submitting Corrected Claims

HCFA-1500

Providers have **90** days from the date of service to submit claims(original claim submission).
Providers have **365** days from the remit date to submit a corrected claim.

- Corrected HCFA-1500 claims can be submitted electronically by entering Frequency code 7 in Loop 2300 Segment CLM05-3
- Corrected HCFA-1500 claims can be submitted on paper, with “Corrected” on the top of the claim form and the previous claim number located in box 22 of the HCFA-1500

Corrected claims can also be submitted through the UHC Provider portal and through Provider Express.

Claim Disputes – ALL PRODUCTS

- First Level Dispute – Reconsideration
- Second Level Dispute - Formal Appeal
- Last Level – Arbitration via American Arbitration Association

Please note: your Advocate cannot override the “Claim Dispute” process

This (the appeals/claim dispute) team is an impartial team of clinical providers who review medical necessity to reconsider your claims. The only time an administrative denial is looked at would be because of timely filing, otherwise all other appeals (claim disputes) are looked at from a medical necessity perspective. Your Advocate does not have the expertise to make that clinical decision.

Claims and appeals resources

- Claim Inquiries & Claim Adjustments
- Online Appeal Submission

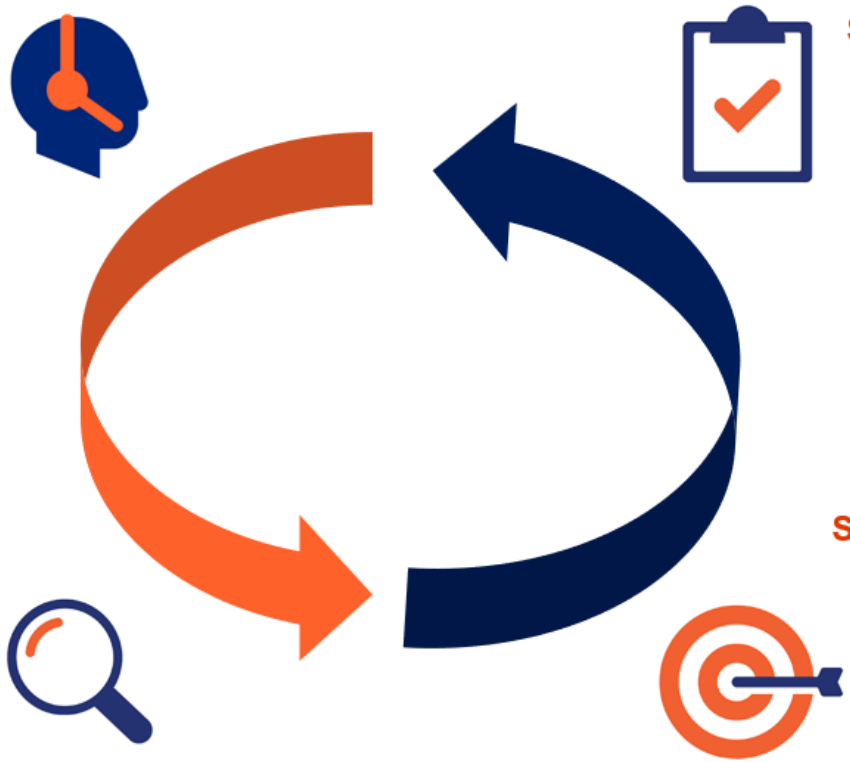
Requesting Escalated Provider Claims Projects-High Level Overview

Step 1

- Provider emails or calls Provider Advocate (PRA) with escalated claims concern.
- PRA will supply the PCI Checklist which includes the email address to submit the completed PCI checklist to.

Step 2

- PCI team receives completed Pre-Submission Checklist and Required Claims Data Spreadsheet.
- PCI team immediately verifies Checklist and Claim Issue Spreadsheet template are accurate and complete.
- Claims project entered 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, if applicable through their PRA.

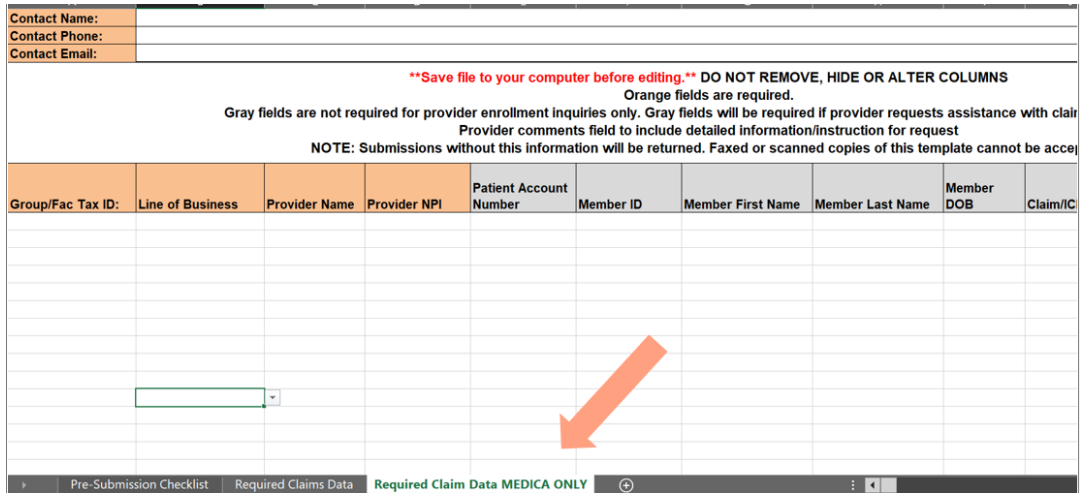
Escalated Provider Claims Projects: Starting The Process

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:

1. Provider Checklist
2. Claims Issue Spreadsheet

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

Example of the Required Claims Data Spreadsheet:



Contact Name:	
Contact Phone:	
Contact Email:	

Save file to your computer before editing. DO NOT REMOVE, HIDE OR ALTER COLUMNS
Orange fields are required.
Gray fields are not required for provider enrollment inquiries only. Gray fields will be required if provider requests assistance with clai
Provider comments field to include detailed information/instruction for request
NOTE: Submissions without this information will be returned. Faxed or scanned copies of this template cannot be acce

Group/Fac Tax ID:	Line of Business	Provider Name	Provider NPI	Patient Account Number	Member ID	Member First Name	Member Last Name	Member DOB	Claim/IC

- **Note: Separate tab for MEDICA Claims, if applicable, that will be sent directly to MEDICA Claims Team**
- **Incomplete or Inaccurate Submissions will be returned**

Optum

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 to the following email address: **providerclaimanalysis@optum.com**

Completed Escalated Claims Projects:

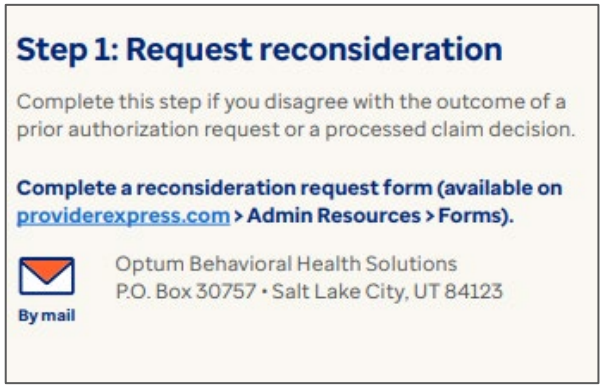
- Upon completion of the project, the provider will receive an outbound email with a spreadsheet attached, which will include detailed information on the outcome of each line item. This email will go to the address that was noted on the incoming email, used to submit the claim issues.
- The project will 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 in a timely fashion to ensure that the contractual dispute process is followed).
  - The outbound spreadsheet will have a comprehensive denial reason for each line item and not a generic denial, to assist providers in working their A/R.
  - Providers will no longer have to call in or request claims assistance if there are questions on the meaning of the standard denial codes on remits. This will now be included on the spreadsheet.
- If there are questions or the provider believes the claims project review is not accurate, the Provider contacts 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.
- 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.

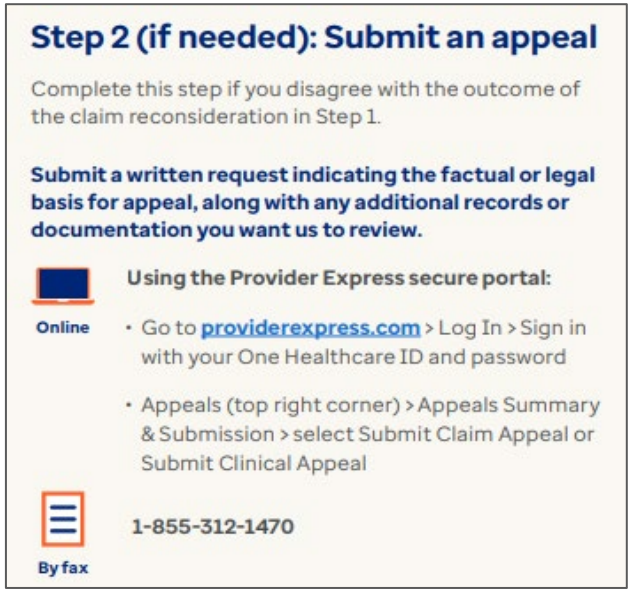
Reconsideration and appeal process: Commercial or Medicare Advantage

Optum Behavioral Health Solutions network providers will follow a 2-step process to disagree with the outcome of a Commercial or Medicare Advantage clinical prior authorization request or claim processing decision. With the 2-step process, providers should request reconsideration review of a Commercial or Medicare Advantage claim before filing 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. Proof of claim timely filing: Include confirmation we received and accepted your claim within your timely filing limit. Refer to your Participation Agreement for your specific timely filing requirements.





- 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.

More information: Review full details on the 2-step reconsideration and appeal process in the National Provider Manual.

Telemental Health

Telemental Health Resources

Provider Express telehealth

Learn more about becoming an telemental health provider:

public.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/tmh.html

Telehealth Billing Quick Reference Guide

Up-to-date policy information and billing guidance on Provider Express:

public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/home/Telehealth_Billing_Guide_Updates.pdf

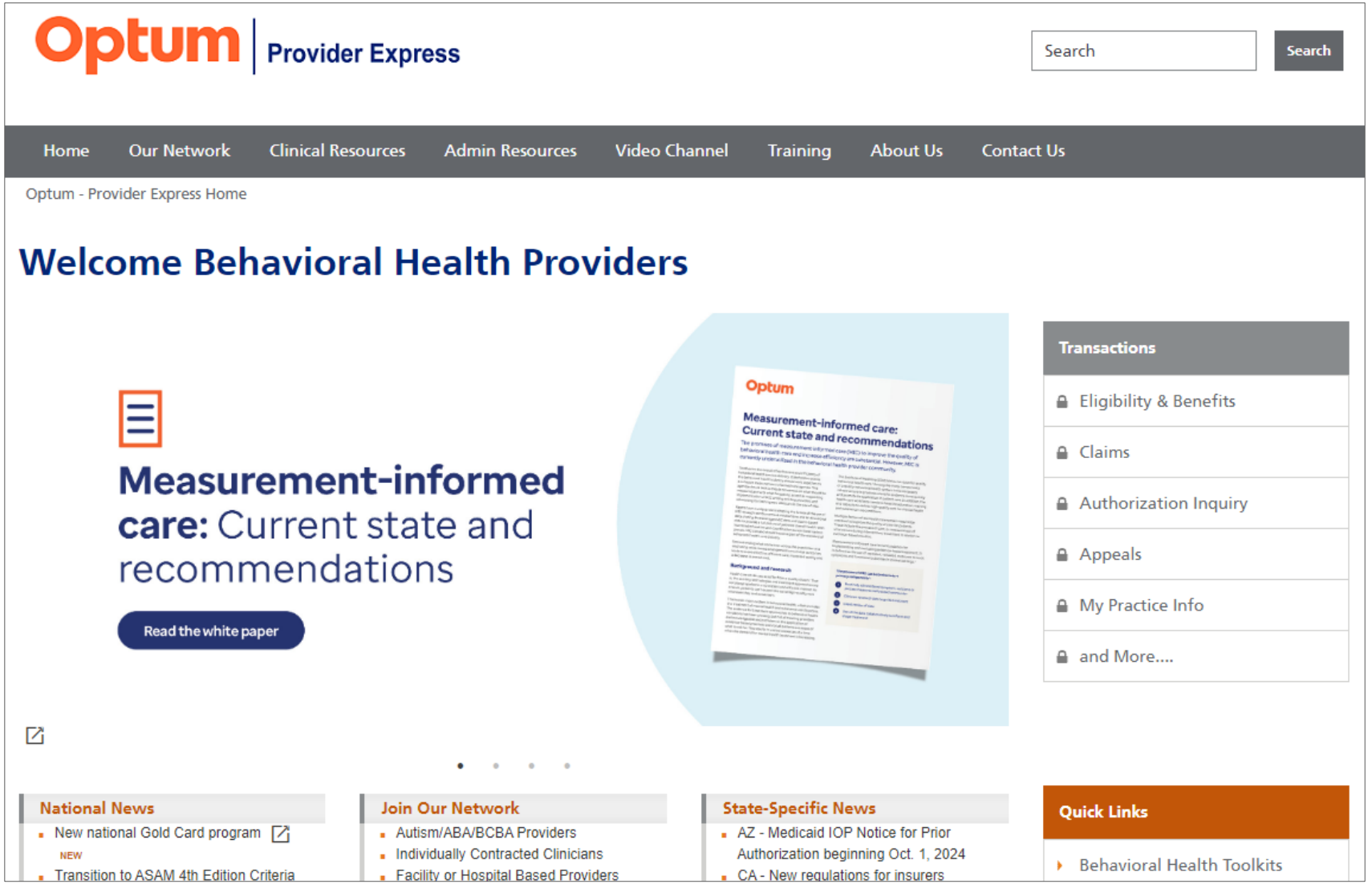
Wisconsin Medicaid Resources

Telehealth Expansion and Related Resources for Providers, including billing guidance for telehealth services and allowable services:

forwardhealth.wi.gov/WIPortal/cms/public/covid19/telehealth-expansion-resources

Website Resources

Providerexpress.com



Clinical Information on Providerexpress.com

Click on the Clinical Resources tab on the home page of providerexpress.com

Clinical Resources for Behavioral Health Providers

Guidelines and Policies

- Clinical Criteria and Guidelines
  Includes ASAM Criteria, LOCUS, CALOCUS-CASII, ECSII Criteria, Medicare Criteria, State and Contract Specific Criteria, as well as Optum Behavioral Clinical Policies and Supplemental Criteria.
- Reimbursement Policies
- Clinical Practice Guidelines
  Guidance about evidence-based practices adopted from nationally recognized entities such as by the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, and the American Society of Addiction Medicine.

Behavorial Health Toolkits

- Behavioral Health Toolkit for Medical Providers
- Clinical and Quality Measures Toolkit for Behavioral Providers
- Foster Care Toolkit
- Intellectual and Developmental Disabilities (I/DD) Toolkit
- Military and Veterans - Behavioral Health Tool Kit for Providers
- Recovery & Resiliency Toolkit

Provider Training Materials

- Cultural Sensitivity Trainings
- Government Agencies

Resources for Patient Care

- Applied Behavior Analysis Information
- Complex Case Management Program
- Consumer Self-Help Organizations
- Coordination of Care
- Mobile Crisis Support by State
- Perinatal Mental Health Toolkit
- Psychiatric Disability Management Program
- Self Care by AbleTo
- Telemental Health
- The Wellness Assessment

Medication Resources

- Position statment on evidence-based treatment adopted by the Federation of State Medical Boards in April 2024
- Genoa Medication Management
- Long-Acting Injectable (LAI) Medication
- Long-Acting Naltrexone for AUD
- Medications for Alcohol and Opioid Use Disorder (MAUD / MOUD)
- Spravato FAQs
- Spravato FAQs – Harvard Pilgrim Specific
- Spravato Overview and FAQs – Western Health Advantage

Administrative Resources

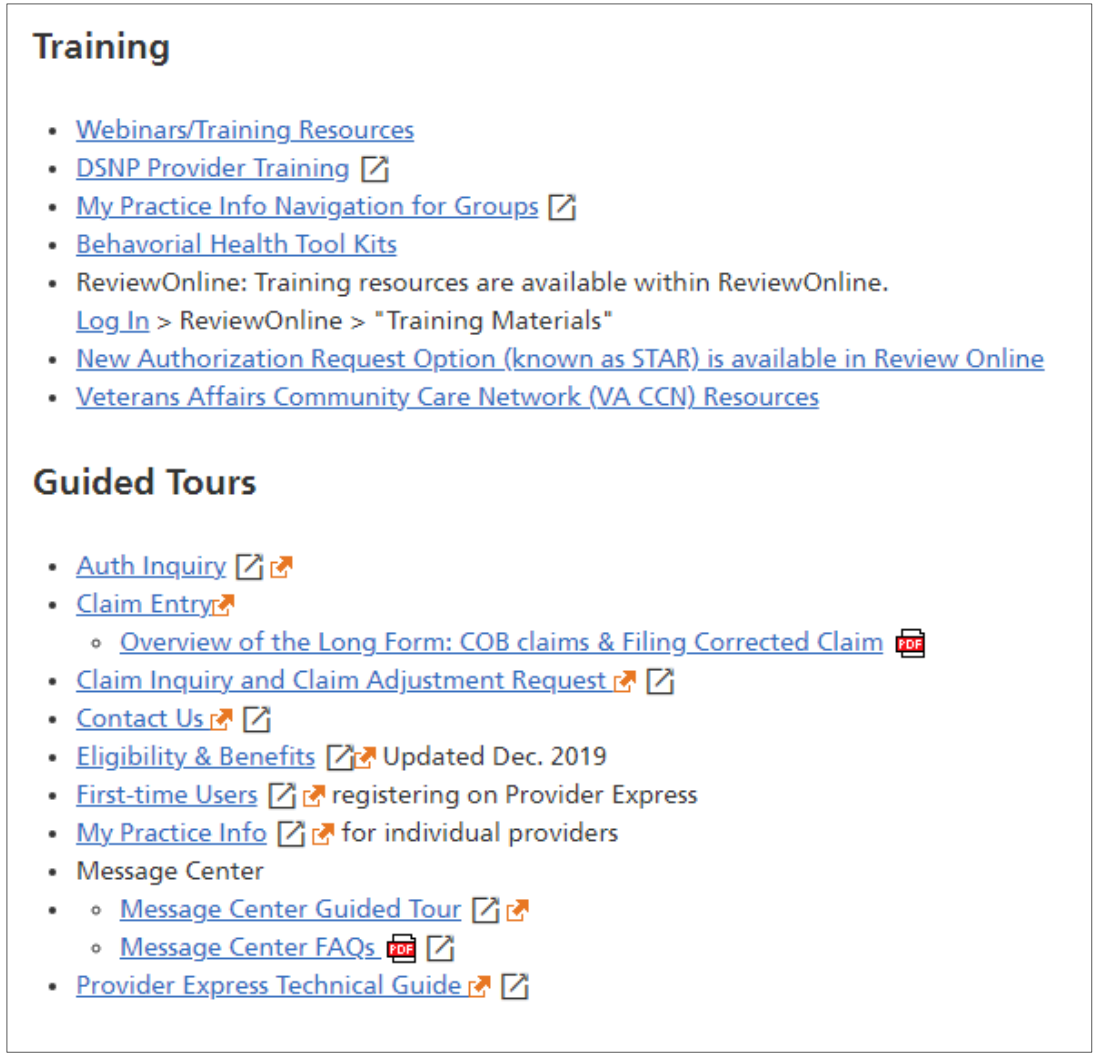
- Express Access Network

Admin Resources on Providerexpress.com

Click on the Admin Resources tab on the home page of Providerexpress.com

Training Information on Providerexpress.com

Click on the Training tab on the home page of Providerexpress.com



Training

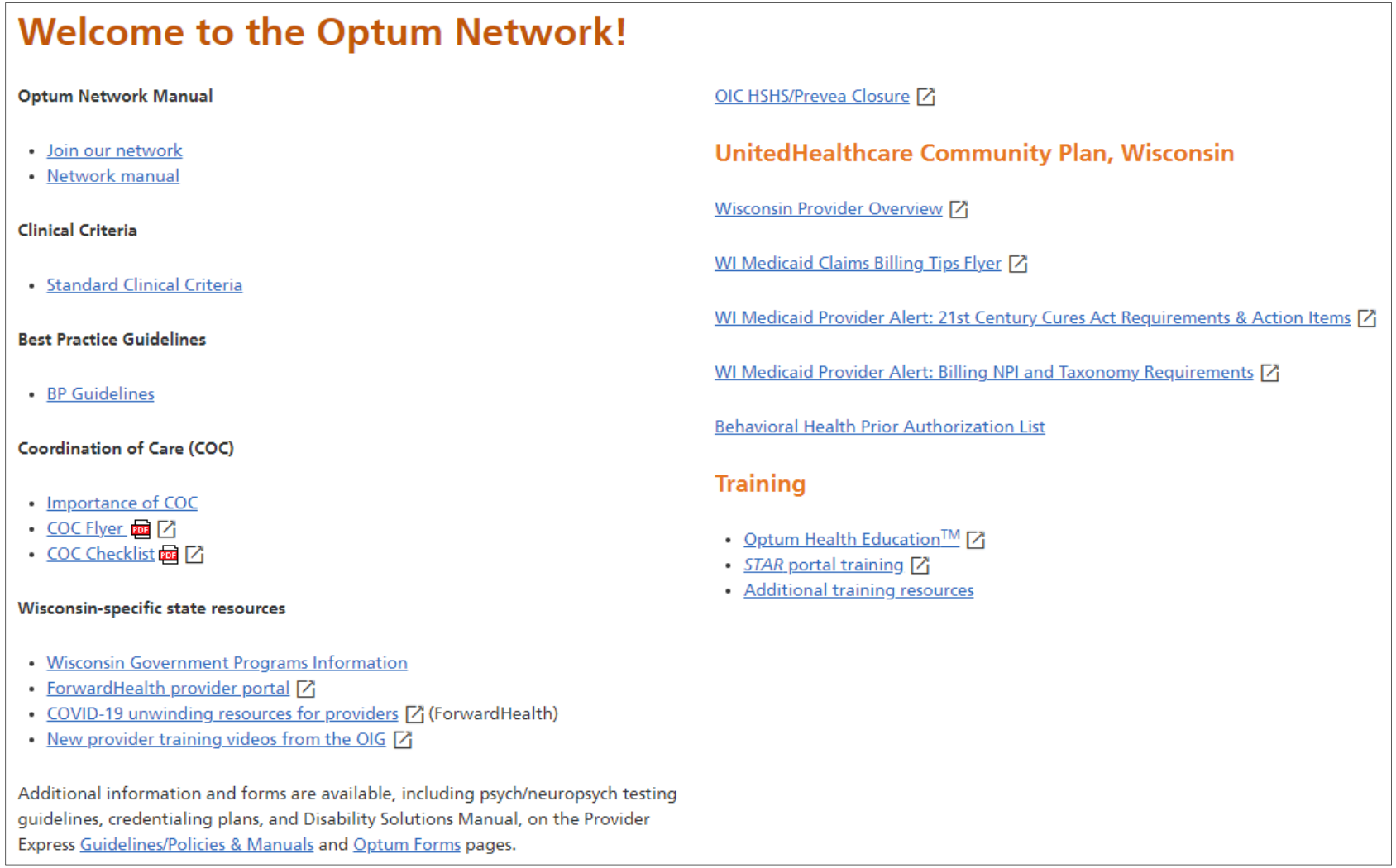
- Webinars/Training Resources
- DSNP Provider Training
- My Practice Info Navigation for Groups
- Behavorial Health Tool Kits
- ReviewOnline: Training resources are available within ReviewOnline.
  Log In > ReviewOnline > "Training Materials"
- New Authorization Request Option (known as STAR) is available in Review Online
- Veterans Affairs Community Care Network (VA CCN) Resources

Guided Tours

- Auth Inquiry
- Claim Entry
  - Overview of the Long Form: COB claims & Filing Corrected Claim
- Claim Inquiry and Claim Adjustment Request
- Contact Us
- Eligibility & Benefits Updated Dec. 2019
- First-time Users registering on Provider Express
- My Practice Info for individual providers
- Message Center
  - Message Center Guided Tour
  - Message Center FAQs
- Provider Express Technical Guide

Wisconsin page on Providerexpress.com

Wisconsin State page



Welcome to the Optum Network!

Optum Network Manual

- Join our network
- Network manual

Clinical Criteria

- Standard Clinical Criteria

Best Practice Guidelines

- BP Guidelines

Coordination of Care (COC)

- Importance of COC
- COC Flyer
- COC Checklist

Wisconsin-specific state resources

- Wisconsin Government Programs Information
- ForwardHealth provider portal
- COVID-19 unwinding resources for providers (ForwardHealth)
- New provider training videos from the OIG

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express Guidelines/Policies & Manuals and Optum Forms pages.

OIC HSHS/Prevea Closure

UnitedHealthcare Community Plan, Wisconsin

Wisconsin Provider Overview

WI Medicaid Claims Billing Tips Flyer

WI Medicaid Provider Alert: 21st Century Cures Act Requirements & Action Items

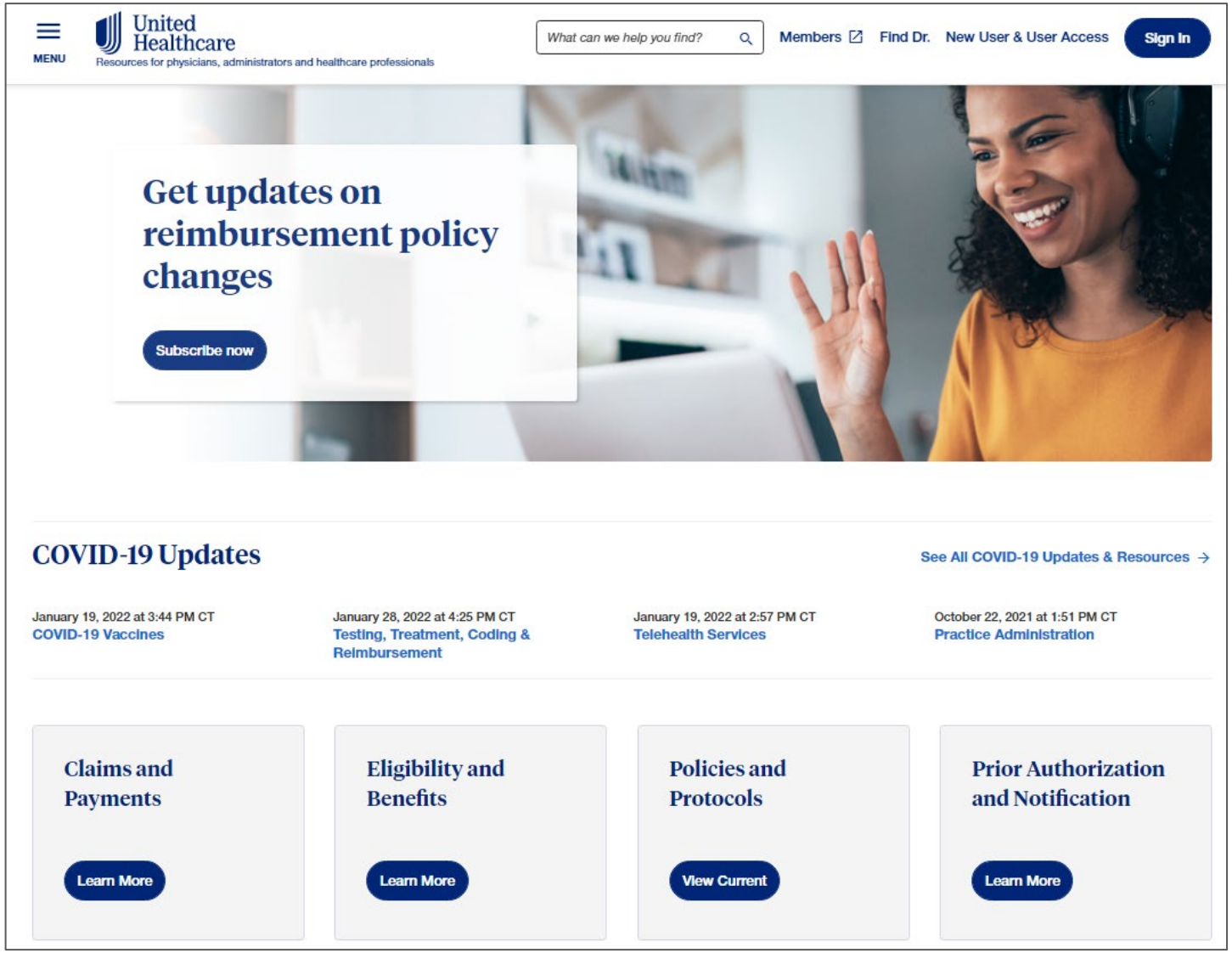
WI Medicaid Provider Alert: Billing NPI and Taxonomy Requirements

Behavioral Health Prior Authorization List

Training

- Optum Health Education™
- *STAR* portal training
- Additional training resources

UHCprovider.com



The Role of your Provider Relations Advocate

- To be the liaison between your organization and our organization
- For all escalated/systemic issues

What Provider Relations Advocates (PRAs) cannot do:

- PRAs are not here to override processes. Your first line of contact should always be the Provider Service Line (the number is on the back of the Member's ID card). If you feel the information is not substantial, please obtain a call reference number and escalate to your PRA.
- PRAs cannot pay claims or adjust claims
- PRAs cannot override the claim dispute process

PRAs are here for COLLABORATION and INNOVATION

- We are working to help advance this program and offer the best services to our Members, along with creating a partnership with our providers
- We are here to help elevate your experience through our online tools and assistance
- We are here to bring compassion and understanding

Provider Relations Advocates Contacts

Who do I contact for an issue? Who is my Provider Relations Advocate?

Provider Service Line

- Call the number on the back of the Member's ID card.
- Optum Provider Service Line: 1-877-614-0484. Contact Us
- Claims reconsiderations can be submitted online Claim Corrections or Resubmission
- Demographics and other updates can be made directly online via Provider Express, see Updating Practice Information for details.

Provider Relations Advocates:

For issues that aren't resolved through Provider Service:

- **Sofia Vela Hayes**, Sr. Provider Relations Advocate
  sofia.vela.hayes@optum.com
  1-612-474-6152

- **Brittni Lehr,** Provider Relations Advocate brittni.lehr@optum.com
  1-952-251-3392

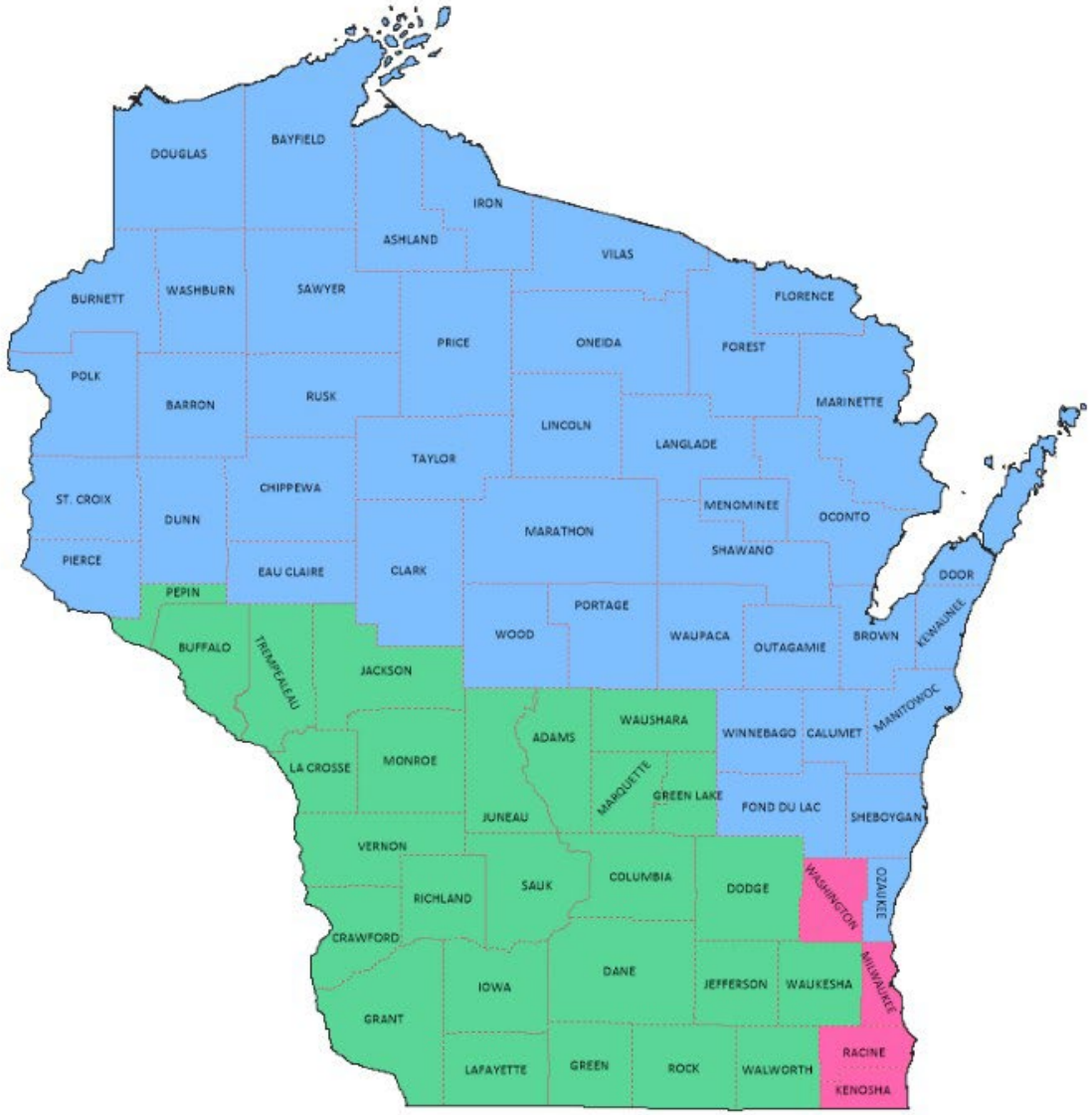
If no resolution, escalate to:

- **Lori Moncherry**, Director
  lori.moncherry@optum.com
  1-763-283-2862

Provider Relations Advocate Assignments by County

Brittni Lehr
Provider Relations Advocate
brittni.lehr@optum.com
T: 1-952-251-3392

Sofia Vela Hayes
Senior Provider Relations Advocate
sofia.vela.hayes@optum.com
T: 1-612-474-6152
F: 1-844-823-8228



Thank you.