Optum | United Healthcare Community Plan

Wisconsin Provider Overview

Optum Provider Services

Published March 2022

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 Form1500.

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

Entry through Provider Express

- providerexpress.com
- Create a login in the upper right-hand corner
- The same 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.

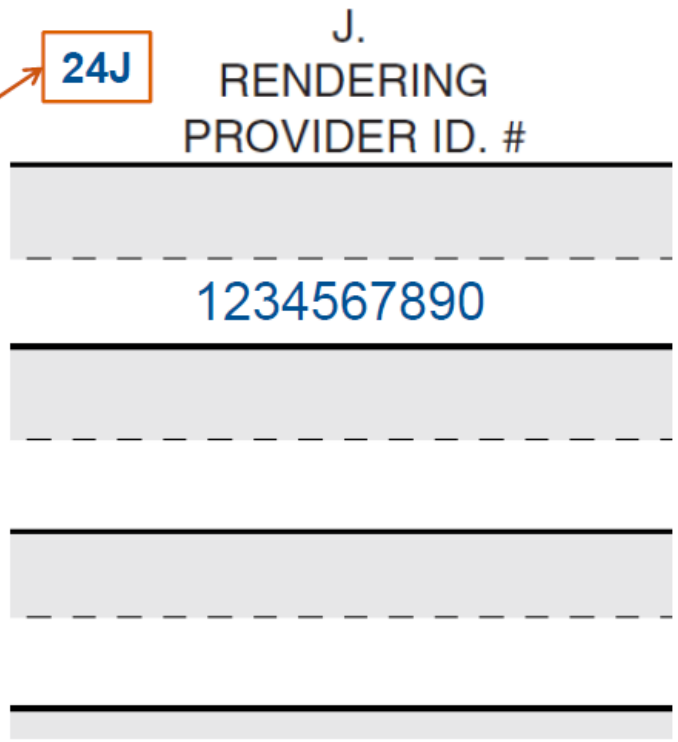
Providers are responsible to obtain Prior Authorizations for applicable services.

- 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.

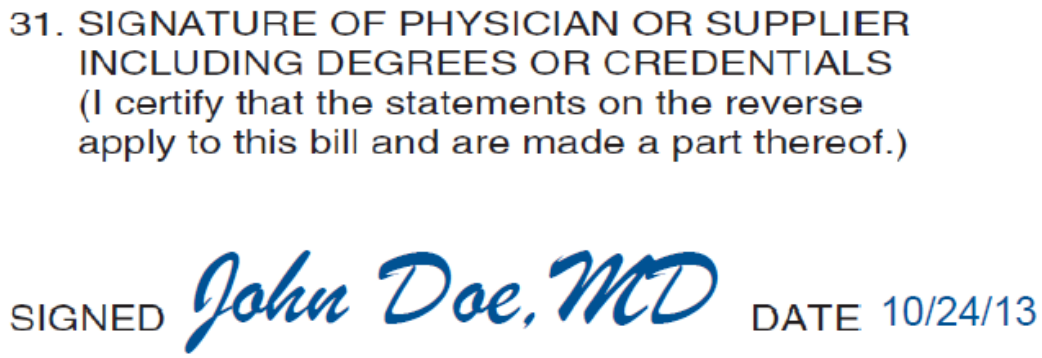
Box 24J
In the **non-shaded field**, enter the **registered NPI number** (Rendering Clinician NPI, if a Licensed Clinician).



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.



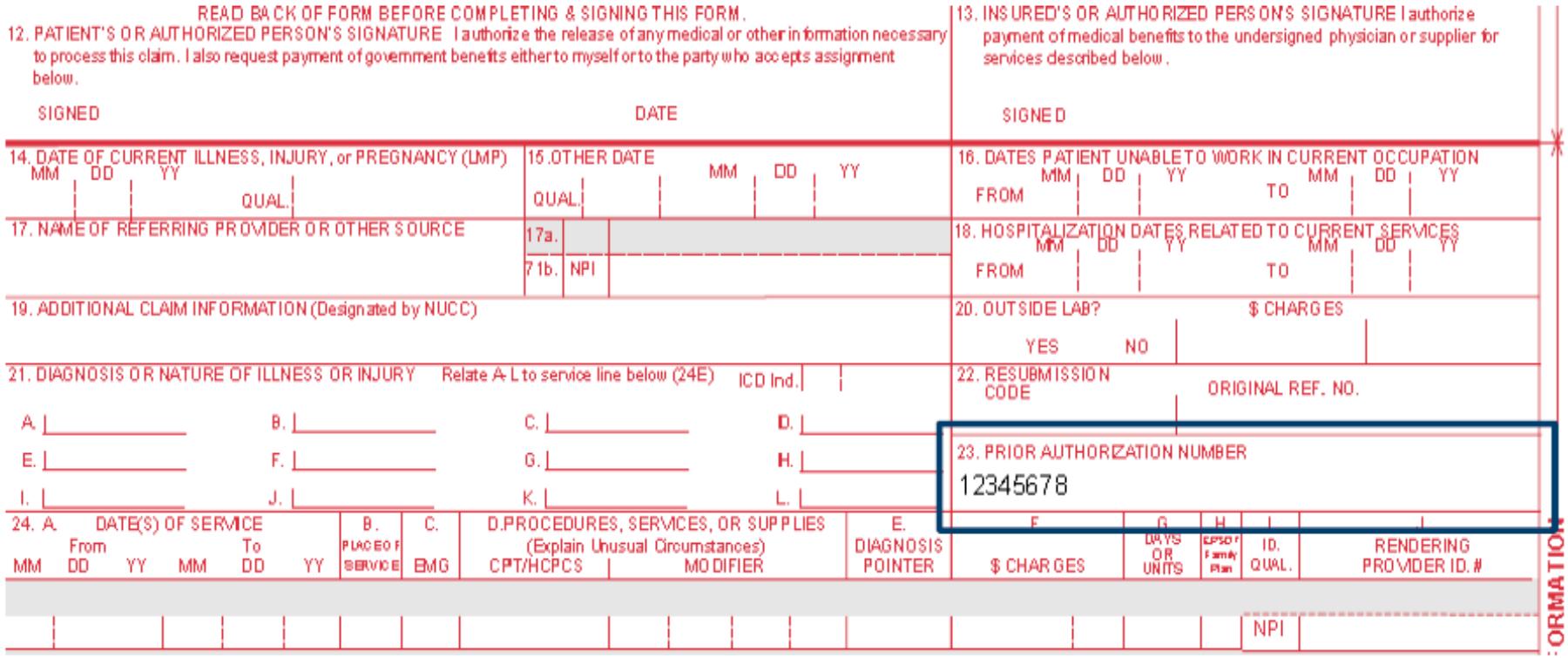
Placement of Billing Group/Agency on Form 1500

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.

UHC/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 in order 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.

Please note that 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 policy found here

Billing Tips

- Claim Billing Tips for WI Medicaid found here
- Look at the codes you are billing to ensure they are covered and check for any PA requirements
- Always ensure the correct modifiers are attached
- Always check the member's eligibility prior to billing
- Always ensure you are providing clear definition as to why you are disputing a claim
- Always ensure that your first point of contact is the Provider Service Line (PSL)
- 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
- **Provider is responsible to verify member eligibility**
- United Healthcare 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 team (the appeals/claim dispute) team is an impartial team of clinical providers who review medical necessity in order 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 Claims Projects

First line of contact is always the Provider Service Line. This team can initiate a claims project on your behalf. Please follow the prompts, asking for Behavioral Health, and Claims when calling the Provider Service Line.

If a project has been escalated to the Advocate, it's the responsibility of the provider to explain the reasoning as to why you are disputing either the underpayment or the denial. UHC/Optum will not work a provider's Accounts Receivable.

Optum has a standard template that is required if you are escalating to your Advocate to dispute claims.

Optum will not initiate an A/R scrub for providers. It is the responsibility of the provider to clearly state why they are disputing the claims in question. If the provider does not understand why claims have denied, they can provide a couple of examples to their Advocate, to see if a project should begin.

Telemental Health

Telemental Health Resources

Provider Express virtual visits

Learn more about becoming an telemental health provider or sign up for Optum virtual visits technology platform:

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

COVID-19 Provider Updates

COVID-19 Provider Updates and up-to-date policy information and billing guidance on Provider Express:

providerexpress.com/content/ope-provexpr/us/en/COVID-19_Provider_Updates/COVID-19_General_Guidance_Updates.html

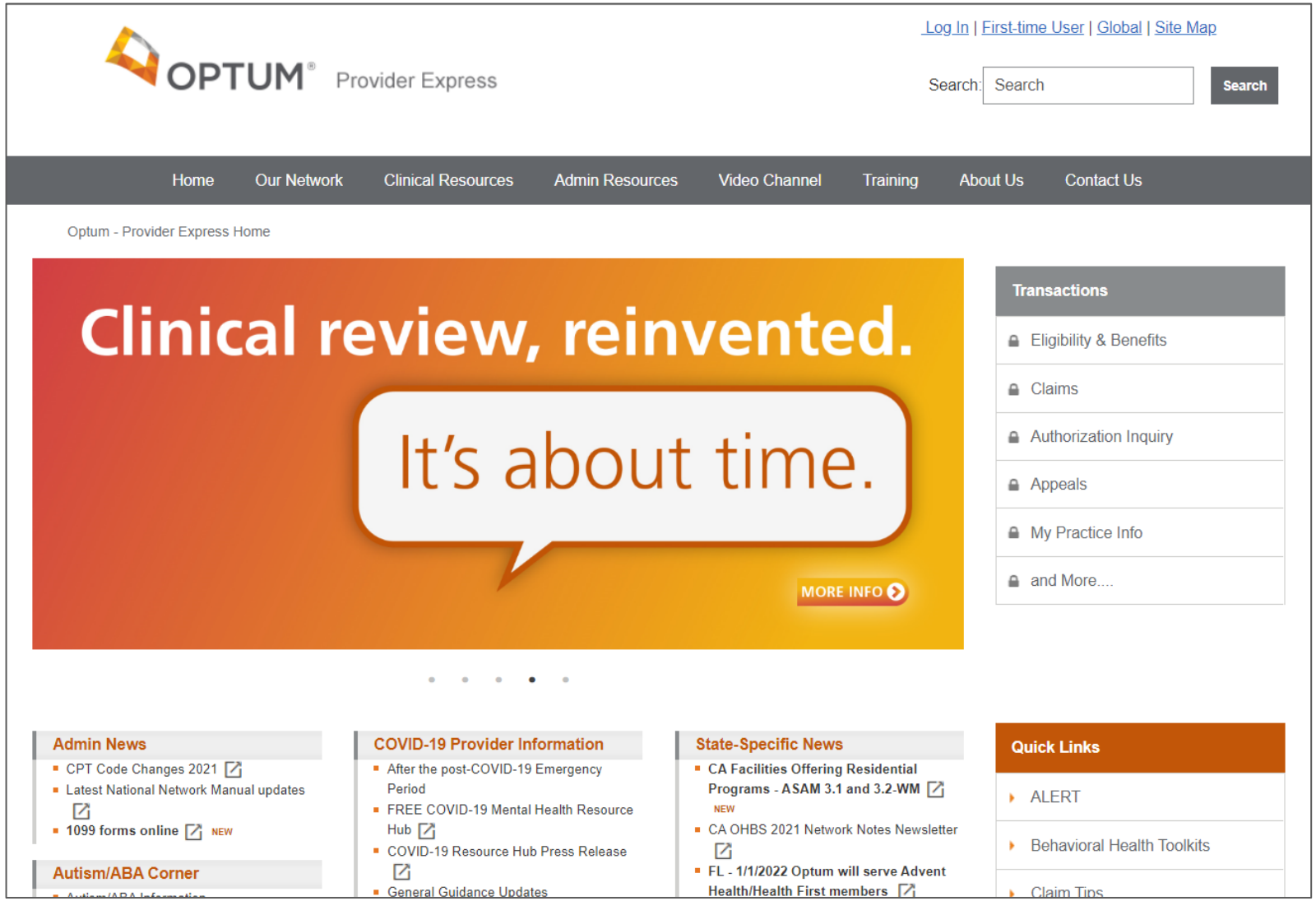
Wisconsin Medicaid Resources

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

forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_resources.html.spage

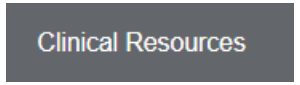
Website Resources

Providerexpress.com



Clinical Information on providerexpress.com

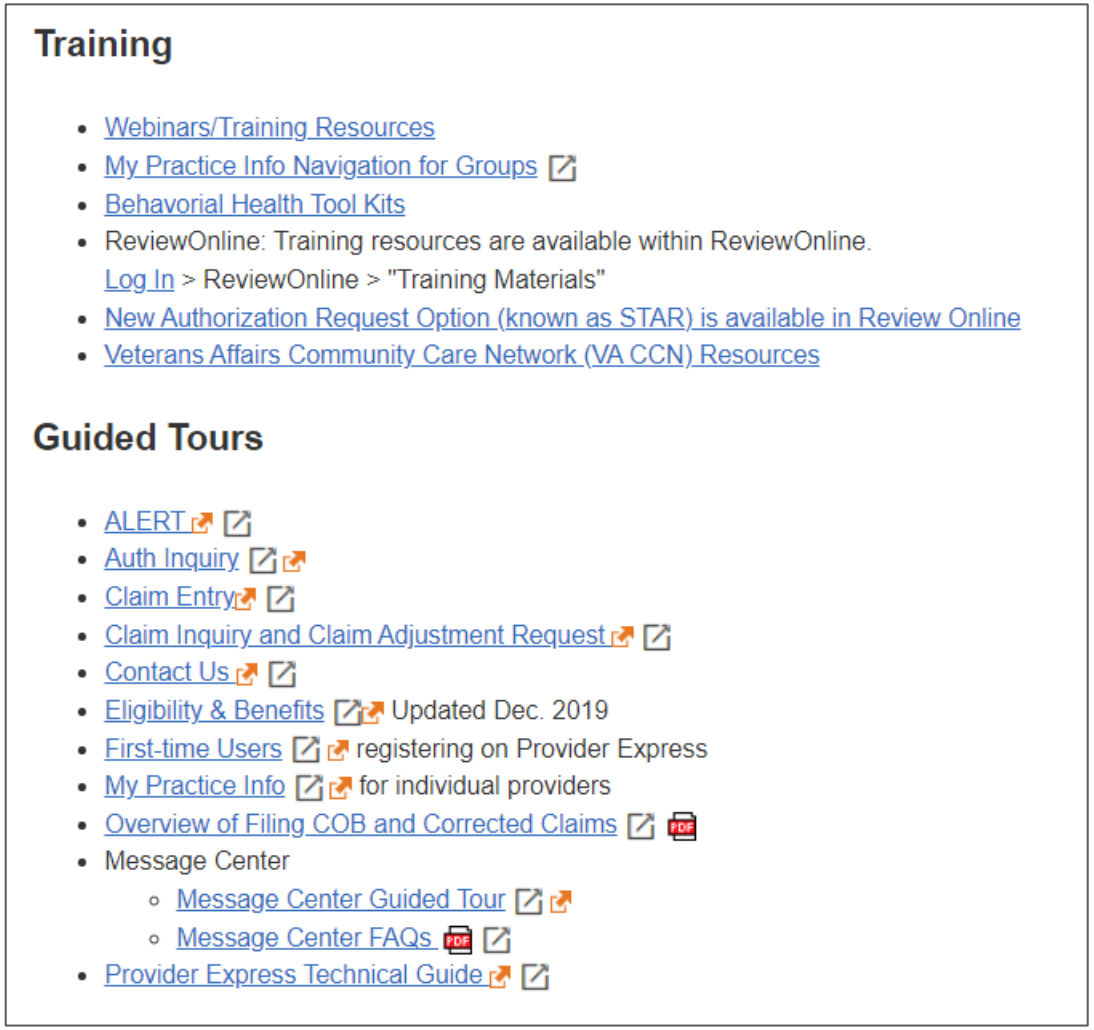
Click on the *Clinical Resources* tab on the home page of providerexpress.com.



Admin/Claims Information on providerexpress.com

Click on the *Admin Resources* tab on the home page of providerexpress.com.

Training Information on providerexpress.com



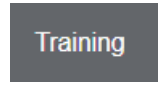
Training

- Webinars/Training Resources
- 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

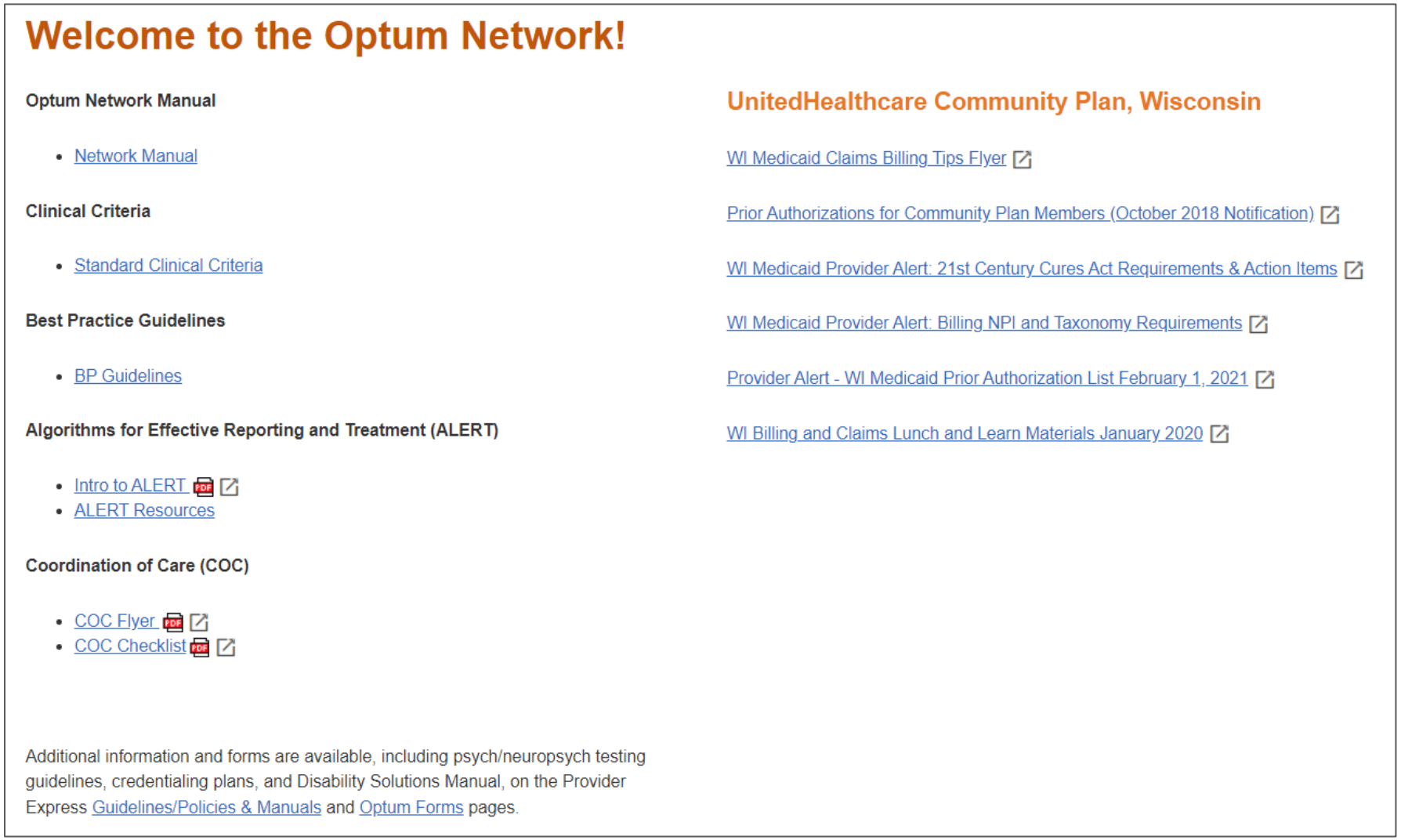
Guided Tours

- ALERT
- Auth Inquiry
- Claim Entry
- 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
- Overview of Filing COB and Corrected Claims
- Message Center
  - Message Center Guided Tour
  - Message Center FAQs
- Provider Express Technical Guide

Click on the *Training* tab on the home page of providerexpress.com.



Wisconsin page on providerexpress.com



Welcome to the Optum Network!

Optum Network Manual

- Network Manual

Clinical Criteria

- Standard Clinical Criteria

Best Practice Guidelines

- BP Guidelines

Algorithms for Effective Reporting and Treatment (ALERT)

- Intro to ALERT
- ALERT Resources

Coordination of Care (COC)

- COC Flyer
- COC Checklist

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.

UnitedHealthcare Community Plan, Wisconsin

WI Medicaid Claims Billing Tips Flyer

Prior Authorizations for Community Plan Members (October 2018 Notification)

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

WI Medicaid Provider Alert: Billing NPI and Taxonomy Requirements

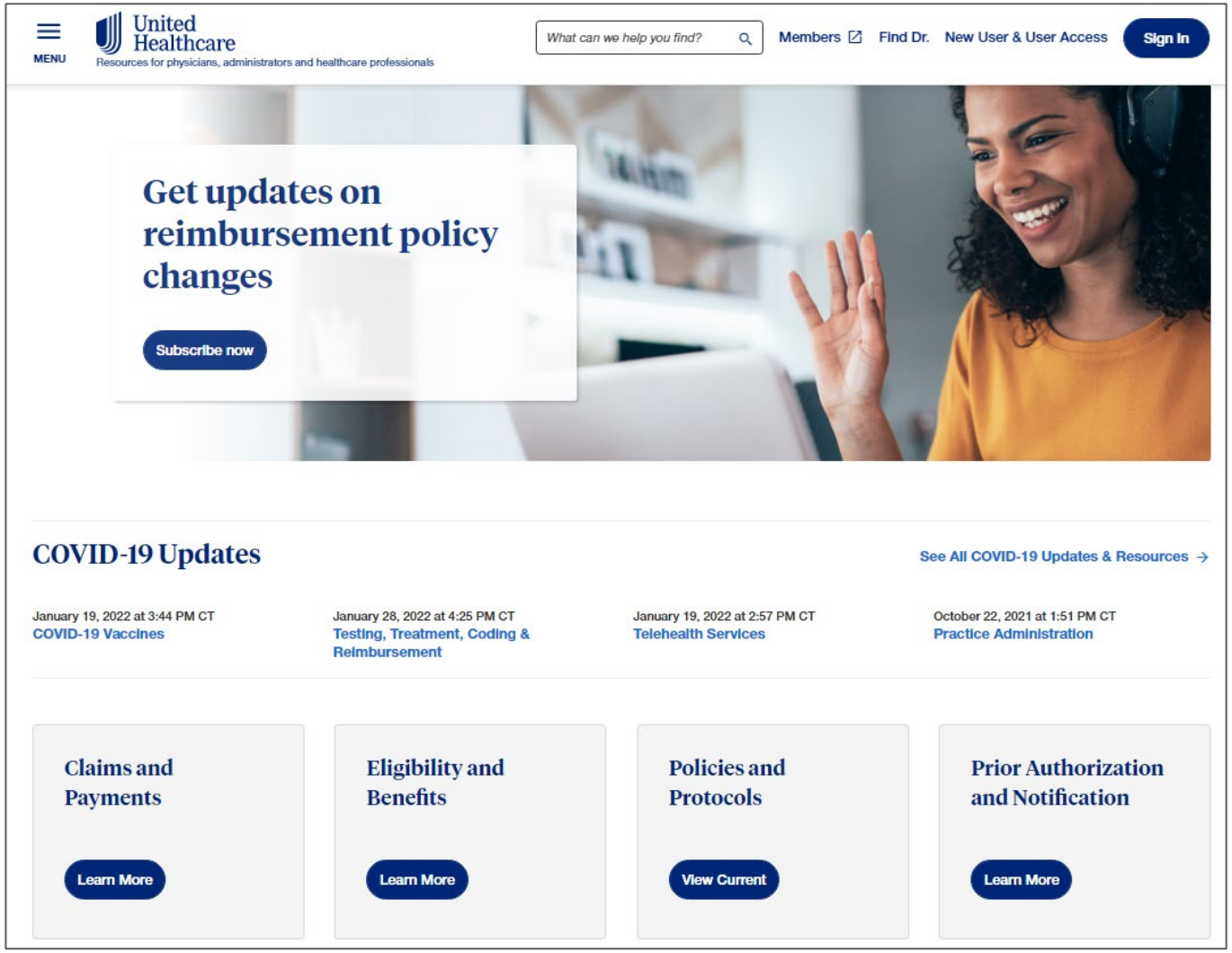
Provider Alert - WI Medicaid Prior Authorization List February 1, 2021

WI Billing and Claims Lunch and Learn Materials January 2020

Our Network

providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/welcomeWI.html

UHCprovider.com



The Role of your Advocate

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

What Advocates cannot do:

- Advocate 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 card). If you feel the information is not substantial, please obtain a call reference number, and escalate to your Advocate
- Advocates cannot pay claims or adjust claims
- Advocates cannot override the claim dispute process

ADVOCATES 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 Contacts

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

Provider Services

Call the number on the back of the card

- Optum Provider Service Line:
  1-877-614-0484

Claims reconsiderations can be submitted online

Several demographic and other updates can be made directly online via Provider Express

Provider Relations Advocates:

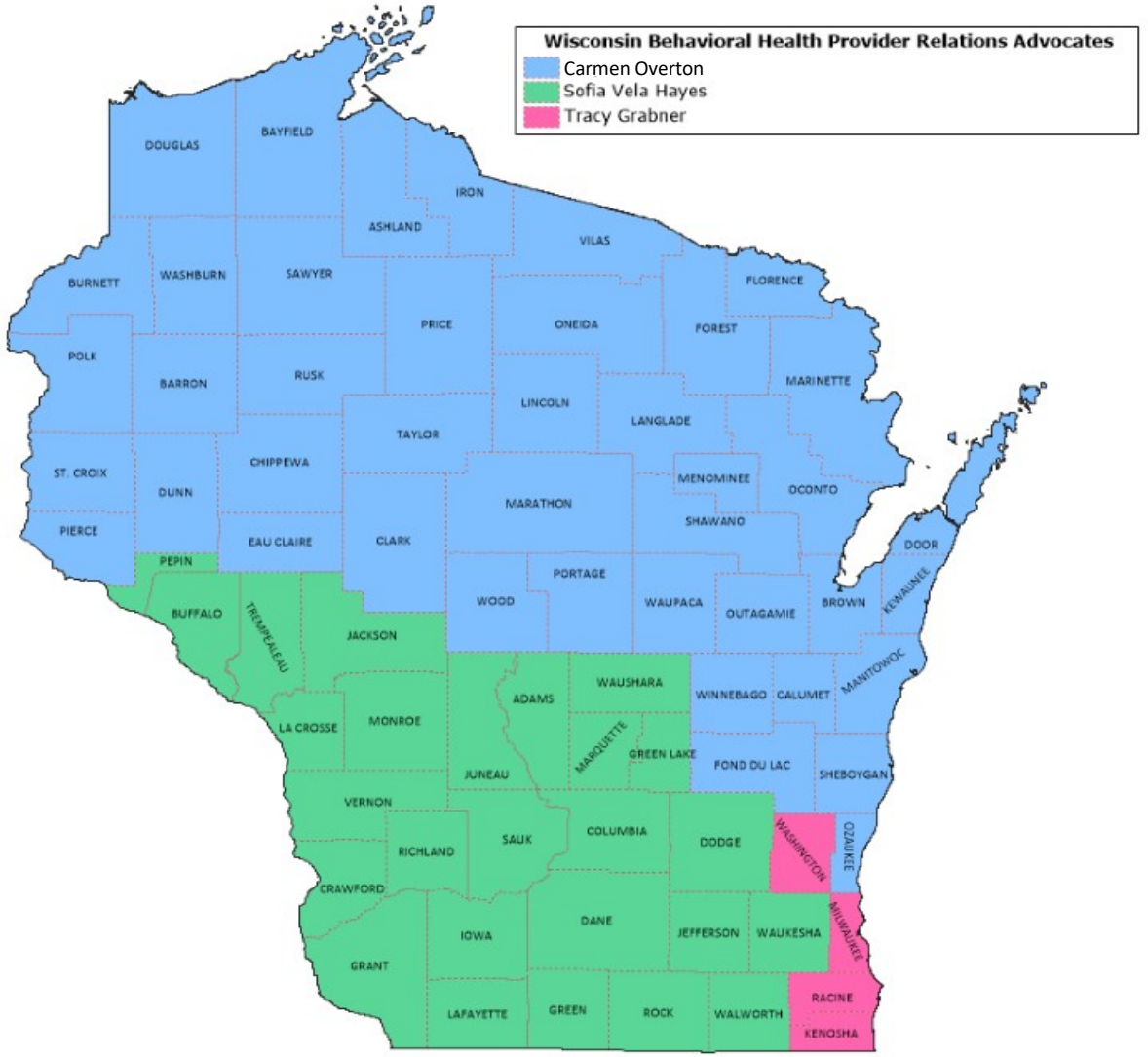
For issues that aren't resolved through Provider Service:

- Sofia Vela Hayes, Sr. Provider Advocate
  sofia.vela.hayes@optum.com
  1-612-474-6152
- Tracy Grabner, Provider Advocate
  tracey.grabner@optum.com
  1-763-330-6144
- Carmen Overton, Provider Advocate
  carmen.overton@optum.com
  1-414-456-3497

If no resolution, escalate to:

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

Provider Advocate Assignments by County



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Thank you.