Optum

Alaska Provider Training

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Alaska Provider Training Agenda

1. What's New & Projects
2. Contraindicated Services
3. Trending Top 5 Denials & Other Denial Reasons
4. Reminders
5. Questions & Answers

What’s New & Projects

What's New

Place of Service 10 is allowable after April 1, 2022

Please refer to e-memo *Reporting of Telehealth Services* sent March 1, 2022 or on our website Alerts, Updates & Announcements (optum.com).

Invalid or Missing NPIs

Providers need to make sure NPI is linked back to Alaska Medicaid Account through Conduent.

Please refer to e-memo *Claims Submitted with a Missing or Invalid NPI Number* sent April 25, 2022 or on our website Alerts, Updates & Announcements (optum.com).

Additional information regarding claims submitted from go-live to current date will be forthcoming.

What's New

H0035 V1

Providers need to review denials for services not covered, these services may actually be denied due to inappropriate diagnosis code. V1 services require a SUD primary diagnosis code on the claim. Please rebill any claims with the appropriate diagnosis code.

Provider Express Updates

Changes made to system. Provider education is in development, but if you have questions please reach out to our Provider Relations Team, akmedicaid@optum.com

Service Authorizations During the Public Health Emergency (PHE)

Service Authorization requirements are currently lifted during the Public Health Emergency.

SFY (State Fiscal Year) service limits will reset when service authorizations do go live.

The Public Health Emergency is currently extended through July 15, 2022.

Check the federal Public Health Emergency for updates on the PHE Declaration at:
https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

Projects

Project Name: H0010 TG V1 and Place of Service 99 Claims Denied

What is Changing: Configuration is being updated to allow place of service 99 with procedure code H0010 TG V1.

What providers need to do: Nothing, the claims are being identified and will be reprocessed once configuration is complete.

Target Completion Date: June 30, 2022

Projects

Project Name: Retro Eligibility Claims Denied Reprocessing Project

What is Changing: Claims that had retro eligibility updates through the end of March 2022 are being reprocessed to pay.

What providers need to do: Nothing, the claims have been identified and the project is underway.

Target Completion Date: May 15, 2022

Projects

Project Name: Eligibility Subgroups/Subtypes Claims Reprocessing Project

What is Changing: Claims that had retro eligibility updates with non-Behavioral Health subgroups/subtypes are being reprocessed to deny appropriately.

What providers need to do: Providers will need to determine the appropriate payer source for the services during the time the participants are not eligible for Behavioral Health services.

Target Completion Date: April 30, 2022

Projects

Project Name: Claims Denied for TPL/Coordination of Benefits Reprocessing Project

What is Changing: Claims that denied for primary insurance on claim form but no resource on file, are being reprocessed to be paid with the appropriate coordination of benefits applied.

What providers need to do: Nothing, the claims have been identified and the project is underway.

Target Completion Date: May 15, 2022

Contraindicated Services

Changes to Contraindicated Services Claims Processing

What's Changing?

Beginning May 1, claims will no longer deny for services being contraindicated to other services.

- Claims that previously denied for contraindicated services will not be reprocessed. Providers who wish to appeal these denials for claims processed before May 1, 2022, will need to submit a second level appeal to the Division of Behavioral Health.
- See next slide for second level appeal instructions.

Why?

- This change is to help reduce administrative burden for providers who are providing 1115 Waiver services to Medicaid participants.

Second Level Appeal Instructions

To submit a second level appeal, follow these guidelines:

1. Second level appeals must be in writing and postmarked within 60 days of the date of the first level appeal decision by Optum or within 60 days of the adverse enrollment or service authorization decision. NOTE: Providers may not file a second level appeal by telephone or any other oral communication.
2. Include a copy of the Optum first level appeal decision, or a copy of adverse enrollment or service authorization decision, a copy of the claim denial or payment notice, a copy of the submitted claim, and supporting documentation considered relevant.
3. Mail to:

   Division of Behavioral Health Attn: Medicaid Section
   3601 C Street, Suite 878
   Anchorage AK 99503

Providers will be notified in writing of the final decision.

Top 5 Trending Denials & Other Denial Reasons

Alaska Top 5 Trending Denials

1	Definite Duplicate Claim
2	Timely Filing
3	Place of Service Inappropriate for Procedure
4	Invalid Procedure Modifier Combination
5	Participant Incarcerated on Date of Service

Definite Duplicate Claim

Definite Duplicate Claim

Definition:

Any claim submitted by a provider for the same procedure, date of service, units, place of service and charge amount will be denied as a definite duplicate. If you feel a claim is denied a duplicate in error, request a review of the claim in question.

If a provider needs to submit a corrected claim, be sure to include the original claim number along with selecting corrected claim type.

Taking the following steps can help you eliminate receiving a duplicate denial:

- Verify the claim has completed processing = (paid/denied)
  - This can be done by checking the remittance advice through Provider Express
- Verify the reason the initial claim did not allow payment
  - Examples of appropriate denials
  - Invalid diagnosis
  - Invalid NPI
  - Invalid Procedure/Modifier combo

A corrected claim will be required if modifications to claim are needed

Timely Filing

Timely Filing

Calculate timely filing by counting the time between the date the service was rendered and the date the claim was submitted to Optum for payment.

AK Timely Filing of Claims

- All claim types must be filed within 12 months of the date services were provided to the patient
- Third party carrier claims
  - Provider must attach explanation of benefits documentation from the third-party carrier to the Alaska Medical Assistance claim
  - Providers must bill Alaska Medical Assistance within 12 months of the service date

Timely Filing Expired - Acceptable documentation must be attached to the claim upon resubmission. Examples of acceptable documentation include:

- A copy of the remittance advice (RA) page showing claim denial
- A copy of the in-process claims page of an RA
- Provider Express or other electronic claim submission transmission report
- Evidence of previous claim receipt by Optum within the timely filing period

Timely Filing

Acceptable Extensions

- Court orders
- Administrative Hearings
- Good cause – (examples: Fire, Storm, Earthquake)
- Department committed an error on previous claim submission
- Claim was filed timely, but not processed

Filing Limits for Adjustments

Adjustment requests must be submitted within 60 days from the date of payment or within 12 months of the date of service if additional amounts are owed to the provider. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply.

Place of Service Inappropriate for Procedure

Place of Service Inappropriate for Procedure

Overview

Optum will reimburse CPT and HCPCS codes when reported with an appropriate place of service (POS). POS Code set, which are two-digit codes submitted on the CMS 1500 Health Insurance Claim Form or its electronic equivalent to indicate the setting in which a service was provided. Please follow the guidance of Alaska Medicaid. Provider should review Administrative and Billing manuals to assist with POS requirements.

A corrected claim will be required to modify the claim for payment

Example:

B08 – inappropriate place of service and procedure code combination (example: H2015 HQ billed with Place of Service 02 but not with a telehealth modifier).

Place of service 10 is not allowed for dates of service prior to 4/1/2022

Invalid Procedure Modifier Combination

Invalid Procedure Modifier Combination

One of the common reasons your claims may be denied is for missing or invalid modifier combinations (procedure code is not consistent with the modifier you have used).

Although the procedure code is a valid procedure code and the modifier is a valid modifier IF the procedure and modifier combination is not appropriate to be used together, the line item will deny as an invalid modifier combination.

If a claim is denied for an invalid modifier combination, a *corrected claim will be required*. Records also may need to accompany the corrected claim in some situations.

Examples:

H2021 billed without the V1 or V2 modifier

H0047 CG HA V1 TF – should be CG V1 HA TF

Primary Modifier Guidance Grids

Entering procedure code modifiers in the correct sequence is necessary for accurate claim payment amounts by Optum.

Entering procedure code modifiers in any other order then shown in the next grid will result in claim denials, underpayments and/or overpayments that must be refunded.

A corrected claim will be required. Records may need to accompany the corrected claim in some situations.

Optum Primary Modifier Guidance for Alaska Medicaid Community Behavioral Health Services as of 7.1.2020

Primary Modifier Guidance for Alaska Medicaid 1115 Waiver Services (optum.com)

Correcting Invalid Modifier Denial

If a line item is denied for an invalid modifier combination, the claim cannot be adjusted. A corrected claim will be required. Records may need to accompany the corrected claim in some situations.

All information requested has to be submitted with the corrected claim in order for the claim to be reconsidered for payment.

Participant Incarcerated on Date of Service

Participant Incarcerated on Date of Service

Providers have submitted claims when the participant was reflecting as incarcerated on the date of service. This subtype is not covered for Alaska Medicaid Behavioral Health services.

If a claim is denied due to a participant having Medicaid eligibility as an incarcerated person and the person is no longer incarcerated, then providers may work with the participant and the Division of Public Assistance to update the type of eligibility.

Eligible Alaska Medicaid Behavioral Health Types

Double check patients Medicaid type

On the next page is a table with Alaska Medicaid eligibility types that do not include coverage for Alaska Medicaid covered Behavioral Health Services.

If a claim is denied due to a participant having Medicare Premium Assistance only or being approved for a Home and Community Based Waiver assessment only, it is due to the type of Medicaid eligibility the participant received that does not cover Alaska Medicaid Behavioral Health Services.

Medicare Premium Assistance Categories

The Medicare program provides assistance with the cost of Medicare premiums, deductibles, and co-insurance. These Medicare assistance categories generally use the financial and non-financial eligibility criteria of the Adult Public Assistance (APA) and Supplemental Security Income (SSI) programs, except that the income and resource limits are higher.

Ineligible for Behavioral Health

Eligibility Code and Subtype	Denial Reason	Remittance Advice Reason Code (RARC)	Claim Adjustment Reason Code (CARC)
19/WD – Waiver Determination/Waiver Applicant	No Benefit Plan Exists	N30	96
20/AI – Medicaid/Incarcerated Medicaid APA Related	Participant Incarcerated on Date of Service	N103	96
20/MI – Medicaid/Incarcerated Newly Eligible-Expansion	Participant Incarcerated on Date of Service	N103	96
20/XI – Medicaid/Non-Newly Eligible	Participant Incarcerated on Date of Service	N103	96
50/NI – Under 21/Incarcerated non-SCHIP Child/Title 19 funding	Participant Incarcerated on Date of Service	N103	96
50/TI – Under 21/Incarcerated Under 21	Participant Incarcerated on Date of Service	N103	96
66/QD – Qualified Disabled & Working Individuals/Qualified Disabled & Working Individuals	Medicare Premium Only	N30	96
67/QM – QMB-only/QMB	Medicare Premium Only	N30	96
68/SL – SLMB Eligible Part B Payment Only/low income Mcare beneficiary	Medicare Premium Only	N30	96
69/AI – Dual APA/QMB/Incarcerated Medicaid APA Related	Participant Incarcerated on Date of Service	N103	96
78/SL – SLMB Plus Eligible Part B/low income Mcare beneficiary	Medicare Premium Only	N30	96

Medicaid related (alaska.gov). If you have questions or need assistance, please contact Optum at 800-225-8764

Other Denial Reasons

Other Denial Reasons

1	Possible Duplicate – This is caused when the same procedure code is billed on multiple lines or multiple claims
2	Provider Out of Network – This is caused when the provider is not affiliated with the agency, or is not an approved provider, on the enrollment file
3	Already Allowed or Not Paid Separately- This is caused when there are duplicate dates of service on the same claim that are included with new day services

Reminders

Optum Pay Reminders

The Optum Behavioral Health payment schedule changed in February 2022. The current Electronic Fund Transfer (“EFT”) payment schedule pays twice a week.

Direct deposits moved to four times a week, on Mondays, Wednesdays, Thursdays, and Fridays.

Claim Processed before 5 p.m. on:	Payment data sent to Optum Pay	Optum Pay Processing	Settled in Provider Account/Direct Deposit Date
Tuesday	Tuesday	Wednesday	Friday
Wednesday	Wednesday	Thursday	Monday
Thursday	Thursday	Friday	Monday
Friday	Friday	Monday	Wednesday
Saturday	Monday	Tuesday	Thursday

Optum Pay Reminders

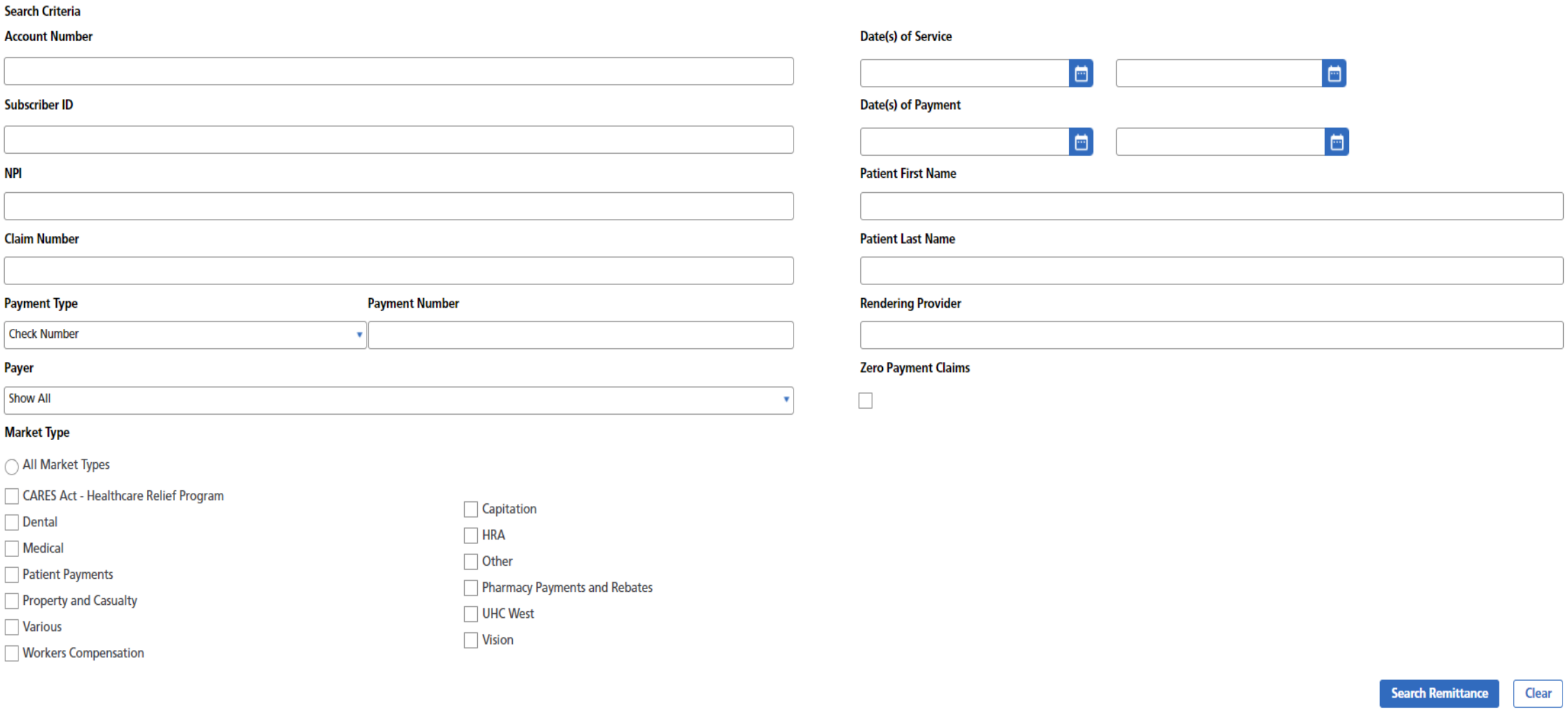
Note: Optum Pay experienced an issue where dates of service were being reported as one day off the actual date of service billed. This was corrected on January 8, 2022. Optum Pay Remittance will reflect accurate billed dates of service at this time.

Optum Pay accelerates claims payments to your organization improving processing accuracy that enables you to reconcile claim payments faster - reducing administrative work for your organization. With Optum Pay you get access to the right tools and solutions so you can spend less time on reconciling claims and more time getting people the care they need.

Searching Optum Pay for adjusted claims payment

- Keep your search broad
- Search by patient first and last name
- Search by dates of service

Optum Pay Search



Q&A

The Provider Relations Team is Here to Help

The Alaska Provider Relations Team is your local guide to Navigating Optum

The Optum Alaska Provider Relations Team can:

- Answer important questions
- Facilitate ongoing process improvements
- Keep you abreast of changes that impact your practice
- Provide useful tools and resources

The Optum Alaska Provider Relations Team:

- Ryan Bender 1-763-361-8891
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- Email: akmedicaid@optum.com
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