Optum

Appeals and Complaints

Vanessa Green, Optum Alaska
Michelle Breazell, Optum
Ryan Bender, Optum Alaska

May 25, 2022

Agenda / Objectives

1. How to File a Clinical Appeal
2. How to File an Administrative Appeal
3. Second Level Appeals and Final Appeals
4. How to Request Optum Reprocess a Claim
5. How to File a Complaint

Summary of Appeals

- An appeal is a request made for re-review of a determination that resulted in a 1) non-coverage determination of a service request or 2) an original claim was denied or reduced, or if payment was reduced due to a recoupment action.
- Appeal reviews are available for post-service cases; appeal reviews are not available for pre-service or concurrent cases
- Providers/facilities may appeal a non-coverage determination, whether it was based on administrative or clinical considerations. Optum does not process appeals related to Alaska Medicaid provider enrollment
- Optum Alaska provides one level of internal appeal following an initial medical necessity denial of requested services.
- A Second-Level Provider Appeal review is available with DBH
- Providers have up to 180 days after the date of the remittance advice for the claim to file an Appeal

How to File a Clinical Appeal

Initial Clinical Review

- The initial review of an authorization request submitted by a provider on behalf of a participant is completed by an Optum Care Advocate. A Care Advocate may only authorize service requests. When a Care Advocate is not able to authorize benefits based on the information provided via Optum Alaska website/Provider Express or telephonically, the Care Advocate may ask the provider for additional information. The timeframes for making the initial determination by Optum Alaska is one hour for an urgent request and 24 hours for a non-urgent request. Upon receipt of the additional information, the Care Advocate will authorize the services requested or suggest an alternative level of care. If the Care Advocate is not able to authorize benefits for services as requested or negotiate an alternative, the Care Advocate will refer the case to the Optum Alaska Medical Director or Physician Reviewer.
- A non-coverage determination of services results when the Optum Medical Director or Physician Reviewer reviews a service request and cannot approve the request because it does not meet the medical necessity criteria established for that level of service. The participant may request a fair hearing with DBH for non-approved services. The provider may file an appeal with Optum.

Clinical Appeal

A provider may request a first level clinical appeal when a request for services was denied due to lack of medical necessity or other clinical reasons. Providers may file first level appeals with Optum.

Examples of clinically reviewed appeals include:

- Appeals of denials of service that are available under the terms of the participant's Behavioral Health Medicaid plan, and that are provided for the diagnosis or treatment of a condition that is covered under the terms of the participant's Behavioral Health Medicaid Services.
- Appeals of denials of service about which there is insufficient information to make a coverage determination.

Clinical Appeal

Follow these guidelines in order to file a clinical appeal:

1. Include the Provider Appeal form and any supporting documentation considered relevant (e.g., chart notes, medical records, etc.).

2. Optum will notify providers in writing of the appeal decision.

To contact the Optum Appeals Department, call 866.245.3040.

Fax: 855.508.9353

Mail to: Optum Alaska Attn: Appeals Department
911 W 8th Ave #101
Anchorage, AK 99501

If the reviewer upholds the initial decision, providers have the right to file a second level appeal

How to File an Administrative Appeal

First Level Administrative Appeal

Administrative Appeal: A request for a review of a non-coverage determination that is based on the benefit coverage or provider manual and that does not require any clinical decision-making.

Administrative Review: A review of plan provisions in order to make a benefit determination which is not based on review of clinical criteria or clinical policy, submitted by Appeal. Examples include:

- Provider fails to obtain pre-authorization when required
- Timely filing requirement are not met
- Provider fee schedule or coding issues

A provider may request a first level appeal if payment of an original claim was denied or reduced, or if payment was reduced due to a recoupment action. Providers may file first level appeals with Optum.

First Level Administrative Appeal

Providers must appeal for individual claim denials resulting from National Correct Coding Initiative (NCCI) edits, including:

- Procedure-to-procedure edits
- Medically unlikely edits
- Units of service edits

For additional information about NCCI regulations, refer to National Correct Coding Initiative (NCCI) National Correct Coding Initiative Edits | CMS or visit the Centers for Medicare and Medicaid Services (CMS) website https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative-medicaid/index.html

First Level Administrative Appeal

Follow these guidelines in order to file a first level appeal:

1. First level appeals must be in writing and received within 180 days of the claim disposition date - the date of the remittance advice (RA). Any appeal submitted past timely will not be considered.
2. Include a copy of the claim denial or payment notice from the RA, a copy of the original claim that was denied or reduced, and any supporting documentation considered relevant (e.g., chart notes, claim check audit report, etc.)
3. Optum will notify providers in writing of the first level appeal decision.

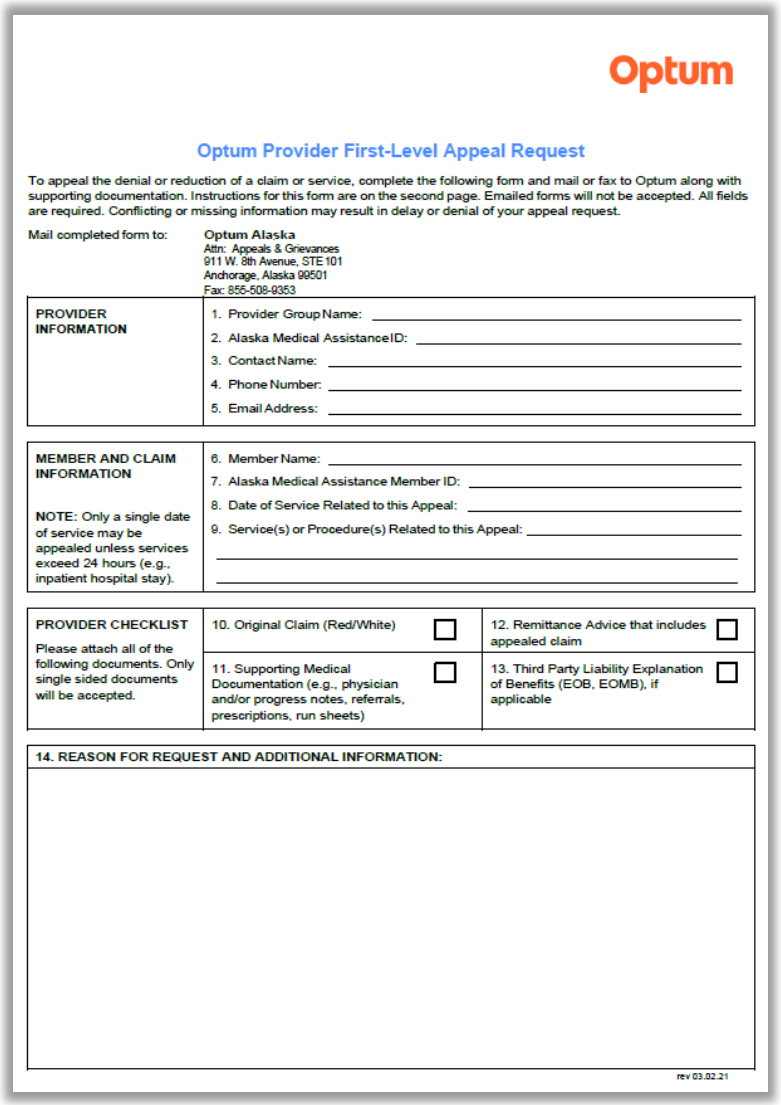
To contact the Optum Appeals Department, call 866.245.3040.

Fax: 855.508.9353

Mail to: Optum Alaska Attn: Appeals Department
911 W 8th Ave #101
Anchorage, AK 99501

If the reviewer upholds the initial decision, providers have the right to file a second level appeal.

First Level Appeals Form



Optum

Optum Provider First-Level Appeal Request

To appeal the denial or reduction of a claim or service, complete the following form and mail or fax to Optum along with supporting documentation. Instructions for this form are on the second page. Emailed forms will not be accepted. All fields are required. Conflicting or missing information may result in delay or denial of your appeal request.

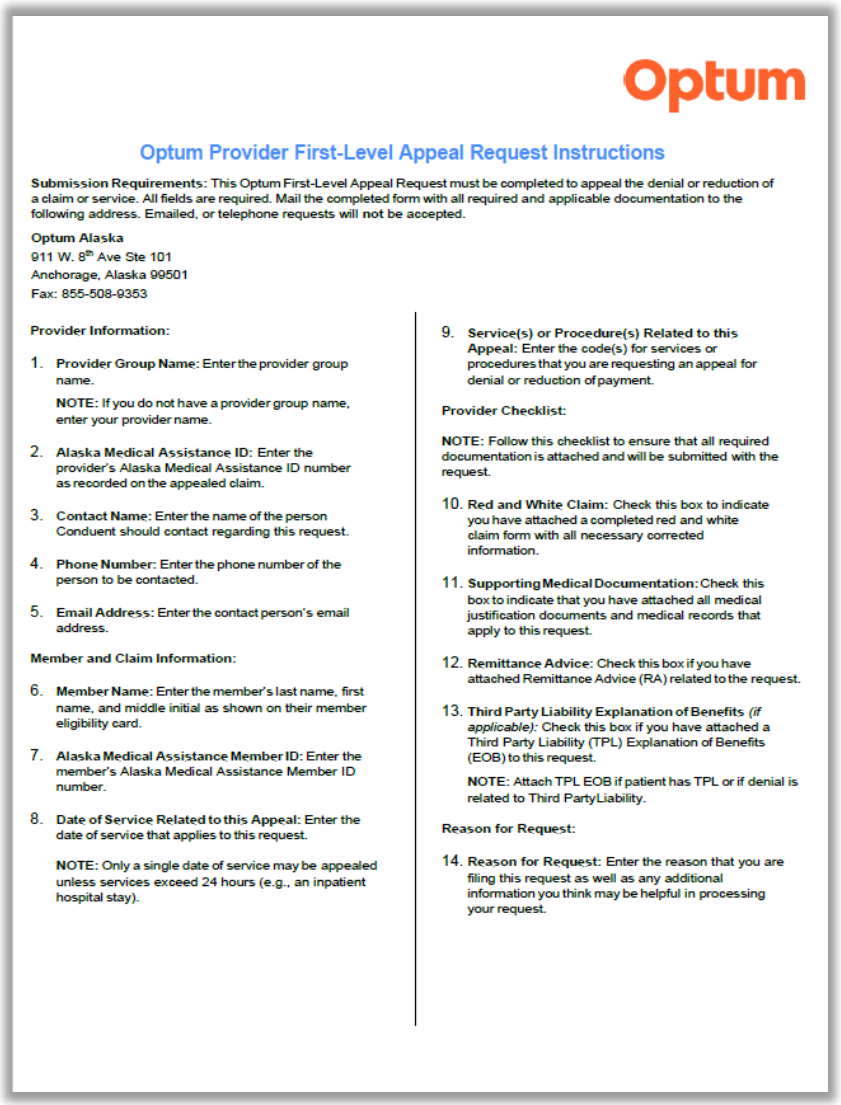
Mail completed form to: **Optum Alaska**
Attn: Appeals & Grievances
911 W. 8th Avenue, STE 101
Anchorage, Alaska 99501
Fax: 855-508-9353

PROVIDER INFORMATION	1. Provider Group Name: _____ 2. Alaska Medical Assistance ID: _____ 3. Contact Name: _____ 4. Phone Number: _____ 5. Email Address: _____
MEMBER AND CLAIM INFORMATION **NOTE:** Only a single date of service may be appealed unless services exceed 24 hours (e.g., inpatient hospital stay).	6. Member Name: _____ 7. Alaska Medical Assistance Member ID: _____ 8. Date of Service Related to this Appeal: _____ 9. Service(s) or Procedure(s) Related to this Appeal: _____ _____ _____

PROVIDER CHECKLIST Please attach all of the following documents. Only single sided documents will be accepted.	10. Original Claim (Red/White) ☐	12. Remittance Advice that includes appealed claim ☐
	11. Supporting Medical Documentation (e.g., physician and/or progress notes, referrals, prescriptions, run sheets) ☐	13. Third Party Liability Explanation of Benefits (EOB, EOMB), if applicable ☐

14. REASON FOR REQUEST AND ADDITIONAL INFORMATION:

rev 03.02.21



Optum

Optum Provider First-Level Appeal Request Instructions

Submission Requirements: This Optum First-Level Appeal Request must be completed to appeal the denial or reduction of a claim or service. All fields are required. Mail the completed form with all required and applicable documentation to the following address. Emailed, or telephone requests will not be accepted.

Optum Alaska
911 W. 8th Ave Ste 101
Anchorage, Alaska 99501
Fax: 855-508-9353

Provider Information:

1. **Provider Group Name:** Enter the provider group name.
   NOTE: If you do not have a provider group name, enter your provider name.
2. **Alaska Medical Assistance ID:** Enter the provider's Alaska Medical Assistance ID number as recorded on the appealed claim.
3. **Contact Name:** Enter the name of the person Conduent should contact regarding this request.
4. **Phone Number:** Enter the phone number of the person to be contacted.
5. **Email Address:** Enter the contact person's email address.

Member and Claim Information:

6. **Member Name:** Enter the member's last name, first name, and middle initial as shown on their member eligibility card.
7. **Alaska Medical Assistance Member ID:** Enter the member's Alaska Medical Assistance Member ID number.
8. **Date of Service Related to this Appeal:** Enter the date of service that applies to this request.
   NOTE: Only a single date of service may be appealed unless services exceed 24 hours (e.g., an inpatient hospital stay).
9. **Service(s) or Procedure(s) Related to this Appeal:** Enter the code(s) for services or procedures that you are requesting an appeal for denial or reduction of payment.

Provider Checklist:

NOTE: Follow this checklist to ensure that all required documentation is attached and will be submitted with the request.

10. **Red and White Claim:** Check this box to indicate you have attached a completed red and white claim form with all necessary corrected information.
11. **Supporting Medical Documentation:** Check this box to indicate that you have attached all medical justification documents and medical records that apply to this request.
12. **Remittance Advice:** Check this box if you have attached Remittance Advice (RA) related to the request.
13. **Third Party Liability Explanation of Benefits** *(if applicable):* Check this box if you have attached a Third Party Liability (TPL) Explanation of Benefits (EOB) to this request.
    NOTE: Attach TPL EOB if patient has TPL or if denial is related to Third PartyLiability.

Reason for Request:

14. **Reason for Request:** Enter the reason that you are filing this request as well as any additional information you think may be helpful in processing your request.

This form is preferred but not required in order to file an appeal.

This form can be found on the Optum Alaska website:

[Guidelines & Policies (optum.com)]

[Service Authorizations (optum.com)]

Second Level Appeals and Final Appeals

Second Level Appeal

A provider may request a second level appeal when:

- The provider is not satisfied with the results of the first level appeal
- The provider is not satisfied with a denied enrollment or disenrollment
- The provider is not satisfied with a service authorization decision
- A second level appeal for National Correct Coding Initiative (NCCI) edits is permissible

A second level appeal must be requested in writing within 60 days of the first level appeal determination to the Division of Behavioral Health

Second Level Appeal

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.

Final Level Appeal

Providers may appeal a previous decision to the Commissioner of the Alaska Department of Health and Social Services (DHSS) when they are not satisfied with the results of the second level appeal only when it relates to denial of a claim for **not meeting the timely filing requirement**.

Final level appeal steps are as follows:

1. An appeal to the DHSS Commissioner must be in writing and postmarked no later than 60 days after the date of the second-level appeal decision by the Division of Behavioral Health. Include a clear description of the issue or decision being appealed and the reason for the appeal.
2. Providers should submit this appeal to:

   Commissioner, Department of Health and Social Services
   PO Box 110601
   Juneau, AK 99811-0601

How to Request Optum Reprocess a Claim

How to Request Optum Reprocess a Claim

If a provider believes there is an error with a claim, they can request that Optum review the claim by:

Emailing the Optum Alaska Provider Relations Team at akmedicaid@optum.com

Contact the Call Center:

(800) 225-8764
8:00 a.m. to 6:00 p.m. Alaska Time
Monday – Friday

How to File a Complaint

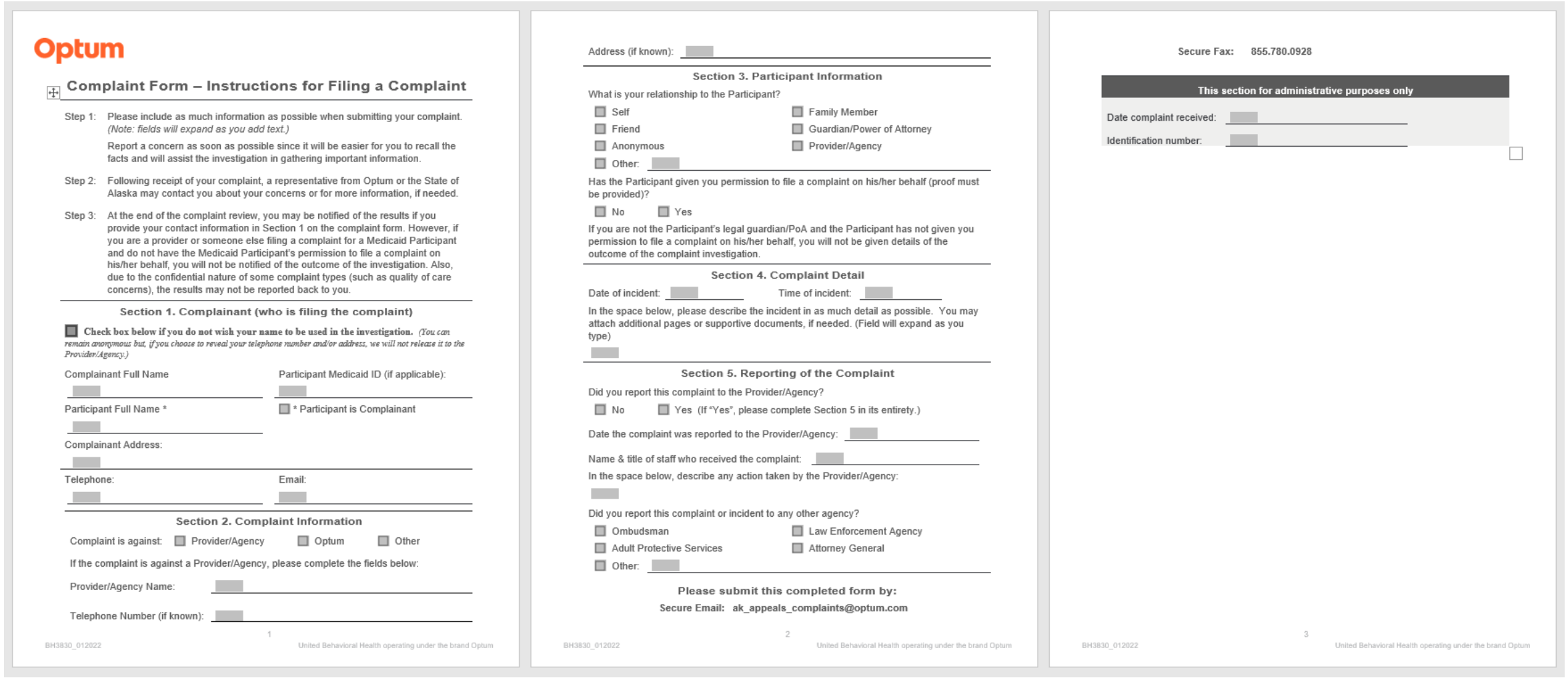
How to File a Complaint

Anyone may file a complaint. Examples of complaints include concerns about quality of care, rudeness of a provider, a provider not respecting Participant rights, a concern about Optum or suspicious behavior. Complaints received are strictly confidential. If you have questions, please call the Optum Alaska Medicaid helpline at 800.225.8764 for assistance.

- Use the online complaint form by Complaint_Form.pdf (optum.com) and submit your complaint by email to ak_appeals_complaints@optum.com
- Print and fax to 855.508.9353, attention Complaints
- Mail to:

  Optum Alaska Attn: Complaints Department
  911 W 8th Ave #101
  Anchorage, AK 99501

Complaint Form



Optum

Complaint Form – Instructions for Filing a Complaint

Step 1: Please include as much information as possible when submitting your complaint. *(Note: fields will expand as you add text.)*

Report a concern as soon as possible since it will be easier for you to recall the facts and will assist the investigation in gathering important information.

Step 2: Following receipt of your complaint, a representative from Optum or the State of Alaska may contact you about your concerns or for more information, if needed.

Step 3: At the end of the complaint review, you may be notified of the results if you provide your contact information in Section 1 on the complaint form. However, if you are a provider or someone else filing a complaint for a Medicaid Participant and do not have the Medicaid Participant's permission to file a complaint on his/her behalf, you will not be notified of the outcome of the investigation. Also, due to the confidential nature of some complaint types (such as quality of care concerns), the results may not be reported back to you.

Section 1. Complainant (who is filing the complaint)

☐ **Check box below if you do not wish your name to be used in the investigation.** *(You can remain anonymous but, if you choose to reveal your telephone number and/or address, we will not release it to the Provider/Agency.)*

Complainant Full Name

Participant Medicaid ID (if applicable):

Participant Full Name *

☐ * Participant is Complainant

Complainant Address:

Telephone:

Email:

Section 2. Complaint Information

Complaint is against: ☐ Provider/Agency ☐ Optum ☐ Other

If the complaint is against a Provider/Agency, please complete the fields below:

Provider/Agency Name:

Telephone Number (if known):

1

BH3830_012022 United Behavioral Health operating under the brand Optum

Address (if known):

Section 3. Participant Information

What is your relationship to the Participant?

☐ Self ☐ Family Member
☐ Friend ☐ Guardian/Power of Attorney
☐ Anonymous ☐ Provider/Agency
☐ Other:

Has the Participant given you permission to file a complaint on his/her behalf (proof must be provided)?

☐ No ☐ Yes

If you are not the Participant's legal guardian/PoA and the Participant has not given you permission to file a complaint on his/her behalf, you will not be given details of the outcome of the complaint investigation.

Section 4. Complaint Detail

Date of incident: Time of incident:

In the space below, please describe the incident in as much detail as possible. You may attach additional pages or supportive documents, if needed. (Field will expand as you type)

Section 5. Reporting of the Complaint

Did you report this complaint to the Provider/Agency?

☐ No ☐ Yes (If "Yes", please complete Section 5 in its entirety.)

Date the complaint was reported to the Provider/Agency:

Name & title of staff who received the complaint:

In the space below, describe any action taken by the Provider/Agency:

Did you report this complaint or incident to any other agency?

☐ Ombudsman ☐ Law Enforcement Agency
☐ Adult Protective Services ☐ Attorney General
☐ Other:

Please submit this completed form by:

Secure Email: ak_appeals_complaints@optum.com

2

BH3830_012022 United Behavioral Health operating under the brand Optum

Secure Fax: 855.780.0928

This section for administrative purposes only

Date complaint received:

Identification number:

3

BH3830_012022 United Behavioral Health operating under the brand Optum

Q&A

Optum