Optum

Claims: Updates, Projects, Modifiers and Denials

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Agenda

1. Updates and Projects
2. Top Denials
3. Procedure Codes \ Modifiers
4. Submitting a Corrected or Void Claim
5. Links, Reminders, and Q & A

Updates

Public Health Emergency

The Public Health Emergency ended on May 11th, 2023. State Fiscal Year (SFY) Limits were reset May 12th, 2023, and Service Authorization requirements have been reinstated as the Public Health Emergency has ended. Moving forward providers will need to submit authorizations for clients who have exhausted their state fiscal limits.

SFY Limits will reset once again on July 1st, 2023.

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

Provider Express

Providers can now view participant Third Party Liability (TPL) information on Provider Express. The TPL information in Provider Express is the same information that is currently in the Optum Claims Payment System. This information also aligns to the MMIS System.

Projects

Projects

What is a project? Is your agency a part of a project?

A project is defined as a single claim or multiple claims that are in the process of or are going to be re-processed.

- Projects can include 1 agency or as many as a hundred agencies.
- Projects can include additional payment and \ or recoups for providers.
- Some projects may include multiple versions. Versions of a project may be closed. While others may be open.
- Provider Relations will be outreaching to agencies and notifying them if \ when they are a part of a project, estimated date of completion, and expected results of that project. And any subsequent follow-up as needed.
- Once a project is complete, Provider Relations will follow-up with agencies to ensure resolution of the project.
- If agencies have questions, please contact Provider Relations at akmedicaid@optum.com

Projects

Project: 911.20 Third Party Liability (TPL) Clean-up – (4 Parts)

What is Happening: Participants were showing TPL coverage in the Optum Claims Payment system, that may have been inaccurate, outdated, and \ or unaccounted for.

What Providers Need To Do: There is no action that providers need to take.

Project Completion Date: TBD

Project Claim Volume: 13,585

Projects

Project: 911.20 Third Party Liability (TPL) Clean-up – cont.

- 911.20 (A) – claims for participants *with no TPL* identified
  - Project Claims Volume: 5,894 claims
  - 71% complete as of 06.09.2023
  - Estimated to be completed: 07.31.2023

- 911.20 (B) – claims for participants *with* TPL, where services should be on TPLA

- 911.20 (C) – claims for participants *with* TPL

- 911.20 (D) – claims for participants *with no TPL,* however, claim may deny for other reasons

Projects

Project: 1125.0 Tribal Claims Paid at Fee For Service

What is Happening: Tribal claims that paid at the incorrect Fee For Service rate are being reprocessed.

What Providers Need To Do: There is no action that providers need to take.
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Project Completion Date: 08/10/2023

Claims Volume: 2,314

Projects

Projects: 53.15 and 53.16 – Retro Eligibility Updates

What is Happening: Claims previously denied for participants having no current Alaska Medicaid eligibility are being reprocessed.

What Providers Need To Do: There is no action that providers need to take.

Project Completion Date: TBD

Claims Volume: 736

Projects - Completed

Projects: 865.3 Invalid Billing NPI Number

What is Happening: Claims were denied for (KD4) N257 Invalid Billing NPI Number due to a file loading error.

What Providers Need To Do: There is no action that providers need to take.

Project Completion Date: 05.12.2023

Claims Volume: 2,090

Denials

Denials

Top Autism Denials

- **N130 (B02) Service not covered for this Provider**
  - **What does this mean?** This denial occurs when the billed code\service is not billable by a provider who is not eligible to provide the service.
  - **How is this corrected?** Verify the code\service is covered by your provider type prior to billing claims via the service specific fee schedule posted. Covered code grids can be found at Optum Alaska - Provider Billing Resources.

- **N77 Invalid provider name, license required**
  - **What does this mean?** This denial occurs when the provider information on the claim does not match the provider information in the Optum claims system.
  - **How is this corrected?** Please provide the name, address, degree, and license level for this service. If an MD, please include the specialty when submitting your claim. Rendering Provider Box 33.

- **N245 Incomplete/Invalid plan in place**
  - **What does this mean?** This denial occurs when a claim is submitted for a participant who has no other insurance listed in the Optum Claims Processing System, but the provider submitted a claim to Optum with an EOB.
  - **How is this corrected?** Verify the participants TPL policy information via Provider Express, Optum Call Center or Provider Relations. Provider Relations can assist with updating TPL policy information if needed.

Denials

Top State Plan Services Denials

- **N130 (B05) Your plan does not cover this expense**
  - **What does this mean?** The denial occurs when the billed code\service is not a covered by Alaska Medicaid.
  - **How is this corrected?** Verify the code\service is covered prior to billing claims via the service specific fee schedule posted. Covered code grids can be found at Optum Alaska - Provider Billing Resources.

- **L03 Send Primary Carrier EOB**
  - **What does this mean?** This denial occurs when the claim is billed for a member with other insurances on file and no primary EOB was submitted with the claim.
  - **How is this corrected?** Verify the members TPL prior to submitting claims and provide the primary EOB at the time of claims submission.

- **N257 Invalid billing provider ID**
  - **What does this mean?** This denial occurs when a claim has an Invalid billing NPI. This means the billing NPI on the claim image is either invalid on the provider detail report or the billing NPI or TIN on the claim image is blank.
  - **How is this corrected?** Verify your claim form is filled out completely and resubmit a corrected claim.

Denials

Top 1115 (V1) Waiver Service Denials

- **517 Invalid procedure modifier combination**-
  - **What does this mean?** This denial occurs when the modifiers are invalid for the procedure code or are not billed in the correct sequence.
  - **How is this corrected?** Please see procedure code/modifier grids for accurate sequencing.

- **TF1 Submitted after provider filing limit**
  - **What does this mean?** This denial occurs when a claim is billed past timely filing.
  - **How is this corrected?** Ensuring that all claims for services are submitted to Optum within 12-months of the date of service. If for any reason a claim is denied, ensure that a corrected claim is submitted within that 12-month of the date of service window. If there are concerns about claims nearing the 12-month timely filing period, please ensure that you are reaching out to the Division of Behavior Health doh.dbh.mpassunit@alaska.gov and Optum akmedicaid@optum.com. Timely Filing (alaska.gov)

- **B01 invalid diagnosis/ CPT Combination**
  - **What does this mean?** This denial occurs when there is an invalid diagnosis code and procedure code combination. Not all diagnosis codes are eligible to be billed with all procedure codes covered by Alaska Medicaid.
  - **How is this corrected? How is this corrected?** Verify the diagnosis and procedure code combination before submitting a claim.
    - V1 waiver services you must supply a SUD (Substance Use Disorder) diagnosis code as the primary diagnosis.

Denials

Top 1115 (V2) Waiver Service Denials

- **B01 invalid diagnosis/ CPT Combination**
  - **What does this mean?** This denial occurs when there is an invalid diagnosis code and procedure code combination. Not all diagnosis codes are eligible to be billed with all procedure codes covered by Alaska Medicaid.
  - **How is this corrected?** Verify the diagnosis and procedure code combination before submitting a claim.
  - V1 waiver services you must supply a SUD (Substance Use Disorder) diagnosis code as the primary diagnosis.
  - V2 waiver services you must supply a MH (Mental Health) diagnosis code as the primary diagnosis.

- **M77 Place of service inappropriate for procedure**
  - **What does this mean?** The servicing location is not eligible to bill for the service provided.
  - **How is this corrected?** Verify the servicing location information is correct on the claim prior to submission.

- **N130 (B05) Your plan does not cover this expense**
  - **What does this mean?** The denial occurs when the billed service is not a covered service.
  - **How is this corrected?** Verify covered services prior to billing claims via the service specific fee schedule posted. Covered code grids can be found at Optum Alaska - Provider Billing Resources.

Procedure Codes / Modifiers

Procedure Codes / Modifiers

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

Entering procedure code modifiers in any other order may result in claim denials, underpayments and/or overpayments that must be refunded.

- 1115 Waiver Services (optum.com)
- Autism Services (optum.com)
- State Plan Services (optum.com)

Procedure Codes / Modifiers

Incorrect Billed Code/Modifier Combination	Correct Code/Modifier Combination
H0007 HB HQ V1 GT	H0007 HQ HB V1 GT
H0047 CG HA V1 TF	H0047 CG V1 HA TF
T1007 FQ V1	T1007 V1 FQ
H2021 V1 HQ FQ	H2021 HQ V1 FQ
H2021	H2021 V1 *or* H2021 V2
97158 XE 95	97158 95 XE
90832 GT FQ	90832 GT *or* 90831 FQ
90846 U7 GT FQ	90846 U7 GT *or* 90846 U7 FQ

Procedure Codes / Modifiers

X Modifier

X modifiers are used to indicate separate services that are medically necessary to occur on the same date of service as another service.

XE Modifier – Separate encounter, service is distinct because it occurred during a separate encounter.
XP Modifier – Separate practitioner, service is distinct because it was performed by a separate provider.
XU Modifier – Unusual non-overlapping service, the service is distinct because it does not overlap usual components of the main service.

95 Modifier

Modifier 95 may continue to be used on telehealth video conferencing claims. While the Public Health Emergency has ended, the Division is aware there is still a need for telehealth services to be provided. While the new regulations are being finalized the 95 modifier will need to be used for billing purposes.

FQ Modifier

Modifier FQ may continue to be used for audio only conferencing claims. While the Public Health Emergency has ended, the Division is aware there is still a need for telehealth services to be provided. While the new regulations are being finalized the FQ modifier will need to be used for billing purposes.

Procedure Codes / Modifiers

Billing Codes: 96130, 96132, and 96136.

Is it permissible to use multiple units of the evaluation code in serial days?

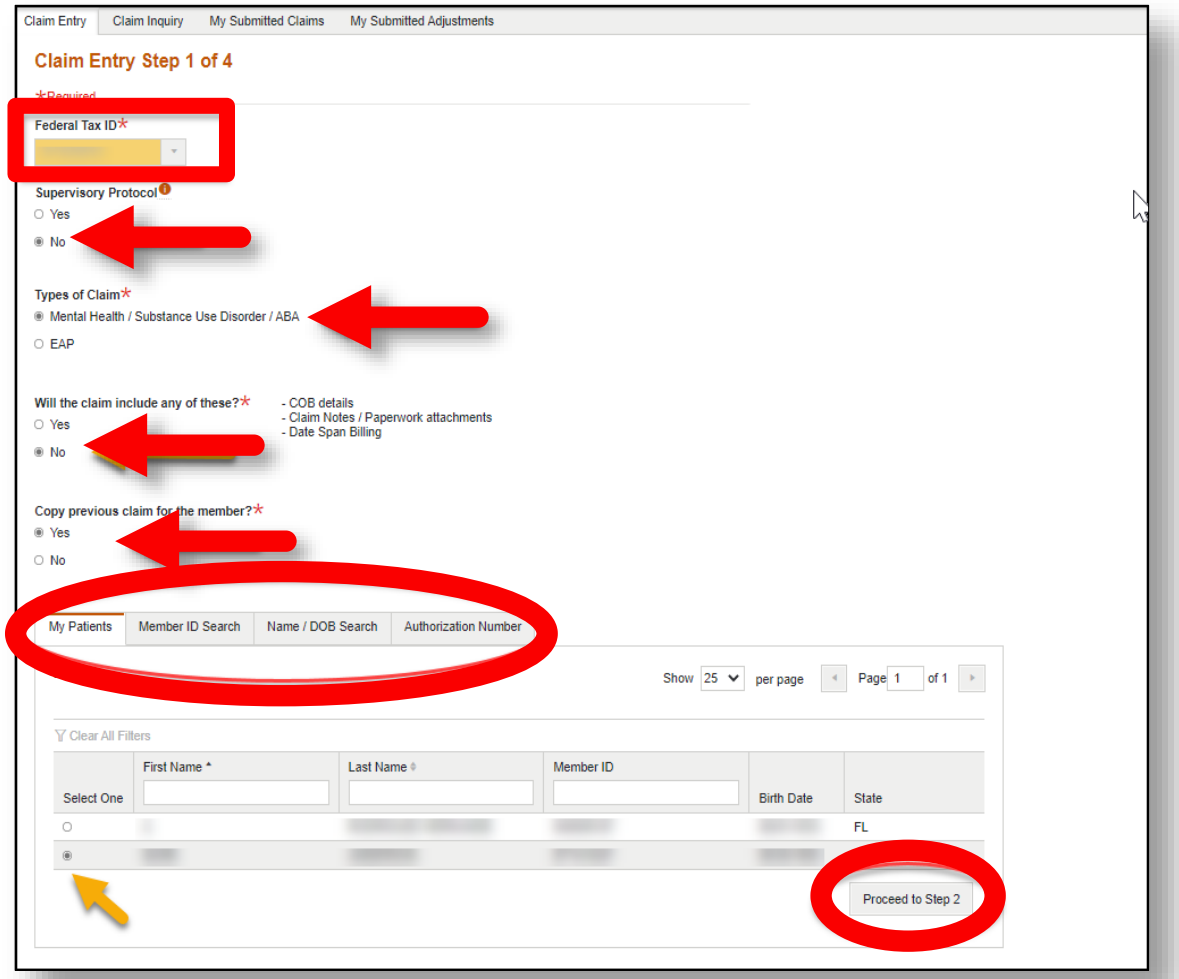
No, It is not permissible to use multiple units of the same evaluation code in serial days in a single testing episode.

When a service is spread out over multiple visits, the total cumulative time spent performing each type of service in the evaluation process (i.e., clinical/diagnostic interview, testing evaluation services, and test administration and scoring) should be reported at the completion of the entire episode of care. The single claim should list both base and add-on codes with the different dates of service linked to the entire episode of evaluation. A single base code should only be submitted for the first unit of each type of service of the evaluation process. Only add-on codes should be used to capture subsequent units of service on the same or different days.

(Centers for Medicare & Medicaid Services [CMS], National Correct Coding Initiative [NCCI] April 1, 2019 Change Report for Add-On Code Edit Changes; MLN Matters® SE17023 Guidance on Coding and Billing Date of Service on Professional Claims).

Submitting a Corrected or Void Claim

Submitting a Corrected or Void Claim



There are several required fields:

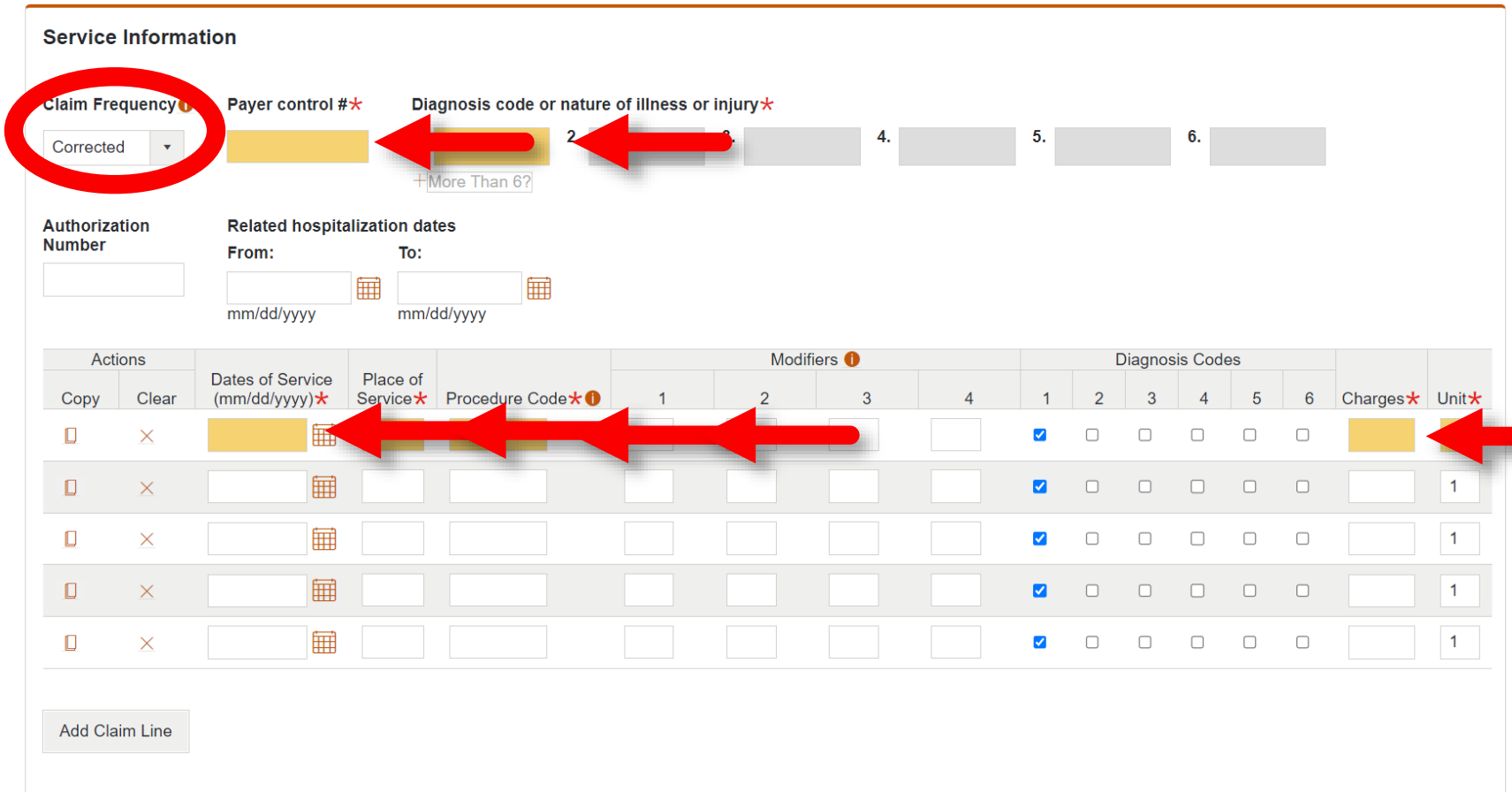
- Federal tax ID
- Supervisory Protocol
- Type of claim
- “Will the claim include any of these?” (default of No is chosen which will bring up the Short Form)
- Copy Previous claim for this member

Complete the member search by:

- Choosing the Member from your *My Patients* list
- Using one of the Member search options

  OR
- Entering an Authorization number

Submitting a Corrected or Void Claim



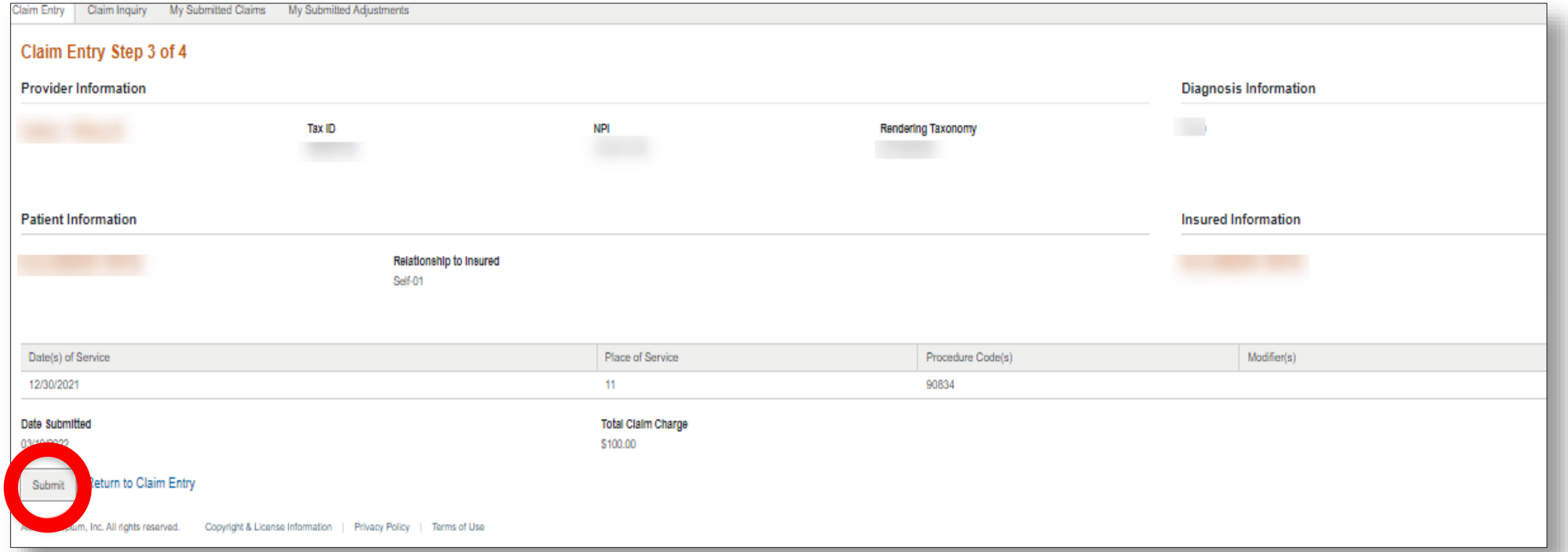
Required Items :

- Original Claim number (Payer Control #)
- Claim Frequency Selected (Corrected)

Submitting a Corrected or Void Claim

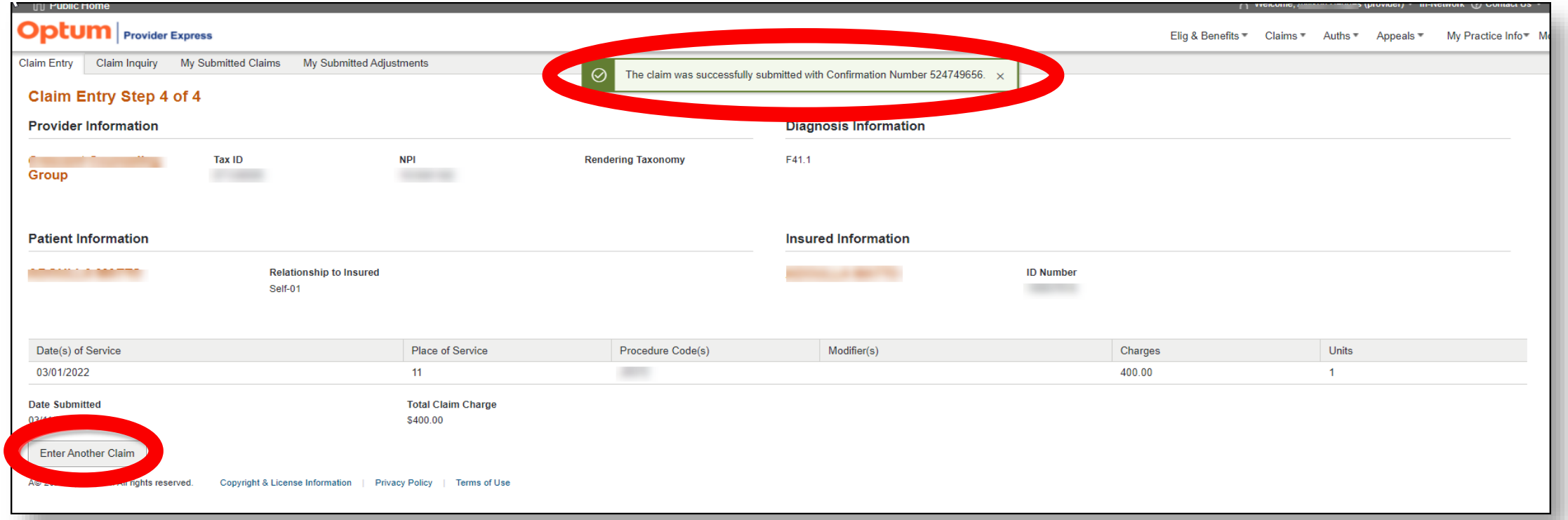
Step 3 allows users to preview basic information on the claim before sending for submission

If all the information is accurate, click the [Submit] button to continue to the final step, or click on the [Return to Claim Entry] option to return to Step 2



Submitting a Corrected or Void Claim

Step 4 yields the same information as in Step 3, with the addition of a Confirmation Number, verifying the claim has been successfully submitted



Submitting a Corrected or Void Claim

Frequency 7 & 8 Claims

Frequency code 7 Indicates the new claim is a replacement or corrected claim – the information present on this claim represents a complete replacement of the previously submitted claim.

Frequency code 8 indicates a void or cancel of prior claim: The information on this claim is an exact duplicate of an incorrect claim previously submitted. This code will void the original submitted claims.

Links

Links

Optum Alaska - Alaska - Optum Provider Portal

Provider Express - Optum - Provider Express Home

Creating a One Healthcare ID - Create One Healthcare ID - One Healthcare ID

Optum Pay- Login (optumhealthpaymentservices.com)

Provider Quick Links Page- Provider Resource Links (optum.com)

Printable ASAM Assessment- ASAM Criteria Intake Assessment Guide

Provider Quick Reference Guide- Optum Alaska Medicaid Behavioral Health - Quick Reference Guide

Reminders

Reminders

- Generally, clean claims that contain all the required information will be paid within 30 days after receipt of the claims. This may exclude claims which require an exception process, such as coordination of benefits (COB) and student status verification, which can delay this process. The procedure for processing claims will be modified as necessary to satisfy any applicable state laws.

- Registered users of Provider Express can use the Claim Inquiry transaction within Provider Express.

- For questions about using the site, issues with requesting a user ID and password, or for technical issues, call the Provider Express Support Center at **(866) 209-9320** from 7 a.m. to 7 p.m. (CST), 4 a.m. to 4 p.m. (AKST) or click on the Chat now button on the Provider Express Contact Us page to chat with a tech support representative online.
- If your agency is having issues with getting Provider Express to accept your rendering and \ or billing NPI number, please reach out to Provider Relations at akmedicaid@optum.com

Reminders

If an agency would prefer to mail in paper claims. Paper claims can be mailed to:

Optum
P.O. Box 30760
Salt Lake City, Utah 84130-0760

Fax:

248.733.6085

Reminders

TPLA (Third Party Liability Avoidance)

Third Party Liability Avoidance (TPLA) is allowed when a specific code or service is non-covered by a Participant's primary insurance carrier. TPLA allows providers to bill directly to Medicaid for that specific code or service without billing the Participant's primary, each time the service is rendered.

Providers will submit an EOB from the Participant's primary insurance carrier once per calendar year (January 1 – December 31) showing the code or service is not covered.

Please be sure that the following items are visible on the EOB:

- Participant Name
- Non-Covered service or code
- Explanation code

A new EOB showing the specific code or service is non-covered will be required January 1 of every year.

If you have questions regarding a Participant’s TPLA coverage, please reach out to the Call Center at 800.225.8764 or Provider Relations at akmedicaid@optum.com

Reminders

Appeals

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. You can find the First Level Appeal form on the Alaska - Optum Provider Portal website

First level appeals must be in writing received within 180 days of the claim disposition date (the date of the remittance advice). Any appeal submitted past timely will not be considered.

The Optum Provider First-Level Appeal Request Form must be completed to appeal the denial or reduction of a claim or service. All fields on the form are required. Once the form is completed, please mail the form with all required and applicable documentation to Optum Alaska. First-Level appeals are not accepted by email, or telephone.

Optum Alaska
Attn: First-Level Appeals
911 W. 8th Avenue, Suite 101
Anchorage, Alaska 99501
Fax: 855.508.9353

Reminders

Call Center

800.225.8764

The call center is available from 8:00 a.m. – 6:00 p.m. AKT, Monday through Friday for questions, or concerns that you may have regarding claims inquiries, participant eligibility, service authorizations or any other inquiry.

Reminders

Uncashed Checks

From time to time, Optum will reach out to a provider \ agency with regards to uncashed checks. These are paper checks that are mailed to the provider \ agency address on file.

Why would a check be uncashed:

- Lost or never received
- Provider \ Agency moved
- Delayed in making a trip to the bank

To ensure that Optum is contacting the right person within your agency, please ensure that any staff member who may handle payments is signed up with Optum to receive Provider Alerts and outreach.

Optum Alaska - Provider Alert Email

Provider Relations

Provider Relations

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 763.324.4406
- Tabetha Thomas 952-251-1143
- Ita Puletapuai 952.324.4006
- Email: akmedicaid@optum.com
- Fax: 1-844-881-0959

Provider Relations

When submitting an inquiry to Provider Relations (akmedicaid@optum.com) please be sure to include the following information:

No PHI (regular email):

- Date of Service
- Provider Name and NPI/TIN
- Reason for the inquiry (as much detail as possible)

Provider Relations

When submitting and inquiry to Provider Relations (akmedicaid@optum.com) please be sure to include the following information:

PHI (secure email):

- Participant Name
- Participant Medicaid ID number
- Claim Number(s)
- Date of Service
- Provider Name and NPI \ TIN
- Reason for the inquiry

This will allow the Provider Relations team to review all inquiries in a timely manner.

Q&A