Claims Updates – Top Claims Denials, Causes and Resolutions

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July 27, 2022

Agenda

1. Updates & Projects
2. Modifiers
3. Trending Top 5 Denials & Other Denial Reasons
4. Reminders
5. Questions & Answers

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Updates & Projects

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Updates

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 October 13, 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

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Projects

Project Name: New Rates as of July 01, 2022

What is Changing: Effective July 01, 2022. New rates went into effect. These rates have been loaded into the Optum system as of July 12, 2022.

What rates were updated:

- State Plan Services
- Mental Health Physician Clinics
- Independent LCSW
- Independent LMFT
- Independent LPC
- *Psychologist – In process*
- *Autism – updated May 26, 2022*
- *1115 – No updates at this time*

What providers need to do: There is nothing for the providers to do currently. Optum will be going back and reprocessing claims for dates of service after July 01, 2022, that were paid with the old rates.

Target Completion Date: July 31, 2022

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Projects

Project Name: Split Claims

What is Happening: When T1007 V1 *or* V2 was billed in conjunction with 908XX, one line paid while the other denied.

What providers need to do: There is nothing for the providers to do currently. Optum is going back and splitting out the claim to allow both lines pay.

Denial Reason Codes:

- B37 – OON (out of network) provider – Services not covered for plan
- B62 – Individual provider name, license required
- FOD – Individual provider name, license required
- CDD – Definite Duplicate Claim

Target Completion Date: August 31, 2022

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Projects

Project Name: Eligibility Cleanup

What is Happening: Claims that were denied when Participant was Medicaid eligible. Optum is currently reloading all eligibility files from 2020 – current to ensure all Participant eligibility is correct.

What providers need to do: There is nothing for the providers to do currently. Once all the eligibility files have been loaded, claims that were incorrectly denied, will be identified and reprocessed.

Denial Reason Code(s):
- S1A – No eligibility found
- B71 – Participant incarcerated
- SS – Separation Member

Target Completion Date: September 30, 2022

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Projects

Project Name: Invalid Procedure\ Modifier Combo

What is Happening: Alaska Medicaid has a requirement for modifiers to be in a specific order to allow to reimbursement. There was a system limit that caused incorrect reimbursement. This is specifically for dates of service 07/01/2021 – 06/10/2022.

What providers need to do: There is nothing for the providers to do currently. Optum is currently working to identify all claims that are impacted, for reprocessing.

Target Completion Date: July 30, 2022

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Modifiers

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Modifiers

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

IF the procedure and modifier combination is not EXACTLY as shown in the primary modifier grid THEN, the line will deny as an invalid modifier combination. Denial code: B46 – Invalid Procedure 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.

Telehealth:

- GT – Telehealth services via interactive audio and video telecommunications systems*
- 95 – Synchronous telemedicine service via real-time audio and video telecommunications*
- FQ – Services furnished using audio only communication technology *

* MUST be billed with Place of Service 02 or 10.

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Modifiers

Examples:

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

H0007 HB HQ V1 GT – should be H0007 HQ HB V1 GT

H2021 HQ V1 FQ XP – should be H2021 HQ V1 FQ

H0007 V1 HQ HA GT – should be H0007 HQ HA V1 GT

H2021 - should be H2021 V1 *or H2021* V2

90832 GT FQ – should be 90832 GT *or* 90832 FQ

90846 U7 GT FQ – should be 90846 U7 GT *or* 90846 U7 FQ

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Modifiers

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 modifier gird will result in claim denials, underpayments and/or overpayments that must be refunded.

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.

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Modifiers

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)

Primary Modifier Grids are currently being updated

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Top 5 Trending Denials & Other Denial Reasons

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Alaska Top 5 Trending Denials

1	Definite Duplicate Claim
2	Timely Filing
3	Place of Service Inappropriate for Procedure
4	TPL – Third Party Liability
5	Participant Not Eligible on Date of Service

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Definite Duplicate Claim

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Definite Duplicate Claim

Duplicate claims occur when providers submit two or more claims with some or all of the same information, including:

- Date of service
- Charges
- Participant ID
- Provider NPI (National Providers Identifier)
- Procedure codes

Denial code: CDD – Definite Duplicate Claim

If you feel a claim is denied a duplicate in error, you can contact Provider Relations and request a review of the denied claim(s).

If a corrected claim needs to be submitted, please be sure to include the original claim number along with selecting corrected claim type, frequency 7 – Corrected.

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Definite Duplicate Claim

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

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

<u>*A corrected claim will be required if modification to a claim are needed.*</u>

Reminder:

Frequency 7 – Corrected Claim

Frequency 8 – Voided

This Frequency information helps tell the system that the claim is a correction or void rather than a duplicate.

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Timely Filing

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Timely Filing

Timely filing is when a provider submits a claim for payment within a determined time limit.

Denial Code:

- TF0 – Submitted after plan filing limit
- TF1 – Submitted after provider's filing limits.

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

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Timely Filing

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

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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.

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Place of Service Inappropriate for Procedure

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Place of Service Inappropriate for Procedure

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*

Place of Service for Telehealth:

02 – **Telehealth other than Participants home** – used when the location where health services and health related services are provided or received, through telecommunication technology. Participants is *not* located in their home when receiving health services or health related services through telecommunication technology.

10 – **Telehealth provided in Participants home** – used when the location where health services and health related services are provided or received, through telecommunication technology. *Participant is located in their home* (which is a location other than a hospital or other facility where the patient received care in a private residence) when receiving health services or health related services through telecommunication technology.

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Place of Service Inappropriate for Procedure

Telehealth place of service codes 02 or 10 must be billed with one of the following appropriate telehealth modifiers:

- GT – Telehealth services via interactive audio and video telecommunications systems
- 95 – Synchronous telemedicine service via real-time audio and video telecommunications
- FQ – Services furnished using audio only communication technology

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 (Telehealth provided in Participants home) is not valid for dates of service prior to 4/1/2022

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TPL – Third Party Liability

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TPL – Third Party Liability

One additional common reason your claim(s) may be rejected \ denied is that the Participant may have TPL (Third Party Liability). TPL refers to the legal obligation of third parties (for example, certain individuals, entities, insurers, or programs) to pay part or all the expenditures for medical assistances furnished under a Medicaid state plan. Providers who bill Alaska Medicaid are required to bill all third-party resources (except the Indian Health Services) prior to billing Alaska Medicaid.

Per CMS (Centers for Medicare and Medicaid Services) 42 CFR § 433.139(b)(1) – *Except as provided in paragraph (e) of this section. If the agency has established the probable existence of third-party liability at the time that claim is filed, the agency must reject the claim and return to the provider for a determination of the amount of liability. The establishment of third-party liability takes place when the agency received confirmation from the provider or a third-party resource indicating the extent of third-party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment is allowed under the agency's payment schedule exceeds the amount of the third party's payment.*

Examples:

- Group health plans
- Self-Insured plans
- Medicare
- Other state or Federal coverage programs

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TPL – Third Party Liability

Providers will need to ensure that all claims submitted to Optum have an EOB (Explanation of benefits), if required.

If electronic (examples: clearing house, provider express), providers will need to submit other insurance information in the appropriate fields. More information can be found at the following link: https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/trainingMain/guidedTour/LongFormOvrvewBH4041.pdf.

If paper claims are submitted, providers will need to include the paper copy of the EOB:
Optum
P.O. Box 30760
Salt Lake City, Utah 84130-0760

Fax: 248.733.6085

_ If TPL information is entered electronically, there is no need to mail\fax EOB's._

If you have questions regarding a Participant's TPL coverage, please reach out to Provider Relations.

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TPLA – Third Party Liability Avoidance

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

Providers will submit an EOB from the Participants primary insurance carrier once per calendar (January 1 – December 31) year 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.

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Participant Not Eligible on Date of Service

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Participant Not Eligible on Date of Service

Providers have submitted claims when the Participant was not eligible on the date of service. Therefore, the participant is not eligible for Medicaid services.

If a claim is denied due to a participant not having Medicaid eligibility providers may work with the participant and the Division of Public Assistance to update eligibility.

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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.

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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

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Other Denial Reasons

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Other Denial Reasons

1

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.

Reason code: W37 – OON (out of network) provider – services not covered for plan.

2

Single Date of Service Billing – Claims should be submitted with a single date of service. Claim lines reporting more than one date of services ("spanned") will be denied.

Reason code: 073 – Deny all claim lines

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Reminders

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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

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Optum Pay Reminders

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

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Submitting an Inquiry to Provider Relations

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

None PHI (regular email):

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

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Submitting an Inquiry to 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.

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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:

- TeriLynn Girmscheid 952.251.2329
- Ryan Bender 763.324.4406
- Vaoita Puletapuai 952.324.4006
- Email: akmedicaid@optum.com
- Fax: 1-844-881-0959

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Q&A

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