Optum

Claims Updates – Top Claims Denials, Causes and Resolutions

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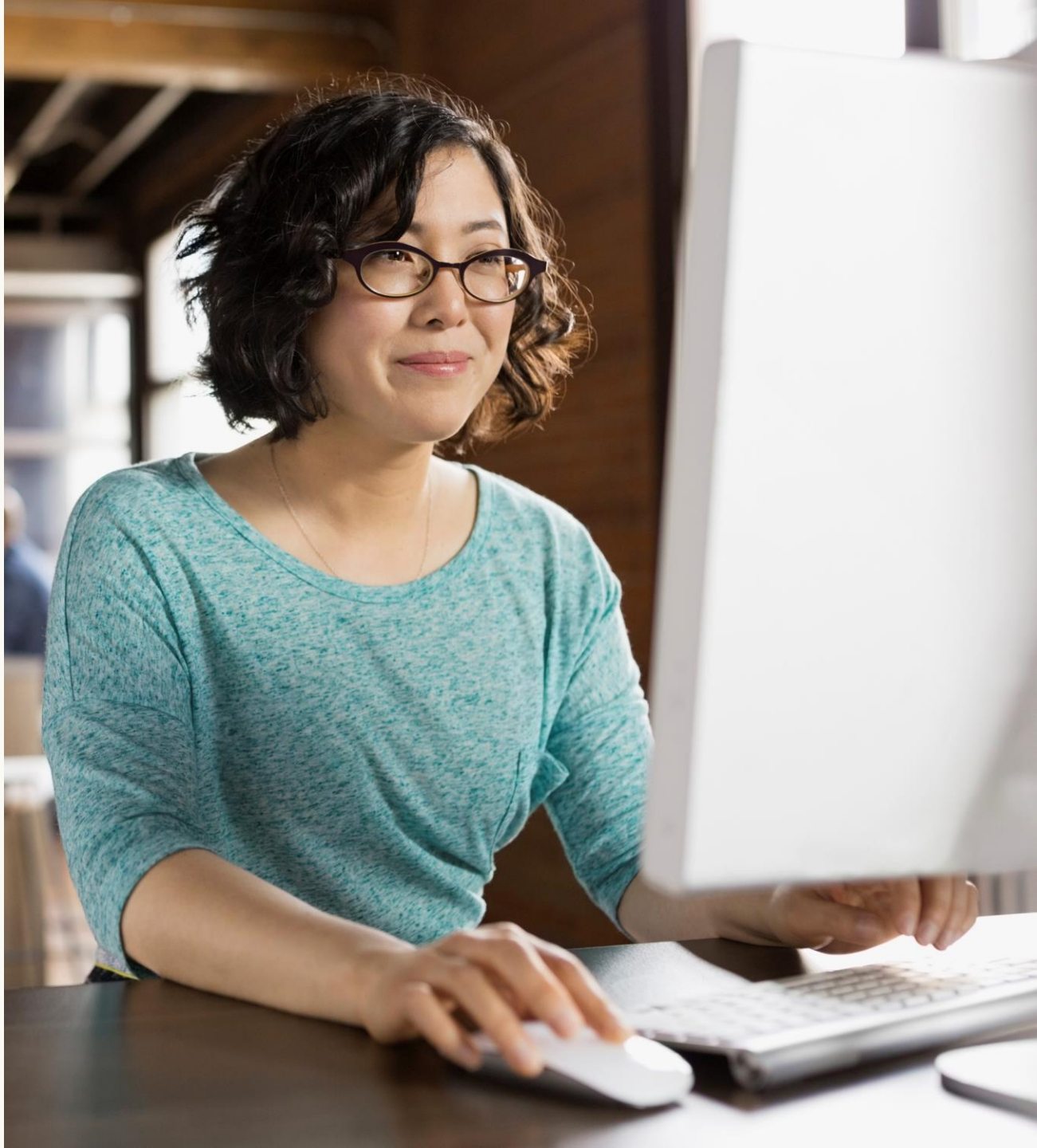

Agenda

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

Updates & Projects

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

Project – New Rates Effective July 1, 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 – rate were updated on May 26, 2022*
- *1115 – No updates at this time*

What providers need to do: There is no action that providers need to take.

Project Completion Date: Complete

Project details: Optum reviewed for impacted claims and did not identify any that required reprocessing.

Project – 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 no action that providers need to take. Optum has 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

Project Completion Date: 8/23/2022

Project Claim Volume: 27

Project Dollars Paid: $915.48

Project – Eligibility Clean-up

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

What providers need to do: There is no action that providers need to take. Optum will identify any needed claims adjustments and claims will be reprocessed.

Denial Reason Code(s):

- S1A – No eligibility found
- B71 – Participant incarcerated
- SS – Separation Member

Project Completion ETA: Q4-2022

Project Claim Volume: 7,400+

Project – Invalid Procedure/Modifier Combination

What is Happening: Alaska Medicaid has a requirement for modifiers to be in a specific order to allow 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 no action that providers need to take. Optum is currently reprocessing claims.

Project Completion Date: 8/18/2022

Project Claim Volume: 1,214

Project Dollars Paid / Recouped: - $442,691.96

Modifiers

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.

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

Modifiers

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

Entering a procedure code and 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. Be sure to indicate that on the resubmitted claim as a *Corrected* Claim. Records may need to accompany the corrected claim in some situations.

All information requested must be submitted with the corrected claim for the claim to be reconsidered for payment.

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

Top 5 Trending Denials Reasons & Other Denial Reasons

Alaska Top 5 Trending Denials

1	Invalid Billing Provider NPI or Billing Provider TIN
2	Invalid Procedure Modifier Combination
3	Definite Duplicate Claim
4	Place of Service Inappropriate for Procedure
5	TPL – Third Party Liability

Invalid Billing Provider NPI or Billing Provider TIN

Invalid Billing Provider NPI or Billing Provider TIN

Providers have submitted claims with Billing TINs or Billing NPIs associated with provider records that are ineligible for BH services. In some cases, the provider record is eligible however the date of service on the claim is not within the provider's specialty date range.

If a claim is denied for this reason, a claim can be resubmitted once the billing information on the claim has been confirmed as correct and accurate.

Invalid Procedure Modifier Combination

Invalid Procedure Modifier Combination

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

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.

Definite Duplicate Claim

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 as 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.

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

A corrected claim will be required if modification to a claim ~~are~~ is needed.

Reminder:
Frequency 7 in box 22 – Corrected Claim
Frequency 8 in box 22 – Voided
This Frequency information helps tell the system that the claim is a correction or void rather than a duplicate.

Place of Service Inappropriate for Procedure

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. The Participant *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. The 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.

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

TPL – Third Party Liability

TPL – Third Party Liability

One additional common reason your claim(s) may be rejected/denied is the Participant may have ~~TPL (~~Third Party Liability (TPL). 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
- Dependent children covered by a parent with commercial group insurance, self-insured plans, Medicare or other state/Federal coverage program.

TPL – Third Party Liability

Providers will need to ensure all claims submitted to Optum have an Explanation of Benefits (EOB) where Third Party Liability (TPL) is evident.

If submitting 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 the Call Center at 800.225.8764 or Provider Relations at akmedicaid@optum.com

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.

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

Other Denial Reasons

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

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

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.

When searching Optum Pay for ***adjusted*** claims payment

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

Submitting an Inquiry to Provider Relations

When submitting and 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)

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.

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
- Email: akmedicaid@optum.com
- Fax: 1-844-881-0959

Q&A