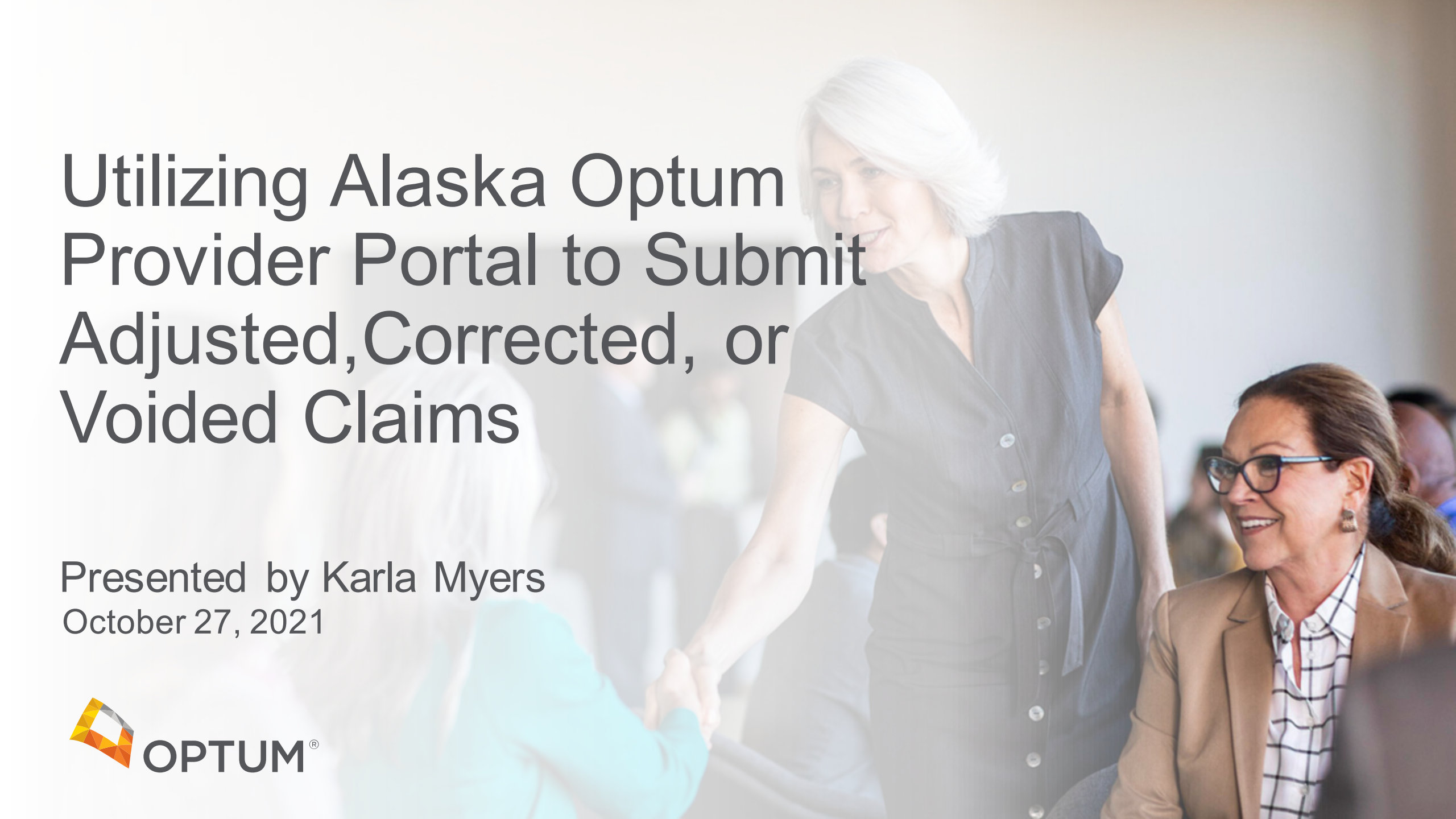
Welcome
Optum Alaska

Utilizing Alaska Optum Provider Portal to Submit Adjusted,Corrected, or Voided Claims



Presented by Karla Myers

October 27, 2021

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Agenda

1. Payment Cycles
2. Alaska Optum Provider Portal
3. Claim Status Summary
4. How to adjust, correct, and void claims
5. Reading a Provider Remittance Advice
6. Questions and Answers
7. Contact the Alaska Provider Relations Team

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Payment Cycles

Electronic Fund Transfers (EDI/835)

- Electronic Fund Transfers – Run on Tuesday and Saturday
- Claims must be in “01” status by 8:00 PM Alaska Standard Time on Monday and Friday.
  - Status “01” is awaiting check run and means the claim is ready to be picked up for the next available check run
- Payments settle in the Providers account on the following:
  - Friday for Tuesday payments
  - Thursday for Saturday payments

Paper Checks

- Paper Checks – Run on Tuesday and Saturday
- Claims must be in “01” status by 8:00 PM Alaska Standard Time on Monday and Friday.
  - Status “01” is awaiting check run and means the claim is ready to be picked up for the next available check run

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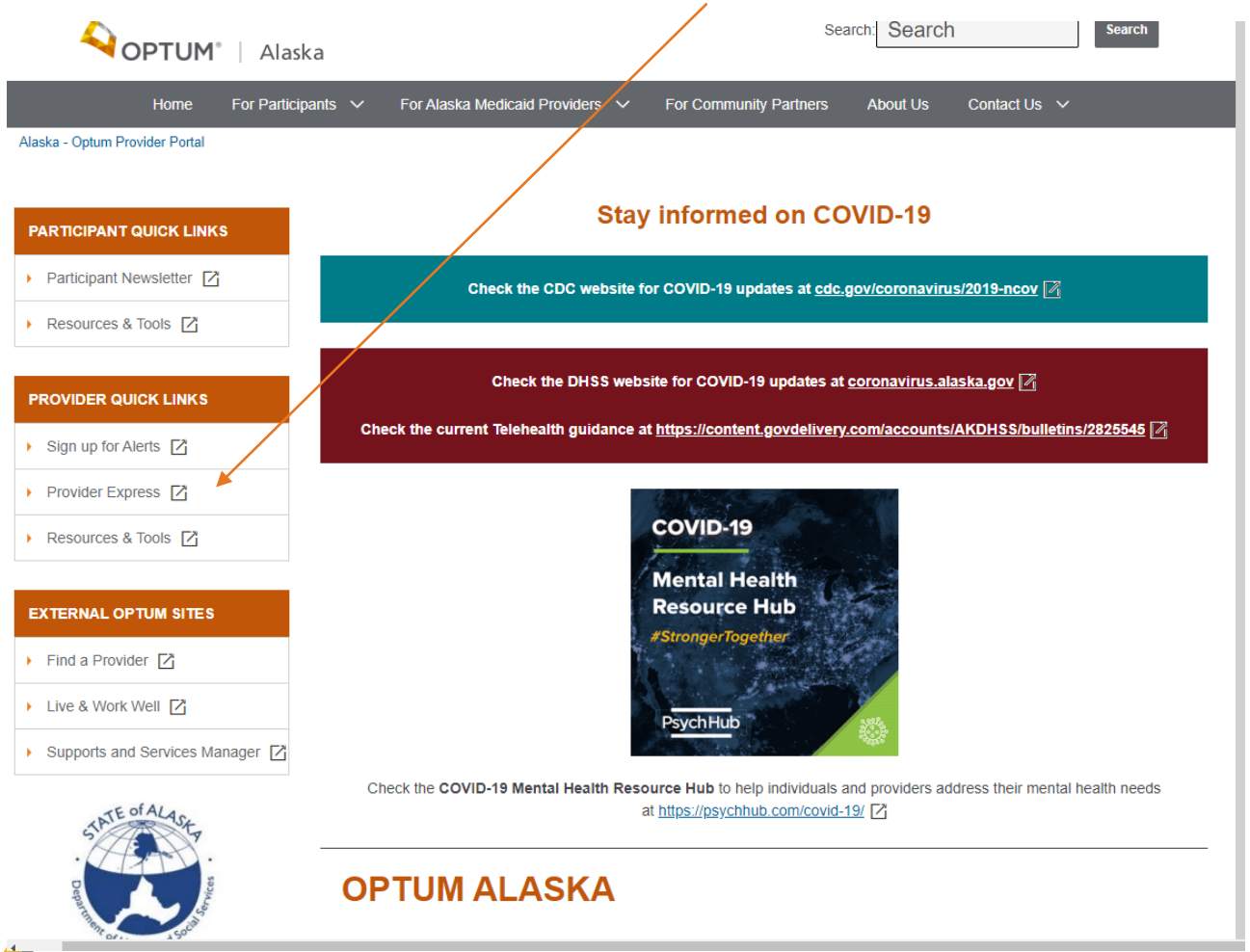
Alaska Optum Provider Portal

Alaska Optum Provider Portal

[Alaska - Optum Provider Portal](#) Click on Provider Express.



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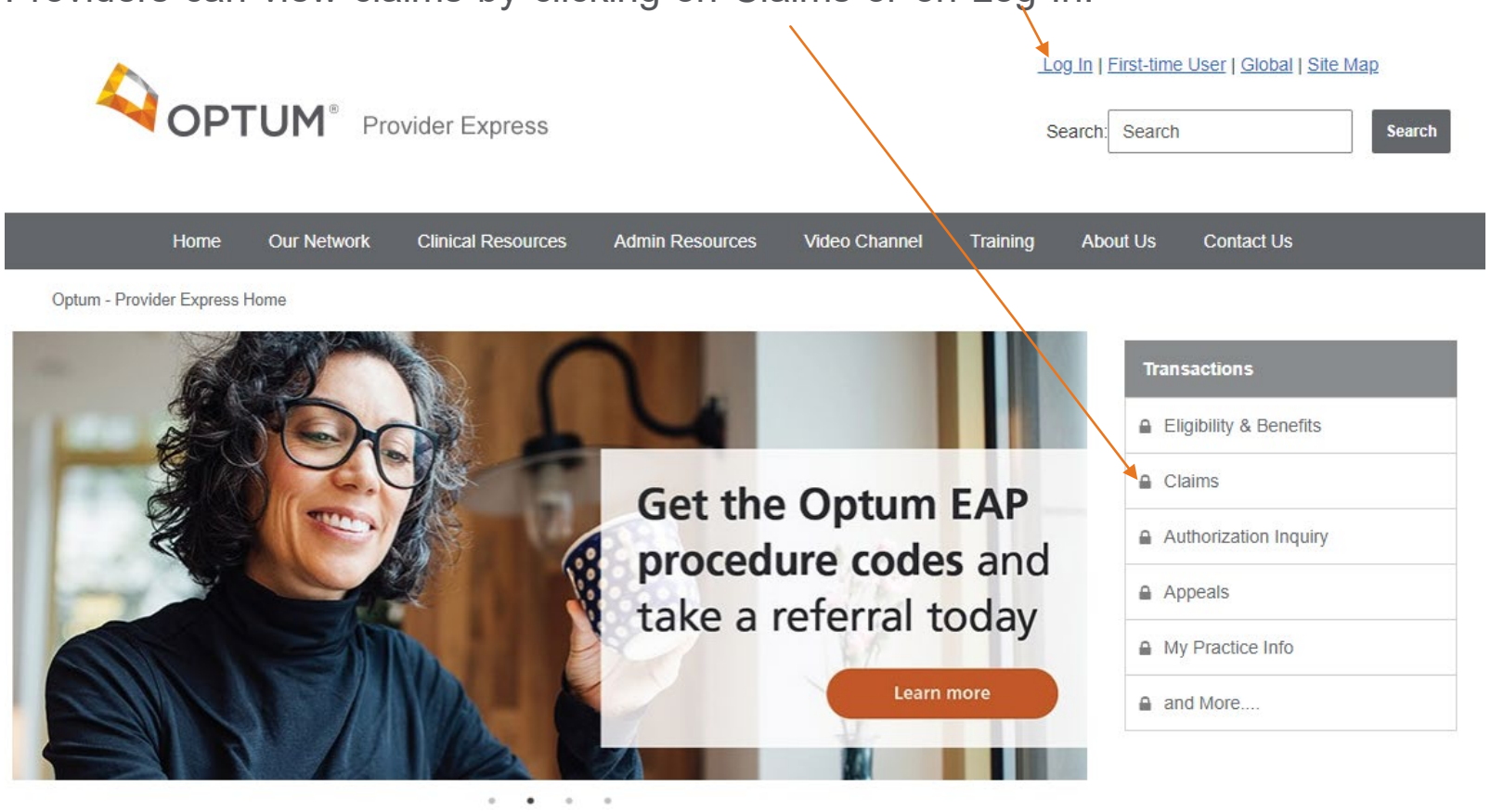
Optum Provider Express

Optum - Provider Express Home

Providers can view claims by clicking on Claims or on Log In.



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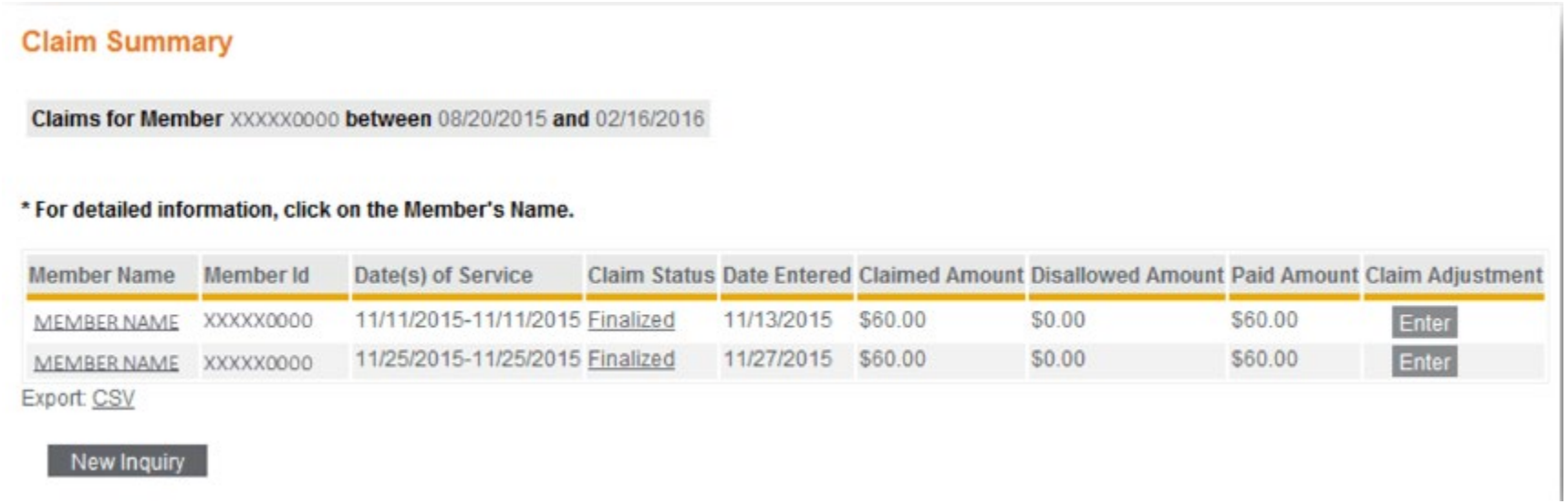
Claim Status Summary

Claim Summary

Claims will display with the parameters of the search criteria entered.

Users have the option to click on the member's name to display a detailed list of that claim.

Claims not fully processed will show Pending in the Claim Status.



Claim Summary

Claims for Member XXXXX0000 **between** 08/20/2015 **and** 02/16/2016

*** For detailed information, click on the Member's Name.**

Member Name	Member Id	Date(s) of Service	Claim Status	Date Entered	Claimed Amount	Disallowed Amount	Paid Amount	Claim Adjustment
MEMBER NAME	XXXXX0000	11/11/2015-11/11/2015	Finalized	11/13/2015	$60.00	$0.00	$60.00	Enter
MEMBER NAME	XXXXX0000	11/25/2015-11/25/2015	Finalized	11/27/2015	$60.00	$0.00	$60.00	Enter

Export: CSV

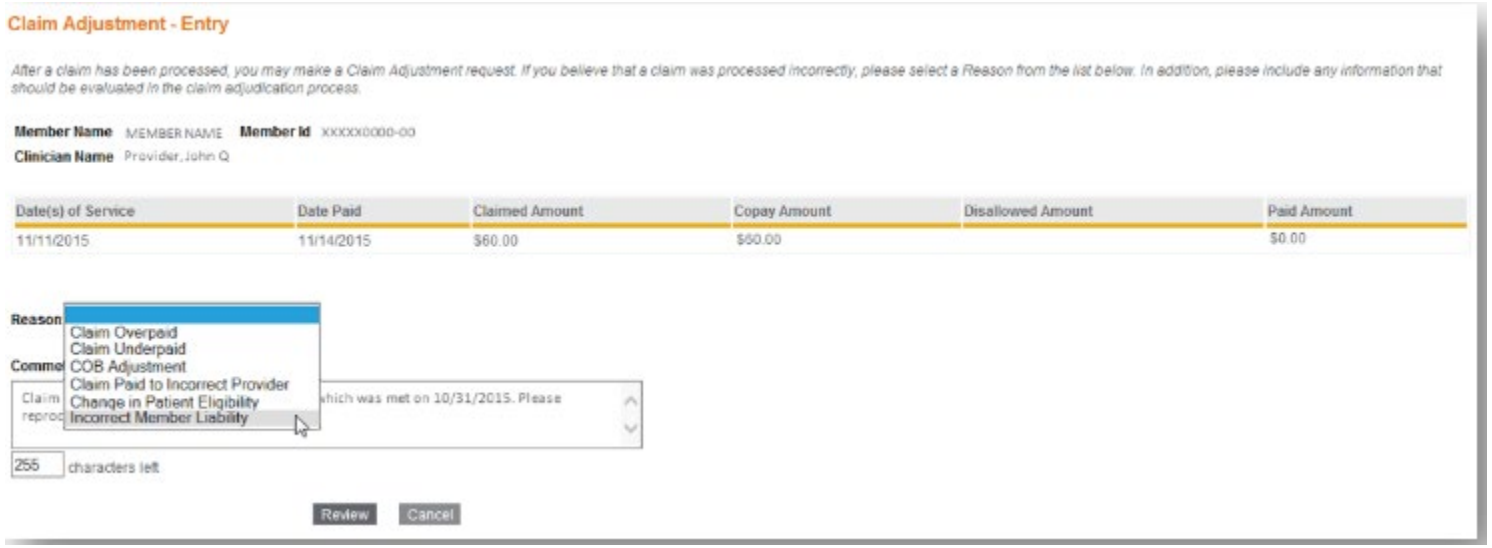
New Inquiry

*If claim amount is not what is expected, click the {Enter} button

Adjusting a Claim

Claim Adjustment Request

The claims adjustment screen displays the reason for the request and is selected from the drop down list.



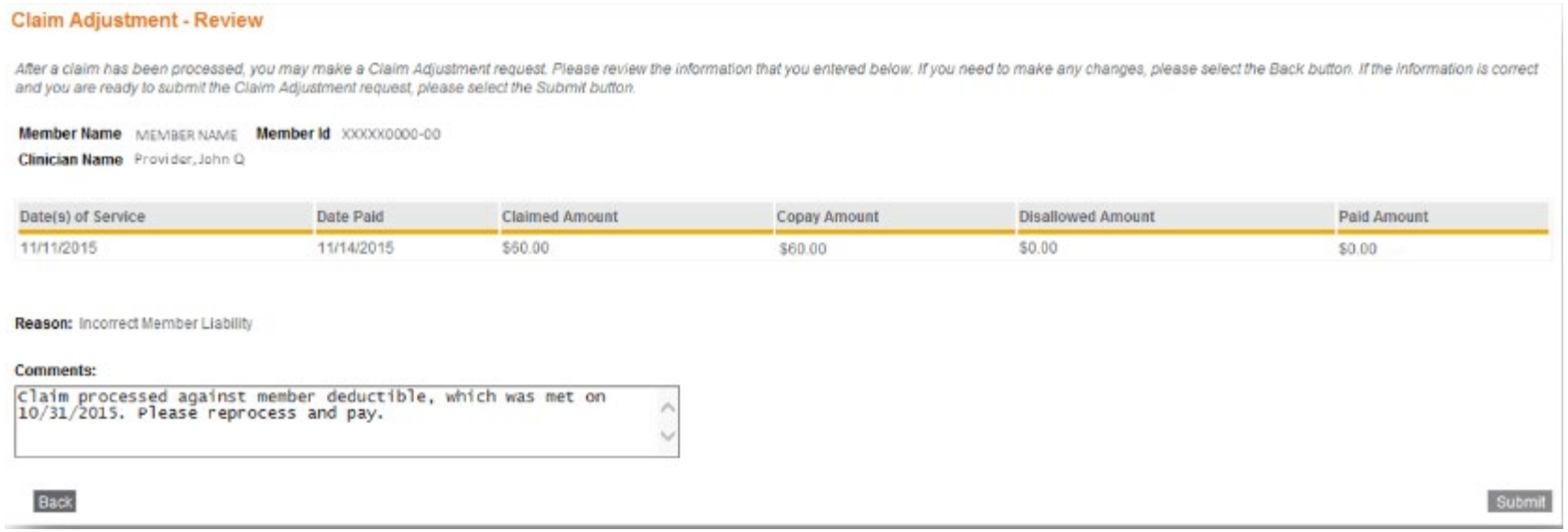
In the comments box, enter a detailed explanation of why the request is being made.

Click the {Review}button to view this request prior to submission.

Claim Adjustment Review

Users will review the information they just entered, prior to submitting the claim adjustment.

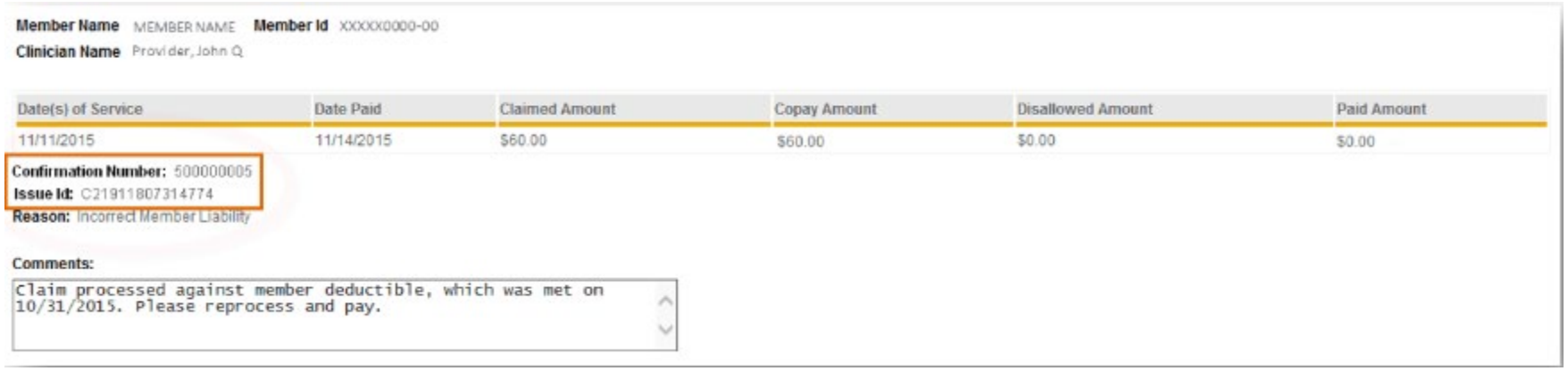
When the request is complete, click the {Submit} button.



Completed Claim Adjustment Request

Users will receive a Confirmation Number and an Issue ID number for each submission.

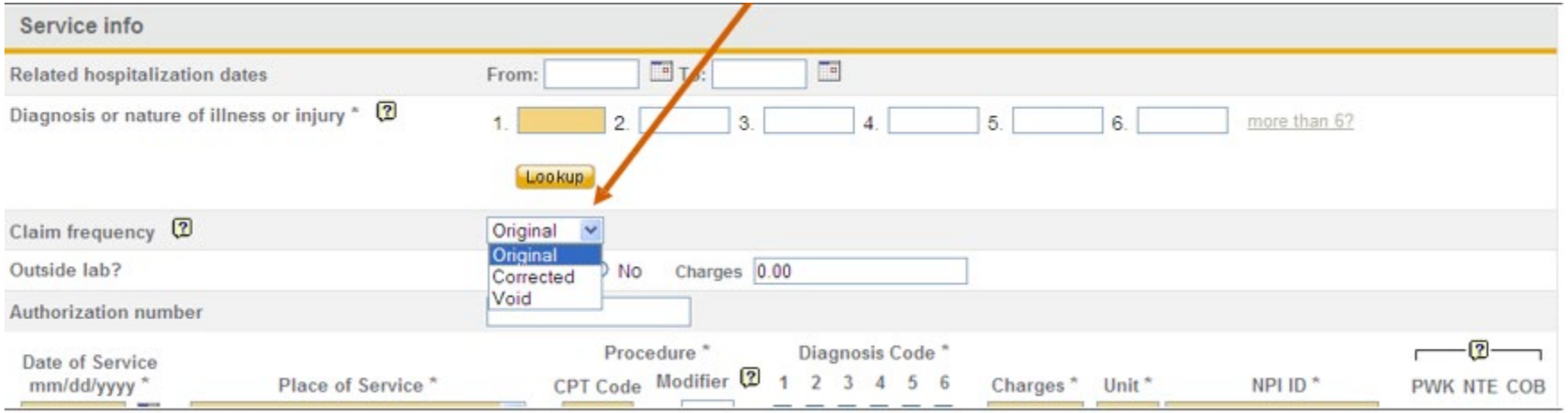
- User may use the Confirmation Number to check the status of a request online
- The Issue ID may be given to any claim representative to check the status of a claim by phone



Correcting a Claim

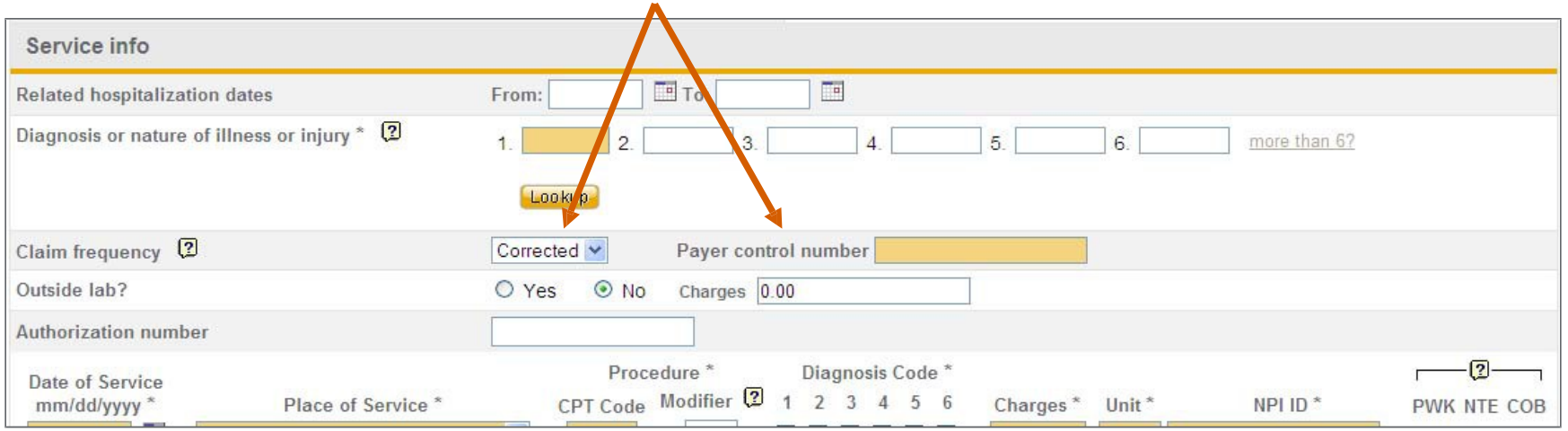
Submitting Corrected Claims

- Regardless of the claim form (short or long), you do have the ability to submit a Corrected claim request as well, when a previously submitted claim had incorrect information on it
- In the Service info section, the “Claim frequency” code is what is used to determine the type of claim you are filing. Provider Express defaults to "Original" but you can change it to "Corrected"



Submitting Corrected Claims (Continued)

Claim frequency - To submit a Corrected claim, you will need to enter the Claim Number found on the claim record in **Claim Inquiry.** The claim number will also be reported on the paper remittance advice or electronic 835 file. You cannot submit a **Corrected** claim until a claim number has been assigned.



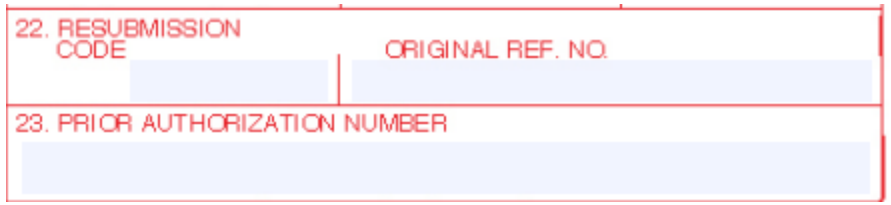
"Payer control number" = Claim number

How to submit a corrected paper claim

CMS-1500 (Professional Claims)

Box 22

- Resubmission Code
  - Enter frequency code "7“
- Original Reference Number
  - List the original claim number that you are correcting



Voiding a Claim

Submitting Void Claims

A void request will void all paid lines on the original claim form. Every line is reprocessed.

- A paid line has the payment voided and deducted from other payments due
- A denied line remains denied
- A pending line is denied. A void transaction is shown on the Remittance Advice as a payment deduction from payment that may be due. Once the void appears on the Remittance Advice, the services may be resubmitted

If the original claim reference number is not shown in the void request, it will not be processed and will appear on your Remittance Advice as an error. Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

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Provider Remittance Advice

Find a Remittance Advice in Provider Express

Click on the PRA link under “More.”

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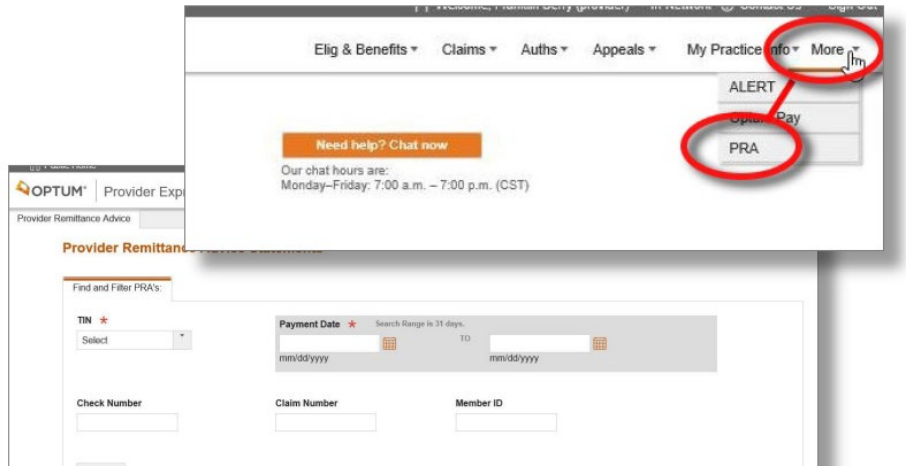
QUICK REFERENCE GUIDE

FINDING PROVIDER REMITTANCE ADVICES (PRA) IN THE SECURE TRANSACTIONS AREA OF PROVIDER EXPRESS

In order to help streamline your financial management and claim reconciliation activities, you can access up to 24 months of payment information at no cost. Below outlines how easy it is to find your PRAs.



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Find a Remittance Advice in Optum Pay

Click on the Payer PRA link. When the PDF icon appears, it is ready to open.

(Click on column he

835 / EPRA	Payer PRA
835 | PDF	PDF
835 | PDF	PDF
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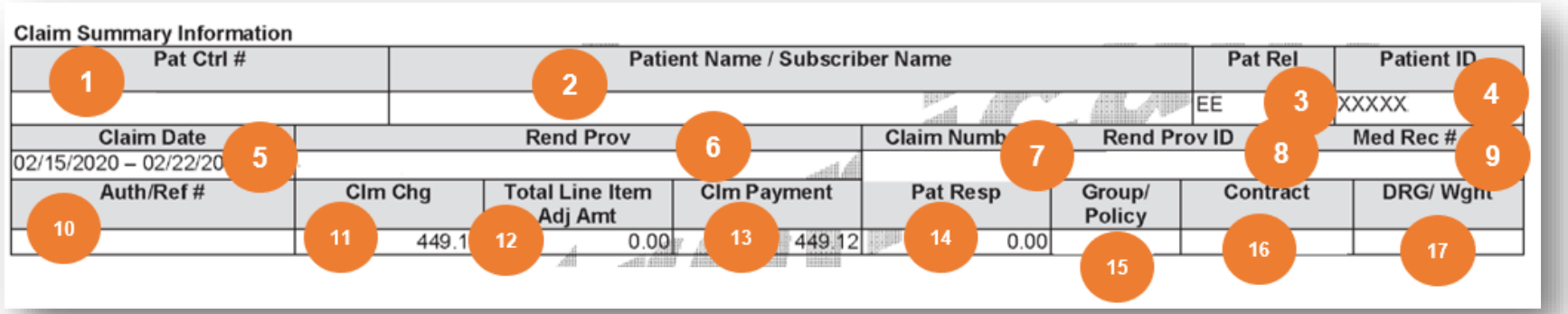
Remittance Advice – Claim Summary Information



1	Pat Ctrl #	Patient control number submitted by provider
2	Patient Name/Subscriber Name	Name of participant receiving the service
3	Pat Rel	Patient Relationship (if patient and participant are different)
4	Patient ID	Subscriber ID with first 7 digits masked
5	Claim Date	Date of service
6	Rend Prov	Rendering provider of services
7	Claim Number	System applied claim ID
8	Rend Prov ID	Rendering provider NPI or rendering provider's system ID
9	Med Rec #	Medical record number submitted by provider
10	Auth/Ref #	Service authorization number
11	Clm Chg	Total charge amount at the claim level
12	Total Line Item Adj Amt	Total claim adjustment at claim level
13	Clm Payment	Total claim payment at claim level
14	Pat Resp	Total participant responsibility
15	Group/Policy	Claim system group ID
16	Contract	Provider Agreement ID in Optum system
17	DRG/Wght	DRG and weight code (note: not required on CMS 1500 professional claim form)

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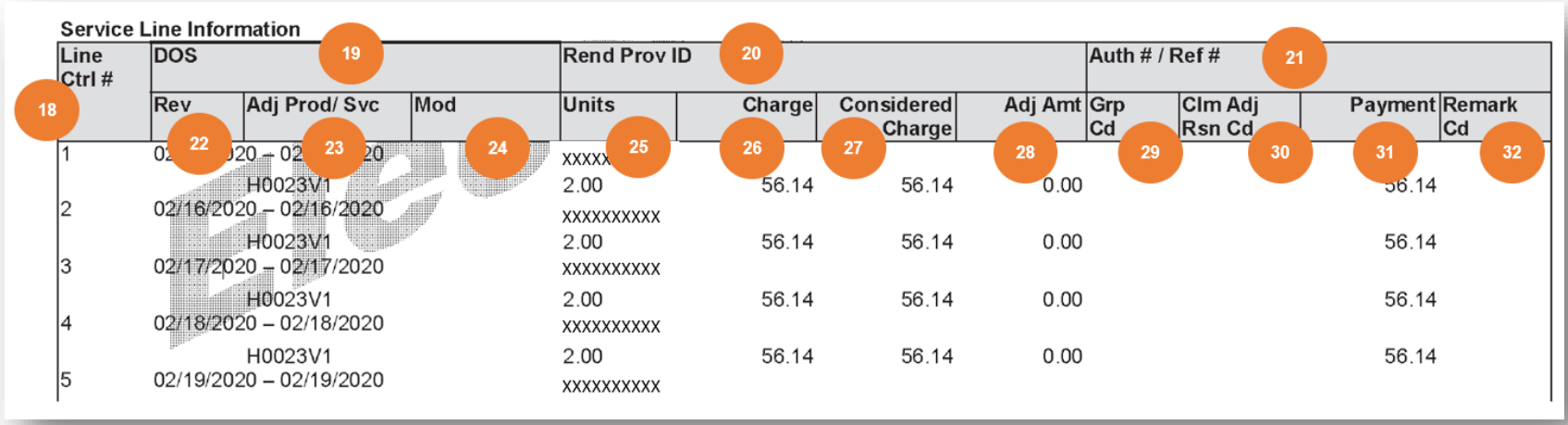
Remittance Advice – #7 Claim Number

Optum Claim Number
20|X|xxxxxxx|00

- Year the claim was received
- Claim submission method
  - X = Electronic
  - 0 = Paper Claim
- Claim document batch, number sequence
- Claim transaction type number
  - 00 = Original
  - 01 = Adjustment

Remittance Advice – Service Line Information



Service Line Information

Line Ctrl #	DOS	Rend Prov ID	Auth # / Ref #									
	Rev	Adj Prod/ Svc	Mod	Units	Charge	Considered Charge	Adj Amt	Grp Cd	Clm Adj Rsn Cd	Payment	Remark Cd
1	02/15/2020 – 02/15/2020			xxxxxxxxxx							
		H0023V1		2.00	56.14	56.14	0.00			56.14	
2	02/16/2020 – 02/16/2020			xxxxxxxxxx							
		H0023V1		2.00	56.14	56.14	0.00			56.14	
3	02/17/2020 – 02/17/2020			xxxxxxxxxx							
		H0023V1		2.00	56.14	56.14	0.00			56.14	
4	02/18/2020 – 02/18/2020			xxxxxxxxxx							
		H0023V1		2.00	56.14	56.14	0.00			56.14	
5	02/19/2020 – 02/19/2020			xxxxxxxxxx							

18	Line control #	Claim line sequence number
19	Date of Service	From and through date of service for claim line
20	Rendering Provider ID	Rendering provider NPI or rendering providers facets ID
21	Auth /Ref #	Service authorization number
22	Revenue code	Revenue code (note: not required on CMS 1500 professional claim form)
23	Adjusted Prod/Service	Disallowed amount line level
24	Procedure code modifier	Modifier codes 2 – 4 billed on claim
25	Units	Number of units billed on claim
26	Charge	Total billed charges on claim
27	Considered Charge	Amount approved
28	Adjustment Amount	Disallowed amount line level
29	Group Code	CMS CAGC Claim Adjustment Group Code
30	Claim adjustment Reason code	CMS CARC Claim Adjustment Reason Code
31	Payment	Claim line paid amount
32	Remark Code	CMS RARC Remittance Advise Remark Code

Provider Level Adjustments

Claim Summary Information

Pat Ctrl #	Patient Name / Subscriber Name	Pat Rel	Patient ID
[redacted]	[redacted]	EE	[redacted]

Claim Date	Rend Prov	Claim Number	Rend Prov ID	Med Rec #
07/15/2021 – 07/15/2021	[redacted]	[redacted]	[redacted]	

Auth/Ref #	Clm Chg	Total Line Item Adj Amt	Clm Payment	Pat Resp	Group/ Policy	Contract	DRG/ Wght
	50.00	50.00	0.00	50.00	15458		

Service Line Information

Line Ctrl #	DOS	Rev	Adj Prod/ Svc	Mod	Rend Prov ID / Units	Charge	Considered Charge	Adj Amt	Auth # / Ref # Grp Cd	Clm Adj Rsn Cd	Payment	Remark Cd
1	07/15/2021 – 07/15/2021				[redacted]							
			T1016GT		0.00	50.00	50.00	0.00			50.00	
					0.00	0.00	0.00	50.00	PR	27	-50.00	N30
TOTALS:						50.00	50.00	50.00			0.00	

Provider Payment Information

Prov Adj Cd	Prov Adj ID	Remark Cd	Prov Adj Amt
		Total Adjustment	[redacted]
		Claim Total	[redacted]
		Prov Pay Amt	[redacted]

REMARK(S) LISTED BELOW ARE REFERENCED IN THE SERVICE DETAIL SECTION UNDER THE HEADING "Remark Cd"

F03 - (F03) We have processed these charges in coordination with Medicare's payment.

M77 - (B08) This place of service is inappropriate for this service.

N130 - (B05) Your Behavioral Health Plan does not cover this expense.

N30 - (SS) Termination via Member-level separation event.

aC8 - (aC8) This charge was originally processed with inaccurate information. This adjustment reverses the original transaction.

United Behavioral Health, operating under the brand Optum

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Provider Level Adjustments

Provider Payment Information

Prov Adj Cd	Prov Adj ID	Remark Cd	Prov Adj Amt
WO	20201029111000006 - 20X532200800	OVR	-50.44
FB	20210515103000004 - 21X262126600	OVP	470.45
FB	20210616103000019 - 21X343022300	OVP	67.30
		Total Adjustment	487.31
		Claim Total	-487.31
		Prov Pay Amt	0.00

REMARK(S) LISTED BELOW ARE REFERENCED IN THE SERVICE DETAIL SECTION UNDER THE HEADING "Remark Cd"

AL3 - (AL3) This charge was originally processed using an incorrect Provider. This adjustment reverses the original transaction.

N30 - (SS) Termination via Member-level separation event.

N522 - (CDD) This claim is a duplicate of a previously submitted claim for this member.

N77 - (B62) Please provide the name, address, degree, license level for this service. If an MD, please include the specialty.

aLA - (aLA) This charge was originally processed with the incorrect claims data. This adjustment reverses the original transaction.

OVR - Overpayment Auto Recovery Amount

PSS - (PSS) Charge exceeds allowable rate for this service or code submitted is not on contracted fee schedule-contact Network Manager for correct code.

aC8 - (aC8) This charge was originally processed with inaccurate information. This adjustment reverses the original transaction.

aL3 - (aL3) This charge was originally processed using an incorrect Provider. This adjustment reverses the original transaction.

OVP - Overpayment Amount

You can save time and reduce paperwork and phone calls by going electronic. Our Site Satisfaction Survey data indicate that online transactions are easy to use and save time. Go to Provider Express today! www.providerexpress.com.

Overpayment Letters

Submitting corrected or voided claims may result in an overpayment. If an overpayment occurs, you will be sent a letter addressing the overpayment. The letter will include:

- Provider/Member information including patient account and ID number
- Claim number and date of service
- What do I need to do
- How was I overpaid
- Where do I send the refund
- What if I don't agree with this request

Frequent Billing Errors

Alaska Frequent Billing Errors

- Procedure Code:
  - Verify the procedure code billed is on the fee schedule
- Modifiers:
  - Should there be a modifier? If yes, be sure to list it and the order is correct
- Place of Service:
  - Is your Place of Service code covered and correct? If yes, be sure to include it
- Rendering provider:
  - Every claim should have a rendering provider, when required for the date of service (note: this is temporarily lifted for 1115 Waiver Services with dates of services on and after April 1, 2021)
- If the claim is a corrected claim, make sure it is marked appropriately
- Span dates:
  - Span date billing is not covered
- Unit issues:
  - Verify your increments match
    - Procedure code is billed in 15 minute increments
    - Participant was seen for 60 minutes billed units should be 4

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Let’s Talk - Questions & Answers

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:

- Act as your Optum Liaison
- Answer important questions
- Facilitate ongoing process improvements
- Keep you abreast of changes that impact your practice
- Provider useful tools and resources

The Optum Alaska Provider Relations Team:

Lisa Brown: 1-763-797-2092

Ryan Bender

Vaoita Puletapuai

Email: akmedicaid@optum.com

Fax: 1-844-881-0959

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Provider Express Technical Support

If you'd like assistance:

Contact support at 1(855)819-5909 or optumsupport@optum.com.

Chat with support (Opens in a new window)

Note: This feature is not advisable for persons with visual impairments and/or who may require audible support.

Thank you for your time!

Karla Myers
Senior Network Claim Liaison

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Prepared: Wendy Salas Associate Director Network Claims Liaison