Claims Updates

Optum Alaska

BH3259_08/2021

Agenda

- Top Claim Denials
- Claims Updates
- Billing Procedures – Services Covered under 7 AAC 135: Where to Send the Claims
- Optum Pay Updates and Provider Express Services
- Reminders

Top 3 Billing Codes with Denials for July to Current

1. **H2015 (all modifiers): Top Denial reasons:**

- B05 – Your plan does not cover this expense. *Main reason is because this code was sunsetted as of 7/1/2021.*
- CDD – Definite duplicate claim (example: exact same claim billed more than one time).
- 346 – Possible duplicate claim (example: same procedure code billed on more than one claim).
- B08 – inappropriate place of service and procedure code combination (example: H2015 HQ billed with Place of Service 02 but not with a telehealth modifier).

Top 3 Billing Codes with Denials July to Current

2. H0047 (all modifiers) Top Denial Reasons :

- B47 – Procedure and modifier combination inconsistent with patient's age(example: H0047 HA V1 TF is for ages 12-17 but patient was 18 on the date of service).
- B01 – Invalid diagnosis/CPT code combination (example: H0047 TG V1 billed with a Behavioral Health diagnosis code vs. a Substance Use Disorder diagnosis code).
- FBM – TPL indicated on claim but no resource on file (example: primary insurance payment included on electronic claim, but Optum does not show participant having primary insurance coverage).
- B08 – Inappropriate place of service for procedure (example: H0047 HA V1 TF with place of service 53)

Top 3 Billing Codes with Denials July to Current

3. H2021 (all modifiers) Top Denial Reasons:

- B08 – place of service inappropriate for procedure (example: H2021 V2 GT billed without place of service 02).
- 346 – possible duplicate claim (example: same procedure code billed on more than one claim for same participant and same date of service).
- B46 – invalid procedure code and modifier combination (example: H2021 GT V2 billed on claim but modifiers are in the wrong position – should be H2021 V2 GT with place of service 02.
- CDD – definite duplicate claim (example: exact same claim billed more than one time).

Psychotherapy Codes Reprocessed Update August 2021

Status Update: This project is ongoing, and the next review should be completed by 9/5/2021. We hope this will capture the remaining claims that need to be reprocessed.

If you notice any denials after 9/5/2021, please contact Optum Provider Relations team and put “psychotherapy denial” in the subject line.

Denied or reduced claims with the following codes will be reprocessed and paid dating back to the first date of service the provider billed Optum. In addition, future claims will pay without unit limits or procedure to procedure denials until the end of the public health emergency.

- 90832
- 90834
- 90837
- 90846
- 90847
- 90849
- 90853

OPTUM®

Rendering Provider Payments Reprocessing to Agency Project Update

Status Update: This project is ongoing, and the estimated completion date is unknown currently. We hope this will capture any recoupments that are still outstanding.

Once this project is complete, Optum will provide an update to all providers with date of completion. After the date of completion, you still show outstanding recoupments, please contact Optum Provider Relations team and put “rendering provider recoupments” in the subject line.

Services Covered under 7 AAC 135: Where to Send the Claims

Optum

Optum processes claims for Community Behavioral Health and Mental Health Physician Clinic services covered under 7 AAC 135:

Community Behavioral Health Services claims with dates of services on and after 7/1/2020

Mental Health Physician Clinic Services claims with dates of services on and after 7/1/2021

The specific procedure codes for Community Behavioral Health and Mental Health Physician Clinic services that may be billed to Optum are at: http://dhss.alaska.gov/dbh/pages/Resources/Medicaidrelated.aspx.

Services Covered under 7 AAC 135: Where to Send the Claims – Continued

Optum

The Optum Primary Modifier Guidance documents contain the procedure codes that may be billed to Optum.

The name of the document for Community Behavioral Health and Mental Health Physician Clinic services is, “Optum Primary Modifier Guidance for Alaska Medicaid Community Behavioral Health Services as of 7.1.2021.” Below is a link to the document.

https://alaska.optum.com/content/dam/ops-alaska/documents/updates-alerts/akPrimaryModGuidance.pdf

Services Covered under 7 AAC 135: Where to Send the Claims – Continued

Conduent

Claims for services covered under other Alaska Medicaid regulations must be billed to Conduent.

For example, if a service is billed with 90832 and the participant does not have a behavioral health diagnosis, then the claim must be billed under the provider's Alaska Medicaid health professional group enrollment and submitted to Conduent.

Claims with procedure codes that are covered by other Alaska Medicaid regulations must be billed to Conduent.

For example, if a service is billed with 90792, then the claim must be billed under the provider's Alaska Medicaid health professional group enrollment and submitted to Conduent.

OPTUM®

Optum Pay and Provider Express Services

The Optum Pay Basic Level of service has been improved and now includes additional payment information. In addition, Provider Express functionality has now been expanded to include the ability to obtain Provider Remittance Advice (PRA) through the secure Transactions section of the portal. The table below outlines some of the main services now available to providers to help with your financial management and claims reconciliation:

Optum Pay and Provider Express Services – Continued

Feature	Optum Pay		Provider Express
	Premium Level	Basic Level	*providerexpress.com*
Access to claims payment data	36 months	13 months	24 months
Single portal access to multi payer remittance PDFs	Yes	Yes	Yes
Data options:			
• Downloadable 835	Yes	Yes	No
• Electronic Remittance PDF (data contained in 835 file)	Yes	Yes	No
• Payer's proprietary remittance PDF (includes data not contained in 835 file, such as state required disclosure language or proprietary remark/adjudication codes)	Yes	Yes	Yes
Third party billing support (reflects provider's access)	Yes	Yes	Yes
Number of new users	Unlimited	Unlimited	Unlimited
Administrative Management (controls access and data per user)	Yes	Yes	Yes
Payment search capabilities	Yes	No	Yes
Data bundling	Yes	No	No
Workflow management tools (sort claims based on reconciliation status and claim count per payment)	Yes	No	No
Fees	0.5% per payment*	No fee	No fee

OPTUM®

Optum Pay and Provider Express Services – Continued

* 0.5% per total payment amount (e.g. $5 for every $1,000 in payments). Billed monthly, taxes may apply. Note that fees for Optum behavioral health claims for providers in Alaska are waived through December 31, 2021. Payments from any other behavioral or medical payer will incur the 0.5% fee per payment. Fees will only be invoiced if over $10 per month and will not accumulate if under $10. Fees will be capped at $2,000 per monthly billing cycle, per TIN. Billed monthly, taxes may apply.

Optum Pay and Provider Express Services – Continued

If you enrolled for Optum Pay Premium Level of service but find that all of the features you need are now available at no cost through Provider Express and/or Optum Pay Basic Level of service, you can easily cancel your Premium enrollment online using the instructions shown below.

How to cancel Premium Level access for Optum Pay

Log in to **Optum Pay** and click on the **Optum Pay Solutions** tab

On the right side of the page, make sure the appropriate **TIN** is selected

Locate **Manage My Plan** and click on **Cancel My Plan**

Select the **Reason for Termination**, then click **Yes, I want to cancel**

For escalation requests or for additional Optum Pay fee information, email optumpay_fees@optum.com.

Please note: Cancellations are effective on the date the form is received by Optum Pay. You won't be charged for any additional days needed to process your request.

Optum Pay and Provider Express Services – Continued

Charges are for non-Alaska Medicaid claims only:

- If you have received charges for Optum Pay fees, they are for payments from non-Alaska Medicaid payers

- If you have not received charges for Optum Pay fees, and you keep your Premium Level Optum Pay service, then you may be charged if you receive payments from non-Alaska Medicaid payers in the future

If you need to check your Optum Pay enrollment status:
Sign in to **Optum Pay**
Select the **Optum Pay Solutions** tab
In the Solutions tab, you can see if you're enrolled in the Basic or Premium version of Optum Pay:

If you're enrolled in the Premium version, you will see the date of enrollment and the user who completed the enrollment process
If you're enrolled in the Basic version, you may not have visibility to certain features (*users in Basic version may see NA in certain columns*)

OPTUM®

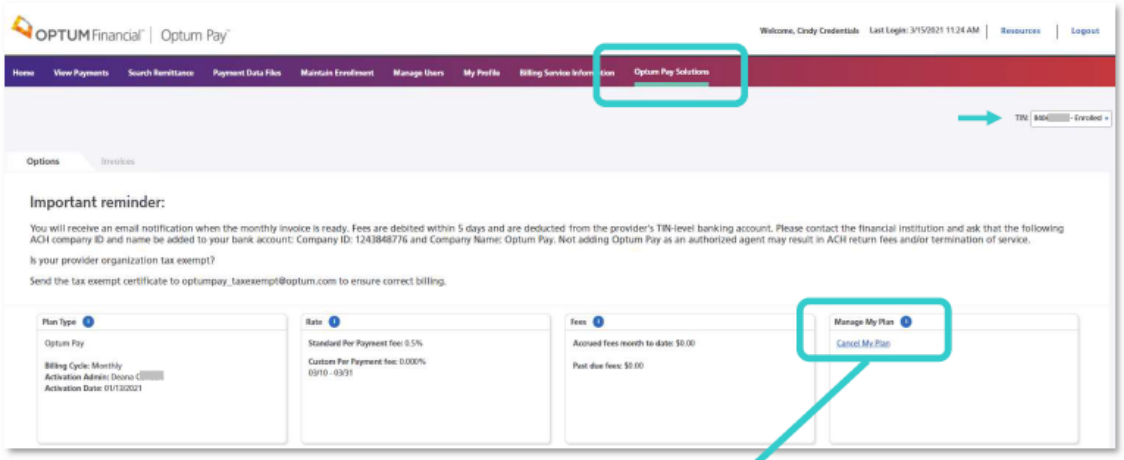
Optum Pay and Provider Express Services – Continued

OPTUM Financial™

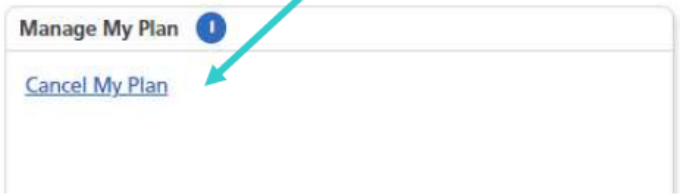
Optum Pay – How to cancel premium level access

This process will be available after March 20, 2021

1 Log into Optum Pay and click on the Optum Pay Solutions tab Make sure the appropriate TIN is selected



2 Click on "Cancel my Plan"



OPTUM®

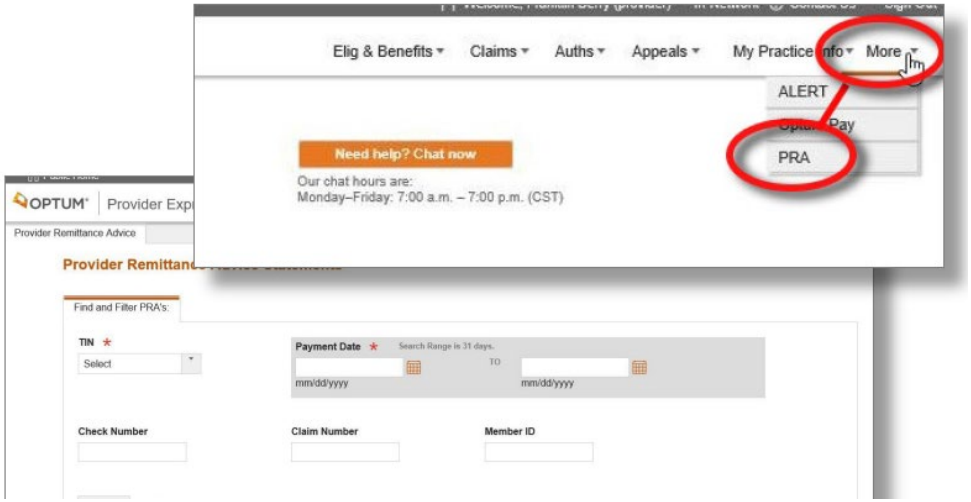
Optum Pay and Provider Express Services – Continued

OPTUM®

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.



Contraindicated Services Reminder

There is now an edit that will catch contraindicated services that are performed on the same day for the same participant, regardless of billing provider. The claims are processed and paid as first-in first-out and the second claim received/processed will be denied as contraindicated to the previous claim.

Providers can refer to the administrative procedures manuals to review which services should not be performed on the same day. The manuals can be found at: http://dhss.alaska.gov/dbh/pages/Resources/Medicaidrelated.aspx

Some examples of contraindicated service codes are:

- H0010 TG V1 Medically monitored inpatient withdrawal management daily and H0047 TG V1 SUD Residential 3.5 Daily
- H0039 V2 Assertive Community Treatment Services and H2021 V2 Community & Recovery Support Services
- H2015 Comprehensive Community Support Services and H0039 V2 Assertive Community Treatment Services

OPTUM®

Timely Filing Reminder

All claims must be filed within 12 months of the date services were provided to the Participant. The 12-month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier. In these cases, providers must bill Alaska Medicaid within 12 months of the service date and attach an explanation of benefits documentation from the third-party carrier to the Alaska Medicaid claim.

Timely Filing of Claims is explained in Section 6.3 of the Provider Manual at: https://alaska.optum.com/content/ops-alaska/alaska/en/providers/guidelines-policies.html

Reminder to Providers about Single Date of Service Billing

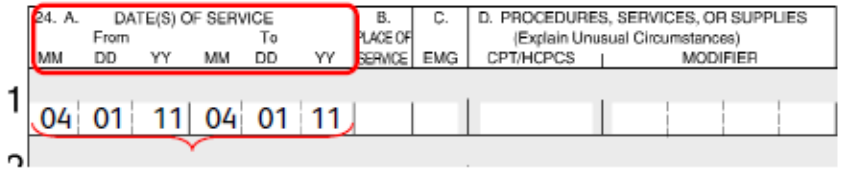
February 28, 2011

ATTENTION: Substance Abuse Disorder Treatment Providers

SINGLE DATE OF SERVICE BILLING

Effective with April 1, 2011 dates of service, claims should be submitted with a single date of service. Claim lines reporting more than one date of service ("spanned" dates of service) will no longer be accepted. (Claims for dates of service prior to April 1, 2011, may be billed with span dates or with single dates of service.)

For example, if the services were rendered on April 1, 2011, then the claim should be submitted with a "from" and "to" date of service of 040111 or 04012011 (MM/DD/YY or MM/DD/CCYY format).



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER
1 04	01	11	04	01	11				
2									

24A.	Dates of Service	**Required**. In the **unshaded** area, enter the "From" and "To" dates services were rendered in MM/DD/YY format. The six-digit format is preferred; however the eight-digit format is also acceptable, such as MM/DD/CCYY. Each service/procedure must be entered on a separate line with no more than six lines per form.

Questions?