Optum

Claims Updates:
Life Cycle of a Claim, Remittance Advice and Recoupments

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Agenda

1. Updates and Projects
2. Life Cycle of a Claim
3. Provider Remittance Advice
4. Recoupments
5. Links, Reminders, and Q & A

Updates

Updates

Service Authorization

Effective 5/12/2023 CMS (Center for Medicare and Medicaid Services) has approved a disaster State Plan Amendment (dSPA) to extend the pandemic era 1135 blanket waiver authority approved on April 2, 2020, to temporarily suspend the Medicaid prior/service authorizations for state plan behavioral health services for 12-months to aid Alaska in the return to routine operations. This approval expires on 5/11/2024.

Service authorization requirements for specific state plan services are suspended from 5/12/2023-5/11/2024. (This does not apply to services under the 1115 BH or SUD waiver)

Service authorizations are suspended for specific state plan services that include services with XE, XU, XP, GT, 95, and FQ modifiers.

1115 BH and 1115 SUD waiver services (all services with V1 or V2 modifier) are EXCLUDED from suspension and existing SA requirements remain in effect.

A full list of the service codes that apply to the specific State Plan Services and Autism codes are located on the Optum Alaska website, here.

Updates

1115 BH Waiver PDF Fillable Form

We at Optum have heard your concerns and have updated and supplied a new fillable PDF form for 1115 waiver services authorization requests. The form can be found on the Optum Alaska website under Service Authorizations or via the link provided below.

Optum Alaska - Forms

Remittance Code Advice and Denial Reason List

Optum uses the national codes for claim adjustment and remittance advice reason codes. The link to the national codes is: External Code Lists | X12. In addition, Optum has provided a list of the most common Denial, Claim Adjustment Reason Codes and Remittance Advice Remark codes with explanations to further assist you in reviewing your claims. The list can be found on the Provider Express portal under Alerts, Updates and Announcements or via the link provided below.

Remittance Advice Codes and Denial Reasons

Updates

Remittance Code Advice and Denial Reason List

Facets Code	CARC Code	RARC Code	Short Description	Long Description	Liability
002			Increased allowable	Increased allowable	N/A
003			Reduced allowable	Reduced allowable	N/A
017			Increased allowable units	Increased allowable units	N/A
018			Reduced allowable units	Reduced allowable units	N/A
073			Deny All Claim Lines	Deny All Claim Lines	N/A
346	18	0	Duplicate	Duplicate	Provider
AK6	234	M15	Tribal Provider Encounter	Encounter Rate applied for this service.	Provider
AKT	234	M15	Tribal Provider Encounter	Encounter Rate applied for this service.	Provider
B01	11	0	Invalid Diagnosis/CPT Combination	This is an invalid diagnosis code and procedure code combination.	Provider
B02	96	N130	Service Not Covered for this Provider	This service is not covered for this provider under your plan.	Member
B05	96	N130	Your plan does not cover this expense	Your Behavioral Health Plan does not cover this expense.	Member
B08	5	M77	Place of service inappropriate for procedure	This place of service is inappropriate for this service.	Provider
B14	109	N418	Please forward to correct carrier	Medical Services not covered under Behavioral Health coverage. Please submit claim to your Medical Health Plan for processing.	Provider
B37	96	N130	OON provider services not covered for plan	Your plan does not cover services you received from a non-network provider.	Member

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 one 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
  - Completed: 07.31.2023

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

- 911.20 (C) – claims for participants *with* TPL
  - Awaiting Re-Work Approval

- 911.20 (D) – claims for participants *with no TPL,* however, claim may deny for other reason
  - Awaiting Re-Work Approval

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.

Completion Percentage: 100% as of 08.09.2023

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.

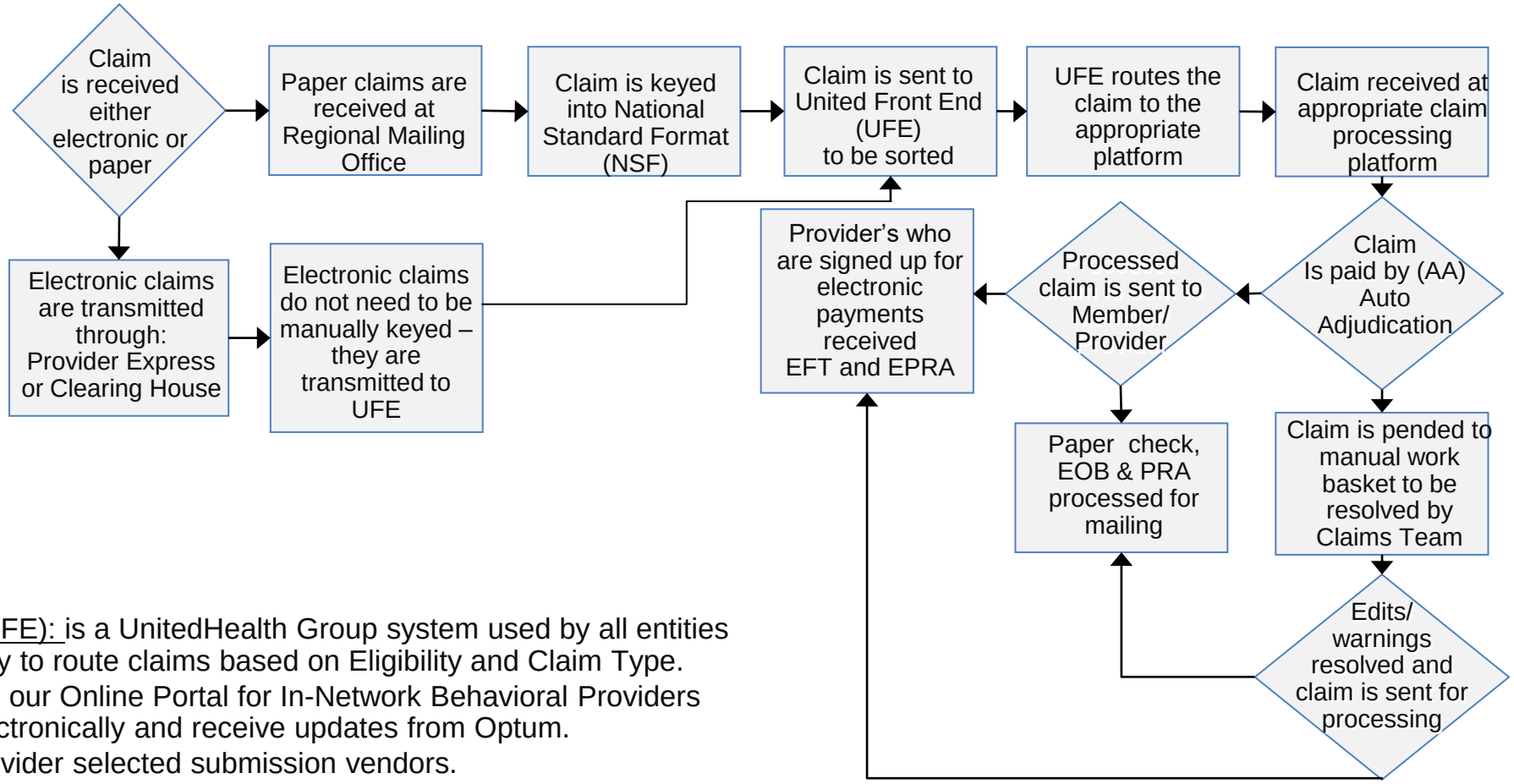
What Providers Need To Do: There is no action that providers need to take.

Project Completion Date: TBD

Claims Volume: 736

Life Cycle of a Claim

Life Cycle of a Claim



Definitions:

United Front End (UFE): is a UnitedHealth Group system used by all entities within the company to route claims based on Eligibility and Claim Type.

Provider Express: is our Online Portal for In-Network Behavioral Providers to send claims electronically and receive updates from Optum.

Clearing House: provider selected submission vendors.

Electronic Fund Transfer (EFT): is the electronic transfer of money from one bank account to another, either within a single financial institution or across multiple institutions, via computer-based systems, without the direct intervention of bank staff.

Auto Adjudication (AA): Claims that are processed by the system without human intervention.

Explanation of Benefits (EOB): An explanation of claim payment, processing or denial to the provider. EPRA is an electronic copy of this form

Provider Remittance Advice (PRA or EPA): An explanation of claim payment, processing or denial to the provider. EPRA is an electronic copy of this form.

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Life Cycle of a Claim

Quality Analysis

- **Sampling**

Industry standard, statistically valid random sampling methodology
HPSM process has the roles clarified if data discrepancies are identified
Policy driven roles & responsibilities regarding sampling and addressing exception process

- **Auditing**

Oversight of individual work queues and inventory to ensure complete sample auditing
Audit the auditor validates auditor proficiency
Collaborative Rebuttal process
Calibration session – ensuring auditor consistency
Policy driven roles & responsibilities with regard to sampling and addressing exception process

- **Reporting**

Calculations are performed at month end close to validate accuracy of quality outcomes
Quality dashboard reporting including:

- Dollar Accuracy Rate
- Claim Payment Accuracy
- Overall Accuracy Rate

Policy driven roles & responsibilities with regard to sampling and addressing exception process

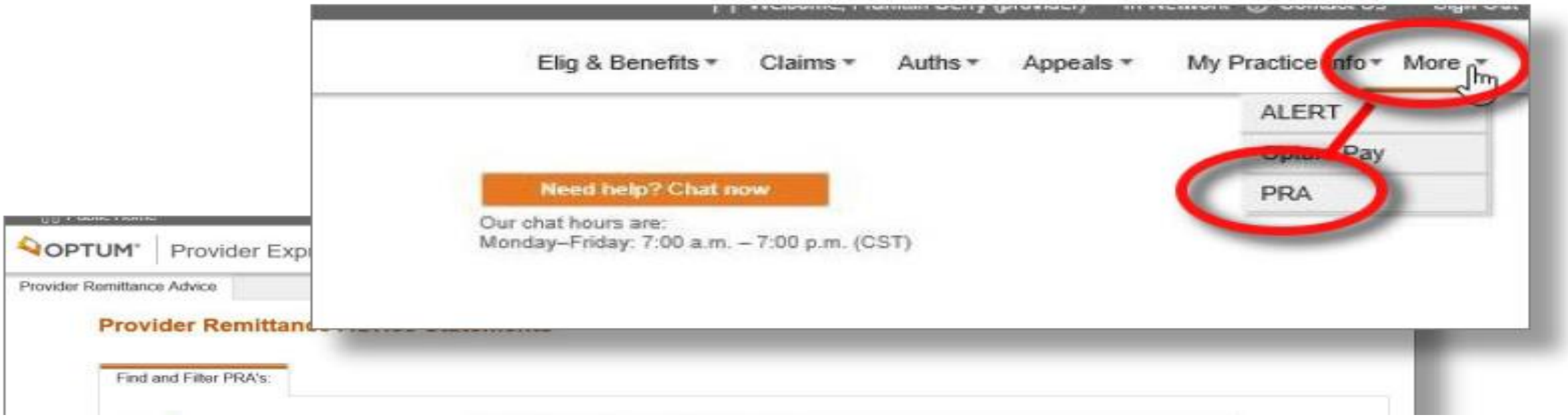
- **Control Environment**

Procedures exist to ensure P&P revisions and newly created P&P's are followed
Policy driven Quantum Operational Controls exist to manage role changes and update role responsibility

Provider Remittance Advice

Provider Remittance Advice

Registered providers can review up to 13 months of payment information through the Provider Express website. Simply log in and Click on the PRA link under “more” on the far-right side of the menu.



Provider Remittance Advice

Click on the Payer PRA link to load the PDF file. Please note, when the PDF icon appears, the file is ready to open.

835 / EPRA	Payer PRA
835 | PDF	PDF
835 | PDF	PDF
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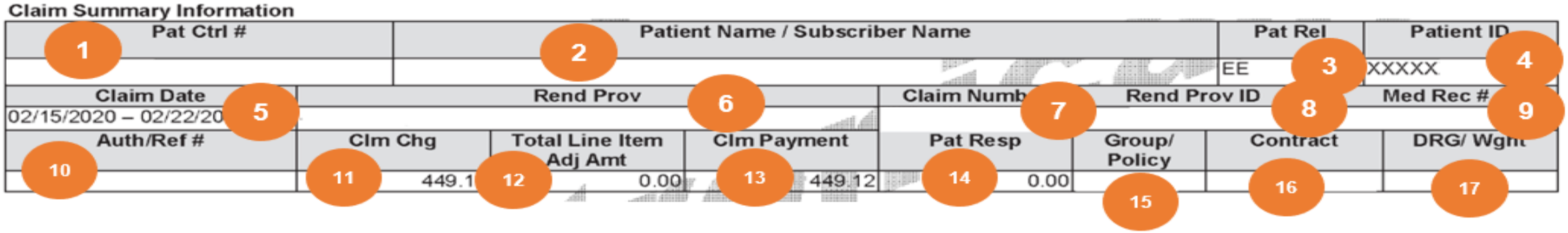
Provider Remittance Advice



1	Pat Crtl #	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 diferent)
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 providers system ID
9	Med Rec #	Medical record number submitted by provider
10	Auth/Ref #	Service authorization number
11	Clm Chg	Total Charge amount of 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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Provider Remittance Advice

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	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	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 Remittance Advice

Provider Payment Information

Prov Adj Cd	Prov Adj ID	Remark Cd	Prov Adj Amt
		Total Adjustment	0.00
		Claim Total	0.00
		Prov Pay Amt	0.00

AL3	This charge was originally processed using an incorrect provider. This adjustment reverses the original transation.
SS	Termination via Member-level separation event.
CDD	The claim is a duplicate of a previously submitted claim for this member.
B62	Please provide the name, address, degree, license lever for this service. This adjustment reverses the original transaction.
aLA	The charge was originally processed with the incorrect claims data. This adjustment reverses the original transaction.
OVR	Overpayment Auto Recovery Amount
PSS	Charge exceeds allowable rate for this service or code submitted is not on contracted fee-schedule- contact Network Manager for correct code.
aC8	This charge was originally processed with inaccurate information. This adjust reverses the original transaction.
aL3	This charge was originally processed using an incorrect provider. This adjustment reverses the original transation.
OVP	Overpayment Amount

Provider Remittance Advice

What does CARC stand for?

CARC stands for Claim Adjustment Reason Code and provides the reason for a claim adjustment made by the payer. They help you understand why the claim amount differs from the billed amount. If no adjustment has been made, the claim will not have a CARC. There are several hundred CARCs and what they represent is standard across the industry. CARC descriptions are often available on electronic remittance advice (ERA) and explanation of benefits (EOB) displays. CARCs can also be used to identify which ERAs need to be posted manually. This can bring certain claims to your attention and help you review these adjusted claims.

What does RARC stand for?

RARC stands for Remittance Advice Remark Code and was first created as a proprietary list by Medicare, but it was later included in the HIPAA rules and has since become an industry standard. RARCs are now used by most insurance providers. RARCs provide supplemental information regarding a rejected or adjusted claim. For example, if the CARC for a denied claim indicates that additional information is required, then the RARC will pinpoint exactly what information needs to be provided so the claim can be reconsidered.

To assist in reviewing your claims Optum has provided a list of the most common Denial, Claim Adjustment Reason Codes and Remittance Advice Remark codes with explanations.

Remittance Advice Codes and Denial Reasons

Recoupments

Recoupments

Adjusters frequently reprocess a claim to release additional benefits or recoup overpaid benefits.

Reasons include:

- Correction of billed information, such as a charge amount or procedure code that alters the original benefit calculation
- Pertinent documentation, which caused the original payment to be reduced or denied, such as a COB verification letter or missing required claim data, is received
- Required referral or pre-authorization is attained
- Reversal of deductible or another plan limit originally applied to the claim
- Eligibility

If Optum finds an overpayment, then Optum will send a provider an overpayment letter stating the overpayment reason and amount. The letters give the provider directions on how to reimburse Optum.

If a refund is not received and the provider continues to bill Optum, then Optum will recoup the funds from a future payment within 28 days. If a claim is denied for exceeding timely filing limits, the provider must file an appeal within 180 days.

Recoupments

Overpayment Letters

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

The letter will include:

- Participant information including patient account and ID number
- Claim number and date of service
- What action is needed by your agency
- Why the overpayment occurred
- Where to send a refund in the amount of the overpayment
- What if I don’t agree with this request

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)
- If you are a billing agency, please include the AK provider agency name you are inquiring about.

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
- If you are a billing agency, please include the AK provider agency name you are inquiring about.

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

Q&A