Claims Processing: Billing with Service Authorizations

Optum Alaska

December 2020

Service Authorizations After Service Limit Exhausted

All Behavioral Health State Plan and 1115 Waiver services fall under this requirement

- Alaska Medicaid participants are allowed a certain number of services per state fiscal year (SFY). Any services over that limit require action by the provider to request a service authorization.
- Claims are processed, paid and counted towards the SFY limit as they are received by Optum.
- All claims processed and paid will count toward the state fiscal limit even if an authorization was obtained by the provider. This is “first in/first out” claims processing.

State Fiscal Year Recipient Service Limits

- The state fiscal year recipient service limits are located on the state website at:

http://dhss.alaska.gov/dbh/Pages/Resources/Medicaidrelated.aspx

Claims Processing Scenario 1:

- Two providers bill the same code during the same SFY:
  - Provider A provides service to participant and does not obtain service authorization because the SFY limit has not been reached at that point in time.
  - Provider B provides the same service to same participant which is unknown to Provider A, and Provider B bills claims to Optum before Provider A.
  - Result: Provider A bills claims and receives denials on the ones that extend beyond the SFY limit because there was not a service authorization obtained prior to those services being provided.

Claims Processing Scenario 2:

- Provider A provides service to participant and does not obtain service authorization because the SFY limit has not been reached at that point in time.
- Participant has primary insurance and Medicaid as secondary. Provider A must bill primary insurance which takes 30-45 days to pay Provider A.
- Provider B provides the same service to same participant which is unknown to Provider A, and Provider B bills claims to Optum before Provider A because Provider B receives the primary insurance EOB before Provider A.
- Result: Provider A receives denials because SFY limit has been reached and no service authorization was obtained.

Claims Processing Scenario 3:

- Participant is approved for retroactive Medicaid eligibility.
- Provider A and Provider B had continued to provide services to participant in anticipation of Medicaid coverage being reinstated.
- Provider A and B are unaware of how many services were provided between them in total and service authorizations were not obtained by either provider.
- Result: Provider A and Provider B are billing timely and both receive denials for claims that go over the SFY limit.

What to do?

- If a service authorization has not been obtained due to an assumption that SFY limits were available to participant but claim is ultimately denied due to the first in/first out scenario, provider should request retroactive authorization.
- When a service authorization number is obtained, provider should resubmit a new claim with authorization number attached.

Instructions for how to request a retrospective authorization

- Submit all relevant medical records/notes along with a cover letter explaining the need for a retrospective review needed due to a first in/first out claim denial
- Mail records and cover letter to:

  Optum Alaska

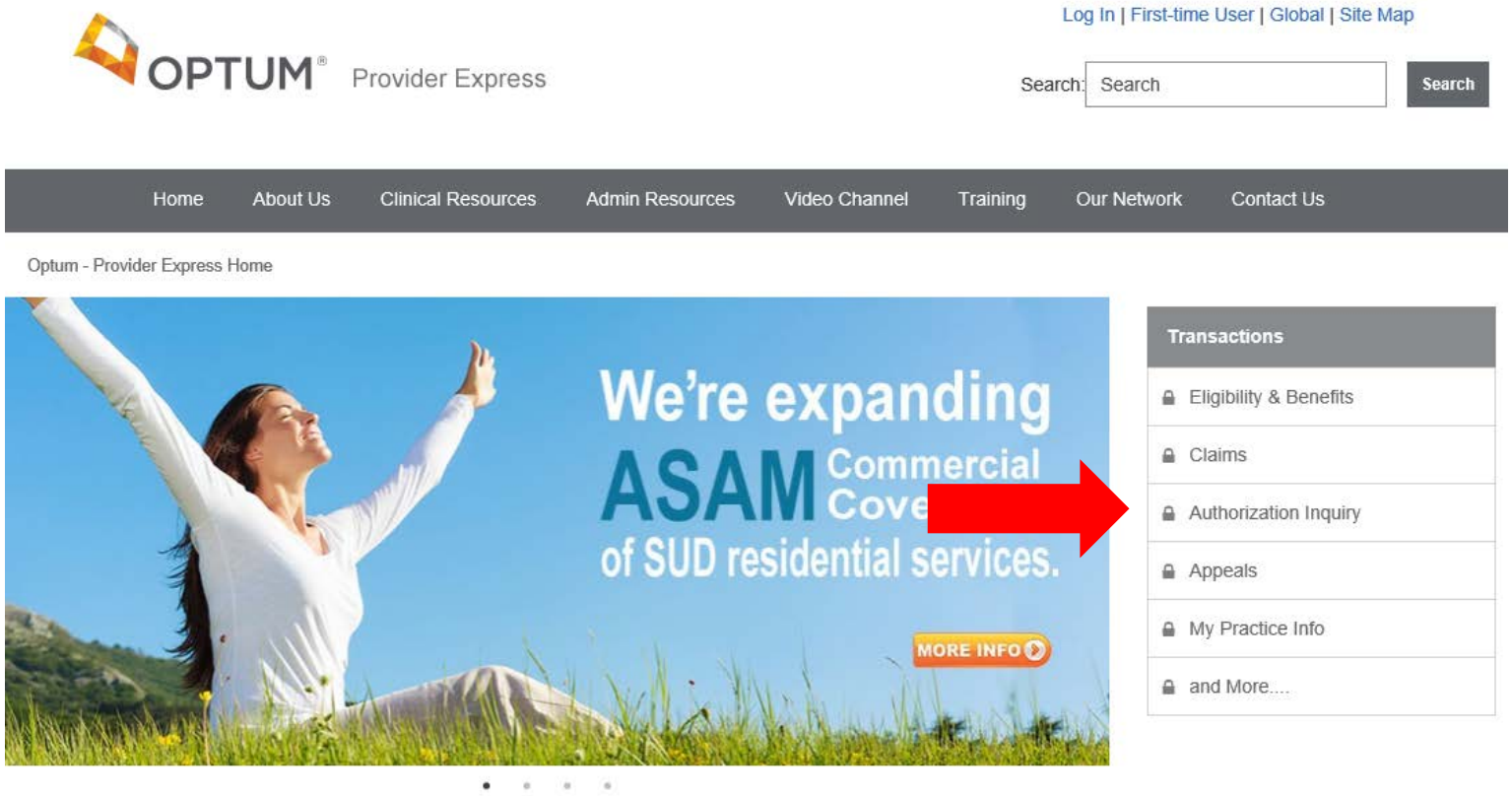
  Attn: Retrospective Review

  205 East Benson Blvd, Suite 100

  Anchorage, AK 99503
- A response will be mailed within 30 days

OPTUM®

Accessing Service Authorization Information



A provider may access Service Authorization information online at Provider Express or by calling Optum Customer Service at 1-800-225-8764.

Autism Services Authorization Process

Optum Alaska

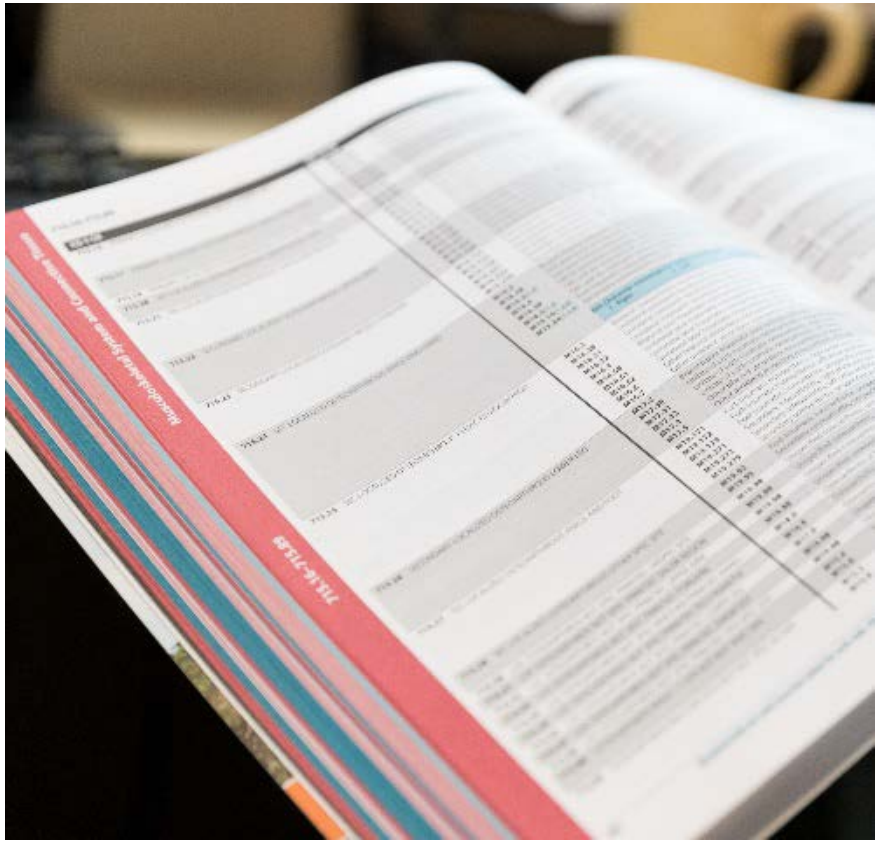
December 2020

Autism Services Service Authorizations

Service authorization requirements will resume when the state of emergency is lifted.

Autism services authorizations will be evaluated and processed by Comagine while claims are paid by Optum.

Providers will continue to submit their service authorization requests in accordance with existing practice to Comagine.



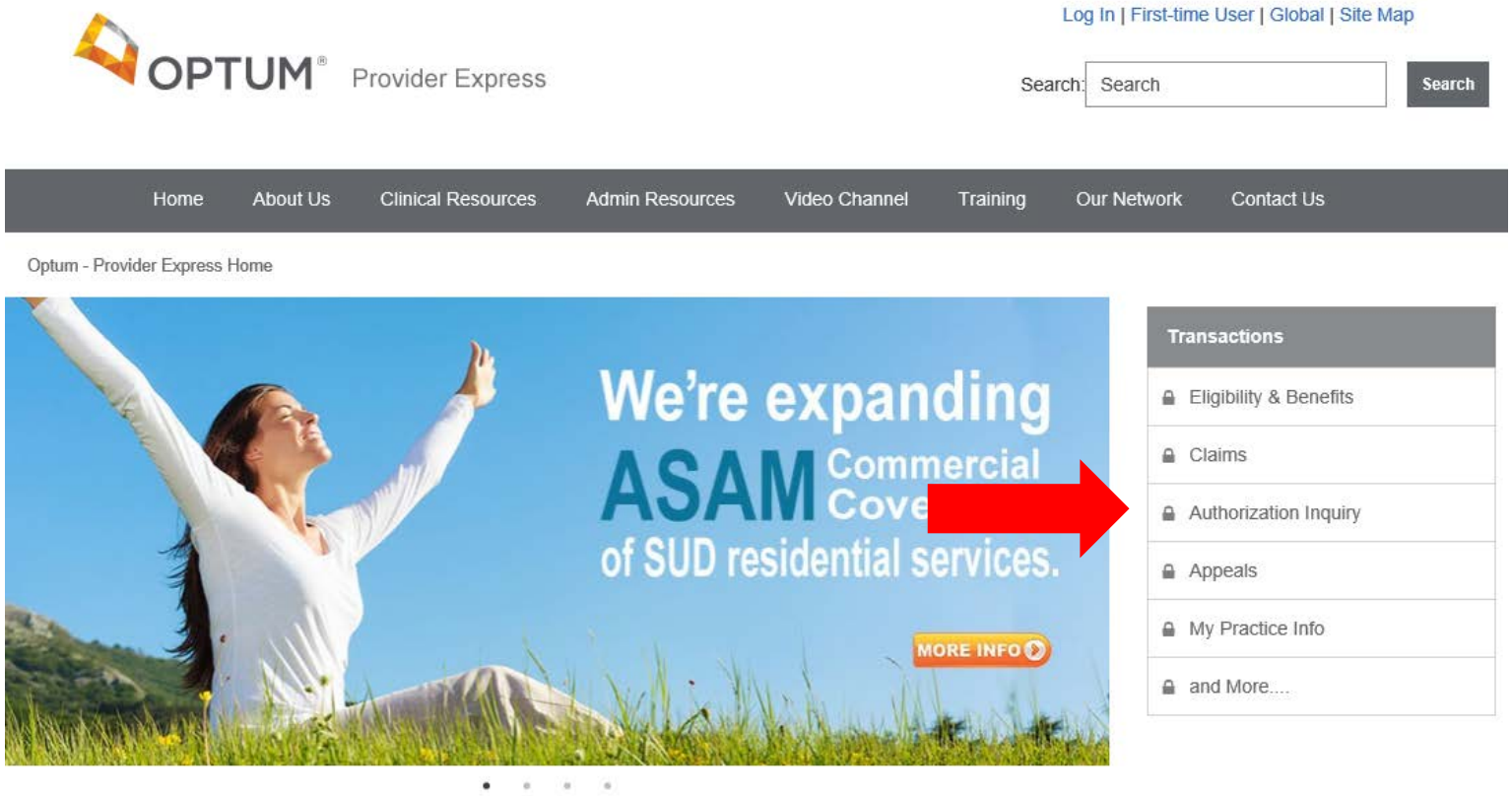
Autism Services Claims Submission

*Communication will occur between Comagine and Optum after the Service authorization has been granted by Comagine

*Optum will **administratively** generate a Optum specific service authorization number which will be mailed to the provider (no additional medical necessity review will occur)

*Providers MUST use the Optum specific service authorization number with their claim submission to avoid denial of claim

Accessing Service Authorization Information



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