UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

CMS-1500 Claims and Dental Claims

Presented by Karen Cockerham, Provider Relations

United Healthcare®

Agenda

- Claim Submission
  - CMS-1500
  - Dental
  - Vision
- Reconsiderations
  - Medical
  - Behavioral
  - Dental
  - March Vision
- Resources
- Questions and Answers

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Acronyms

- CMS – Centers for Medicare and Medicaid Services
- DOS – Date of Service
- EDI – Electronic Data Interchange
- FDA – Food and Drug Administration
- HCFA – Health Care Finance Administration
- INN – In-Network
- NDC – National Drug Code
- OON – Out-of-Network
- RFP-Request for Participation
- UHC- UnitedHealthcare

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Our Service Lines

- UnitedHealthcare

- Optum Behavioral Health

- March Vision

- UnitedHealthcare Dental

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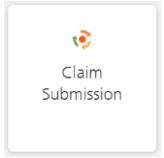
Claim Submission

How to file Medical/Behavioral CMS-1500 claims

- Submit claims using the CMS-1500 Claim Form (v 02/12)
- Standard Timely Filing for Par Providers - 90 calendar days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 180 calendar days from DOS.
- Newborn Claims Timely Filing – 180 calendar days from DOS.
- Secondary Claims Timely Filing - 90 calendar days from date of Primary EOB for INN Providers & 180 for OON providers from the Primary EOB date.

- For electronic submission:
- Payer ID 87726
- Claims Mailing Address:



UnitedHealthcare Community Plan
P.O. BOX 5240
Kingston, NY 12402

- Claim Submission Tool for Medical Professional claims (CMS 1500) on our UnitedHealthcare Provider Portal (formerly Link)

- Behavioral Health Professional claims (CMS-1500) on our Provider Express Portal
- Click claim entry

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How to file Dental claims

- HIPAA-Compliant 837D file

HIPAA-Compliant 837D file

- The 837D is a HIPAA-compliant EDI transaction format for the submission of dental claims.
- This transaction set can be used to submit health care claim billing information, encounter information or both, from providers of health care services to payers via established claims clearinghouses.

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How to file Dental claims

Paper Claims

- Refer to the Quick Reference Guide for addresses and phone number information.
- 100% of all clean paper claims will be paid or denied within 30 calendar days of receipt.
- 100% of all clean electronic claims will be paid or denied within 21 calendar days of receipt.

Submitting Claims

To receive payment for services, practices must submit claims via paper or electronically.

Dentists must submit an American Dental (ADA) Dental Claim Form (2012 version or later).

Computer-generated forms are recommended.

Attach documentation and radiographs if applicable.

Attachments are required for pre-treatment estimates and for the submission of claims for complex clinical procedures.

Refer to the Exclusions, Limitations and Benefits section in the Dental Services manual to find the recommendations for dental services.

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How to file Dental claims

- Timely filing
  - All claims, including secondary claims, should be submitted within 90 calendar days from the date of service for participating providers or within 180 calendar days from the date of service for non-participating providers.

Electronic Claims

- Electronic claims processing requires access to a computer and usually the use of practice management software.
- Electronically generated claims can be submitted through a clearinghouse or directly to our claims processing system via the internet.
- UnitedHealthcare Community Plan partners with electronic clearinghouses to support electronic claims submissions.
- If you wish to submit claims electronically, contact your clearinghouse to initiate this process.
- While the payer ID may vary for some plans, the Payer ID for **Community Plan members is GP133**.
- Please refer to the Important Addresses and Phone Numbers section for additional information as needed.
- Electronic submission is private as the information being encrypted.
- Call **1-877-897-4941** for more information regarding electronic claims submission.

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Tips for successful Dental claim resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services at 1-800-822-5353 if you cannot verify a claim is on file.
- Do not resubmit validated claims on file unless submitting a corrected claim with the required indicators.
- File adjustment requests and claims disputes within contractual time requirements.
- If you must exceed the maximum daily frequency for a procedure, submit the medical records justifying medical necessity. If you have questions, call Dental Provider Services.
- UnitedHealthcare Community Plan is the payer of last resort. This means you must bill and get an EOB from other insurance or source of health care coverage before billing UnitedHealthcare Community Plan.
- Secondary claims must be received within 365 days from the date of service, even if the primary carrier has not made payment.
- When submitting appeal or reconsiderations requests, provide the same information required for a clean claim. Explain the discrepancy, what should have been paid and why.

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How to file MarchVision Care claims

- Use our convenient online provider portal: eyeSynergy.com
- Submit claims electronically or via paper claim using the standard 1500 Claim Form
- Standard Timely Filing for Participating Providers - 90 calendar days from the date of service (DOS)
- Non-Contracted Providers Timely Filing 180 calendar days from DOS

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- **Online provider portal: eyeSynergy.com**

eyeSynergy®

- **For electronic submission:**

  Payer ID 52461

- **Claims Mailing Address:**

  MARCH® Vision Care
  6601 Center Drive West, Suite 200
  Los Angeles, CA 90045

Reconsiderations

MEDICAL

When Should You Submit a Claims Reconsideration?

- You should submit a claims reconsideration request through the Claims tool when you believe a claim was processed incorrectly. Situations for reprocessing include, but are not limited to:
  - Paid amount is different than what provider expected
  - Claim was filed in a timely manner, when provider has proof
  - Claim was denied for no authorization, when provider has an authorization number
  - Difference in Coordination of Benefits (COB) information

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How Do I Submit a Medical Claims Reconsideration Within the Tool?

Click **Create Claim Reconsideration** to start your reconsideration request or submit a corrected claim.

Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.

Need a paper form because you are unable to submit your reconsideration online? Use our Single Paper Claim Reconsideration Request Form found at the link below and mail to the claims mailing address:

https://www.uhcprovider.com/content/dam/provider/docs/public/claims/UHC-Single-Paper-Claim-Reconsideration-Form.pdf

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Example of How to Submit Corrected Claim

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Corrected Claims - Claims

- In **Amount Requested,** enter the total amount you expect for the claim, including any previous payments.
- Select Resubmission of a Corrected Claim as the Request Reason from the pulldown menu.
- Help us understand the situation by adding a New Comment.

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Example of How to Create a Reconsideration

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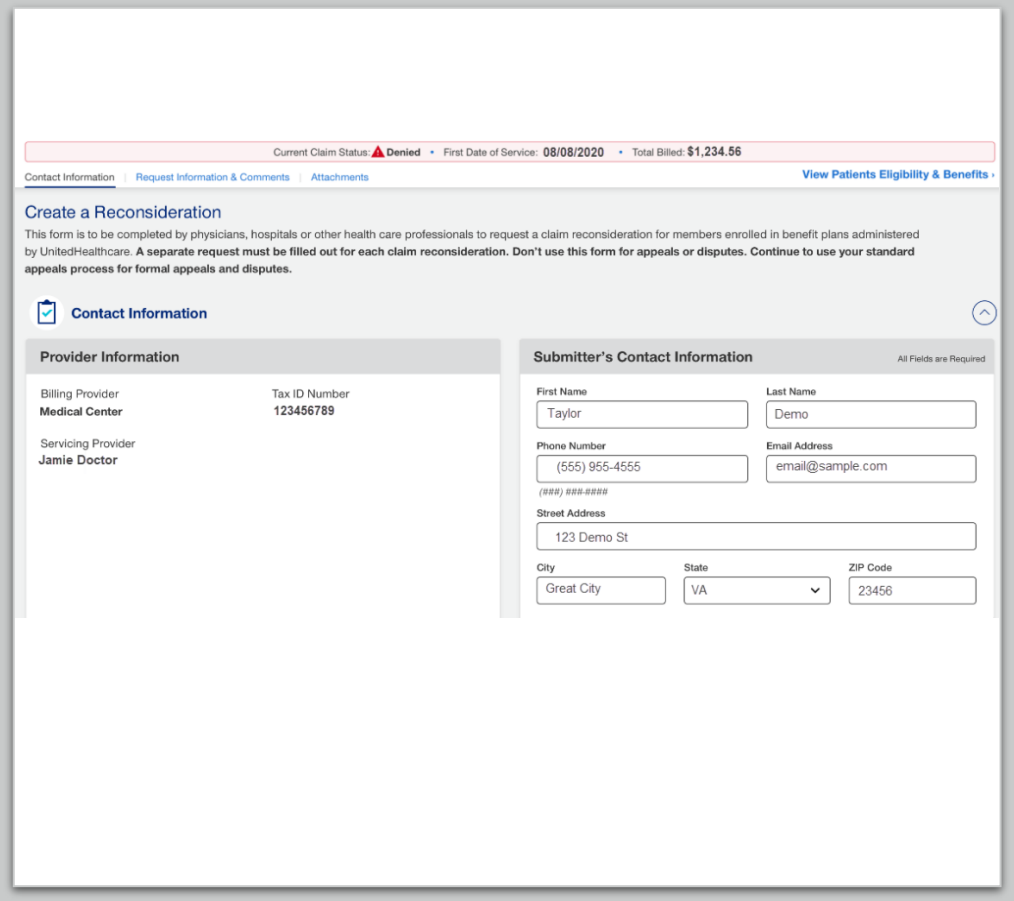
MEDICAL

- Scroll down to review the details
- Enter your contact information in the Submitter's Contact Information section.
- Once Submitted, document the ticket number received



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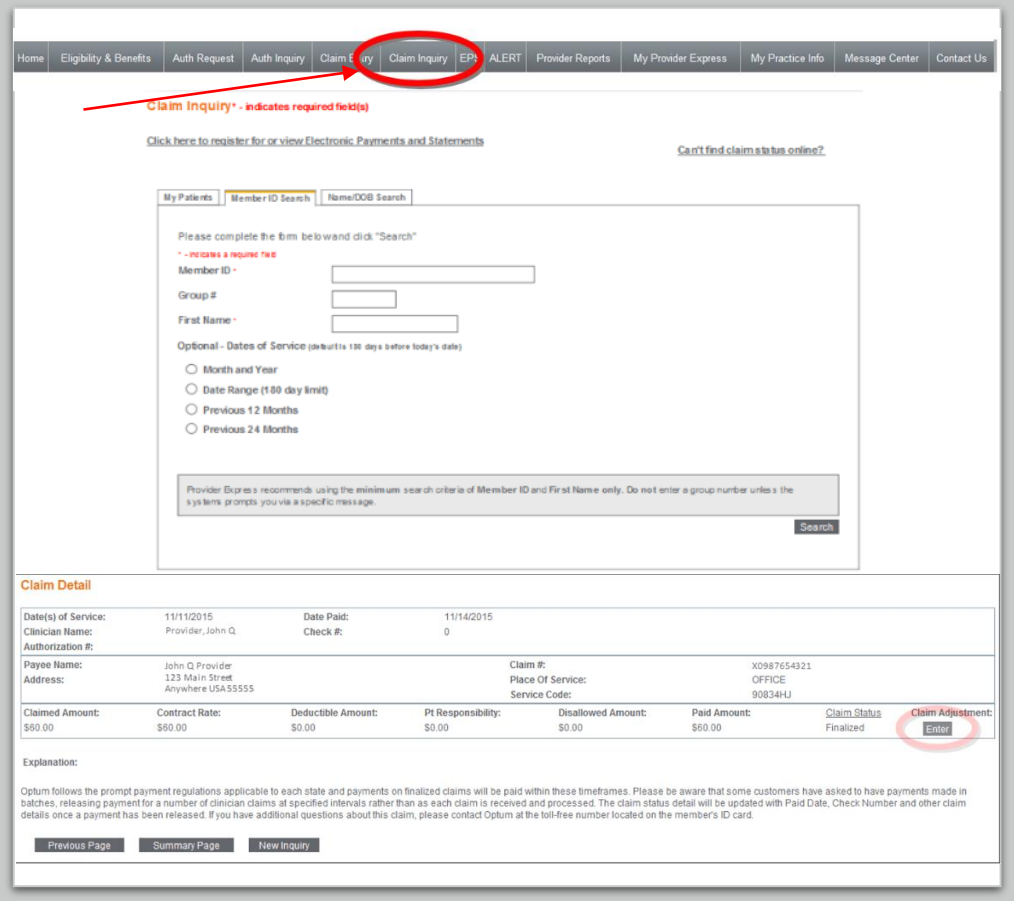
BEHAVIORAL

How do I Submit a Claims Reconsideration?

Securely login to Provider Express

- Claim Inquiry
- Search for claim
- Click Enter under claim adjustment

Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.



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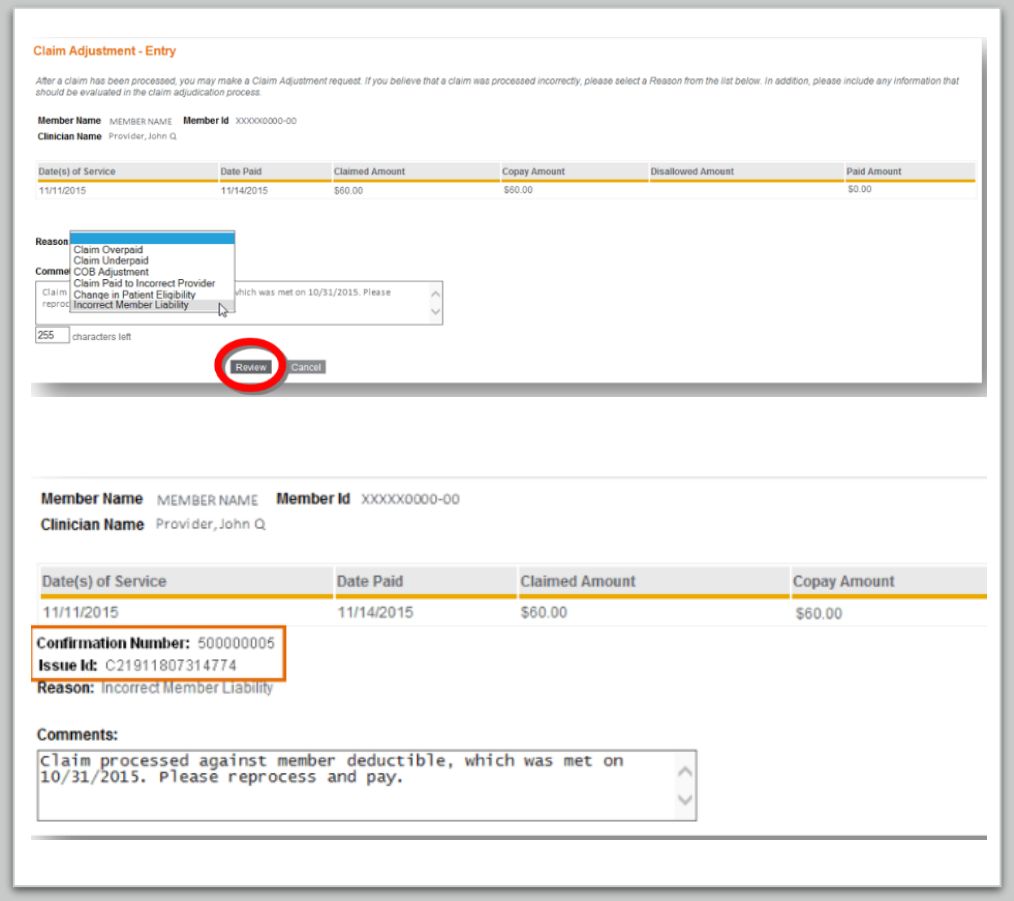
BEHAVIORAL

- Select a reason from the dropdown
- Select Review
- Review details and add necessary comments on next screen
- Select Submit
- Once Submitted, document the Confirmation Number and Issue ID



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MEDICAL & BEHAVIORAL

What if I don't agree with the outcome of my Claim Reconsideration?

- If you disagree with the outcome of your Claim Reconsideration, please take the issue to your Indiana Medical or Behavioral Advocate Team.

Medical

Northern Indiana – Lori Reeder – lreeder@uhc.com

Central Indiana - Karen Cockerham –karen.cockerham@uhc.com

Southern Indiana – Kim Berry **–** kim_berry@uhc.com

Behavioral Health

Belen Stewart – belen.stewart@optum.com

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MEDICAL & BEHAVIORAL

What is the next step in the Reconsideration Process?

- If you still disagree with the outcome of your claim after the Advocate team has escalated, your next step is to file a formal appeal.
- Must be submitted within 60 calendar days from the failed reconsideration
  - Mail to:
    - UnitedHealthcare Community Plan of Indiana,
      Attn: Appeals and Grievances Unit
      PO Box 31364
      Salt Lake City, UT 84131-0364
    - Submit within Claims on our UnitedHealthcare Provider Portal

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MEDICAL & BEHAVIORAL

What if I still disagree?

- If you still disagree with the outcome of your formal dispute, you may file a Formal Provider Grievance.
- Must be submitted within 120 calendar days from the failed Dispute (Must include additional or new information).
- Mail to:

  - UnitedHealthcare Community Plan of Indiana
    Attn: Appeals and Grievances Unit PO Box 31364
    Salt Lake City, UT 84131-0364

- Submit within Claims on our UnitedHealthcare Provider Portal

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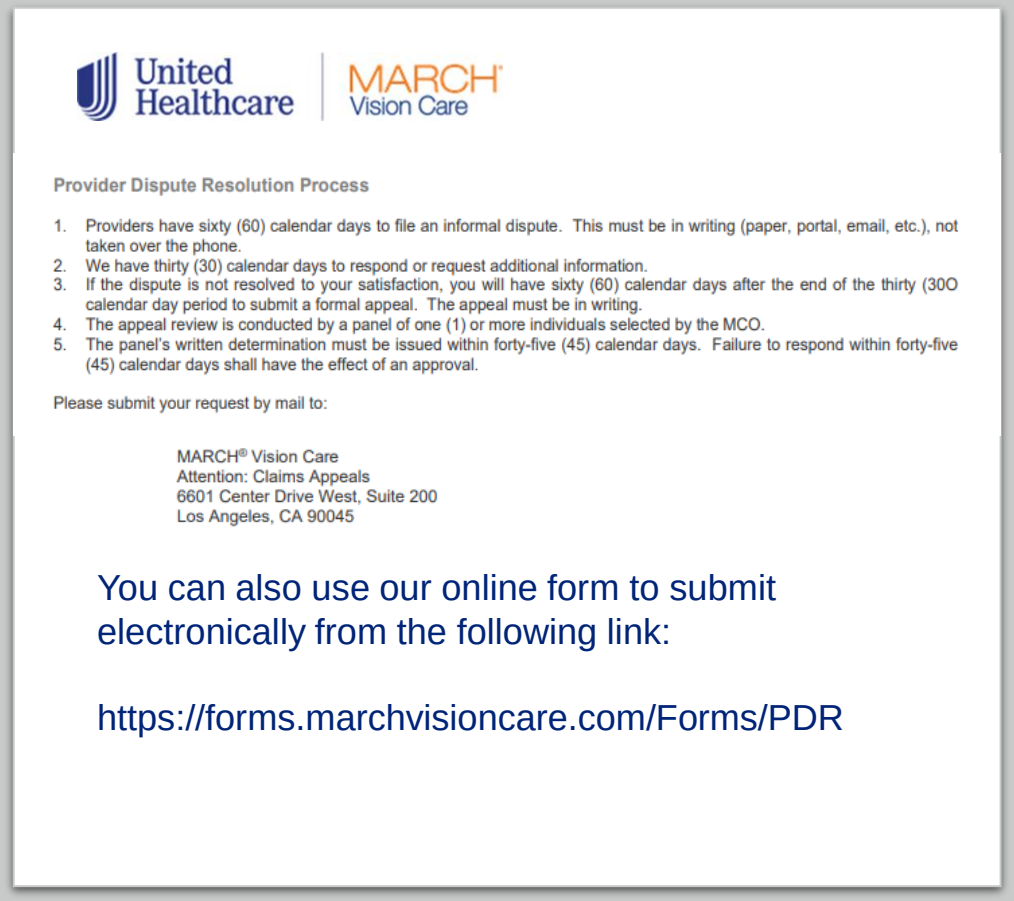
March Vision

How do I Submit an Informal Dispute?

Providers have 60 calendar days from the original EOB date to submit a Claim Reconsideration.



United Healthcare | MARCH Vision Care

Provider Dispute Resolution Process

1. Providers have sixty (60) calendar days to file an informal dispute. This must be in writing (paper, portal, email, etc.), not taken over the phone.
2. We have thirty (30) calendar days to respond or request additional information.
3. If the dispute is not resolved to your satisfaction, you will have sixty (60) calendar days after the end of the thirty (30O calendar day period to submit a formal appeal. The appeal must be in writing.
4. The appeal review is conducted by a panel of one (1) or more individuals selected by the MCO.
5. The panel's written determination must be issued within forty-five (45) calendar days. Failure to respond within forty-five (45) calendar days shall have the effect of an approval.

Please submit your request by mail to:

MARCH® Vision Care
Attention: Claims Appeals
6601 Center Drive West, Suite 200
Los Angeles, CA 90045

You can also use our online form to submit electronically from the following link:

https://forms.marchvisioncare.com/Forms/PDR

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How to file Dental Corrected Claims

- **Corrected claim process**

  Providers who receive a claim denial and need to submit a corrected claim should submit a corrected claim and appropriate documentation, if necessary, to:

- **Corrected Claims Address**

  P.O. Box 481

  Milwaukee, WI 53201

- You can submit a request for an additional claim review, if a claim was denied due to missing information, missing tooth number/ surface on the original submission or you have additional information you feel may change the claim payment decision.
- The determination of a corrected claim request will be provided a remittance statement within 30 days of receipt.

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How do I dispute how a dental claim was processed/denied?

Appealing a denied claim payment

- Providers have the right to appeal a claim payment that is fully or partially denied. UnitedHealthcare will follow state and Federal guidelines in the management of the appeals process, including 405 Indiana Administrative Code (IAC) 1-1.6.
- Providers may submit an Informal Objection within 60 days of the adverse claim determination ("claim denial"). This Informal Objection must be submitted in writing at the address below. The Informal Objection will be reviewed and resolved within 30 days.
- If providers are not satisfied with the resolution to the Informal Objection, providers may submit a Formal Appeal in writing within 60 days of the Informal Objection to the same address below. The Formal Appeal will be reviewed and resolved within 30 days.

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Resources

Additional Claims Trainings on UHCprovider.com

Referrals: Interactive User Guide

Track-It Self-Paced User Guide

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Administrative Provider Resources – Medical and Vision Claims

- Education resources for submitting claims are available on our provider website.
- Claim system configuration follows Federal and Indiana Medicaid claims billing guidelines.
- Accept paper or electronic claim submissions.
  - Link to file **professional** claims with United Healthcare **UHCprovider.com/claims**

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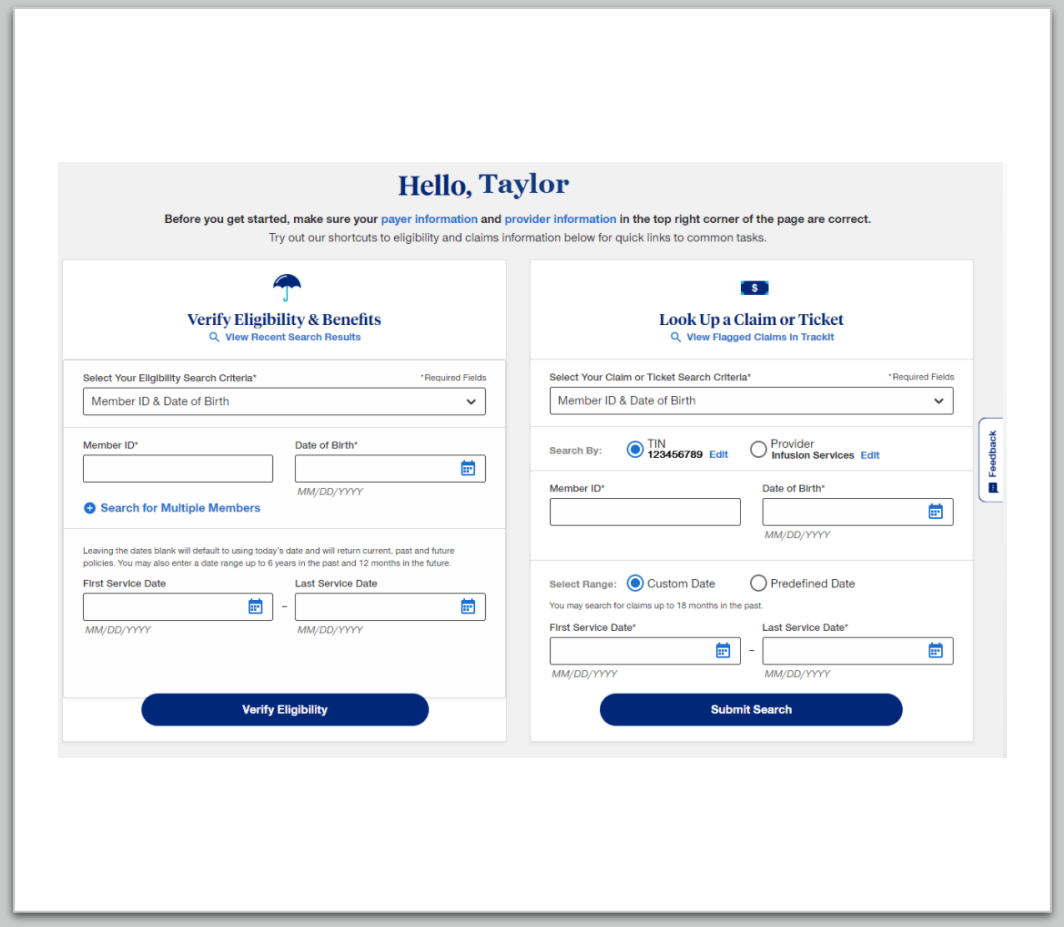
Medical Claims and Eligibility

- Check claim status
- Check member eligibility status
- Start a claim reconsideration or appeal once claim ID is pulled up
- Obtain electronic image of a member's Hoosier Care Connect Insurance Card



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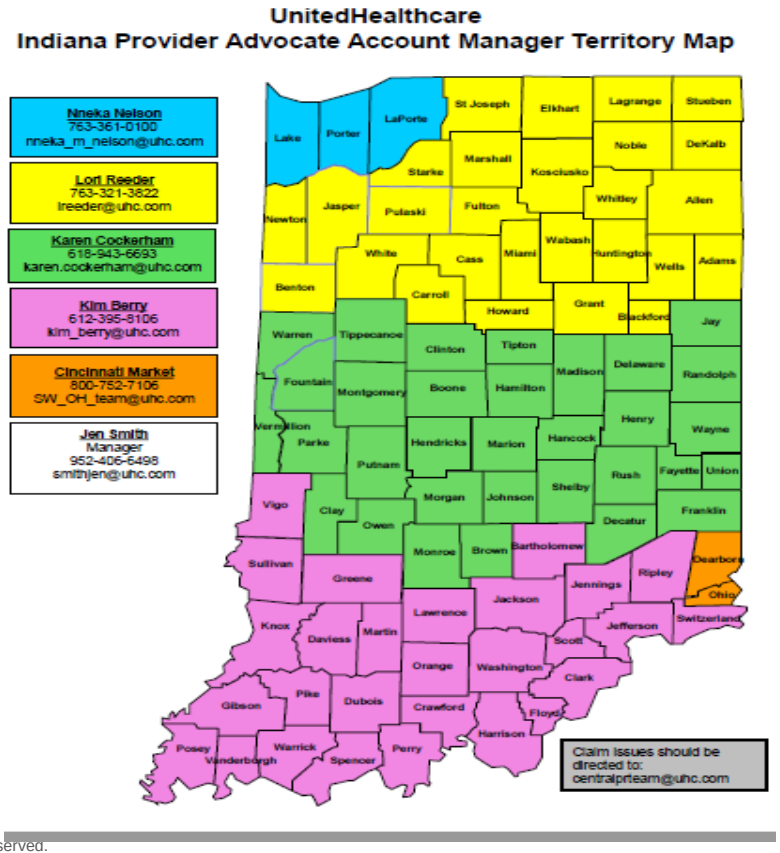
Provider Advocate Teams

Indiana Provider Advocate Account Manager Territory Map



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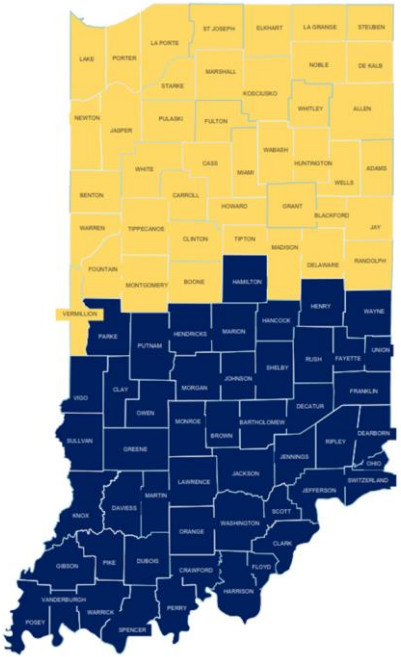
Your Dental Advocate Team

Catrice Campbell
Provider Advocate
763-283-4522
catrice_campbell@uhc.com

Paul Curry III
Provider Advocate
952-202-2072
paul_curry@uhc.com



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Your Optum Behavioral Health ABA Advocate

Nacole Thompson
Provider Advocate
ABA Therapy- all counties
952-406-6449
Nacole.Thompson@optum.com

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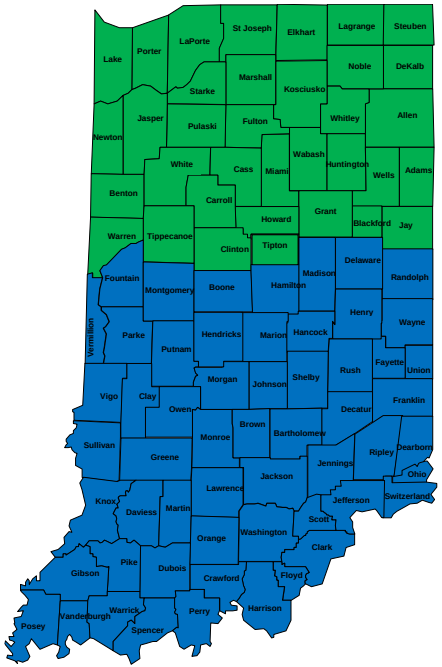
Your Optum Behavioral Health Advocate Team

Belen Stewart
Provider Advocate
Behavioral Health
612-632-5962
Belen.Stewart@optum.com

David Hoover
Senior Provider Advocate
Behavioral Health
763-330-7588
David_Hoover@optum.com



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Questions and Answers

Thanks for Attending Today's Session

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Provider Reference Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- MarchVision: www.marchvisioncare.com
- Optum Behavioral Health: www.providerexpress.com

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