UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

Tips for billing and correcting *CMS-1500* and UB-04 Claims

Presented by Jen Smith, Manager of Provider Advocacy & Account Management

United Healthcare®

Agenda

- Our Service Lines
- Claim Submission
- General Billing Reminders
- How to Submit Corrected Claims
- When to Escalate a Claim
- Questions and Answers

Acronyms

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

Our Service Lines

- UnitedHealthcare

- Optum Behavioral Health

- March Vision

- UnitedHealthcare Dental

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 and 180 for OON providers from the Primary EOB date.

- For electronic submission: utilize 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
- Behavioral Health Professional claims (*CMS-1500*) on our Provider Express Portal

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.

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.

Claims Submission Tips

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

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 Coverage, Limits and Billing for Specific dental Services section in the Dental Services module to find the recommendations for dental services.

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.

Tips for successful Dental claim resolution

- Do not let claim issues grow or go unresolved.
- Call Provider Services at 1-844-402-9118 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 a provider 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 Providers 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 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.

How to file MARCH® Vision Care claims

- Use our convenient online provider portal: eyeSynergy.com.
- Submit claims electronically or via paper claim using the *CMS-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.

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

eyeSynergy®

➢ **For electronic submission:**

Payer ID 52461

➢ **Claims Mailing Address:**

MARCH® Vision Care
Attn: Medicaid Vision Claims
PO Box 30989
Salt Lake City, UT 84130

Reconsiderations

MEDICAL

When Should You Submit a Claims Reconsideration?

- Claim reconsideration requests should be submitted through the Claims tool when 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 .

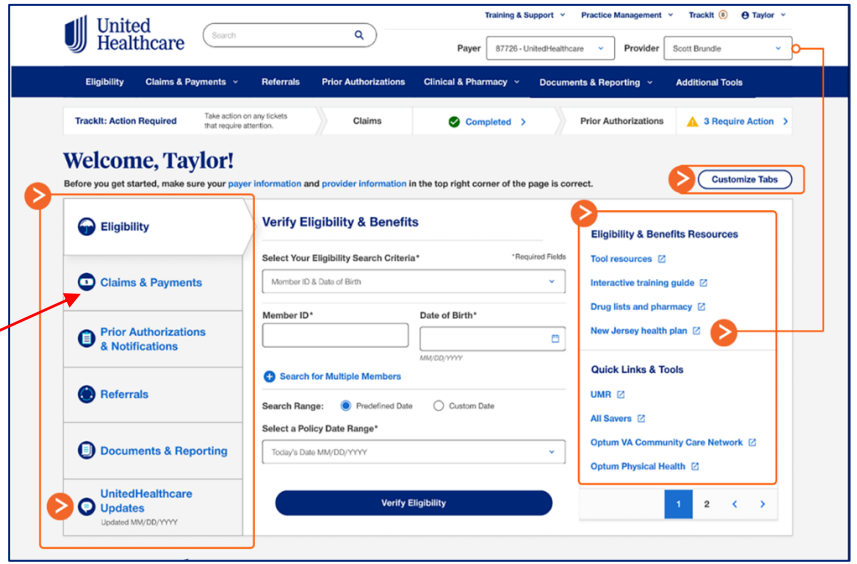
How Do I Submit a Medical Claims Reconsideration Within the Tool?

- 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

Claims Tool

- With the Claims tool, you can:
  - View claims information for multiple UnitedHealthcare plans.
  - Access letters, remittance advice documents and reimbursement policies.
  - Submit additional information requested on pended claims.
  - Flag claims for future viewing.
  - Submit corrected claims or claim reconsideration request.
  - Receive instant printable confirmation for your submissions.



Example of How to Submit Corrected Claim

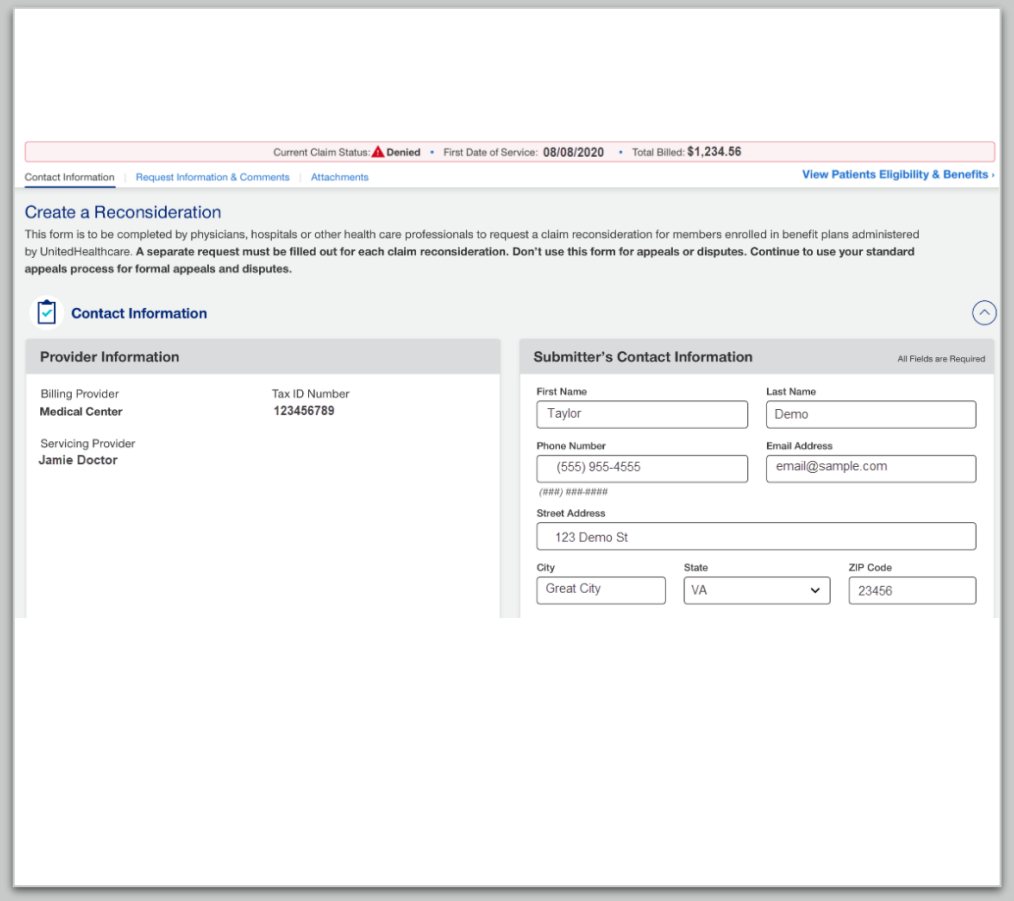
Corrected Claims

- 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.

Example of How to Create a Reconsideration

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.



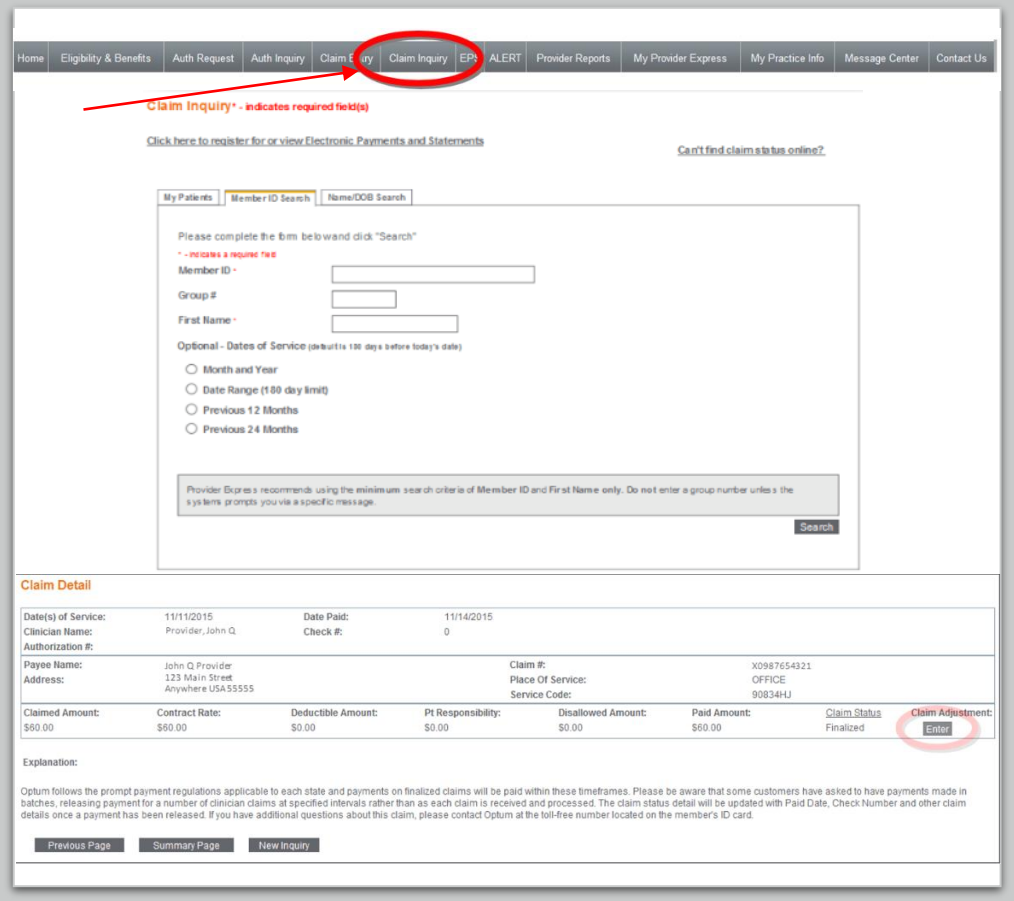
BEHAVIORAL

How do I Submit a Claims Reconsideration?

Securely log in to Provider Express.

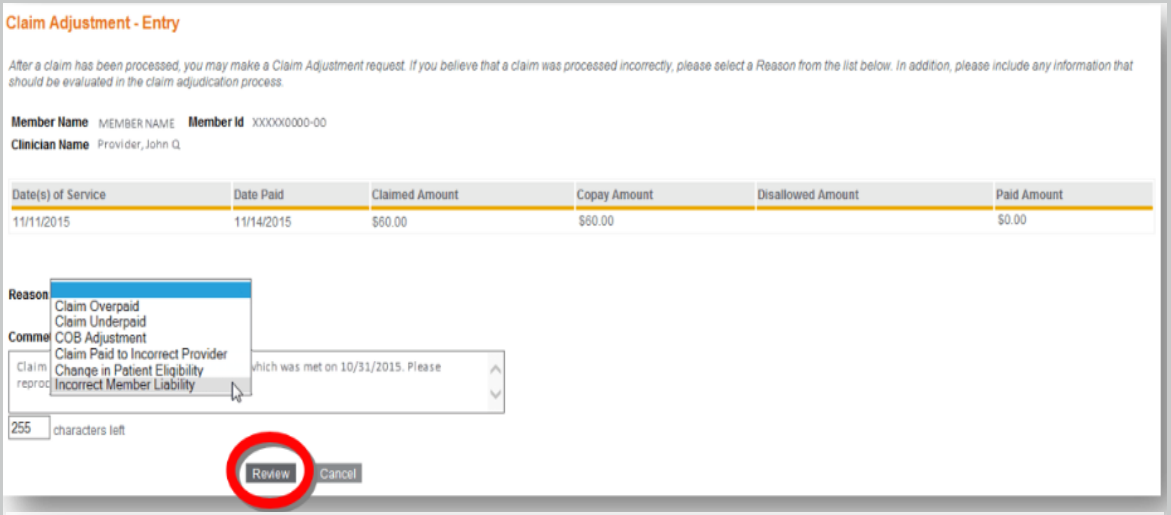
- **Claim Inquiry**.
- Search for claim.
- Click **Enter** under claim adjustment.

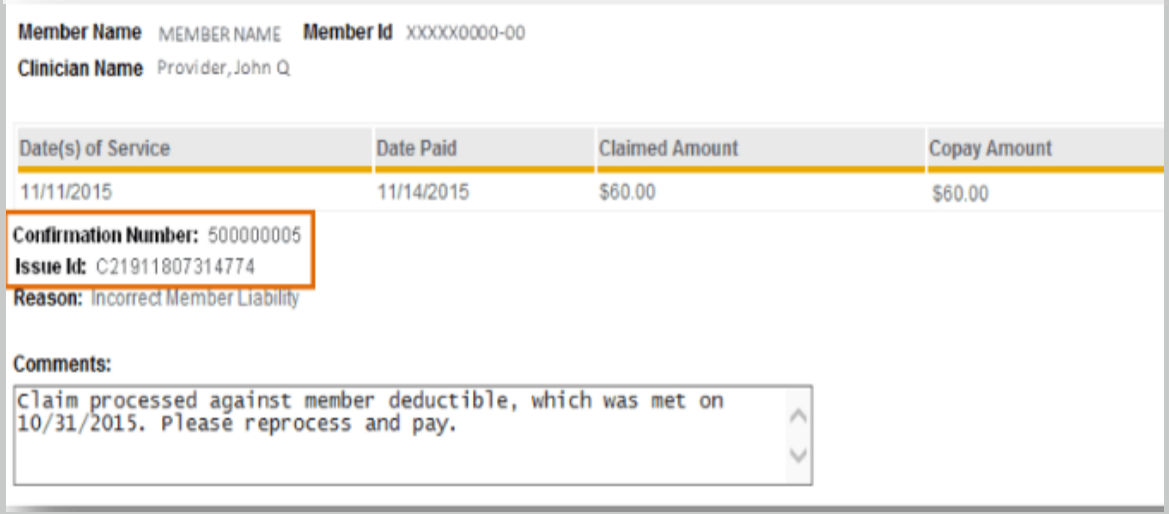
Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.



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.





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 escalate the issue to your Indiana Medical or Behavioral Advocate Team.

Medical

Regions 1 and 2 – Lori Reeder – lreeder@uhc.com

Regions 3 and 4 – Karen Cockerham – karen.Cockerham@uhc.com

Region 5 – Kelly Carpenter **–** kelly_carpenter@uhc.com

Behavioral Health

Northern IN – Belen Stewart – belen.stewart@optum.com

Central and Southern IN – Paulette Means – paulette.means@optum.com

MEDICAL & BEHAVIORAL

What is the next step in the Reconsideration Process?

- If you continue to disagree with the outcome of your claim after the Advocate team has escalated, your next step is to file a Formal Dispute.
- 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 the UnitedHealthcare Provider Portal.

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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 tool on our UnitedHealthcare Provider Portal.

MARCH® Vision Care

How do I Submit an Informal Dispute?

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

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

Provider dispute resolution process

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

Please submit your request by mail to:
UnitedHealthcare I March Vision Care
Attn: Medicaid Vision Appeals
PO Box 30988
Salt Lake City, UT 84130

How to file Dental Corrected Claims

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

  UHC Dental

  PO Box 481

  Milwaukee, WI 53201

- Providers 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 on a remittance statement within 30 days of receipt.

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

- UnitedHealthcare will follow state and Federal guidelines in the management of the appeals process, including 405 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 and 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 which will be reviewed and resolved within 30 days.

UnitedHealthcare Community & State

Hoosier Care Connect Health Plan UB-04 Claims

United Healthcare®

Claim Submission

How to file Medical/Behavioral UB-04 Claims

- Submit claims using claim submission tool on UHCprovider.com.
- Standard Timely Filing for Par Providers 90 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
  PO BOX 5240
  Kingston, NY 12402

Electronic Secondary Claims

- **Primary Payer Paid Amount**: Submit the primary paid amount for each service line reported on the 835-payment advice or EOB. The paid amount on institutional claims can be submitted at the claim level.

- **Adjustment Group Code:** Submit other payer claim adjustment group code as found on the 835-payment advice or identified on the EOB. Deductible, co-insurance, copayment, contractual obligations and/or non-covered services are common reasons why the other payer paid less than billed.

- **Adjustment Reason Code:** Submit other payer claim adjustment reason code as found on the 835-payment advice or identified on the EOB. Deductible, co-insurance, copayment, contractual obligations and/or non-covered services are common reasons why the other payer paid less than billed.

- **Adjustment Amount:** Submit other payer adjustment monetary amount.

- **Preference:** Submit professional claims at the line level and institutional claims at either the line or claim level. The service level and claim level should be balanced. UnitedHealthcare follows 837P/837I guidelines.

COB Electronic Specifications

- For secondary or institutional claims to be paid electronically, the COB information must be submitted in the applicable loops and segments.
- Loops IDs include:

  - 2320 Other Subscriber Information
  - 2330A Other Subscriber Name
  - 2330B Other Payer Name
  - 2330C Other Payer Referring Provider
  - 2330D Other Payer Rendering Provider
  - 2330E Other Payer Service Facility Location
  - 2330F Other Payer Supervising Provider
  - 2430 Line Adjudication Information

- To learn more about submitting secondary/COB claims electronically to UnitedHealthcare, please consult your vendor, 837P/837I Implementation Guide, or our Companion Guides page for eCOB specifications.

General Billing Reminders

Tips for Claim Submission

- An occurrence code is required for all types of bill except for an outpatient type of bill. UnitedHealthcare follows the guidance found on the IHCP Claims Submission and Processing, the link is provided on the next slide.

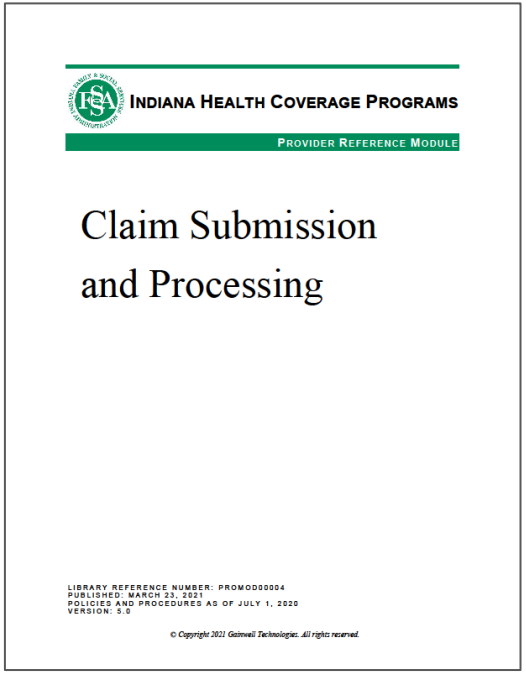
- Rejected Claims are not visible in our claims system – Claim rejections that appear on clearinghouse reports have not been accepted by UnitedHealthcare and should be corrected and resubmitted electronically to avoid timely filing denials.

- Secondary Claims – When another insurance plan is primary and UnitedHealthcare is secondary, the secondary claim can be submitted electronically. Information from the primary payer's EOB/COB should be included in the electronic claim.

General Billing Reminders – IHCP Modules

UnitedHealthcare Community Plan of Indiana follows the Indiana Medicaid Claims Submission and Processing Module

A facility's enrolled service location address should always be billed in box 1 of the UB-04. This includes the ZIP + 4.



General Billing Reminders - NDC

Unique Identifier Assigned to Medication under Section 510 of United States Federal Food Drug and Cosmetic Act

First five digits identify the manufacturer of drug and are assigned by the FDA

The remaining six digits are assigned by the manufacturer and identify the specific product and package size.

If eleven digits not included on the label, add a leading zero to create a 5-4-2 NDC

If package NDC is 66733-948-23 the billing will be 66733-0948-23

Place the valid NDC on claim without hyphens or spaces

If the NDC number on internal container and external package do not match – list only the NDC number from internal package

Detailed info can be located in the Injections, Vaccines and Other Physician-Administered Drugs Module

General Billing Reminders – NDC Units

- The actual decimal quantity administered, and the units of measurement are required on the claim. If reporting a partial unit, use a decimal point. (i.e., if three 0.5 ml vials are dispensed, report mL1.5).
  - GR0.045
  - ML1.5
  - UN2.0

- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. Do not zero fill, leave remaining positions blank. Please refer to the following examples:
  - 1234.56
  - 2
  - 12345678.123

- Requiring the NDC information will differentiate drugs that share the same HCPCS, CPT, or Revenue Codes for drug preferences and enhance reimbursement processes.

- The NDC requirement will not apply to child and adult immunization drug codes.

General Billing Reminders on Reimbursement Policies

- If you are experiencing claim denials for a specific code or service, check the Reimbursement Policies page as the denial may be related to a Reimbursement Policy.

- Reimbursement Policies can be found:

  https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-policies/reimbursement-community-state-policies-indiana

Note: All UnitedHealthcare Community Plan of Indiana Reimbursement Policies have been approved by the state.

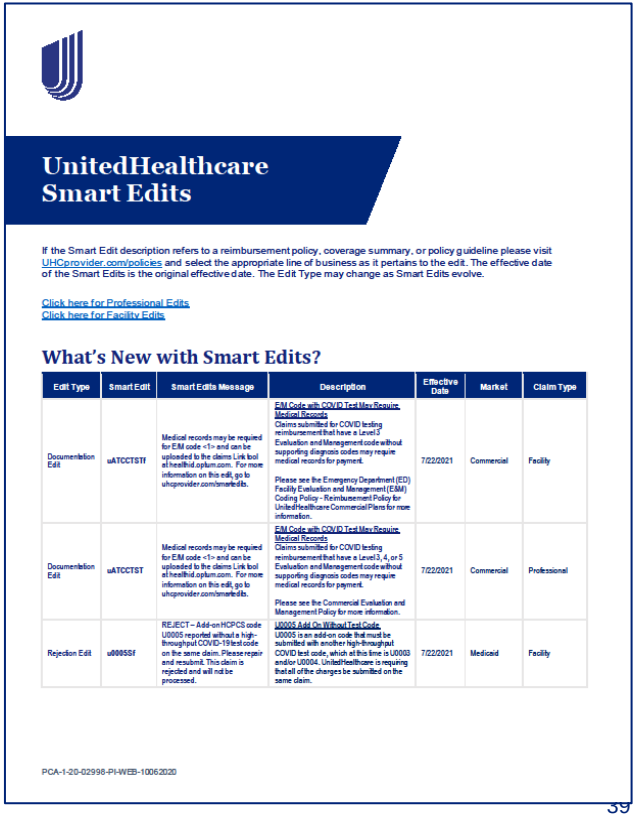
General Billing Reminders - Smart Edits

- Smart Edits is a claims optimization tool that identifies billing errors within a claim and allows care providers the opportunity to review and repair problematic claims. Smart Edits are sent within 24 hours of a claim submission, so you can review identified claims in a matter of hours instead of potential claims denials days later.

- When claims are submitted accurately and in compliance with the latest policies and regulations, it results in less re-work, quicker approvals and faster payments.

- Link to documentation on portal:

  Smart Edits | UHCprovider.com



UnitedHealthcare
Smart Edits

If the Smart Edit description refers to a reimbursement policy, coverage summary, or policy guideline please visit UHCprovider.com/policies and select the appropriate line of business as it pertains to the edit. The effective date of the Smart Edits is the original effective date. The Edit Type may change as Smart Edits evolve.

Click here for Professional Edits
Click here for Facility Edits

What's New with Smart Edits?

Edit Type	Smart Edit	Smart Edits Message	Description	Effective Date	Market	Claim Type
Documentation Edit	uATCCTSTf	Medical records may be required for E/M code <1> and can be uploaded to the claims Link tool at healthid.optum.com. For more information on this edit, go to uhcprovider.com/smartedits.	E/M Code with COVID Test May Require Medical Records Claims submitted for COVID testing reimbursement that have a Level 3 Evaluation and Management code without supporting diagnosis codes may require medical records for payment. Please see the Emergency Department (ED) Facility Evaluation and Management (E&M) Coding Policy - Reimbursement Policy for UnitedHealthcare Commercial Plans for more information.	7/22/2021	Commercial	Facility
Documentation Edit	uATCCTST	Medical records may be required for E/M code <1> and can be uploaded to the claims Link tool at healthid.optum.com. For more information on this edit, go to uhcprovider.com/smartedits.	E/M Code with COVID Test May Require Medical Records Claims submitted for COVID testing reimbursement that have a Level 3, 4, or 5 Evaluation and Management code without supporting diagnosis codes may require medical records for payment. Please see the Commercial Evaluation and Management Policy for more information.	7/22/2021	Commercial	Professional
Rejection Edit	u000SSf	REJECT – Add-on HCPCS code U0005 reported without a high-throughput COVID-19 test code on the same claim. Please repair and resubmit. This claim is rejected and will not be processed.	U0005 Add On Without Test Code U0005 is an add-on code that must be submitted with another high-throughput COVID test code, which at this time is U0003 and/or U0004. UnitedHealthcare is requiring that all of the charges be submitted on the same claim.	7/22/2021	Medicaid	Facility

PCA-1-20-02998-PI-WEB-10062020

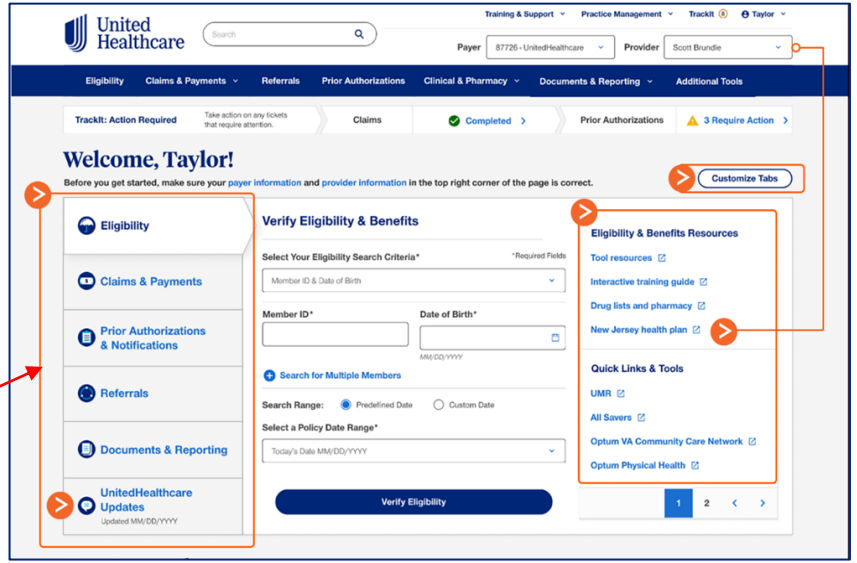
Corrected Claims

Corrected Claims – UB-04

- Electronic Corrected Claims.
  - Corrected UB-04 claims can be sent electronically.
  - Using the appropriate Bill Type to indicate that it's a replacement of a previous claim.
  - If you cannot submit corrected claims using EDI, submit a claim reconsideration request via the Claims Tool via the UnitedHealthcare Provider Portal in the same manner as you would for a HCFA or *CMS-1500* claim form.

Claims Tool

- With the Claims tool, you can:
  - View claims information for multiple UnitedHealthcare plans.
  - Access letters, remittance advice documents and reimbursement policies.
  - Submit additional information requested on pended claims.
  - Flag claims for future viewing.
  - Submit corrected claims or claim reconsideration request.
  - Receive instant printable confirmation for your submissions.



Submit Corrected Claim

- Proceed to the “Submit Corrected Claim” tab to submit your claim correction.

When to Escalate a Claim

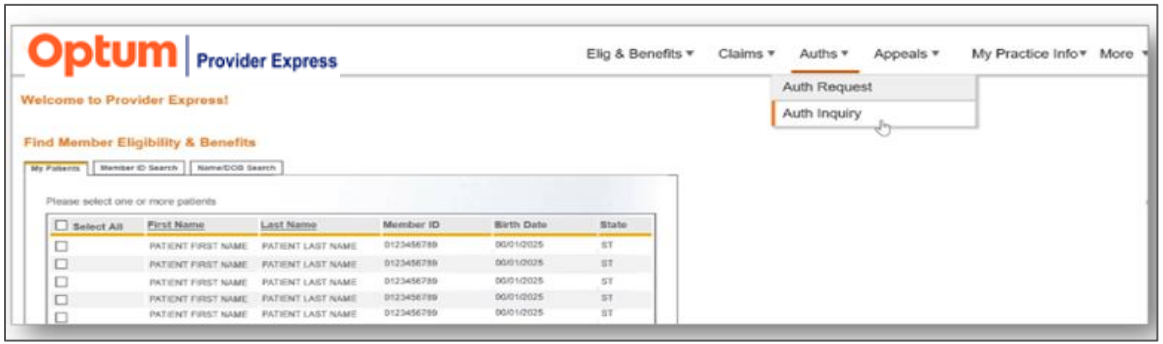
When Should I Escalate a Medical Claim to a Provider Advocate?

- 1st Level Dispute (Reconsideration)
- 2nd Level Appeal

When Should I Escalate a Behavioral Health Claim?

Lack of response after submitting an Authorization request:

1. Check the Provider Express portal.
2. Call the number on the back of the member's ID card.
3. If 1 and 2 do not provide a response, please reach out to your Provider Relations Advocate.



Behavioral Health Advocates

Northern IN:
Belen Stewart
belen.stewart@optum.com

Central & Southern IN:
Paulette Means
paulette.means@optum.com

Resources

Additional Claims Trainings on UHCprovider.com

Claims Research Project

Document Library Interactive User Guide

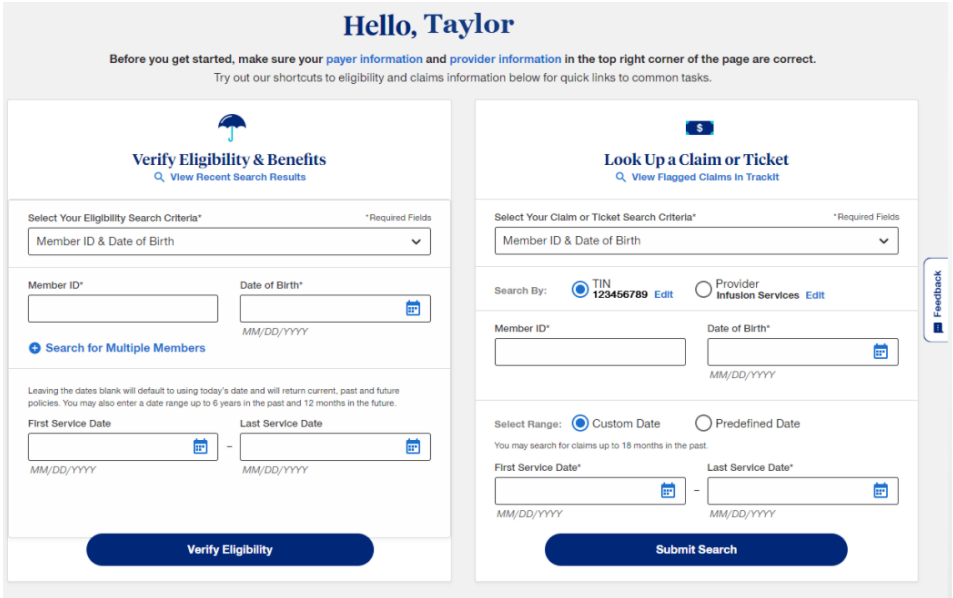
CommunityCare Provider Portal User Guide (chameleoncloud.io)

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 medical claims with United Healthcare **UHCprovider.com/claims**

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.



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: Provider Express - Indiana Medicaid

Provider Advocate Teams

Your Medical Network Provider Advocate Team

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Kelly Carpenter
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Territory & all FQHC/RHC's

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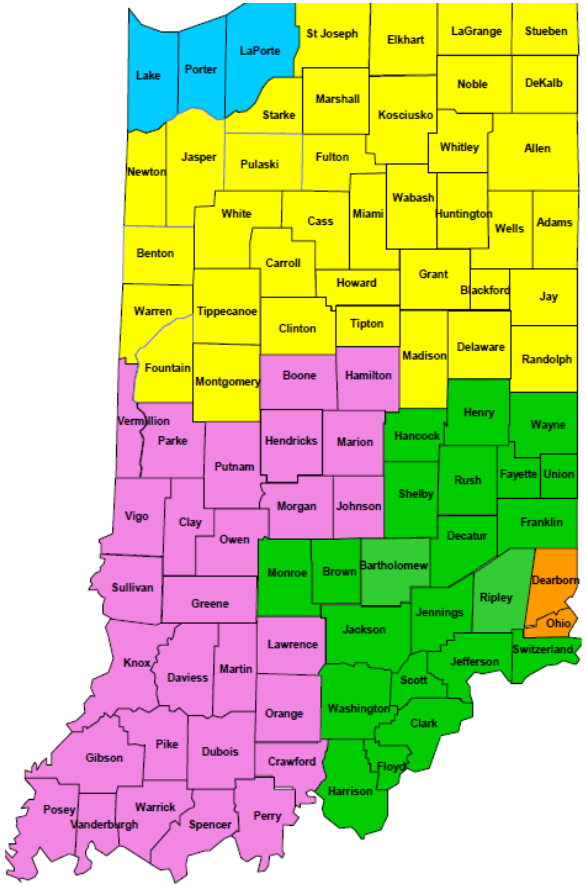

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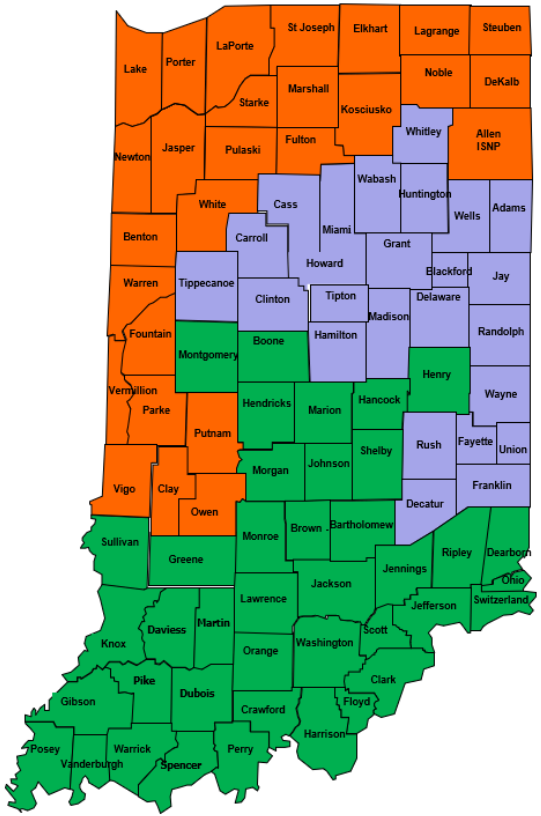

Your Optum Behavioral Health Advocate Team

Belen Stewart
Senior Provider Relations Advocate
612-632-5962
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Paulette Means
Senior Provider Relations Advocate
612-476-6567
Paulette.Means@optum.com

Olivia Smith
Provider Advocate
ABA Therapy– All counties
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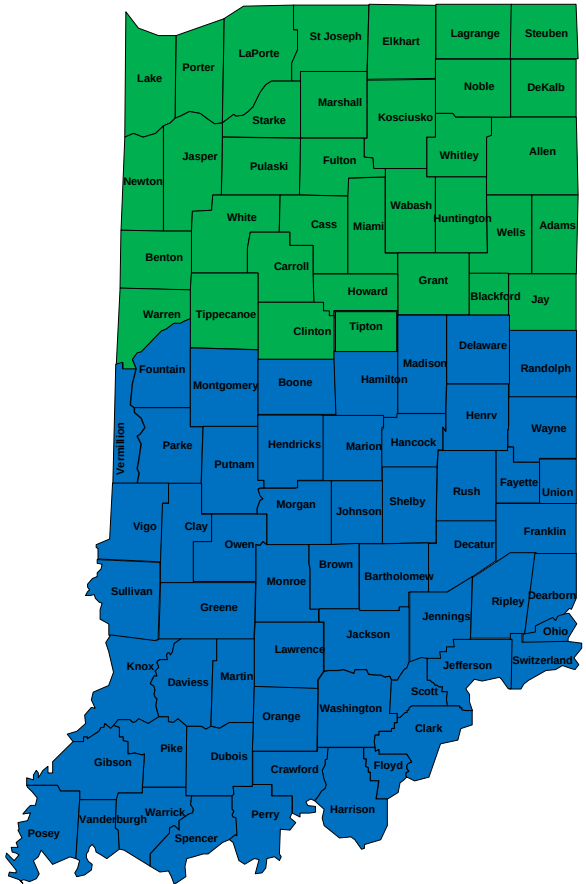
Olivia.Smith14@optum.com



Your Dental Advocate Team

Kristy Jachowske
Provider Advocate (all counties)
763-273-9594
Kristy_jachowske@uhc.com

Your March Vision Advocate

Vicky Quintanilla
Sr. Provider Relations Advocate
714-601-4336
Vicky.quintanilla@uhc.com
(Vicky covers all Indiana counties)

Questions and Answers

Thank You for Attending Today's Session