UnitedHealthcare Community & State

Hoosier Care Connect Health Plan Claims 201

Presented by Jodie Hattery, Vice President, Provider Services

United Healthcare®

Our Service Lines

- UnitedHealthcare

- Optum Behavioral Health

- March Vision

- UnitedHealthcare Dental

Claim Submission Tips

Tips For Claim Submission

- Rejected Claims – Claim rejections that appear on clearinghouse reports have not been accepted by UnitedHealthcare and should be corrected and resubmitted electronically.
- Secondary Claims – When another commercial insurance plan is primary and UnitedHealthcare is secondary, the secondary claim can be submitted electronically. Information from the primary payer's EOB/COB can be included in the electronic claim.
- Most corrected claims can be sent electronically.
- Unlisted Codes – If you're submitting EDI claims with an unlisted service code, up to 80 characters of notes can be sent at the claim and service line level for the following loops and segments:
  - Professional: 2400 NTE or SV101-7
  - Institutional: 2300 NTE or SV202-7
  - Consult your vendor or the 837 Implementation Guide for fields required in the loop and segment.

Electronic Secondary Claims

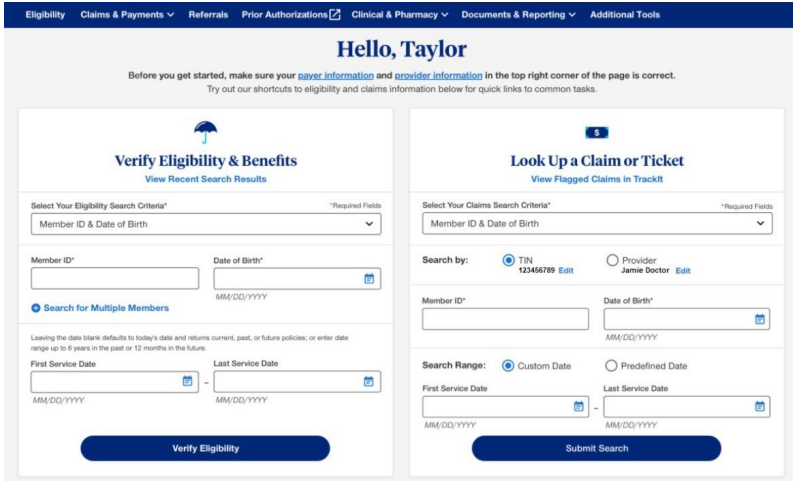
- **Primary Payer Paid Amount**: Submit the primary paid amount for each service line reported on the 835 payment advice or EOB. The paid amount on institutional claims can be submitted at the claim level.
- **Adjustment Group Code:** Submit other payer claim adjustment group code as found on the 835 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.

Coordination Of Benefits - Electronic Specifications

- For secondary professional or institutional claims to be paid electronically, the Coordination Of Benefits (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.

Claims Tool

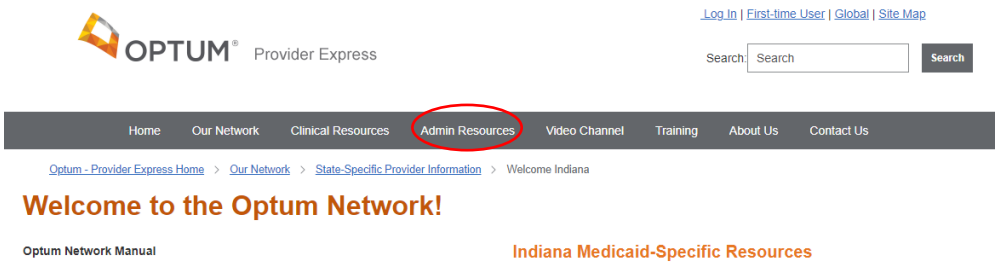
- **With the Claims tool, you can:**
  - View claims information for multiple UnitedHealthcare plans.
  - Access letters, remittance advice documents and reimbursement policies.
  - Submit additional information requested on pended claims.
  - Flag claims for future viewing.
  - Submit corrected claims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



Behavioral Health Tips For Claim Submission

Claim tips can be found by clicking Admin Resources on the Provider Express – Indiana page

- Claims Problem Resolution
- Claim Submission Hints
- Outpatient Claims
- Training



DENTAL Claim Submission Tips

- Most claim forms have 10 fields for recording procedures. Each procedure must be listed separately and must include the following information, if applicable:
  - Any missing teeth
  - When submitting for periodontal or prosthodontic procedures, this area should be completed. An “X” can be placed on any missing tooth number or letter when missing.
- If the number of procedures exceeds the number of available lines, the remaining procedures must be listed on a separate, fully completed claim form.
- Dental Record of Services
  - Place in the Remarks Section
  - Some procedures require a narrative. If space allows, you may record your narrative in this field.
  - Otherwise, a narrative should be attached to the claim form, preferably on practice letterhead with all pertinent member information.
- By Report procedures
  - All “By Report” procedures require a narrative along with the submitted claim form. The narrative should explain the need for the procedure and any other pertinent information.

DENTAL
Claim Submission Tips – ICD-10 Instructions

- 29a Diagnosis Code Pointer:
  - Enter the letter(s) from Item 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary **diagnosis** pointer first.
- 29b Quantity:
  - Enter the number of times (01-99) the procedure identified in Item 29 is delivered to the patient on the date of service shown in Item 24. The default value is “01”.
- 34 Diagnosis Code List Qualifier:
  - Enter the appropriate code to identify the diagnosis code source:
    - B = ICD-9-CM AB = ICD-10-CM (as of Oct. 1, 2013)
- 34a Diagnosis Code(s):
  - Enter up to 4 applicable diagnosis codes after each letter (A.-D.). The primary diagnosis code is entered adjacent to the letter “A.”

This information is required when the diagnosis may have an impact on the adjudication of the claim in cases where specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions.

General Billing Reminders

General Billing Reminders – Box 33

- **Box 33 Requirements**
  - **BILLING PROVIDER INFO** & PH #–Enter the service location name and address (including ZIP Code+4) as listed on the provider enrollment profile for the billing or group provider. The address in this field should match the service location (practice site) address (not the home office [legal], pay-to or mail-to address) on file for the billing or group provider.
  - **33a –** Billing Provider NPI – enter the billing or group provider NPI.

General Billing Reminders - NDC

NDC Requirements

- NDC information differentiates drugs that share the same HCPCS, CPT, or Revenue codes for drug preferences and enhances reimbursement processes.
- The NDC requirement will not apply to child and adult immunization drug codes
- The first five digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA).
- The remaining 6 digits are assigned by the manufacturer and identify the specific product and package size.
- A valid NDC without spaces or hyphens should be placed on the medical claim.

General Billing Reminders - NDC

NDC Requirements

- If the NDC number on the container is different than the NDC number on the external package;
  - The NDC submitted must be the actual valid NDC number on the container from which the medication was administered (If a medication has both an exterior and interior packaging containing an NDC, the interior packaging NDC should be listed on the claim).

- Sometimes the NDC on the label does not include the 11 digits. If this occurs, it will be necessary to add a leading zero to the appropriate section to create a 5-4-2 configuration (i.e. 66733-0948-23 in the following sample).
  - XXXX-XXXX-XX = 0XXXX-XXXX-XX
  - XXXXX-XXX-XX=XXXXX-0XXX-XX
  - XXXXX-XXXX-X=XXXXX-XXXX-0X

General Billing Reminders – NDC

➢ NDC Unit of Measure (UOM)

UOM	Description	General Guidelines
F2	International Unit	International units will mainly be used when billing for Factor VIII-Antihemophilic Factors
GR	Gram	Grams are usually used when an ointment, cream, inhaler, or bulk powder in a jar are dispensed. This unit of measure will primarily be used in the retail pharmacy setting and not for physician-administered drug billing.
ML	Milliliter	If a drug is supplied in a vial in liquid form, bill in millimeters.
UN	Unit	If a drug is supplied in a vial in powder form, and must be reconstituted before administration, bill each vial (unit/each) used.

Note: ME is also a valid unit of measure, but we recommend using the appropriate UN or ML indictor as this is generally how drugs are priced.

General Billing Reminders - NDC

NDC Units Dispensed

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.

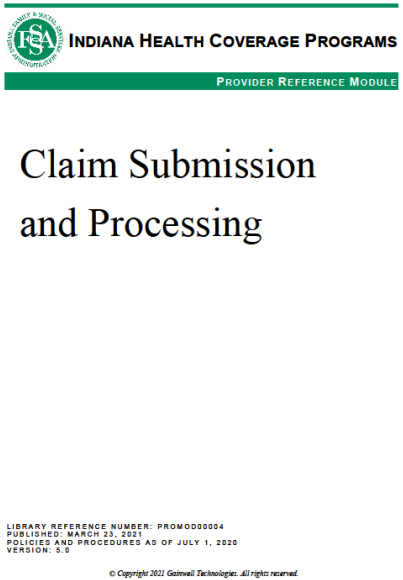
Please refer to the following examples:

- 1234.56
- 2
- 12345678.123

General Billing Reminders – IHCP Modules

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

https://www.in.gov/medicaid/providers/provider-references/provider-reference-materials/ihcp-provider-reference-modules/



General Billing Reminders
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 here

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.

General Billing Reminders - Smart Edits Con't

What do Smart Edits Communicate?

A message on your 277CA clearinghouse rejection report will explain why the claim was flagged and provide direction on how to resolve and resubmit the claim. The message will always begin with P4999, followed by the edit mnemonic, which is a short combination of letters that identifies a unique edit.

Smart Edits are designed to identify the specific error that triggered the edit. An example Smart Edit message is:

- P4999mPI SmartEdit (mPI): Per the Medicare Physician Fee Schedule, Procedure Code [XXXXX] describes a physician interpretation for this service and is inappropriate in Place of Service [XX].

For more information on the type of Smart Edits you may receive, and what response is needed to accurately process your claim, visit the Smart Edits Frequently Asked Questions (FAQs) found under "Smart Edits resources" on the www.uhcprovider.com/smartedits page.

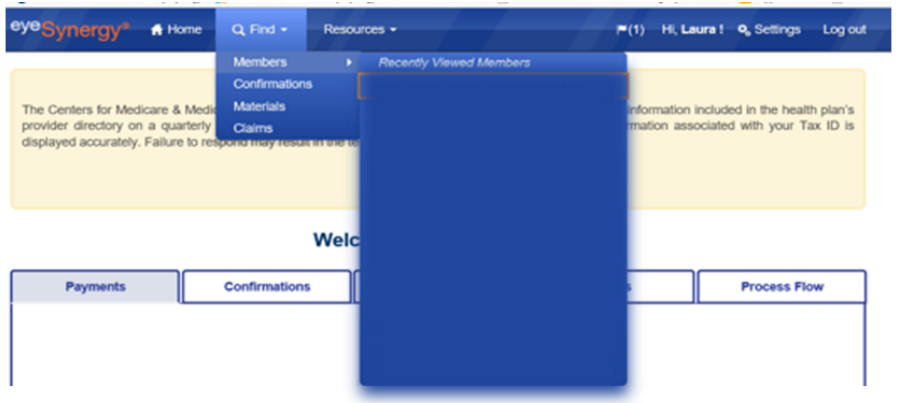
Behavioral Health

General Billing Reminders

- Clinicians should submit valid ICD-10CM Mental Health/Substance Abuse primary diagnosis codes.
- List all secondary diagnoses as clinically appropriate
- Coordination of Benefits can be updated by the member annually by calling Optum Behavioral Health
- Medication Management providers are no longer required to obtain authorization or complete an Outpatient Treatment Progress Report (OTPR) for their patients
- Submit a Place of Service code that matches the level of care provided
- For Observation - Outpatient Place of Service code should be used whenever observation bed level of care lasts less than 24 hours and results in a discharge to a less restrictive level of care
- Send to the correct claims mailing address OR Payer ID as found on the member ID card.
- Claims Customer Service Phone Number is located on the back of the member's ID card
- Appeals should be sent to:
  UnitedHealthcare Community Plan of IN
  Attn: Appeals and Grievances Unit
  PO Box 31364
  Salt Lake City, UT 84131-0364
- Provider Demographic information should be updated online through the Provider Express portal – "My Practice Info"

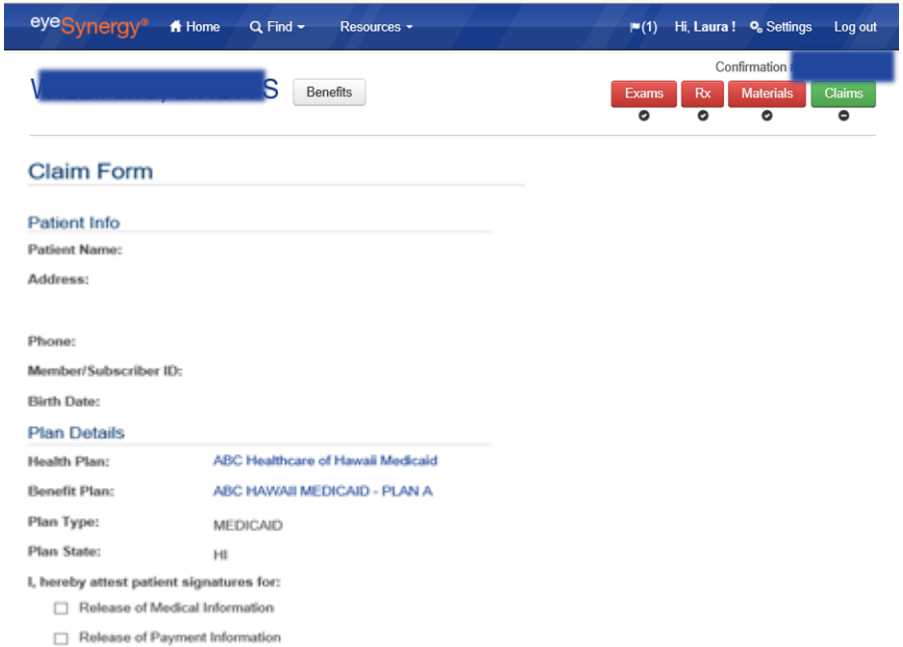
March Vision Care - General Billing Reminders

- Login to providers.eyeSynergy.com
- Find Member; if on “Recently Viewed members, click on the member's name. Otherwise click on “Members” to get to the “Find a Member” Search screen.



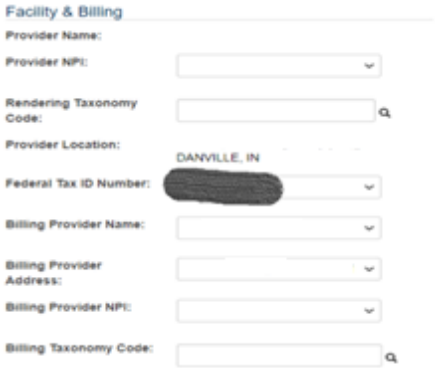
March Vision Care - General Billing Reminders

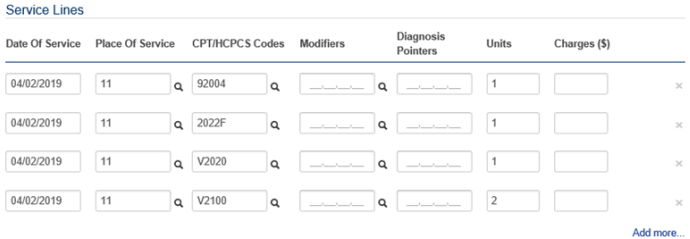
- The Exam, Rx and Materials boxes should be red; click on green Claims box. Next review patient information, plan details, and any applicable check boxes.



March Vision Care - General Billing Reminders

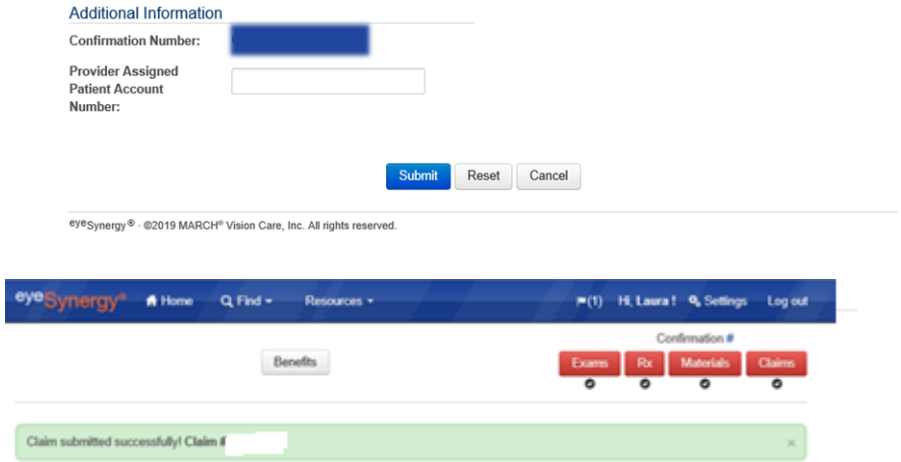
- Enter diagnosis codes and service lines with applicable charges, then review Facility and Billing information.
- Provider Name, NPI and Location will pre-populate based on information from Exam Results page
- Rendering Taxonomy – Provider will need to enter Taxonomy registered with the state of Indiana
- Federal Tax ID, Billing Provider Name, Address and NPI will pre-populate based on information on file for the provider.
- Billing Taxonomy – Provider will need to enter Taxonomy registered with the state of Indiana





March Vision Care - General Billing Reminders

- Confirmation Number – this is prepopulated
- Provider Assigned Patient Account number is an optional field; you can add the patient account number specific to your office if you would like to.
- Then click “Submit”.



DENTAL General Billing Reminders

- Using ADA Codes
  - Providers must use Current Dental Terminology (CDT) codes.
  - You may order a current CDT book by calling the ADA or visiting the catalog website at adacatalog.org
- Invalid or incomplete claims:
  - If claims are submitted with missing/incomplete information or outdated claim forms, the claim will be rejected or returned to the provider and a request for the missing information will be sent.
    - For example, if the claim is missing a tooth number or surface, a letter will be generated to the provider requesting this information.
- Supernumerary teeth
  - UnitedHealthcare recognizes:
    - Letters “A” through “T” for primary teeth
    - Numbers “1” to “32” for permanent teeth
  - Supernumerary teeth should be designated by
    - Codes AS through TS or
    - 51 through 82
  - Designation of the tooth can be determined by using the nearest erupted tooth. If the tooth closest to the supernumerary tooth is # 1 then the supernumerary tooth should be charted as #51, likewise if the nearest tooth is A the supernumerary tooth should be charted as these procedure codes must be referenced in the patient’s file for record retention and review.

DENTAL

General Billing Reminders - Overpayments

- If you identify an overpayment, notify us immediately.
- Send the overpayment within the time specified in your Agreement.
- If your payment is not received by that time, we may apply the overpayment against future claim payments in accordance with our Agreement and applicable law.
- If you prefer us to recoup the funds from your next payment, call Provider Services.
- If you prefer to mail a refund, please send an “Overpayment Return Check” or “Return Overpayment through the Adjustment Request” form.
- Attach a letter to the check and include the following:
  - Name and contact information for the person authorized to sign checks or approve financial decisions.
  - Member identification number (e.g., ACC, DD, ALTCS EPD)
  - Date of service.
  - Original claim number (if known)
  - Date of payment
  - Amount paid
  - Amount of overpayment
  - Overpayment reason
  - Check number

Corrected Claims

Corrected Claims – CMS-1500

Electronic Corrected Claims

- Most corrected claims can be sent electronically. Use frequency code 7 on the 837 transaction to indicate that it's a replacement of a previous claim.
- If you aren't currently submitting corrected claims using EDI, it's best to start with a small batch of claims for various UnitedHealthcare payers to ensure they're accepted and processed accurately.
- If you can't submit corrected claims using EDI, submit a claim reconsideration request within the Claims Tool via the UnitedHealthcare Provider Portal.

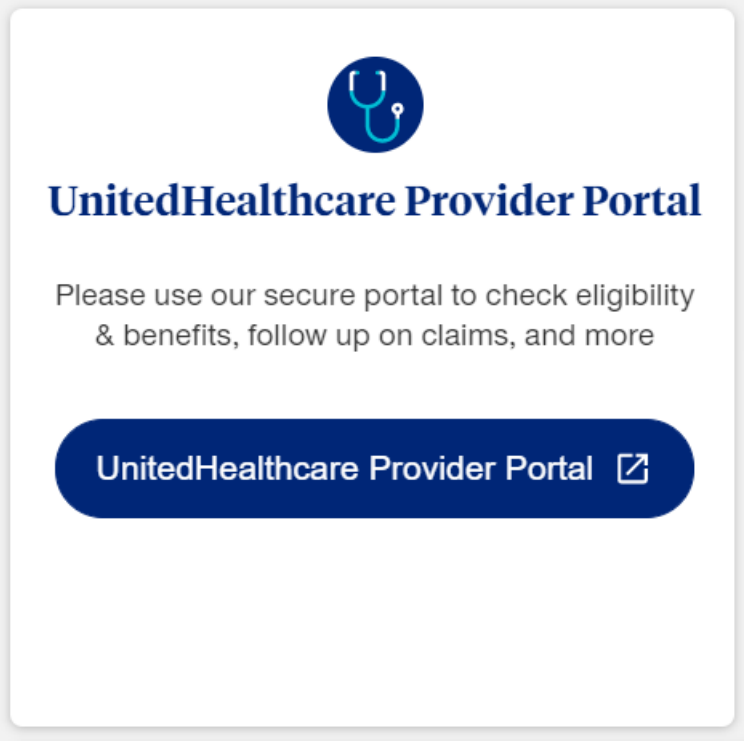
Corrected Claims – UB-04

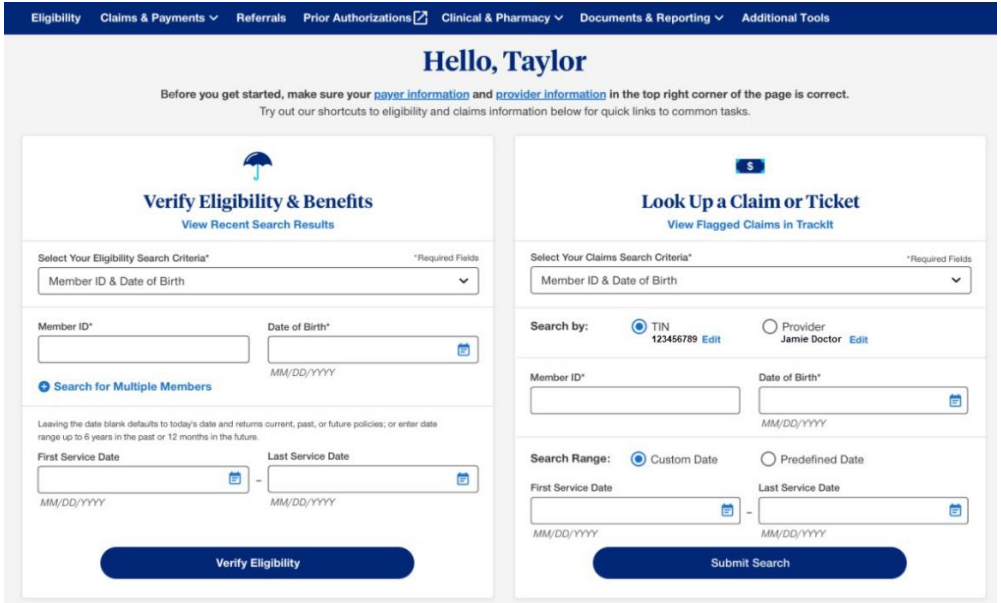
Electronic Corrected Claims

- Corrected UB claims can be sent electronically. Using the appropriate Bill Type to indicate that it's a replacement of a previous claim.

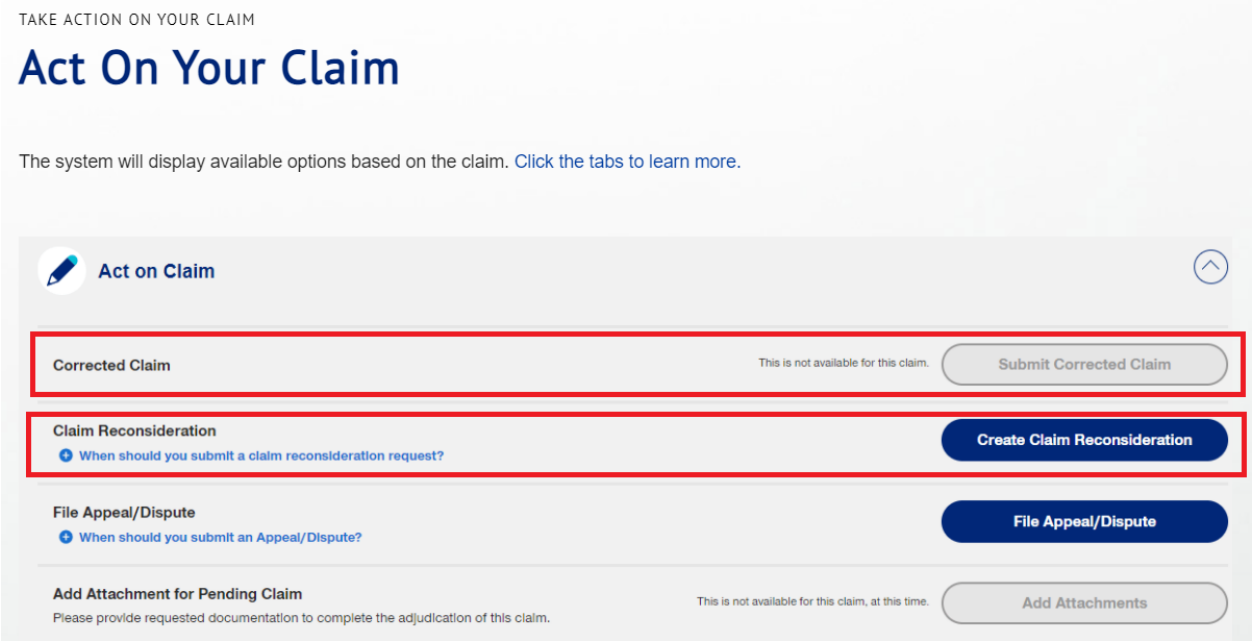
- If you can't submit corrected claims using EDI, submit a claim reconsideration request via the Claims Tool via the UnitedHealthcare Provider Portal in the same manner as you would for a CMS-1500.

Corrected Claims – Claims Tool



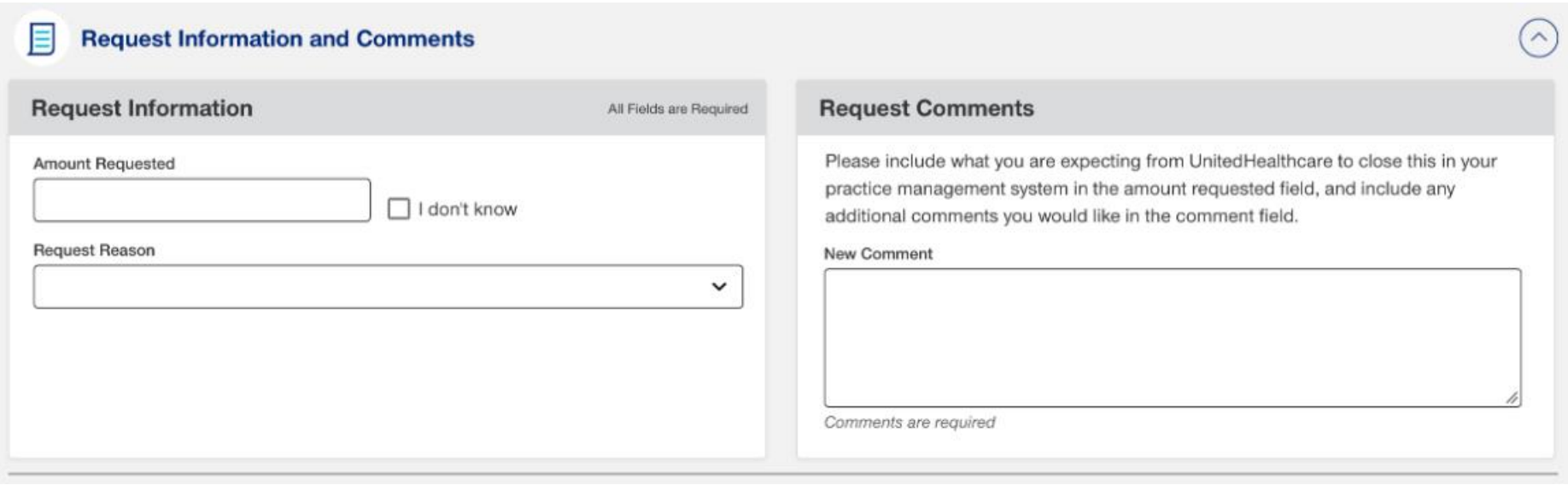


Corrected Claims - Claims Tool



- The "**Submit Corrected Claim"** button will only display if the services were billed in the professional claim format and the option to correct electronically is available.
- Otherwise, proceed to the "**Request Claim Reconsideration"** button below the "**Submit Corrected Claim**" button, to submit.

Corrected Claims - Claims Tool



- In ”**Amount Requested”** field**,** 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.
- Add context and situational details in the “**New Comment”** field.

When to Escalate a Claim

When Should I Escalate a Claim to a Medical Advocate or SNF Claims Team?

- Per the Administration Guide, Par Providers must adhere to the following filing limits from the date of the ***original*** processing/denial date to dispute a claim, this includes all levels of dispute:
  1) Reconsideration – 90 Days
     1.5) – Send to Advocate or SNF Claims Teams
  2) Formal Dispute – 60 Days from the failed Reconsideration
  3) Formal Provider Grievance – 120 Days from the failed Dispute (must include additional or new information)
  - It is imperative that unresolved claims are sent to the Advocate or SNF Claims Teams prior to the 270 days allowed to complete all levels.
- We recommend sending to an Advocate or the SNF Claims Team between Steps 1 & 2 or 2 & 3 above. Our Claims teams will review and advise if a Formal Dispute or Formal Provider Grievance is required if they are unable to overturn and/or process to the providers expectation.

Where Should I Escalate a Claim to an Advocate or the SNF Team?

MEDICAL ADVOCATE TEAM

- If you are a health system or provider with a dedicated Claims/Internal Advocate, please email to that dedicated Advocate.
- If you do not have a dedicated Claims/Internal Advocate, utilize the claims template and email to: centralprteam@uhc.com.
  - If you need the claims template and instructions, you can request those from the Central PR Team via email at centralprteam@uhc.com .

SKILLED NURSING FACILITY CLAIMS TEAM

- Send unresolved SNF claims to: snfprteam@optum.com.

Behavioral Health

Claims Problem Resolution

Typically, there are 2 types of claim issues:

1. The claim was submitted with incorrect/inaccurate information
2. The claim was processed incorrectly

To resolve type 1:

- Can be done electronically through Provider Express – Indiana
- Complete a new CMS-1500 claim form and write “CORRECTED CLAIM” across the top and submit with the correct claim information and mail to the address on the statement

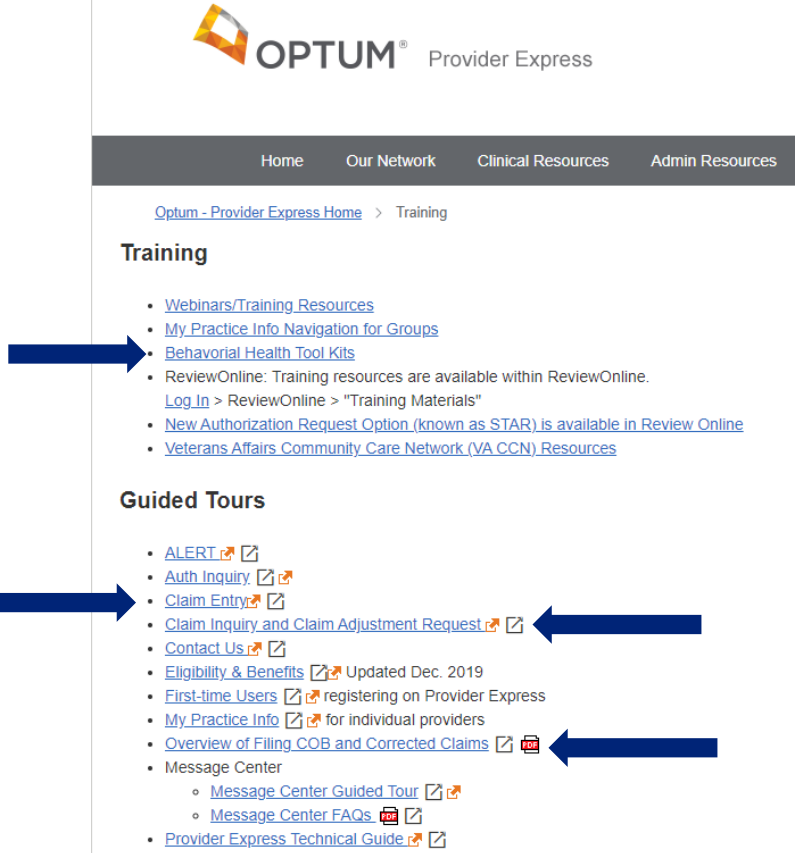
To resolve type 2:

- Login to Provider Express and look up the claim via Claim Inquiry transaction and file a Claim Adjustment Request.
- Contact a claims representative via Provider Express’ Live Chat
  - Locate the claim from the claim detail page then click “Have questions about claim status?” to access Claims Live Chat
  - Call the Customer Service number on the back of the member’s card or on the EOB/PRA

Behavioral Health

Additional Training Resources

- Training
  - Behavioral Health Tool Kits
- Guided Tours
  - Claim Entry
  - Claim Inquiry and Claim Adjustment Request
  - Overview of Filing COB and Corrected Claims



Meet Your Advocate Teams

Your Medical Network Provider Advocate Team

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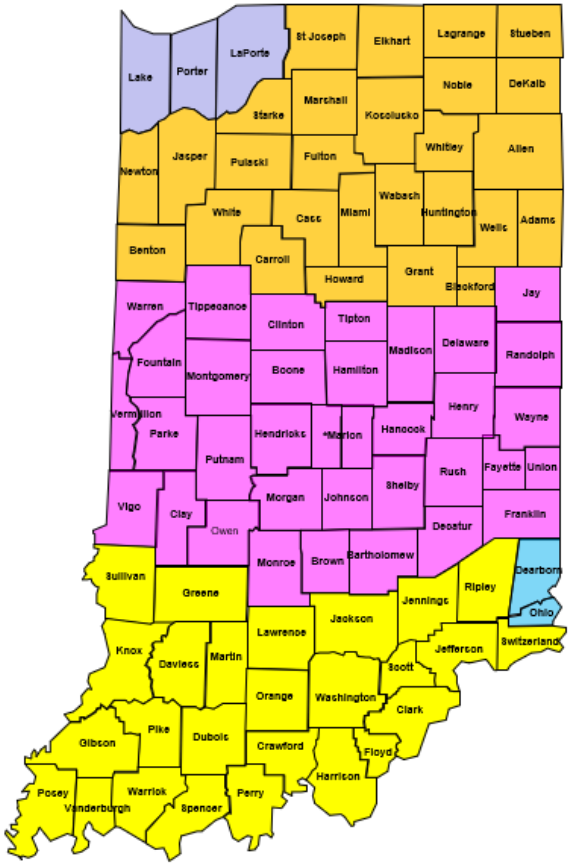

Jodie Hattery
VP, Provider Market Ops
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Your Skilled Nursing Provider Engagement Team

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Tiffany Cashion
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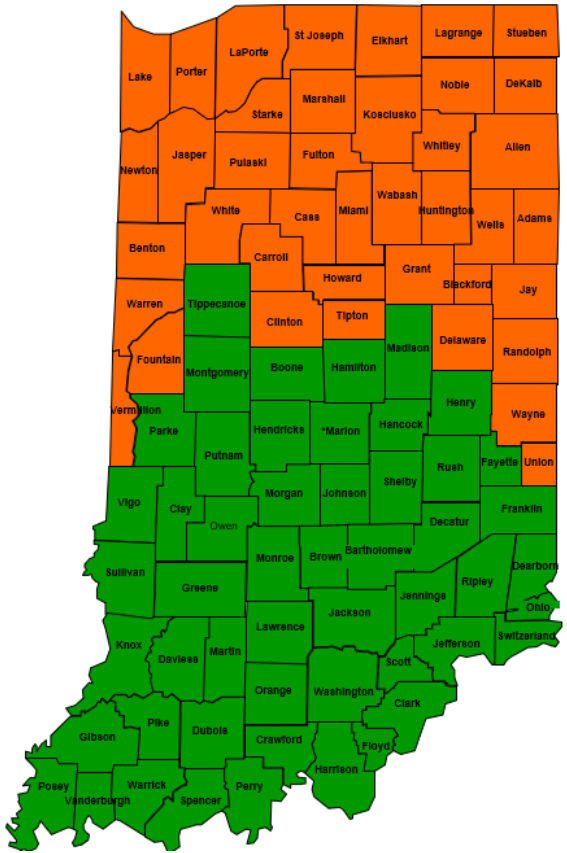

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Your Optum Behavioral Health Advocate Team

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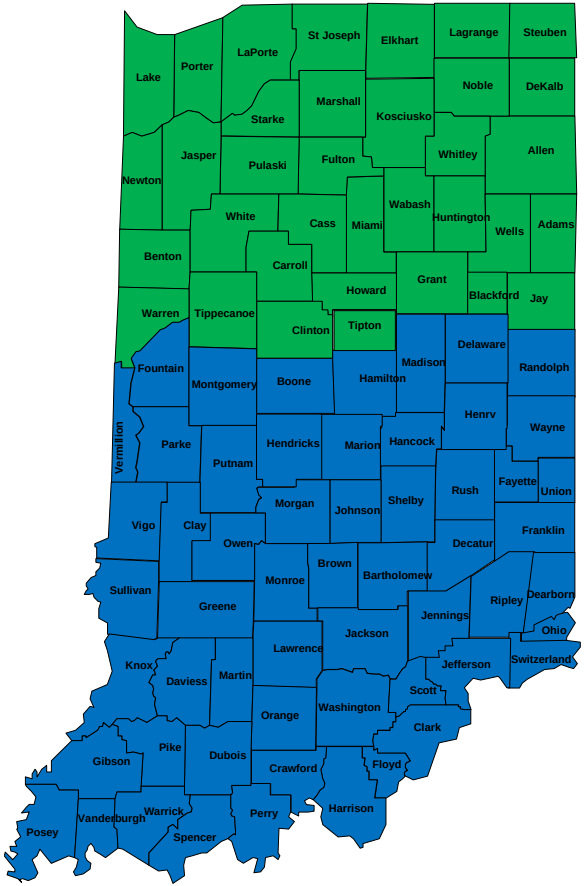

Your Optum Behavioral Health ABA Advocate

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

Your March Vision Advocate

Cassandra Pattison
Sr. Provider Relations Advocate
210-474-5592
Cassandra_Pattison@uhc.com

(Cassandra covers all Indiana counties)

Your Dental Advocate Team

Catrice Campbell
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763-283-4522
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Paul Curry III
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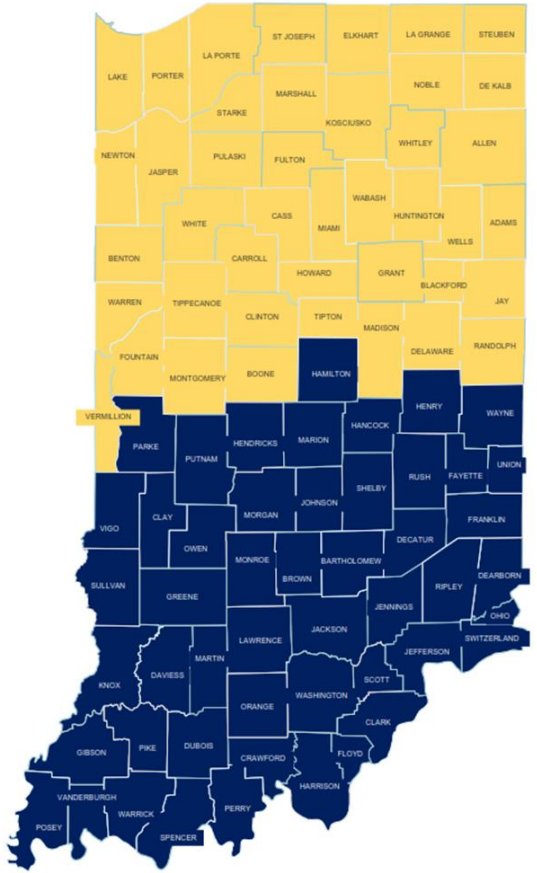
paul_curry@uhc.com



Thank you

Questions & Answers

PCA-4-21-02948-C&S-PRES_09232021

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 - IN Medicaid