UnitedHealthcare Community Plan

2024 IHCP Works Annual Seminar

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

United Healthcare

PCA-01-24-01026-UHN-PRES_05282024

Agenda

1. Our Service Lines
2. Claim Submission
3. General Billing Reminders
4. How to Submit Corrected Claims
5. When to Escalate a Claim
6. 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
- COB – Coordination of Benefits
- INN – In-Network
- NDC – National Drug Code
- OON – Out-of-Network
- PAR – Participating
- RFP – Request for Participation
- UHC – UnitedHealthcare
- NDC – National Drug Code

Our Service Lines

- UnitedHealthcare

- Optum Behavioral Health

- March Vision Care

- UnitedHealthcare Dental

Claim Submission

Submit Professional/Behavioral Health Claims

- Submit claims using the *CMS-1500* Claim Form (v 02/12) or *UB-04* form, whichever is appropriate.
- Standard Timely Filing for Participating Providers – 90 calendar days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 90 calendar days from date of service (DOS).
- Newborn Claims Timely Filing – 180 calendar days from date of service (DOS).
- Secondary Claims Timely Filing – 90 calendar days from date of Primary Explanation of benefits for In-network Providers and 90 calendar days for Out-of-network 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: uhcprovider.com
- Behavioral Health Professional claims (*CMS-1500*) on our Provider Express Portal: Optum Provider Express

Submit Dental Claims

HIPAA-compliant 837D file

- The 837D is a HIPAA-compliant EDI transaction format for the submission of dental claims.
- Electronic payer ID is GP133
- 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.

Submit Dental Claims (cont.)

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.

Dental Claims Submission Tips

- To receive payment for services, practices must submit claims via paper or electronic submission.
- Dentists must submit CDT codes using 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.

Dental Claims: Timely Filing

- Participating providers, all claims including secondary claims, should be submitted within 90 calendar days from the date of service.
- Non- participating providers, all claims should be submitted within 90 calendar days from the date of service.

Electronic Dental 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, the information is being sent encrypted.
- Call **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 **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.

Tips for Successful Dental Claim Resolution (cont.)

- 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 844-402-9118.
- 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 90 calendar 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.

Submit MARCH® Vision Care Claims

- Use our convenient online provider portal:
- 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 - 90 calendar days from date of service (DOS).

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

eyeSynergy®

- For electronic submission:

  Payer ID 52461

- Claims Mailing Address:

  MARCH Vision Care

  Attn: Medicaid Vision Claims

  P.O. Box 30989

  Salt Lake City, UT 84130

Reconsiderations

Medical: When to Submit a Claim 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 of timely filing.
- Claim was denied for no authorization, when provider has an authorization number.
- Difference in coordination of benefits (COB) information.

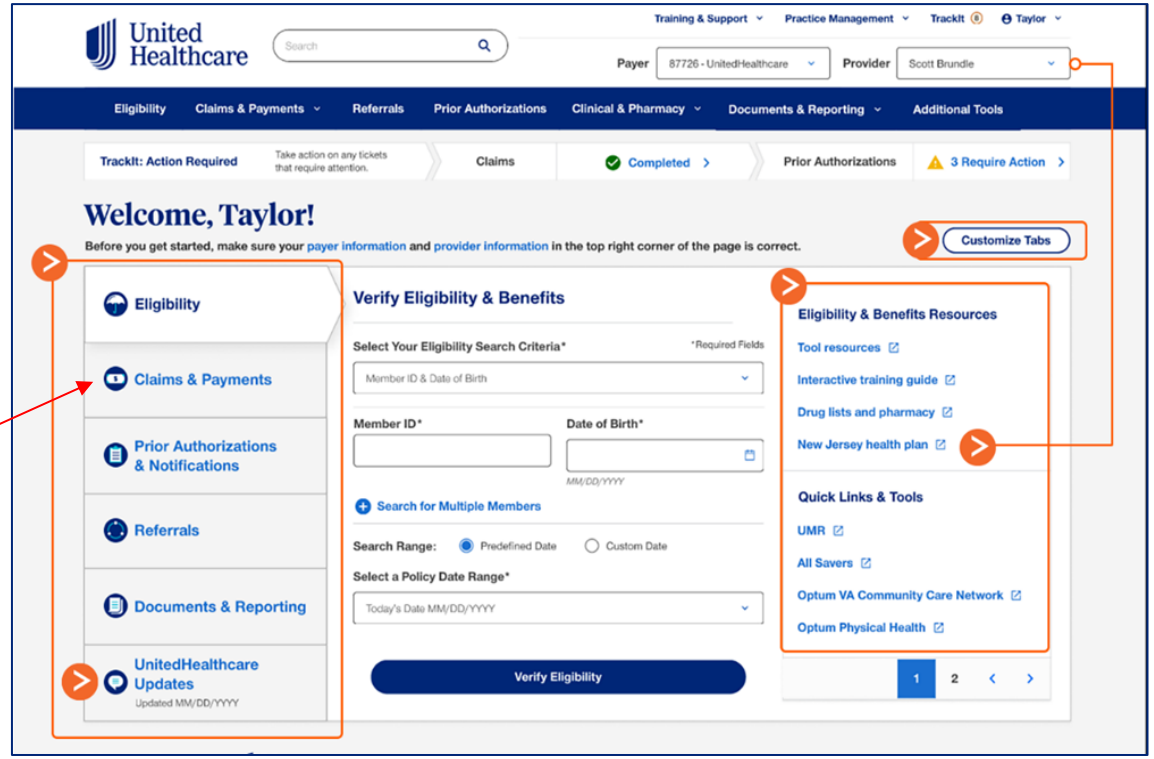
Medical: How to Submit a Claim Reconsideration (cont.)

Within the Provider Portal, from the claim:

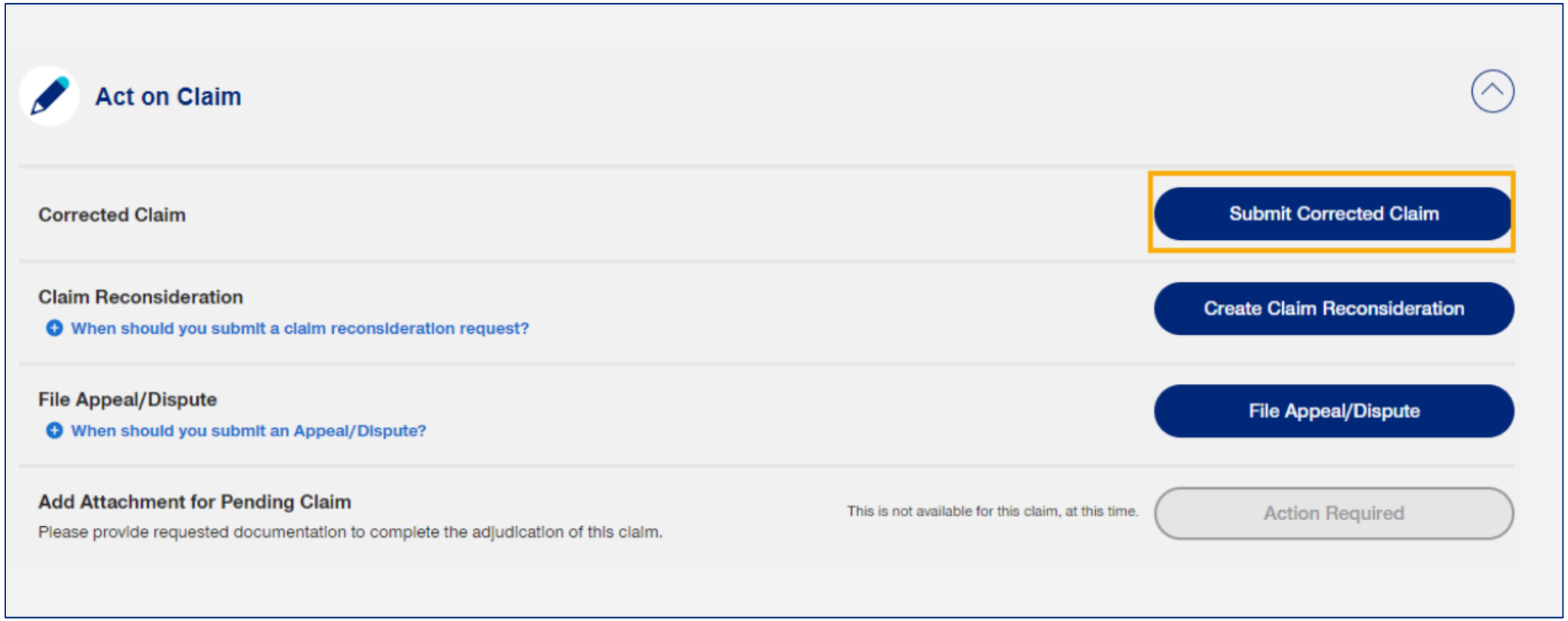
- Click **Create Claim Reconsideration** to start your reconsideration request or to submit a corrected claim. Reconsideration Claim Form
- Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.
- Need a paper form because you are unable to submit your reconsideration online? Use our Single Paper Claim Reconsideration Request Form and mail to the claims mailing address: P.O. Box 5240 Kingston, NY 12402-5240

Provider Portal: Claims Function

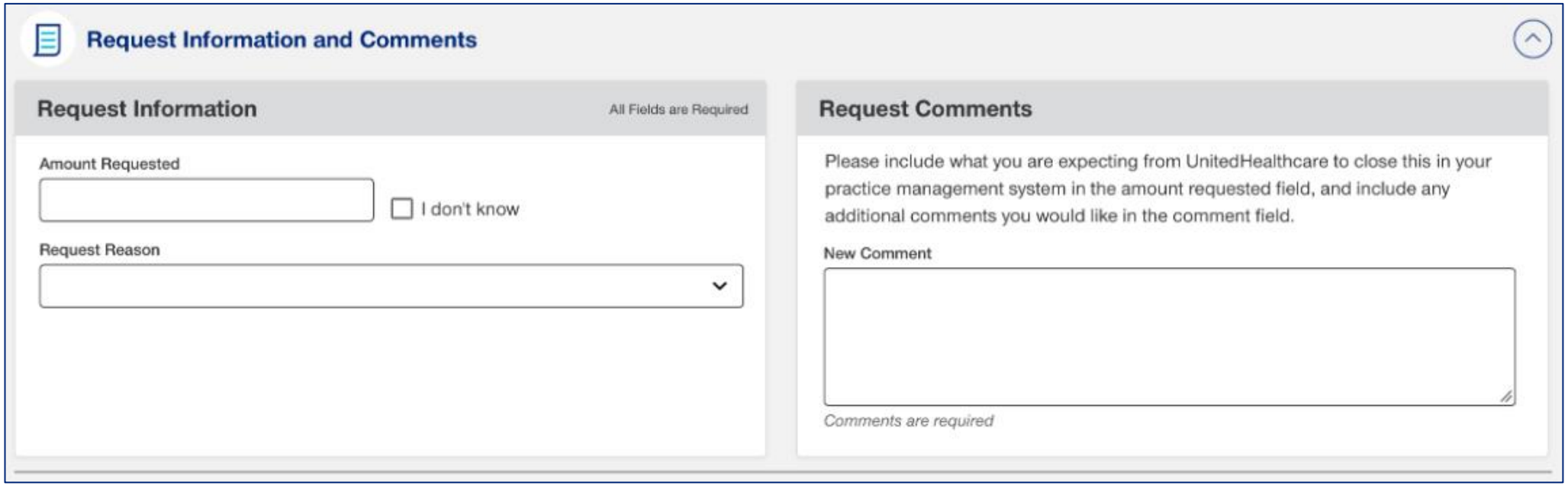
- View claims information for multiple UnitedHealthcare plans.
- Access letters, remittance advice documents, and reimbursement policies.
- Submit additional information requested on pended claims.
- Flag claims for future viewing.
- Submit corrected claims or claim reconsideration request.
- Receive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



Medical: Submit a Corrected Claim

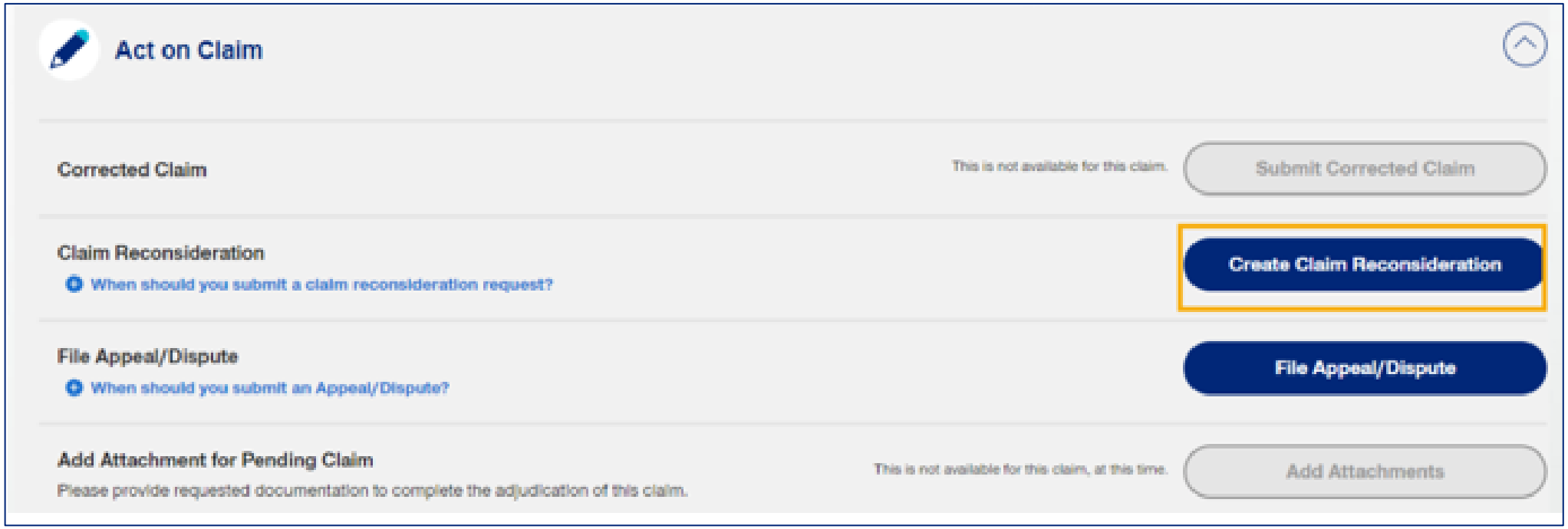


Medical: Submit a Corrected Claim (cont.)



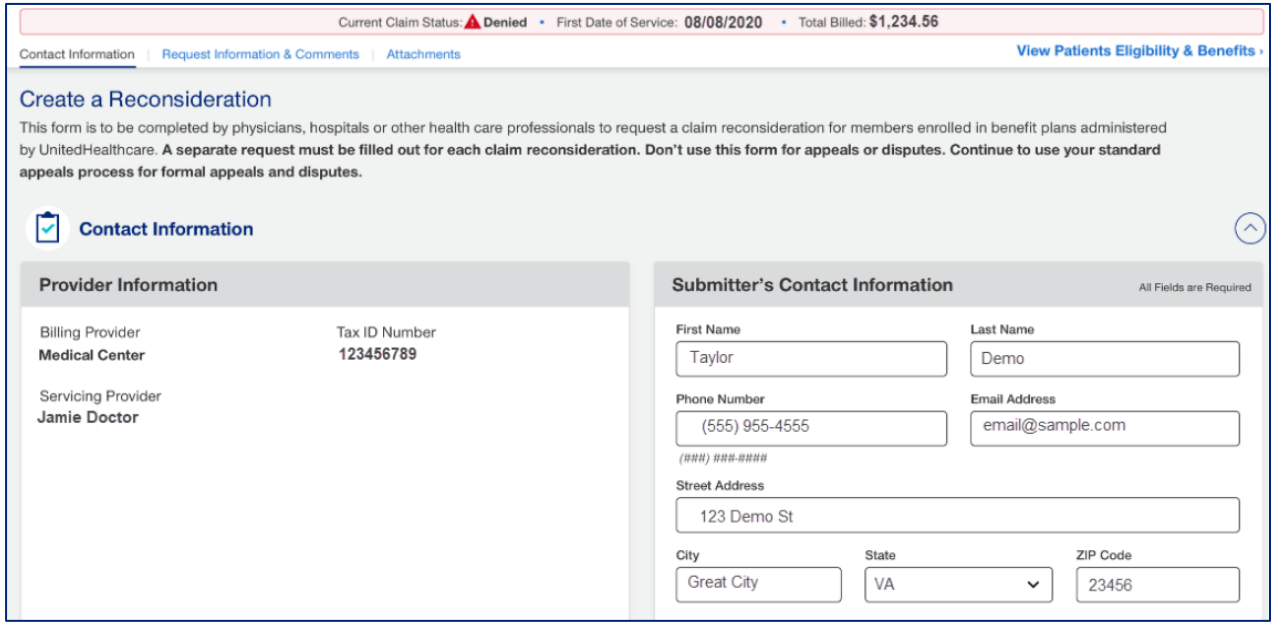
- In Amount Requested, enter the total amount you expect for the claim, including any previous payments.
- Select ‘Resubmission of a Corrected Claim’ as the Request Reason from the pulldown menu.
- Help us understand the situation by adding a New Comment.

Medical: Submit a Reconsideration



Medical: Submit a Reconsideration (cont.)

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

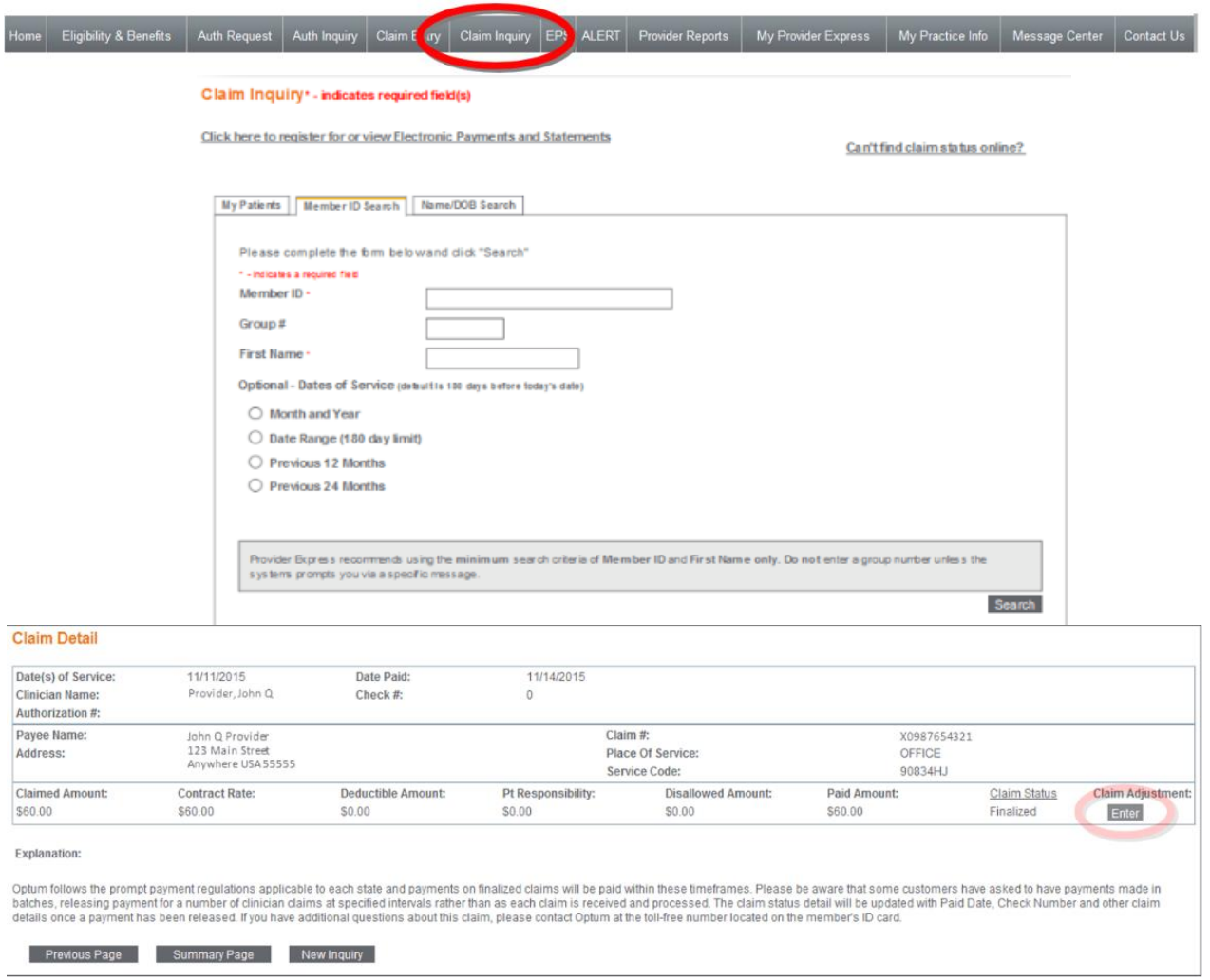


Behavioral: Submit a Reconsideration

Securely log in to Provider Express.

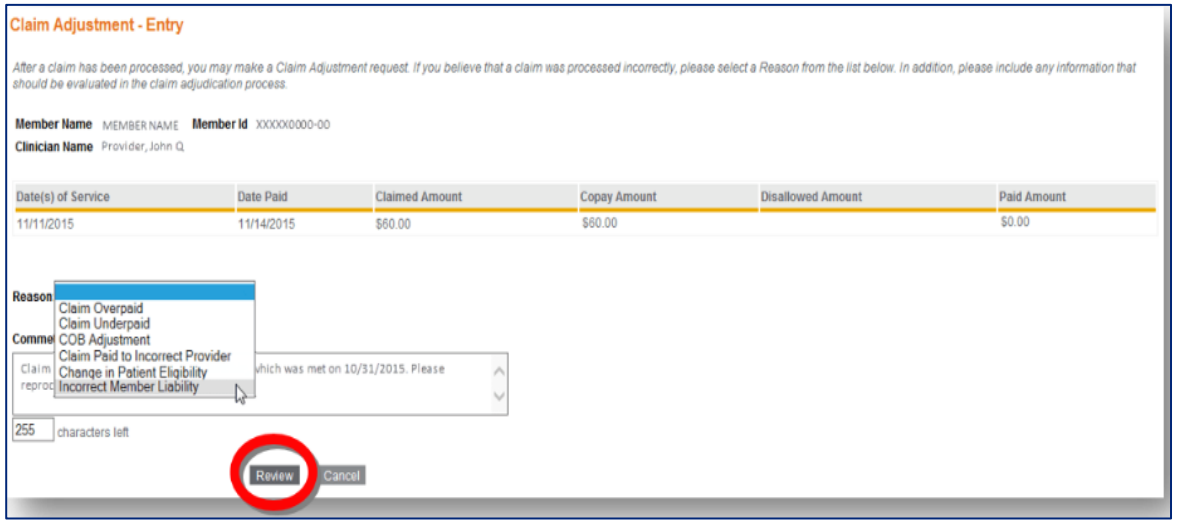
- Click **Claim Inquiry.**
- Search for claim.
- Click **Enter** under claim adjustment.

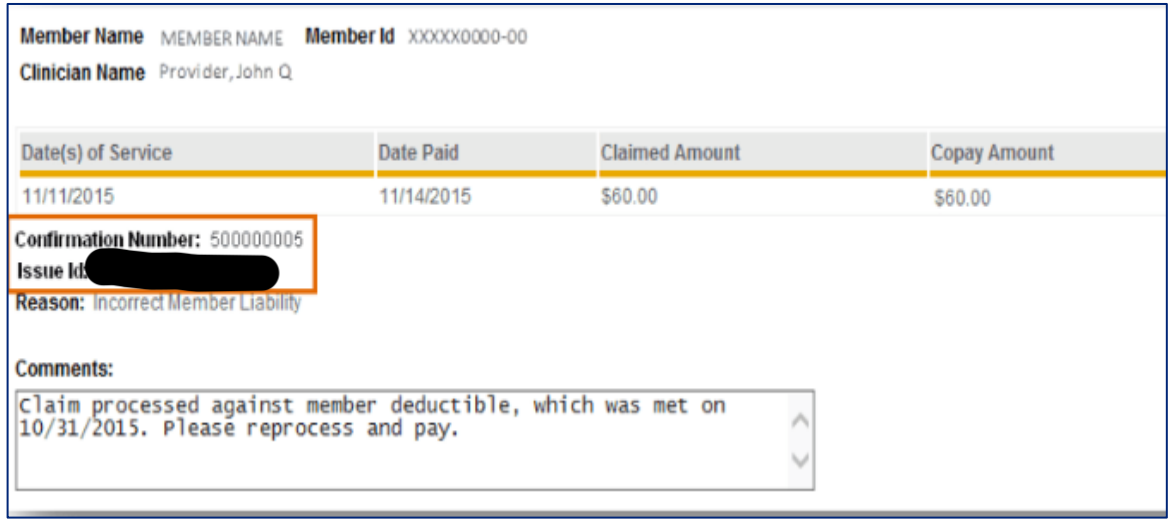
Providers have 90 calendar days from the original EOB date to submit a Claim Reconsideration.



Behavioral: Submit a Reconsideration (cont.)

- 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: Claim Reconsiderations

If you disagree with the outcome of your Claim Reconsideration, please escalate the issue to your Indiana Medical Team.

Medical

Regions 1 – Lori Reeder – lreeder@uhc.com

Region 2 – Michelle Cole – michelle_b_cole@uhc.com

Regions 3 – Vida Smith – vida.j.smith@uhc.com

Region 4 – Karen Cockerham – karen.Cockerham@uhc.com

Region 5 – Stacey Keyes – Stacey.keyes@uhc.com

FQHC/RHCs – Kelly Carpenter – kelly_carpenter@uhc.com

Behavioral Health: Claim Reconsiderations

If you disagree with the outcome of your Claim Reconsideration, please escalate the issue to your Indiana Behavioral Advocate Team.

Northern IN – Paulette Means – paulette.means@optum.com

Central and Southern IN – Kristin Johnson – Kristin.johnson24@optum.com

Medical and Behavioral: Claim Reconsiderations

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 within 60 calendar days from the failed reconsideration.

- Submit within ‘Claims’ on the United Healthcare Provider Portal: Claims, billing and payments | UHCprovider.com
- Mail to:

UnitedHealthcare Community Plan of Indiana

Attn: Appeals and Grievances Unit

P.O. Box 31364

Salt Lake City, UT 84131-0364

Medical and Behavioral: Claim Reconsiderations (cont.)

If you still disagree with the outcome of your formal Dispute, you may file a Formal Provider Grievance within 120 calendar days from the failed Dispute (must include additional or new information).

- Submit within ‘Claims’ on the UnitedHealthcare Provider Portal: Claims, billing and payments | UHCprovider.com
- Mail to:

UnitedHealthcare Community Plan of Indiana

Attn: Appeals and Grievances Unit

P.O. Box 31364

Salt Lake City, UT 84131-0364

MARCH Vision Care: Submit an Informal Dispute

Providers can also use our online March Vision provider dispute 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) not taken over the phone.
- UHC has 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 30 calendar day period to submit a formal appeal. The formal appeal must be in writing (paper, portal, and email) not taken over the phone.

MARCH Vision Care: Submit an Informal Dispute (cont.)

Provider dispute resolution process (cont.)

- 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:

United Healthcare I March Vision Care

Attn: Medicaid Vision Appeals

P.O. Box 30988

Salt Lake City, UT 84130

Dental: Submit 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

P.O. 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 calendar days of receipt.

Dental: Dispute How a Claim Was Processed

- 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.

- Mailing Address

  P.O. Box 30567 Salt Lake City, UT 84130-0567

Facility Claims (UB-04)

Submit Facility Claims

- Submit claims using claim submission tool on UHCprovider.com.
- Standard Timely Filing for Par Providers – 90 calendar days from the date of service (DOS).
- Non-Contracted Providers Timely Filing – 90 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 & 90 calendar days 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

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, coinsurance, 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, coinsurance, 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

- 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 Electronic Data Interchange (EDI) page for eCOB specifications.

General Billing Reminders

Tips for Claim Submission

- An occurrence code is required for all types of bills except for an outpatient type of bill. UnitedHealthcare follows the guidance found on the IHCP Claims Submission and Processing in the provider reference module. **Indiana Medicaid Claims Submission and Processing**
- 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.

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.

National Drug Code (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

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 (e.g., 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 8 digits before the decimal and 3 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.

Reimbursement

- 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:

  Reimbursement Policies for Community Plan of Indiana | UHCprovider.com

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

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	u0005Sf	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 – UB-04

Electronic Corrected Claims

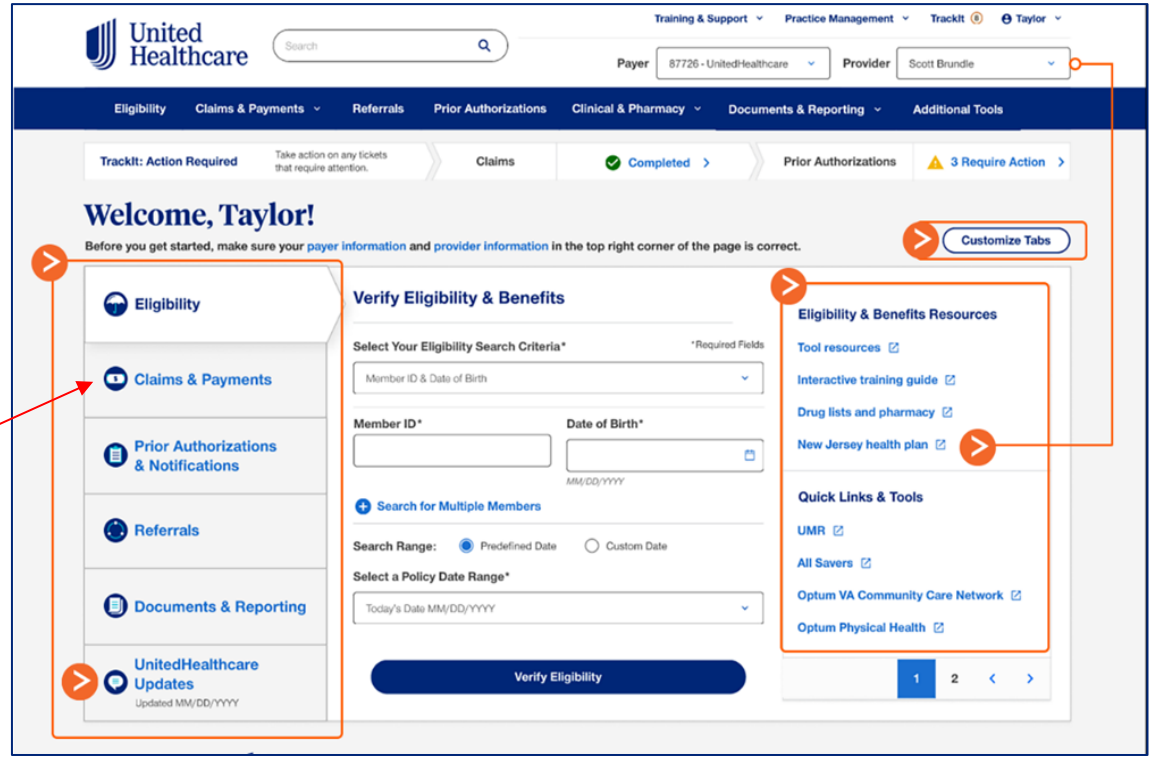
- Corrected UB-04 claims can be sent electronically.

Claims, billing and payments | UHCprovider.com

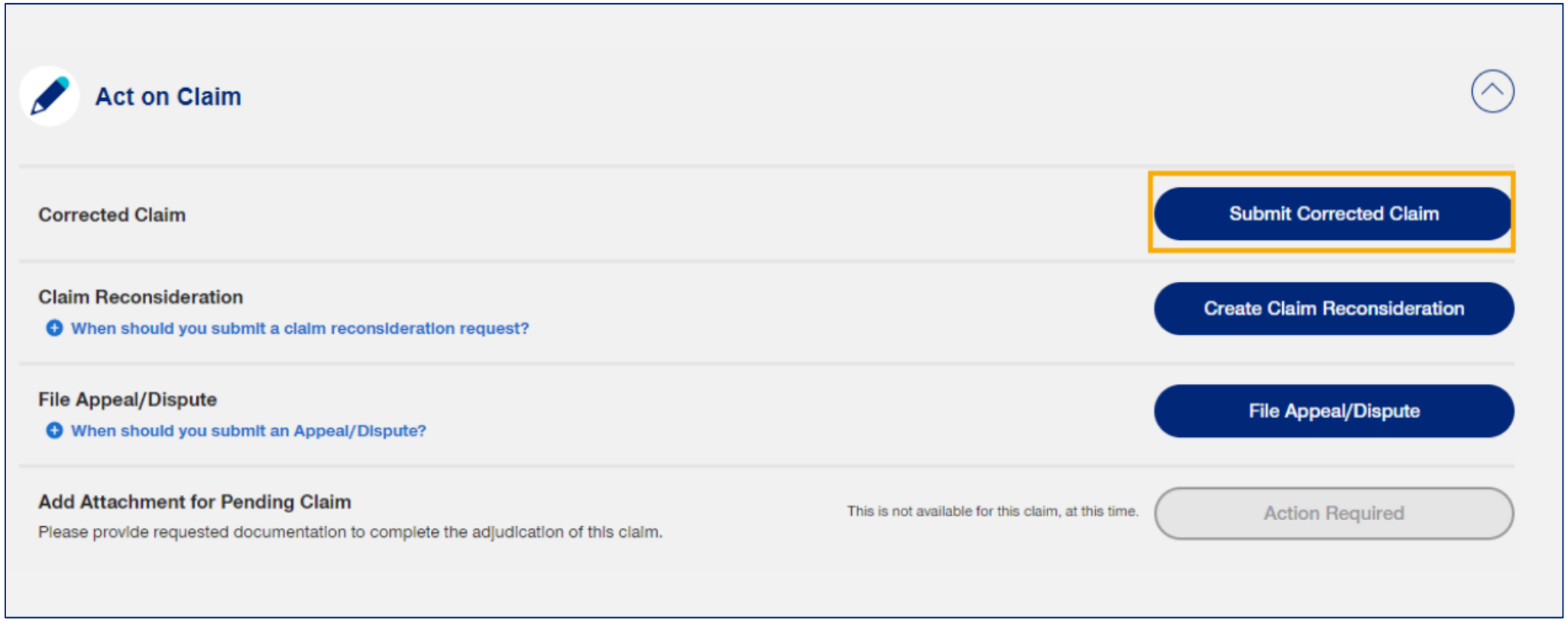
- Using the appropriate Bill Type to indicate that it's a replacement of a previous claim.
- If you cannot submit corrected claims using EDI, submit a claim reconsideration request via the Claims Tool via the UnitedHealthcare Provider Portal in the same manner as you would for a HCFA or *CMS-1500* claim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

Claims Function

- 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.



Facility: Submit a Corrected Claim



Escalate a Claim

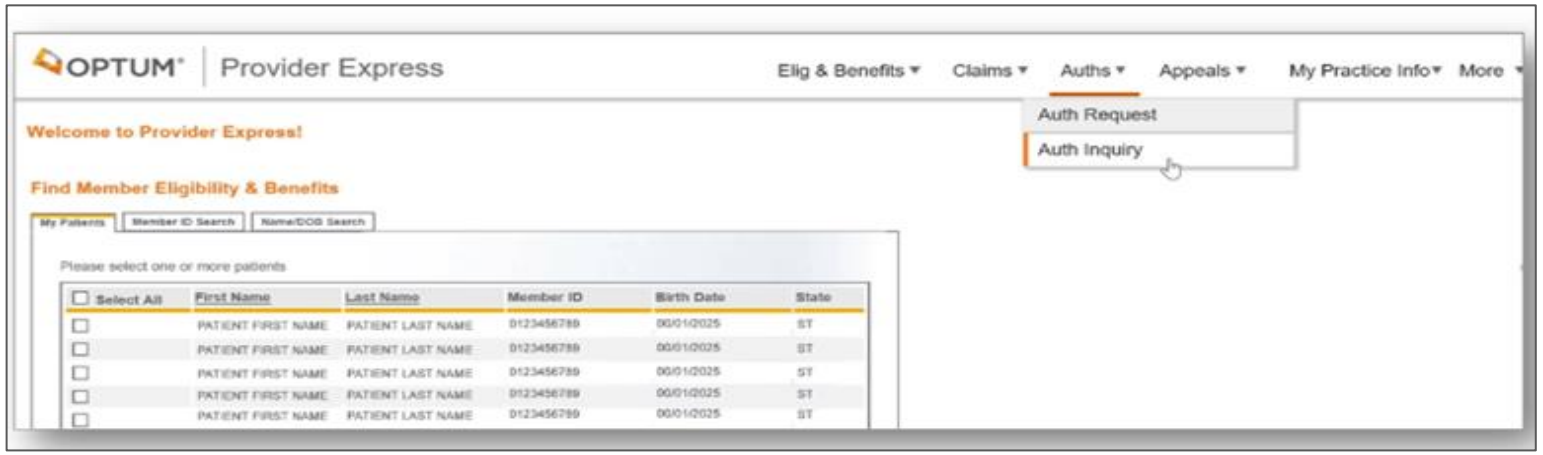
Escalate to a Provider Advocate

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

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

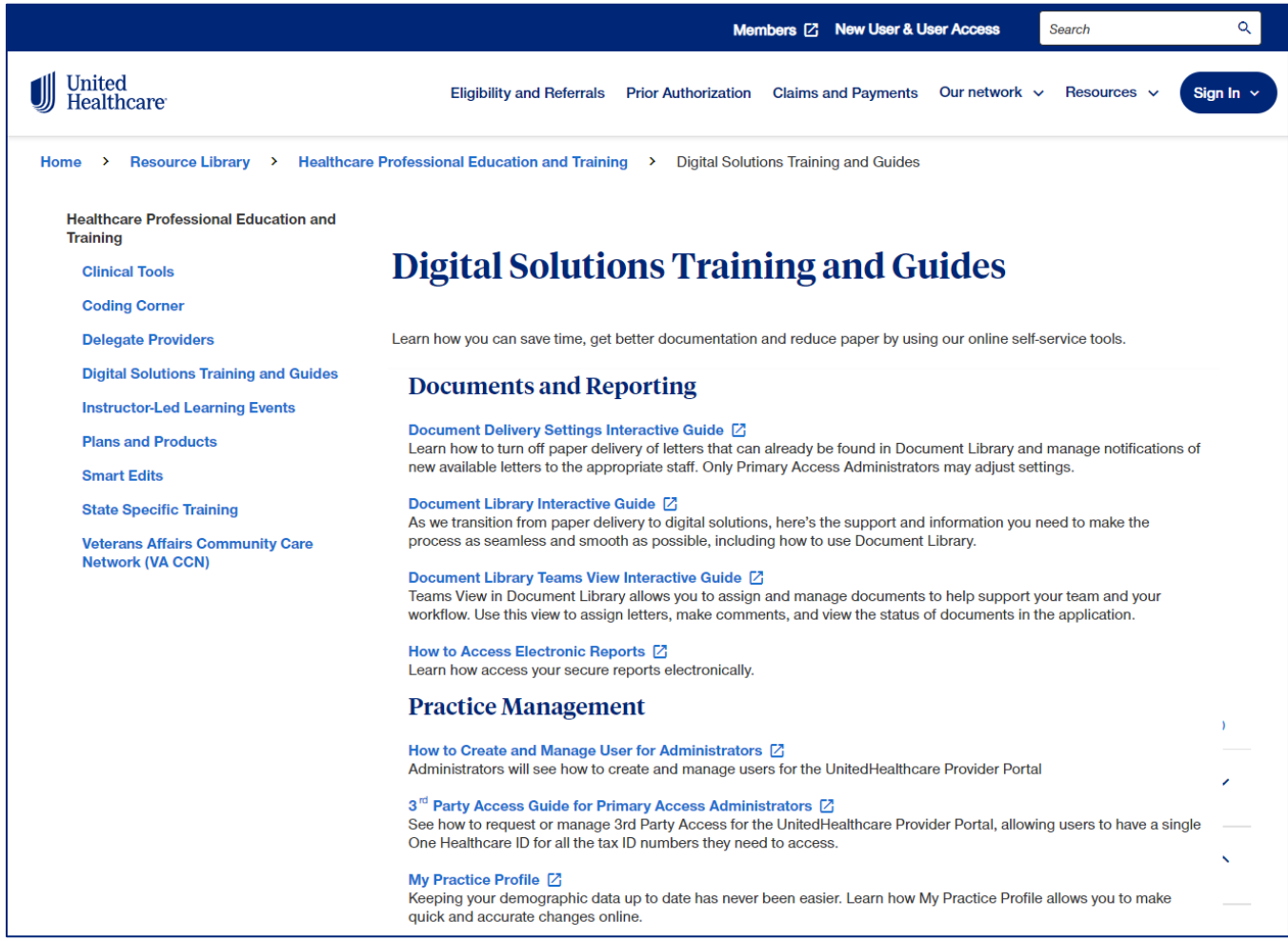
Northern IN:
Paulette Means
paulette.means@optum.com

Central & Southern IN:
Kristin Johnson
Kristin.johnson24@optum.com

Resources

Additional Claims Trainings on UHCprovider.com

- Claims Research Project (chameleon-4-prod.s3.amazonaws.com)
- Document Library Interactive User Guide (chameleon-4-prod.s3.amazonaws.com)
- CommunityCare Provider Portal User Guide (chameleon-4-prod.s3.amazonaws.com)

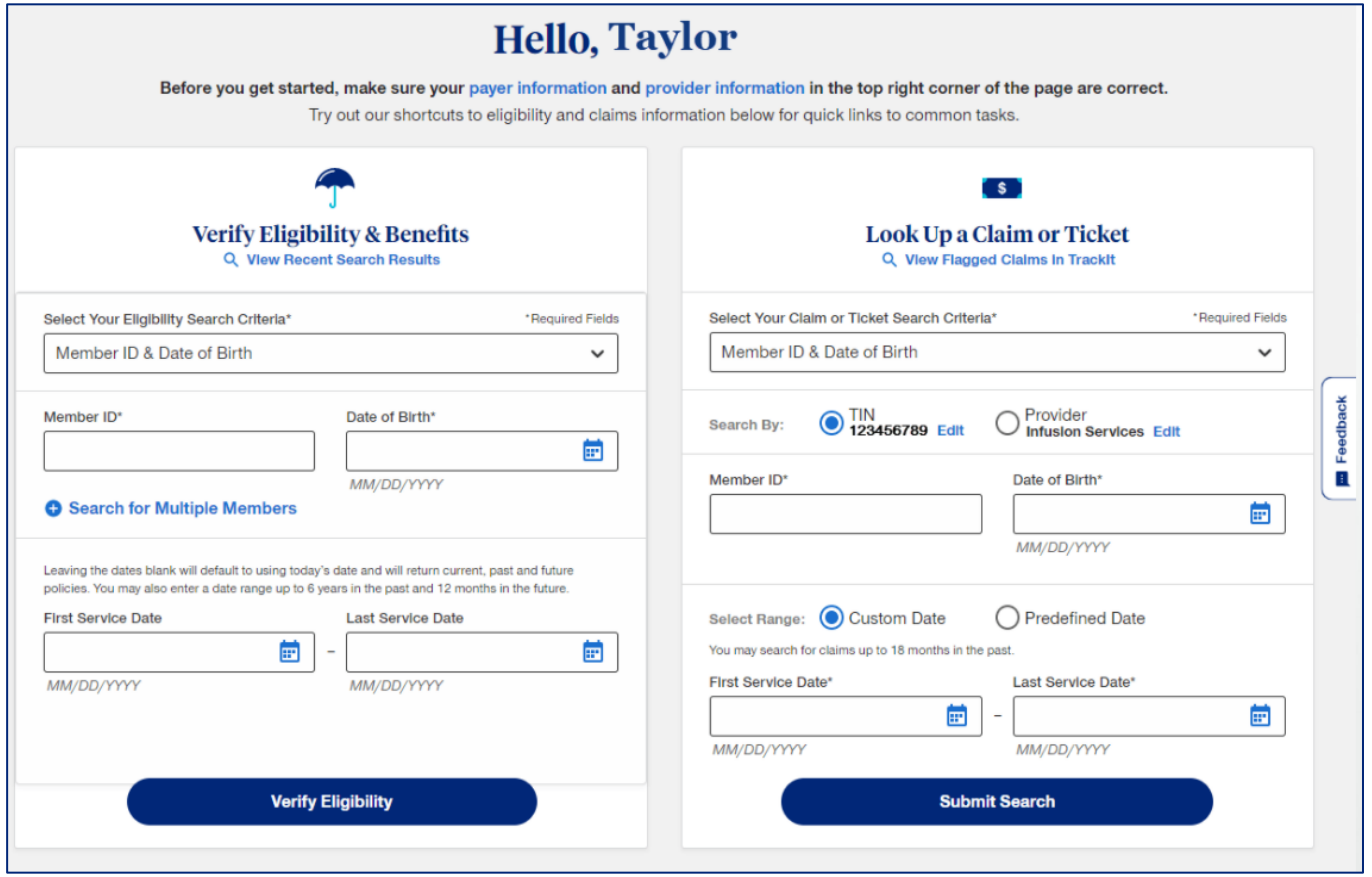


Administrative Provider Resources – Medical and Vision Claims

- 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 and Pathways Insurance Card



Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- March Vision: marchvisioncare.com
- Optum Behavioral Health: Provider Express – Indiana Medicaid

Medical Network Provider Advocate Team

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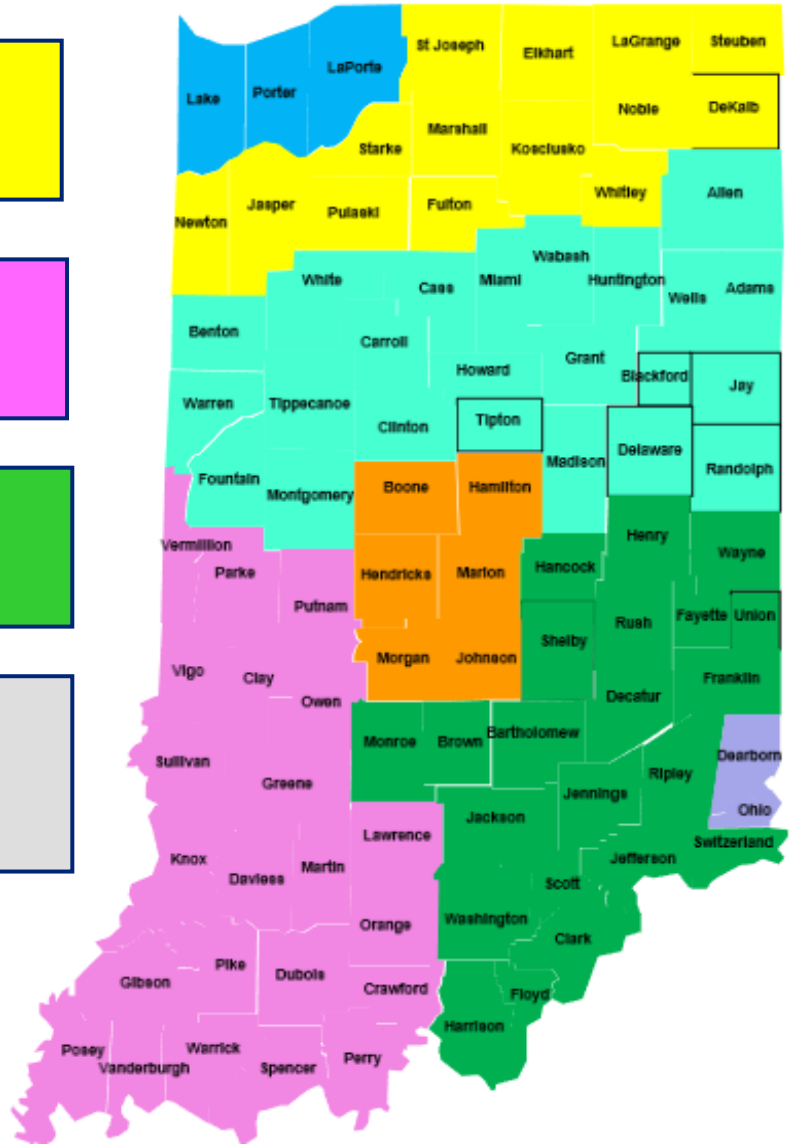

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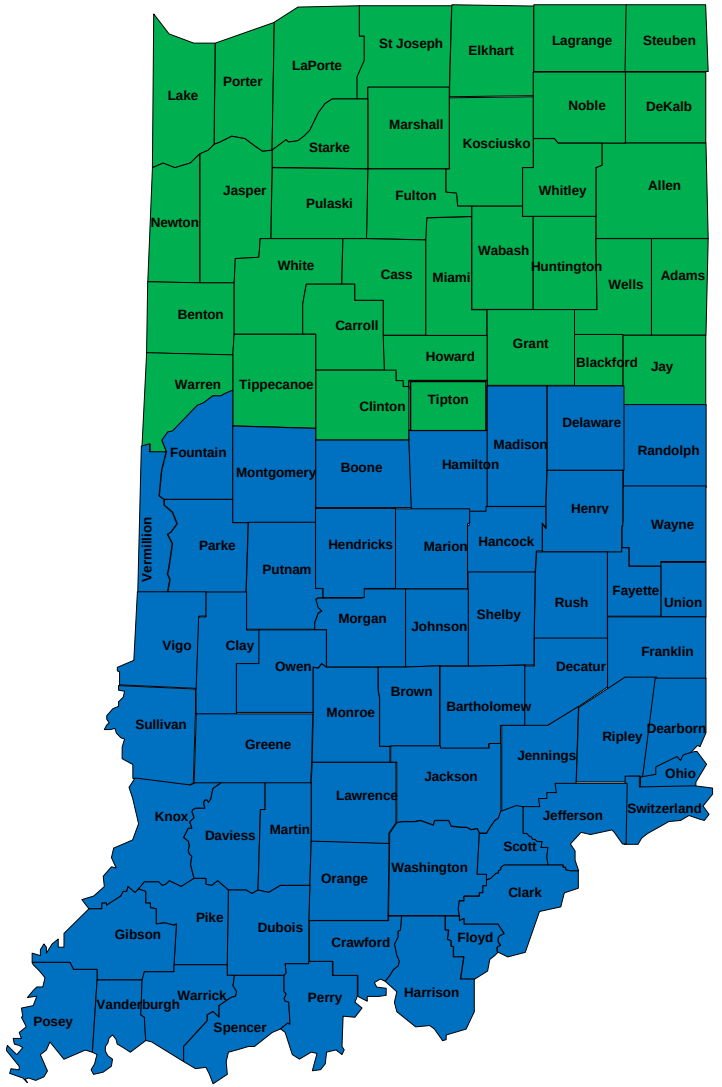

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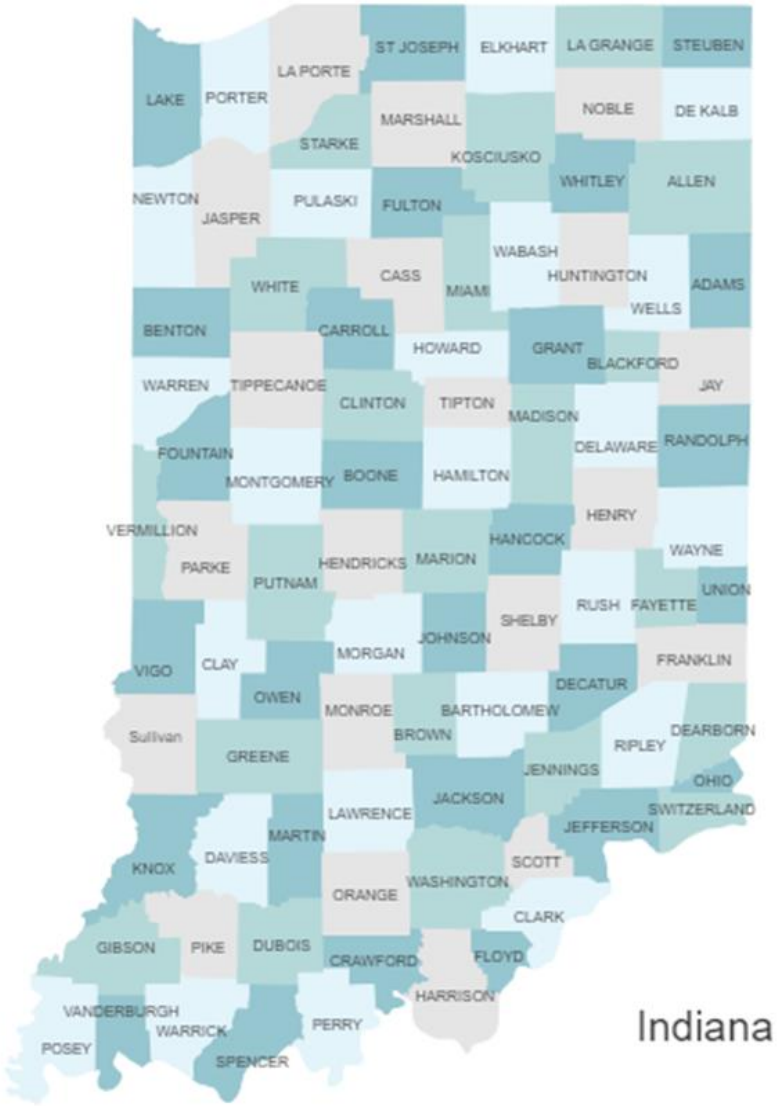

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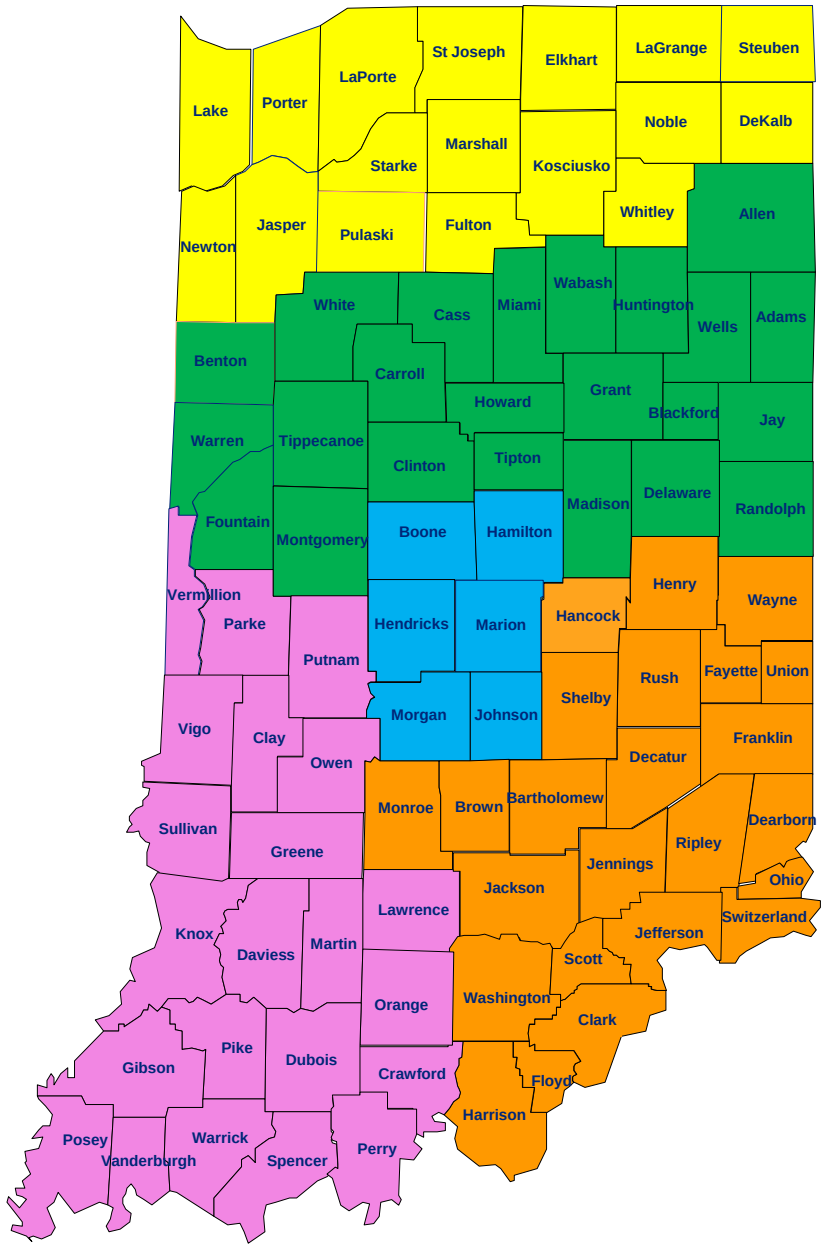

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Thank you

Questions?

United Healthcare