UnitedHealthcare Community Plan of Iowa

Annual Provider Training

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Agenda

Communication

Prior Authorization

Appeals

Claims and Billing

Communication

Communication – Where to go for help

Provider Services

- Can help with all general and specific needs
- Call **888-650-3462**

Link is your gateway to UnitedHealthcare's online self-service tools for:

- Eligibility and Benefits
- Claims Management
- Claims Reconsideration
- Community Care
- Provider Data Management

To access these tools and applications on Link, sign into UnitedHealthcareOnline.com using your Optum ID. If you do not have an Optum ID, you can register for one. You will be redirected to Link after you sign-in.

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Communication – Additional help

Provider Advocates

- Escalated Inquiries

- Training needs aside from online resources

- Staff contact maps are available at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Information
  - Behavioral Health Advocates
  - Home-and Community-Based Services Advocates
  - Skilled Nursing Facility/Nursing Facility Advocates
  - Physician/Hospital Advocates

Other resources

- UHCCommunityPlan.com provides ongoing training and reference guides

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Communication – Quick Reference Guide

Prior Authorization Requests	• Phone: 888-650-3462 • Fax: 888-899-1680 • UnitedHealthcareOnline.com > Link > Eligibility & Benefits • UnitedHealthcareOnline.com > Notification/Prior Authorizations
Paper Claims Submission	UnitedHealthcare Community Plan P.O. Box 5220 Kingston, NY 12402-5220
Electronic Claims Submission	• UnitedHealthcareOnline.com > Link > Claims Management • UnitedHealthcareOnline.com > Claims & Payment > Claims Submission • Payer ID: **87726**
Claims Status	• Provider Services: 888-650-3462 • UnitedHealthcareOnline.com > Link > Claims Management • UnitedHealthcareOnline.com > Claims & Payments > Claim Status
Claims Appeals	UnitedHealthcare Community Plan Attn: Appeals Department P.O. Box 31364 Salt Lake City, UT 84131
Provider Advocates	UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Information

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Prior Authorization

Prior Authorizations

All out-of-network services require prior authorization

- A list of applicable services requiring prior authorization is available at UHCCommunityPlan.com > For Health Care Professionals > IA > Prior Authorization list

Turn Around Times

Prior authorizations requests will be processed within:

- 7 calendar days for a standard request
- 3 business days for an expedited request
- 24 hours for pharmacy requests

May 2016 Managed Care Performance Data for Completing Prior Authorization Requests

UnitedHealthcare Community Plan's average timeframe for processing prior authorizations were:

- 99.8 percent of medical prior authorizations were completed within 7 calendar days
- 100 percent of medical prior authorizations were for expedited requests completed within 3 business days
- 100 percent of pharmacy prior authorizations were completed within 24 hours

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Prior Authorizations continued

Continuity of Care

From April 1, 2016 through March 31, 2017, we will honor standing prior authorizations for 90 calendar days for acute outpatient services when a member joins our health plan.

Prior Authorization Documentation

Be sure to include **all** supporting documentation. Acute Medical Prior Authorization Forms are available at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Provider Forms.

You can access information about radiology and cardiology services requiring prior authorization at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Radiology/Cardiology.

Behavioral Health

- Prior authorization is not required for behavioral health outpatient services (mental health and substance use), behavioral health intervention services (BHIS), habilitation services or children's mental health (CMH) waiver.
- Prior authorization is required for inpatient services, psychiatric medical institutions for children (PMIC), partial hospitalization, day treatment, intensive outpatient, peer support, and autism/ABA services.
- PMIC authorizations are approved for 30-day increments
- Call Provider Services at 888-650-3462

Appeals & Claim Reconsiderations

Appeals

As a care provider, if you are appealing on behalf of a member for medical or behavioral health services:

- Call Provider Services at **888-650-3462**,
- Fax to **801-994-1082**
- Write to:

  Grievance and Appeals
  PO Box 31364
  Salt Lake City, UT 84131-0364

Appeals must be filed within 30 days from the notice of action date. The appeal form is on **UHCCommunityPlan.com** > For Healthcare Professionals > Iowa > Provider Forms.

We will review and send a decision within 30 business days of receiving the appeal.

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Claims Reconsideration

Online Options:

To access the Claims Reconsideration application on Link, sign in to UnitedHealthcareOnline.com using your Optum ID or register for one. You will be redirected to Link after signing in and will be able to access the application.

OR

UHCCommunityPlan.com > For Healthcare Professionals > IA > Provider Forms > Claim Reconsideration Form

Mail:

UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

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Claims Resolution Dispute Process

If you are not satisfied with the outcome of a claim reconsideration request, you may submit a claim dispute using the process outlined in your Provider Manual at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Administrative Manual.

Mail to:
UnitedHealthcare Community Plan
Attn: Provider Dispute
PO Box 31364
Salt Lake City, UT 84131

Reviews take 60-90 days depending on the complexity of the claim.

Claims and Billing

Claims Submission Guidelines

Submit claims using the current 1500 claim form or UB-04 with appropriate coding including, but not limited to, ICD-10, CPT and HCPCS coding. Claim submissions must include:

- Member name, Medicaid ID and date of birth
- Your tax ID number (TIN) or employer identification number (EIN)
- National provider identifier (NPI)
- Nationally recognized Centers for Medicare & Medicaid Services Correct Coding Initiative (CCI) standards as outlined at cms.gov.

- **Timely filing deadline:** 180 days from date of service
- **Claims processing timeline:** “Clean claims” are adjudicated within 14 days of receipt.
- You may not balance bill members for services covered under their benefit plan.
- When you are contracted with us as part of a group, payment is made to the group, not the individual care provider.
- If you work with a clearinghouse, use Payer ID 87726

Claims Adjudication Process

Top 10 denial reasons

- Resubmit with primary carriers Explanation of Benefits
- Duplicate claim submission
- Termination (member not eligible)
- Service is not contracted
- Missing Clinical Laboratory Improvement Amendments (CLIA) certification number
- Non-covered service by plan
- Date requested prior to subscriber's effective date
- Billed code has been paid for in another billed procedure
- Packaged Service
- Missing/invalid value code

Claims Submission Tips By Provider Type

Durable Medical Equipment

- Claims must be filed on the CMS-1500 form or the electronic equivalent
- Some DME supplies require prior authorization, please see UHCCommunityPlan.com > For Health Care Professionals > Iowa > Prior Authorization
- Pharmacies must be contracted as a DME provider if supplying medical equipment and/or supplies to members

Claims Submission Tips By Provider Type

Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC)

- HCPCS Billing
  - FQHCs/RHCs should bill using the T1015 - all-inclusive face-to-face encounter code
  - The T1015 code should be submitted on Box 24D line 1of the claim, with any and all subsequent claim lines containing the applicable specific procedure codes for services rendered as “informational only” and billed at $0
  - Claims submitted without the “informational only” procedure codes will be denied

Claims Submission Tips By Provider Type

Behavioral Health

- Use CMS-1500 for CPT/HCPCS codes
- Use UB-04 for Revenue Codes and/or Revenue + HCPCS code combinations
- Refer to the Fee Schedule/Payment Appendix for appropriate codes and modifiers
- Care providers should contact their Network Manager for details regarding what NPI to include in Box 24J as this depends on the provider's contract
  - Find your Network Manager at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Behavioral Health Network Manager Map

Claims Submission Tips By Provider Type

Integrated Health Homes and Chronic Condition Health Homes

- Use the CMS-1500 form and include the following information:
  - Place of Service:
    - Code 11 for office
    - Code 12 for home
    - Code 22 for on campus-outpatient hospital
    - Code 50 for FQHC
    - Code 52 for Community Mental Health Center
    - Code 72 for RHC
    - Code 99 for other place of service

- Submit the Health Home claim per member per month using the national provider identifier, taxonomy, and zip code that was included on the Iowa Medicaid Enterprise provider application for the health home.
- Include the ICD-10 diagnosis code.

Claims Submission Tips By Provider Type

Family Planning

- Prior authorization is not required for any family planning services
- Bill with the family planning clinic's NPI in box 24J
- Birth control service fee (SE modifier)
  - We are recognizing the SE modifier for family planning clinic provider as outlined in informational letter 1270.

Maternal Health Centers and Screening Centers

- Bill with the applicable Maternal Health Center or Screening Center NPI in box 24J

Claims Submission Tips By Provider Type

Nursing Facility/Skilled Nursing Facility/Intermediate Care Facilities (ICF)

- Prior authorization is not required for custodial care
- Prior authorization is required for skilled nursing facility care
- Value codes:
  - Report in field(s) 39-41 “Value Codes and Amounts” of the UB-04 form. Enter the appropriate value code(s), followed by the number of covered or non-covered days in the billing period. If more than one value code is shown for a billing period, they are shown in ascending order. The number of units billed in field(s) 39-41 must equal the number of units billed in field 46 “Units of Service”.
    - 80 Covered days
    - 81 Non-covered days

- Client participation amounts
  - UnitedHealthcare Community Plan receives client participation amount information from IME. The client participation amount is loaded into our claims processing system. Care providers are to bill the total claim amount. Any client participation amounts would be withheld and indicated on the remittance advice.

Claims Submission Tips By Provider Type

Home Health

- For Medicare non-covered home health services, submit the following:
    - For electronic submissions, write “Not Homebound” in the 2300 loop – billing or claim note
    - For paper submissions, write “Not Homebound” in box 80 - remarks

- Bill each claim on a separate line

Claims Submission Tips By Provider Type

Hospice

- Prior authorization is not required
- Third Party Liability (TPL)
  - For members with primary insurance, use TPL information for services not on the Medicare non-covered list or defined as Pay and Chase per the State's TPL policy. Include the following payer information in the form fields:
    - 50a-c Payer Identification – Primary: Enter primary payer name and information
    - 54 – Prior Payments: Enter amount paid by primary payer
    - 55 – Estimated Amount Due: Enter the estimated primary payer co-pay, deductible and co-insurance amount
- Value Codes
  - Report in field(s) 39-41 - "Value Codes and Amounts" of the UB-04 form. Enter the appropriate value code(s), followed by the number of covered or non-covered days in the billing period. If more than one value code is shown for a billing period, they are shown in ascending order. The number of units billed in field(s) 39-41 must equal the number of units billed in field 46 - "Units of Service".
    - 80 Covered days
    - 81 Non-covered days

Claims Submission Tips By Provider Type

Hospice (cont.)

- Pass-through payments
  - Enter the name of the facility and its National Provider ID (NPI) in field 80 “Remarks”. Hospice care providers will be reimbursed for 95 percent of a nursing facility’s daily room and board.

- Please follow correct ICD-10 coding guidelines when submitting claims and be sure to report the primary diagnosis for the terminal illness on the claim. A list of non-reimbursable ICD-10 diagnosis codes is available in the Iowa Medicaid Hospice Provider Manual.

Claims Submission Tips By Provider Type

HCBS Waiver Providers

- HCBS waiver services are authorized through the community-based case managers during care planning assessment and determination of needs

- Bill using the ICD-10-CM diagnosis code Z76.89 - “Persons encountering health services in other specified circumstances”

- Date span billing
  - Codes listed as per diem in the HCBS billing code chart are allowed to be date span billed if the number of units in the span is equally divisible to the number of days.
    - Ex – 22 units in a 22 -day span
  - Codes not listed as per diem are allowed to be date span billed without consideration to the number of days in the date span.
    - Ex. S5125 – 15 minutes billed 100 units over a 30 day time period.
  - For more information please reference reimbursement policy – UHCCommunityPlan.com > For Health Care Professionals > Iowa > Reimbursement Policies > From-to-Date Policy (2016R0113E)

Claims Submission Tips By Provider Type

HCBS Waiver Providers continued

- Providers with an atypical NPI (Ex. X001234567) should not put the atypical NPI in the NPI field on claims forms.

Claims Submission Tips By Provider Type

Transportation

- Non-Emergency Medical Transportation(NEMT)
  - To schedule a NEMT trip, the member may call MTM at 888-513-1613
  - Submit claims for NEMT to MTM

- Waiver non-medical transportation
  - MTM contracted non-medical waiver transportation providers
    - Authorized through the community-based care managers during care planning assessment and determination of needs to MTM
    - Schedule transportation trip directly with MTM prior to transport
    - Submit claims to MTM

  - UnitedHealthcare Community Plan-contracted non-medical waiver transportation providers
    - Authorized through the community-based case managers during care planning assessment and determination of needs to the provider
    - Submit claims to UnitedHealthcare Community Plan

  - Non contracted non-medical waiver transportation providers
    - Authorized through the community-based case managers during care planning assessment and determination of needs to the provider
    - Submit claims to UnitedHealthcare Community Plan

Coordination of Benefits

- Medicare primary crossover claims began automatically crossing over from Medicare to the MCO July 25, 2016.

- UnitedHealthcare Community Plan follows the State's Third Party Liability policy
  - If service code billed is on the Medicare non-covered list or defined as Pay & Chase, a remittance advice or other documentation from the primary insurance is not required
  - Otherwise, you should either bill the primary carrier to obtain the primary carrier's EOB/EOMB or obtain other state-approved documentation

- Cost avoidance exceptions
  - Prenatal care for a pregnant woman
  - Coverage derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency
  - Preventive pediatric services

Questions?

Thank You!