UnitedHealthcare Community & State

Hoosier Care Connect Health Plan UB-04 Claims

Presented by Karen Cockerham, Provider Relations

United Healthcare®

Agenda

- Our Service Lines
- Claim Submission
- General Billing Reminders
- 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
- FDA – Food and Drug Administration
- HCFA – Health Care Finance Administration
- INN – In-Network
- NDC – National Drug Code
- OON – Out-of-Network
- RFP-Request for Participation
- UHC- UnitedHealthcare

Our Service Lines

UnitedHealthcare

Optum Behavioral Health

Claim Submission

How to file Medical/Behavioral UB04 Claims

- Submit claims using UB04 Claim Form
- 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
  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, 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

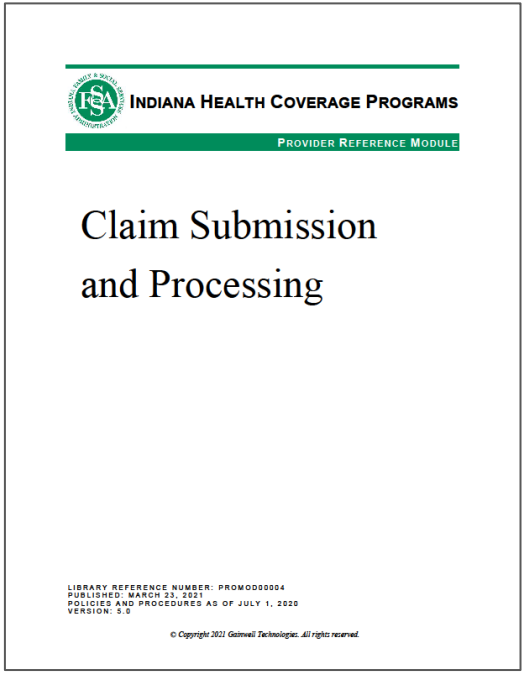
- An occurrence code is required for all types of bill except for an outpatient type of bill. UnitedHealthcare follows the guidance found on the IHCP Claims Submission and Processing, the link is provided on the next slide.
- Rejected Claims are not visible in our claims system – Claim rejections that 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 Processing Module

A facilities enrolled service location address should always be billed in box 1 of the UB04. This includes the ZIP + 4.

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


INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Claim Submission and Processing

LIBRARY REFERENCE NUMBER: PROMOD00004
PUBLISHED: MARCH 23, 2021
POLICIES AND PROCEDURES AS OF JULY 1, 2020
VERSION: 5.0

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

https://www.in.gov/medicaid/providers/files/injections-vaccines-and-other-physician-administered-drugs.pdf

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 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.

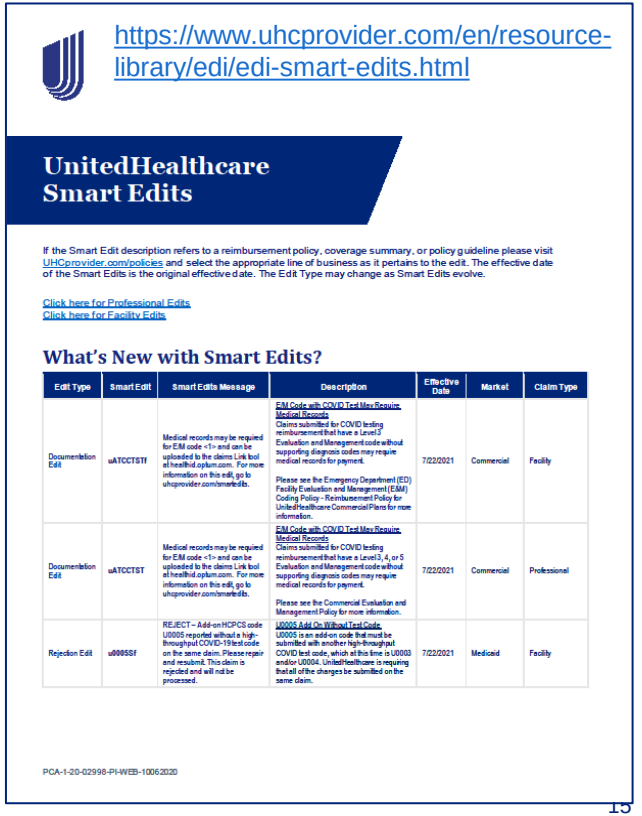
Note: All UnitedHealthcare Community Plan of Indiana Reimbursement Policies have been approved by the state.

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.

Smart Edits | UHCprovider.com



https://www.uhcprovider.com/en/resource-library/edi/edi-smart-edits.html

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

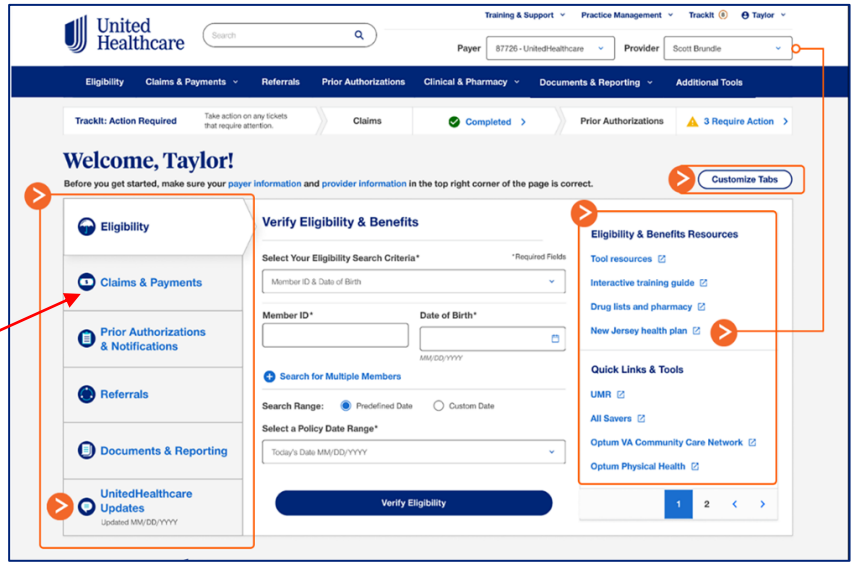
Corrected Claims

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



Create Claim Reconsideration

- The **Submit Corrected Claim** button will only display if the services were billed in the professional claim format, not for charges normally billed on a UB-04.
- Proceed to the Request Claim Reconsideration tab below the Corrected Claim action to submit a correction for a claim billed in the institutional format.

When to Escalate a Claim

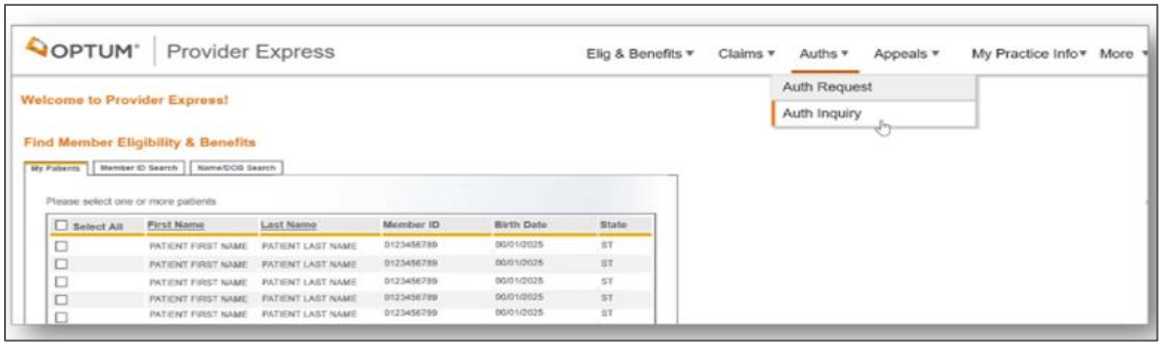
When Should I Escalate a Medical Claim to a Provider Advocate?

- 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.



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Claims Training

Additional Claims Trainings on UHCprovider.com

Claims Research Project

Document Library Interactive User Guide

Questions and Answers

Thanks for Attending Today’s Session

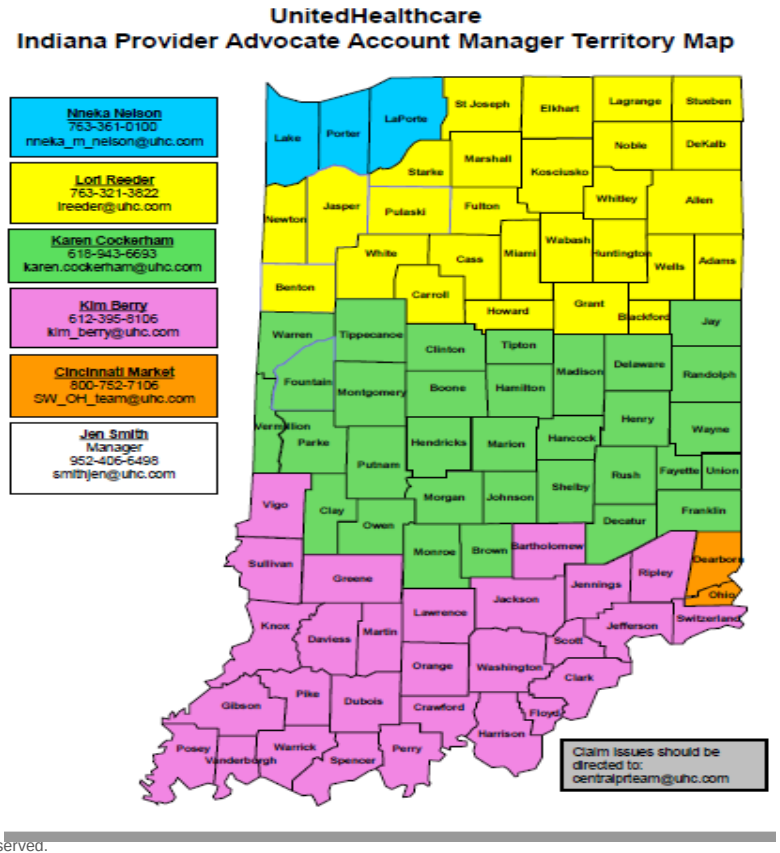
Provider Reference Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- Optum Behavioral Health: www.providerexpress.com

Provider Advocate Teams

Indiana Provider Advocate Account Manager Territory Map



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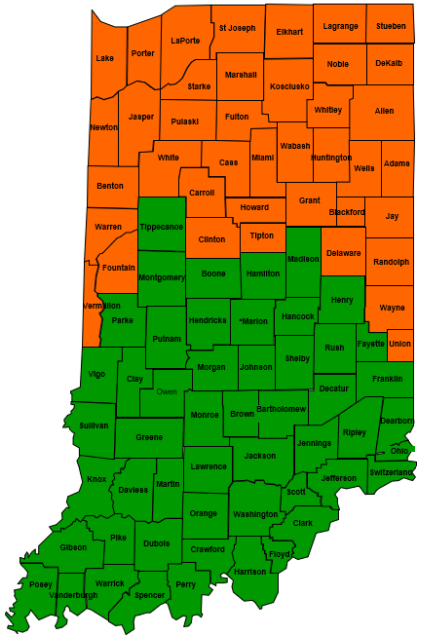

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