



Optum Idaho Claims Training Update November 2014

Agenda

- Introductions
- Overview of Claim Submission Guidelines
 - Supervisory Protocol and Rostered Clinicians
 - Placement of NPI #
 - Placement of Billing vs. Rendering Clinician Information
 - Billing of Community Based Rehabilitative Service (CBRS) Claims
- Overview of Provider Express Claim Submission Process
- Idaho Medicaid Fee Schedule Updates
- FAQs



Introductions

- Today's presentation will be Hosted by the following Optum Idaho Staff:
 - Monika Mikkelsen, Network Director
 - Lori Grimmett, Intake Customer Service Manager
 - Krystle Berg, Senior Business Process Analyst



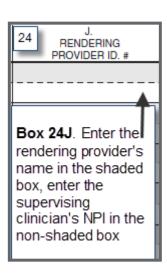
Overview of Claim submission Guidelines

- Optum Idaho follows Claim submission guidelines as defined by the following organization:
 - CMS (Centers for Medicare & Medicaid Services)
- Supervisory Protocol and Rostered Clinicians
 - During the credentialing process all organizations supplied a listing of clinicians that render services to members
 - Only those clinicians that meet credentialing criteria, (e.g., independently licensed), will be loaded and linked within Optum's systems
 - Non-independently licensed clinicians and para-professionals are required to have their services "supervised" by the individual clinicians noted above



Placement of NPI#

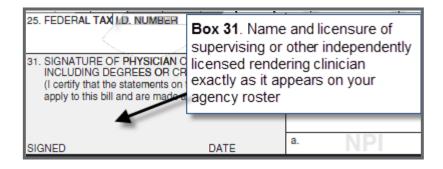
Box 24J: Enter the rendering provider's name (may be non-licensed)
in the shaded portion, and the NPI number of the independently
licensed supervising clinician in the non-shaded portion





Placement of Billing vs. Rendering Clinician Name

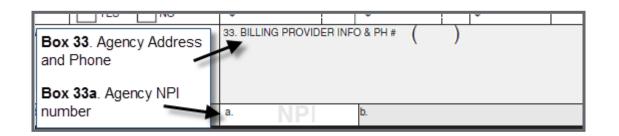
- Box 31: Enter the name and licensure of the independently licensed clinician who is supervising delivery of services or directly rendering the services; the name and license should be the same as it appears on the agency roster
- Only independently licensed clinicians should appear in Box 31





Placement of Billing vs. Rendering Clinician Name

- Box 33: Agency name, address, and phone number
- Box 33a: Agency NPI number





Billing of Community Based Rehabilitative Service Claims (CBRS)

- Optum Idaho recognizes that not all CBRS services are rendered in a traditional location, (e.g., office or school) and that services may be rendered in-home or other locations in the community
- These modifiers are informational and will not impact reimbursement
- The patient's medical records must contain information to support the use of modifiers
- When billing for CBRS that occurred in multiple locations (places of service) on the same date of service utilizing HCPC code H2017, the following modifiers may be utilized: (see next page)



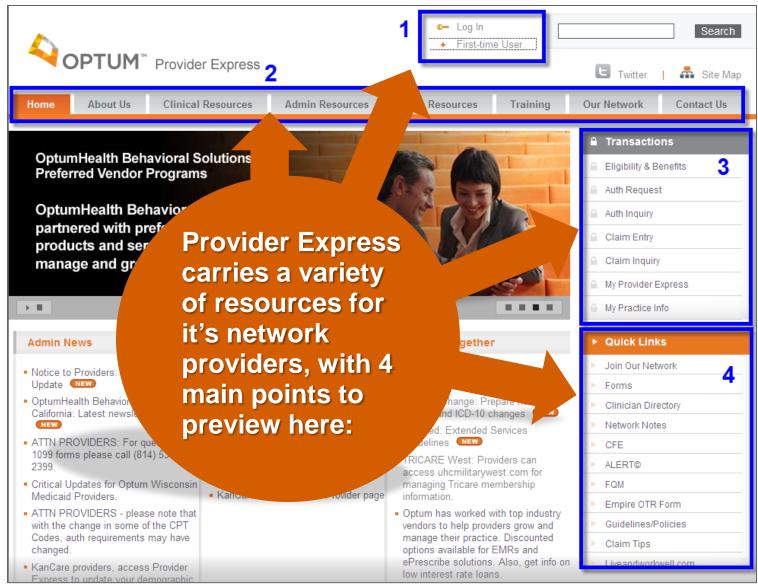
Modifier Use for CBRS

Continued:

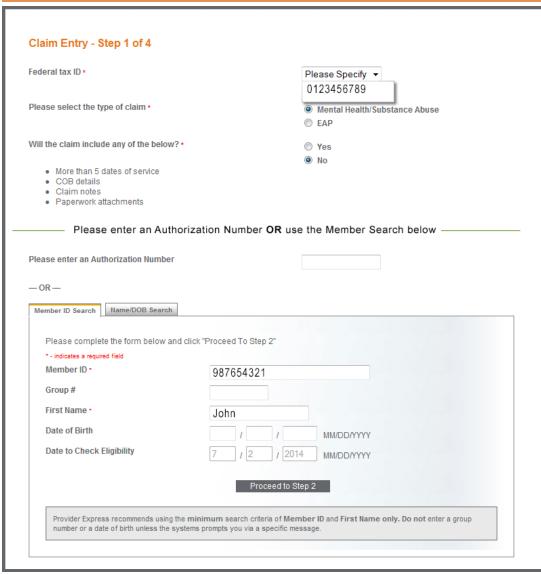
- 25 = Two-position numeric code appended to an Evaluation and Management (E&M) code to indicate a "significant, separately identifiable E&M service was provided by the same physician on the same day of a procedure or other service."
- 76 = Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier 76 to the repeated service.



Home Page



Claim Entry – Step 1 of 4 (Express/Short Form)

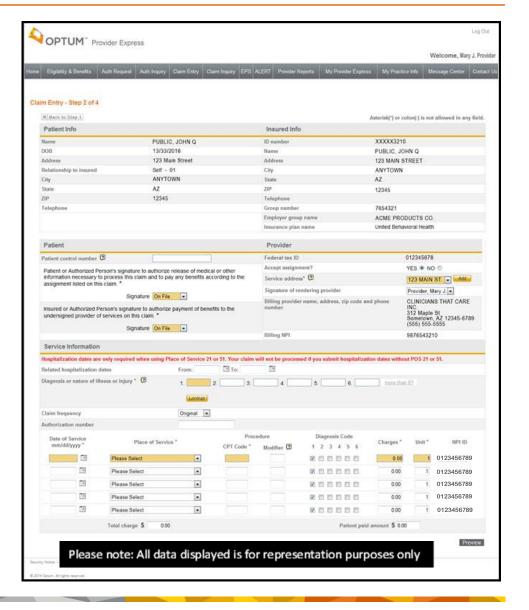


- Users can file professional MH/SA and EAP claims online using Claim Entry
- Users can search for a member using an authorization number, OR Member ID, OR Name/DOB
- The default claim is considered the express form however, if a claim needs additional information, such as paperwork or notes, the user can file the long form.
- Group logins will be prompted to choose a provider's name, and rostered groups can enter new rostered providers on the form.



Claim Entry – Step 2 of 4 (Express/Short Form)

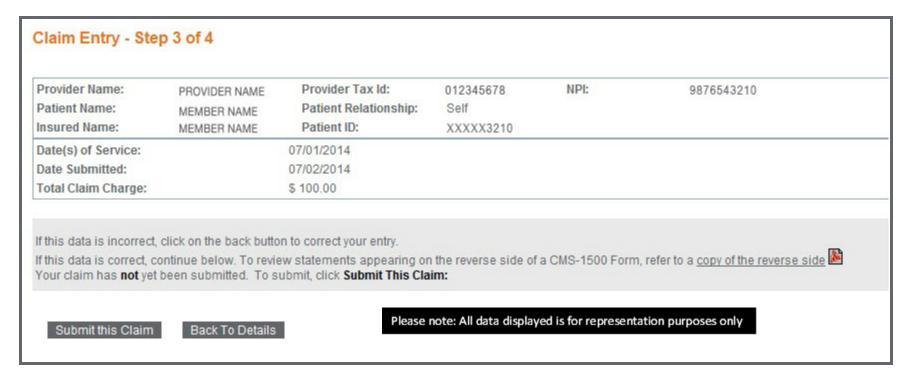
 Once the member information is found, Provider Express will bring up the claim form. The member info is auto-filled in at the top, and the required fields for the user are highlighted in orange





Claim Entry – Step 3 of 4 (Express/Short Form)

 Step 3 allows for users to review basic information on the claim before sending it for submission





Claim Entry – Step 4 of 4 (Express/Short Form)

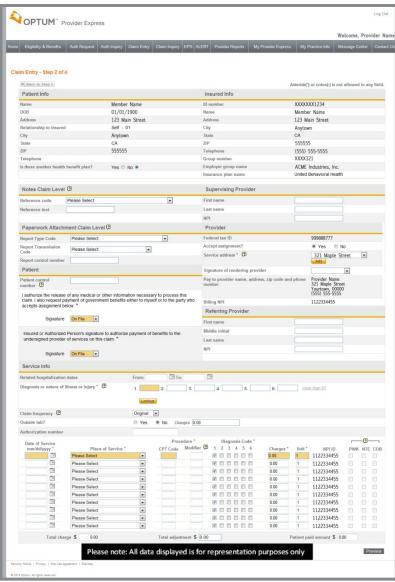
 Step 4 yields the same information as in Step 3, with the addition of a confirmation number, which is the user's assurance that the claim has been successfully submitted



• Provider Express recommends users print out this page – the confirmation number can be used to look up the status of this claim, and can be used by Provider Express technical support staff to aid in assistance as needed



Claim Entry – Long Form

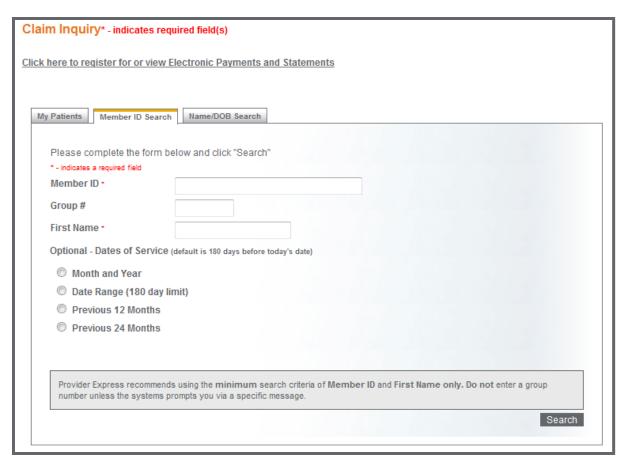


- If a claim needs to be filed with any of the following...
 - COB Details
 - Claim Notes
 - Paperwork Attachments
 - Other Supplemental Information
 - More than 5 Dates of Service
- ...Users may be prompted to file the Long Form.



Claim Inquiry

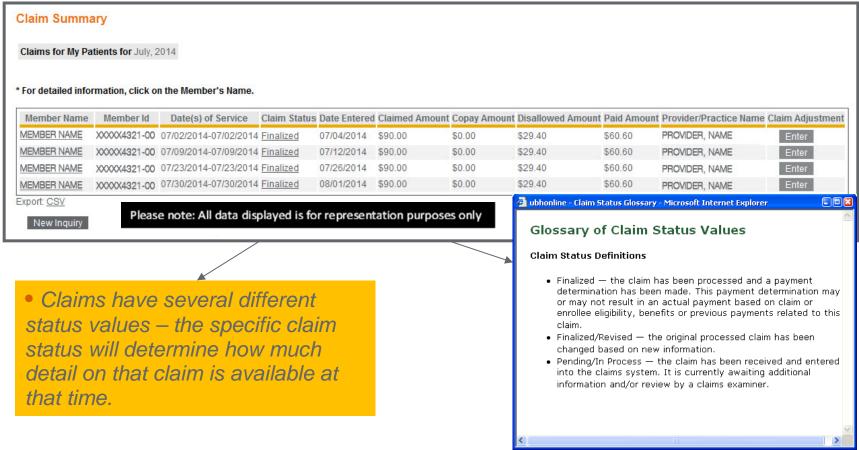
- This feature allows users to look up the status of claims paid to the individual or group, based on the login. There are several options to use in the search:
 - My Patients
 - Member ID
 - Name/DOB
- Search dates can be adjusted up to 24 months in the past





Claim Inquiry – Summary

 Any claims found within the parameters of the criteria entered will be displayed. Users can click on the member's name to get to the detail list on that claim. Users can also click on the 'Enter' button to submit an online claim adjustment





Claim Inquiry – Detail List

 The Claim Detail List includes the date(s) of service. To get to the full detail, just click on a date. Adjustment requests as well can be made on this page





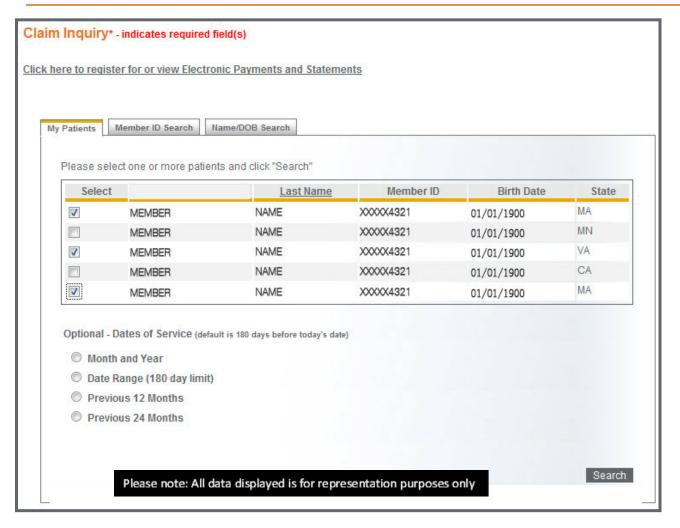
Claim Inquiry - Detail

 Clicking on the date of service will bring up the full detail for the claim. Again, depending on the status of the claim, information available will vary. Adjustments as well can be requested from this screen





Claim Inquiry – My Patients



 Users can choose one or more names from My Patients, to search multiple claims within the specified date range



Claim Inquiry – My Patients Summary List

 The Claim Summary list contains basic information on the available claims based on the previous search criteria. From here, users can click on a member's name for more detail on each claim line, or can click the Export button to send the summary information to a .csv file





Idaho Medicaid Fee Schedule Updates

- When were there changes to the fee schedule?
 - August 2014
 - For use beginning with dates of service 8/1/14 and forward
- Why are there changes to the fee schedule?
 - Providers can more easily bill for services rendered under supervisory protocol
 - Obtain accurate provider level reimbursement
- What changed?
 - Two additional modifiers allowable:
 - HO used when service was rendered by a non-rostered, master's level or bachelor's level paraprofessional
 - U1- used when service was rendered by a non-rostered prescriber



Example: Fee Schedule Update

UBH/OPTUM IDAHO MEDICAID PROFESSIONAL REIMBURSEMENT SCHEDULE

CPT Code	Modifier	Description	Unit	Fee: MD	Fee: PHD	Fee: Master's Level	Fee: APRN or other prescribing nurse practitioner; Physician Assistant (PA)
90791		Psychiatric Diagnostic Evaluation; used for diagnostic assessment or reassessment, if required. This code should not be used in conjunction with 99201-99215. This code does not include psychotherapeutic services. When appropriate, report with interactive complexity add on code 90785. Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	\$140.00	\$99.00	\$99.00	\$99.00
90791	GT	Psychiatric Diagnostic Evaluation; used for diagnostic assessment or reassessment, if required. This code should not be used in conjunction with 99201-99215. This code does not include psychotherapeutic services. When appropriate, report with interactive complexity add on code 90785. Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	\$140.00	Not Valid	Not Valid	NA
90791	НО	Psychiatric Diagnostic Evaluation; used for diagnostic assessment or reassessment, if required. This code should not be used in conjunction with 99201-99215. This code does not include psychotherapeutic services. When appropriate, report with interactive complexity add on code 90785. Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	\$99.00	\$99.00	\$99.00	NA
90791	U1	Psychiatric Diagnostic Evaluation; used for diagnostic assessment or reassessment, if required. This code should not be used in conjunction with 99201-99215. This code does not include psychotherapeutic services. When appropriate, report with interactive complexity add on code 90785. Psychotherapy services, including for crisis, may not be reported on the same day. (1 unit = 1 visit)	Unit	\$99.00	\$99.00	NA	\$99.00



Billing with Double Modifiers

- Claims that require a double modifier (for example, 90791 + HO + 25 or 90791 + U1 + 76) cannot be billed through Optum's Provider Express site (<u>providerexpress.com</u>) at this time. Any claim that requires a double modifier may be billed in one of 2 ways:
 - EDI
 - Submission of claims via mail
- Claims that require no modifier or a single modifier (for example, 90791 NONE or 90791 + GT) are not affected and may continue to be billed through Provider Express.



Question and Answers







Optum looks forward to building our relationship with you and serving Idahoans through the Idaho Behavioral Health Plan.

Thank You!