OPTUM® | Maryland

August 2020 Provider Council Meeting
Questions and Answers (Q&A)

This Q&A document addresses questions and concerns raised by the provider community during August's Provider Council Meeting, held on August 14 at 10 a.m.

**Please note that the responses included in the August Q&A only reflects operational updates and processes implemented during August 2020. The information contained within this document may be outdated and should not be relied upon. Please view the most current Provider Alerts for the most up-to-date information.*

Telehealth

1. **During the COVID-19 state of emergency, is the state considering paying for brief phone check-ins? Given the patients' lack of available technology and time, we are performing a lot of 10-minute phone calls.**
   The Behavioral Health Administration (BHA) continues to review all options regarding telehealth. At this juncture, there has been no change in the standards concerning the time required to bill various codes.

Eligibility/Insurance

1. **Please confirm that there is no copay for uninsured patients.**
   Per the Behavioral Health Administration (BHA), there is no copay for uninsured participants.

Authorization

1. **As a SUD Provider Type 50, previously we have been instructed to request an initial authorization to receive 12 units over two months, then request a concurrent authorization to receive 300 units over six months for H0004 and H0005. Now, when I attempt to request an initial authorization, I get the full 300 units over six months right away. I have been advised by the call center that this is correct, but can you please issue written instructions as a reference prior to the end of the authorization grace period to avoid issues later?**
   The call center is correct. The parameters for SUD outpatient bundles on both initial and concurrent, are now 300 units over six months.

2. **Can we have an update on the insurance authorization and active insurance issue that is causing many of the denials?**
   Providers should modify the start date of the authorization when requesting authorization to begin on the needed date. If your request has already been approved, please complete an authorization correction form and request that the start date be moved back to a given date. Backdating to July 1 is possible through December 31.

3. **All my authorizations from the prior ASO are not loaded in Incedo yet. (Again, is there another option?)**
   All Beacon authorizations that will be loaded, have been loaded. Providers may need to open new authorizations. Please contact the call center for guidance.

4. **Authorizations that were "auto-approved" have end dates that are not a full six months (e.g., request date January 1, 2020 – July 1, 2020 (six months) versus January 1, 2020 – June 28, 2020). Code H0031 has been denied in the past if there are three in one rolling calendar year. The H0031 code is used for assessment to request authorization. If dates are not a full six months (referring to January 1, 2020 – July 1, 2020), providers will be forced to submit more than two in a rolling calendar year. Will these visits be denied or is there a grace period for this billing code?**
   Providers should not run into this problem, as code H0031 does not require authorization. The limitation is on the claims to pay if used in excess of the 3x per year.

5. **The prior ASO used to provide a full "six-month" authorization. Optum Maryland's authorizations rarely are a full six months. Some of our billing codes are date sensitive (i.e., we can only submit two H0031 per rolling year). However, this code is for assessment to request authorization. Since the authorizations will be less than one year, how are we to submit H0031 as we will be submitting three within one rolling calendar year?**
   Authorizations follow the authorization parameters set by the state, which is 180 days in many cases. However, H0031 does not require authorization. Generally, the limit is two per rolling year. Providers would receive a denial for a 3rd submission within that time frame.

6. **In reference to the Provider Alert that went out on August 11, 2020, regarding authorization closure, Optum Maryland indicated that forms need to be submitted. In this circumstance, what form do you use? The Clinical Discharge or Outpatient Discharge form?**
   For levels of care that require clinical review (i.e., non-level one treatment), the provider should submit the Clinical Discharge form. For all treatment that is auto-

approved without clinical review (i.e., level one outpatient treatment), use the Outpatient Discharge form.

7. **Regarding PRP authorizations from January through June 30, I called Optum Maryland and was told not to worry about it, but not sure if I can trust that answer. So, January 1 through June 30 should be given six visits/units and we are seeing four and five units given.**
   Yes, that answer is correct. Clean, approved claims will pay for services from January 1 to June 30 without regard to authorization, so do not worry that there are not six units over that period. For dates of service July 1 and beyond, there must be an approved authorization on file for claims to adjudicate (deny or pay).

8. **Can we please have that list of auto-approved examples for PRP?**
   Right now, no PRP requests are being auto-approved. The PRP forms are under review, and there will be some situations for Adult PRP that do not require completion of the functional criteria section. If none of the exclusionary criteria is met (see Medical Necessity Criteria), functional criteria are not required for approval in the following situations:
   - *Individual has category A diagnosis and receives SSI or SSDI*
   - *Individual has been found not competent to stand trial or not criminally responsible due to mental disorder and receives SSI or SSDI*
   - *Individual is in a Maryland state psychiatric facility for more than three months, is NOT DDA eligible, and requires RRP on discharge*

9. **Providers were informed that we have 30 days to enter authorizations, but that's not always true or fair when they are taking so long to be approved and requirements change in the middle of the month. We've called and asked questions to make sure we are entering them in correctly, but it takes two weeks to get a response. Everyone you speak to gives a different answer. Who can we contact directly for PRP questions? Optum Maryland is now sending letters to our clients saying they're denied because the provider did not submit the necessary documentation to support the need for this treatment.**
   Providers should reference the PRP FAQ, which contains an abundant amount of information. Also, at this time, Optum Maryland has ceased sending administrative denial letters to participants. For questions regarding PRP, contact the call center at 1 (800) 888-1965.

10. **We have PRP claims that have been denied due to dual insurance (Medicare and Medicaid). What should providers do in this situation?**

Medicare does not cover PRP services. *PRP services are covered under Medicaid. A correction has been made to Optum's processes to bypass the coordination of benefits for PRP claims. This correction went into place on September 3. Optum Maryland is working to reprocess the claims. If you have an approved authorization, please contact customer service and have them review the claim(s).*

11. **Does authorization for code H2018 include the separate billing for the bed?**
Code H2018 only covers the PRP. If you are providing RRP, the RRP authorization plan should be utilized, and the T2048 code must be selected. To populate this code, choose the state funding option.

12. **Our members continue to report significant time-out and gateway errors when attempting to enter authorizations. This is contributing to ongoing backlog due to the inability to consistently enter authorizations. Can Optum Maryland address efforts to improve consistency in this area?**
Providers should capture screenshots of these errors and communicate these issues to the Optum Provider Relations team right away, so we can troubleshoot the issue. We are not aware of any global timeout/gateway errors at this time.

13. **What are providers supposed to do if Optum Maryland denies an IOP-SUD service 1-14 days later, and a participant has already started the program? We are being told we can only backdate an authorization seven days. So, in this case, we can't even backdate to at least get paid for OP services.**
Authorizations can be backdated to July 1 until December 31. After that time, providers will be able to backdate up to 14 days for non-urgent treatment when needed. If an authorization request is denied for medical necessity, that decision must be appealed rather than just entering a new authorization.

14. **For MDRN, is the provider required to enter an authorization for those services, or will the authorization be entered by the Regional Area Coordinator for MDRN?**
Yes, an authorization is required for all MDRN services as of July 1, 2020. The provider will enter the authorization, while the Regional Area Coordinator approves. Providers have until December 31, 2020, to enter an authorization into the Incedo Provider Portal, retroactive to July 1, 2020. A provider will enter an authorization into the Incedo system and the review/approval will be completed by the Regional Area coordinator at BHA. Providers should not bill for services for 7-1-20 or later until they have an approved authorization.

15. **As a PT27, does our psychiatrist require authorizations for codes 99201-99205 & 99212-99215 to be billed out?**
    A request must be entered, although no clinical information is required. The request will be auto-approved if the participant is eligible, and the provider has the applicable service on their fee schedule.

16. **When completing the discharge authorization, will that discharge all active authorizations? We usually have active authorizations for psychiatric services (E/M) and clinical codes. In many cases, a client will be discharged from therapy but not E/M.**
    If you ask for an authorization to be end dated, all codes associated with that authorization will be end dated. You can use therapy-only and medical management only authorization plans to have them separate. Please review the Update Regarding Medication Management and Therapy Units Provider Alert further details.

17. **What is the turnaround time for authorization requests to be reviewed and/or approved? Providers are not allowed to submit claims unless the authorizations are approved.**
    Authorization approval timelines are as followed:
    - Emergent levels of care when the participant is in the ER are turned around in one hour. The provider should call Optum Maryland at 1-800-888-1965 to pre-certify these requests. Please do not enter these requests in the Incedo Provider Portal.
    - Urgent levels of care are turned around in 24 hours. See Provider Alert for more information on Urgent levels of care.
    - Non-urgent care must be turned around within 14 days.

18. **Should providers void any authorizations that come to our queue that are not for the CSA to approve such as TCM?**
    Providers should not void the tasks for TCMs that come into your work queue – we will remove them for you. Contact the call center at 1 (800) 888-1965. We are working with our development team to understand why these tasks are being misdirected and to stop it from happening.

Overlapping Authorizations

1. **Can you please address the denial due to the overlap in dates? We have to discharge and reenter. Is this issue being addressed?**

If you try to enter an authorization and already have an authorization for the same codes on file for overlapping dates, the second request will either pend or remain in process. Claims attached to that authorization will deny for not having an approved authorization.

2. **Is it necessary to discharge and resubmit authorizations when units have been exhausted?**
   The authorization must be end dated if units are exhausted before the end of the span. That will allow for a new request to be entered without having overlapping dates.

3. **Will Optum Maryland adjust the units to match the authorizations?**
   Dates are adjusted as appropriate for levels of care that are clinically reviewed.

4. **Have they addressed the concurrent when time remains on the authorization but not units?**
   If you have exhausted the units in an authorization, please follow the instructions outlined in the New Procedure for Requesting Authorization End Date alert on August 11, to have the authorization end dated. Once you complete the process listed in the alert, a new authorization can be requested.

Claims/Billing

1. **We have both an OMHC and PRP. Did the estimated payments include both programs?**
   Estimated payments were developed at the TIN level for those programs with payments in 2019.

2. **Can you please explain why so many claims are remaining in the "in process" status with $0 approved? It was my understanding that claims were supposed to be processed within 24 hours of submission and if not, two weeks at the maximum. These claims are taking far longer than two weeks to process.**
   The ‘in process” status means that the claim has not gone all the way through the check write process. For additional details regarding the claim’s current status, click the “+” sign to the left of the claim number to expand the details. The requirement pertaining to claims is that clean claims (those that do not require additional information to support, meet all submission requirements) will process within 14 days and that claims, which require additional information, documentation or correction, would either pay or be denied within 30 days.

3. **Should we contact the call center for 300 claims?**
   If you have 300 claims with the same denial reason, sharing a few examples with a representative from the Optum Maryland call center should be sufficient to

identify the issue and develop a resolution. If you have multiple denial explanations, then be sure to share each of the unique situations so that a plan can be put in place for review and appropriate action.

4. **I am seeing all the H2018 being pended. Does this mean we will not get paid the following week if we bill the week prior?**
   All H2018's are manually validated to ensure the appropriate payment for encounters received, and therefore claims may have taken longer to complete.

5. **We have a group practice and were told multiple times that the "drop-down" would be loaded with all of our providers' information for billing. However, there is a CMS-1500 form, which requires us to manually enter all information in Incedo. Is this going to change? Billing through our clearinghouse is going to complicate the process when the authorized units are in Incedo?**
   Provider affiliations are not auto-populated in Optum Maryland's system. When filling out the CMS-1500 form, enter the rendering provider NPI in box 24J.

6. **Optum Maryland is still denying claims that should be approved. What is Optum Maryland doing to correct the "charge exceeds allowed amount" error?**
   Optum Maryland is aware of an issue and is currently working with our technology partners to resolve. There is typically a second denial reason on claims that is not visible to providers. The most common denial when this issue occurs is when the authorized units have been exhausted for that service.

   If you have confirmed that the appropriate number of units remain on the authorization, or you cannot determine the denial reason, please contact the call center with specific claim examples. The call center will open a claims research ticket.

7. **Is Optum Maryland planning to accept the GC modifier? Medicare requires this modifier when residents are involved in the care. Medicaid doesn't require the modifier; however, they will accept it. It appears that Optum Maryland is denying claims submitted with this modifier. We have thousands of claims that are possibly impacted.**
   There are currently no exclusions/restrictions around the GC modifier. Any claims that come in with that modifier will be processed as informational. We currently have a ticket open with our IT partners to allow the informational modifiers to flow through the system. In the interim, all claims billing these modifiers that were denied incorrectly are being reprocessed by Optum Maryland.

Reconciliation

1. **Several programs have not received any 835s and the reconciliations are also well below the submitted claims. Additionally, the new-day claims were less than 25% of the provided services at several programs. Please advise.**
   Optum Maryland is performing a quality assurance review to all PRAs and 835s prior to release. As of September 1, we were 88% complete with this process.
2. **When will PRAs accompany payments?**
   PRAs accompanied all payments this past week's check write. A few remaining PRAs are being worked from the past two runs.

3. **Who do we contact if no payment was received?**
   Please contact maryland.provpymt@optum.com for questions concerning payments.

4. **If we have claims for services prior to June 30 that have not been submitted, how do we assure they are counted toward reconciliation?**
   Optum Maryland and MDH has developed a proposed process that would be incorporated into the weekly payment process that would delineate claims based on date of service (DOS) and offset payments where appropriate, and pay dollars associated to new day claims. This proposed process would help clarify which claims are applicable to reconciliation timeframe.

   - *The weekly payment process will be separated into two cycles, all executed on the same timeline as the current payment process*
     - *Sunday: Cycle 1- Claims for DOS prior to 8/3/2020:*
       a. *Provider has Estimated Payment balance? Claims are offset against balance.*
       b. *Provider has Estimated Payment balance that is met with claims adjudicated? Offset occurs and remaining balance is paid.*
       c. *Provider has no estimated payment balance or never had an Estimated Payment? Claims are paid.*
     - *Sunday: Cycle 2- Claims for DOS 8/3/2020 and after:*
       a. *Claims eligible for payment are paid – regardless if provider has Estimated Payment balance or not.*
     - *Thursday: Provider can access PRAs, 835s, and payment information in their Payspan Account.*

5. **Will 835s include denied claims starting August 3? How will we know what claims denied entered after August 3? I have not seen any denials on the paid 835.**
   As of August 3, 835s will contain paid and denied claims. Denials are listed on the PRA and 835.

6. **Payments are not matching the claims submitted and without EOB, we cannot appeal. What is the resolution?**
   Some EOBs are still pending from the first two check runs. The EOBs that have been delivered represent payment of processed claims for the week.
   The balance of EOBs will be sent out shortly. Please view the Provider Alert that details more information about appeals.

7. **It appears that the filing limit for appealing denied claims has been changed from one year to 90 days. Is this true?**
   Please view the Provider Alert that details more information about appeals.

General

1. **Has all of Optum Maryland been trained on who the CSA/LBHA is? Why do people in provider relations call us and have no clue that we approve for Optum Maryland? They never understand what we are trying to say.**
   We have educated our call center on who the CSA/LBHA are and what functions they perform.