Home & Community- Based Services (HCBS) Provider Billing Training

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Network Operations Team

Director, Network Operations

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SW New Mexico

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PROVIDER ADVOCATE TERRITORY LISTING (including zip codes/counties)

IS AVAILABLE AT:

http://www.uhccommunityplan.com/health-professionals/NM/provider-information

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Objectives

By the end of this training, you will:

- Review where to locate changes to the CoLTS program
- Review UnitedHealthcare Community Plan (UHCP) Member Benefits
- Review UHCP's Service Coordination & Utilization Management
- Review Provider Role & Responsibilities
- Review Claim submissions processes and how to work common denial codes
- Learn where to locate various handouts and resources to assist you in your role.

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CoLTS Program Updates

Stay Connected

Providers are reminded to stay connected, and informed of changes to the CoLTS program. Information can be obtained from:

HSD website at:
http://www.hsd.state.nm.us/mad/registers/2011.html

Aging & Long-Term Services Department at:
http://www.nmaging.state.nm.us/Aging_Network_Division.html

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Member Benefit Reminders

UHC Community Plan CoLTS Member ID Card

UnitedHealthcare Community Plan

RxBin: 610494
RxPCN: 9999
RxGrp: ACUNM

UnitedHealthcare Community Plan Member ID Card
Coordination of Long-Term Services (CoLTS)
Member Name: SUBSCRIBER BROWN
Member Number: 999999999 **Group:** 32103
Effective Date: 02/01/10
PCP Name: PROVIDER BROWN
PCP Phone Number: (999) 999-9999
NM PRC Ins. Div., Managed Health Care Bureau: 888-427-5772

Member: Your PCP and service coordinator must coordinate your health care, except in an emergency, or for family planning services.
For emergencies, call 911, or go to the nearest hospital emergency room.

Other Numbers:
Member Services/Service Coordination:
1-877-236-0826, TTY 711
OptumHealth New Mexico:
1-866-660-7185, TTY 1-800-855-2881
Transportation: 1-866-913-2492

Claims Submission Address
PO Box 31350
Salt Lake City UT 84131-0350

Electronic Payer ID 87726

- **PCP Designation for Duals = "Medicare PCP"**
- **PCP Designation for Medicaid only members = PCP's name**

*** Note member's group number***

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Member Benefit Levels

- Member benefits are based on the eligibility/LOC category.
  - **Refer to the UHCP Member Handbook or the New Mexico Administrative Code (NMAC) for detailed list of member benefits (covered and non-covered); provider responsibilities, etc.**
    - NMAC 8.307.7 – Coordinated Long-Term Services, Benefit Package (State Plan/1915(b) Waiver); available to all CoLTS members
    - NMAC 8.307.18 – CoLTS 1915(c) Home and Community-Based Services Waiver
    - NMAC 8.315.4 – Other Long Term Care Services, Personal Care Option Services
    - NMAC 8.314.6 – Long Term Care Services Waivers, Mi Via Home and Community-Based Services Waiver. (Note: CoLTS members only receive their 1915b waiver services (i.e. acute care) from UHCP. Long term services are received via their Mi Via budget).

(Regulations can be found at: http://www.nmcpr.state.nm.us/nmac/)

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Member Eligibility Categories

Dual NF LOC

NF Resident	**B Services Only**
Community NF LOC – HCBS/DEW	**B & C Services**
Community NF LOC – HCBS/PCO	**B Services Only + PCO**

Dual Mi Via

Community NF LOC – HCBS	**B Services Only**

Non Dual Eligible NF LOC

NF Resident	**B Services Only**
Community NF LOC – HCBS/DEW	**B & C Services**
Community NF LOC – HCBS/PCO	**B Services Only + PCO**

Non Dual Mi Via

Community NF LOC – HCBS	**B Services Only**

Healthy Dual

Community no NF LOC	**B Services Only**

(Refer to website for available resource document: New Mexico CoLTS Group Numbers)

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UHC Community Plan Member Group Numbers

UnitedHealthcare Community Plan New Mexico Group Numbers

PHASE 1	
32100	NM MCAID DUAL NF LOC DEW
32101	NM MCAID DUAL MI VIA
32102	NM MCAID NON DUAL NF LOC DBW
32103	NM MCAID NON DUAL MI VIA
32104	NM MCAID HEALTHY DUAL
32110	NM MCAID DUAL NF LOC INF
32112	NM MCAID NON DUAL NF LOC INF
32120	NM MCAID DUAL NF LOC PCO
32122	NM MCAID NON DUAL NF LOC PCO
32152	NM MCAID DUAL NF LOC DEW A
32153	NM MCAID DUAL MI VIA A
32154	NM MCAID HEALTHY DUAL A
32155	NM MCAID DUAL NF LOC INF A
32156	NM MCAID DUAL NF LOC PCO A
32172	NM MCAID DUAL NF LOC DEW B
32173	NM MCAID DUAL MI VIA B
32174	NM MCAID HEALTHY DUAL B
32175	NM MCAID DUAL NF LOC INF B
32176	NM MCAID DUAL NF LOC PCO B

PHASE 2	
32125	NM MCAID DUAL NF LOC DBW 2
32126	NM MCAID DUAL MI VIA 2
32127	NM MCAID NON DUAL NF LOC DEW 2
32128	NM MCAID NON DUAL MI VIA 2
32129	NM MCAID HEALTHY DUAL 2
32130	NM MCAID DUAL NF LOC INF 2
32131	NM MCAID NON DUAL NF LOC INF 2
32132	NM MCAID DUAL NF LOC PCO 2
32133	NM MCAID NON DUAL NF LOC PCO 2
32157	NM MCAID DUAL NF LOC DBW 2 A
32158	NM MCAID DUAL MI VIA 2 A
32159	NM MCAID HEALTHY DUAL 2 A
32160	NM MCAID DUAL NF LOC INF 2 A
32161	NM MCAID DUAL NF LOC PCO 2 A
32177	NM MCAID DUAL NF LOC DBW 2 B
32178	NM MCAID DUAL MI VIA 2 B
32179	NM MCAID HEALTHY DUAL 2 B
32180	NM MCAID DUAL NF LOC INF 2 B
32181	NM MCAID DUAL NF LOC PCO 2 B

PHASE 3	
32134	NM MCAID DUAL NF LOC DEW 3
32135	NM MCAID DUAL MI VIA 3
32136	NM MCAID NON DUAL NF LOC DEW 3
32137	NM MCAID NON DUAL MI VIA 3
32138	NM MCAID HEALTHY DUAL 3
32139	NM MCAID DUAL NF LOC INF 3
32140	NM MCAID NON DUAL NF LOC INF 3
32141	NM MCAID DUAL NF LOC PCO 3
32142	NM MCAID NON DUAL NF LOC PCO 3
32162	NM MCAID DUAL NF LOC DEW 3 A
32163	NM MCAID DUAL MI VIA 3 A
32164	NM MCAID HEALTHY DUAL 3 A
32165	NM MCAID DUAL NF LOC INF 3 A
32166	NM MCAID DUAL NF LOC PCO 3 A
32182	NM MCAID DUAL NF LOC DEW 3 B
32183	NM MCAID DUAL MI VIA 3 B
32184	NM MCAID HEALTHY DUAL 3 B
32185	NM MCAID DUAL NF LOC INF 3 B
32186	NM MCAID DUAL NF LOC PCO 3 B

PHASE 4 & 5	
32143	NM MCAID DUAL NF LOC DEW 45
32144	NM MCAID DUAL MI VIA 45
32145	NM MCAID NON DUAL NF LOC DBW45
32146	NM MCAID NON DUAL MI VIA 45
32147	NM MCAID HEALTHY DUAL 45
32148	NM MCAID DUAL NF LOC INF 45
32149	NM MCAID NON DUAL NF LOC INF45
32150	NM MCAID DUAL NF LOC PCO 45
32151	NM MCAID NON DUAL NF LOC PCO45
32167	NM MCAID DUAL NF LOC DBW 45 A
32168	NM MCAID DUAL MI VIA 45 A
32169	NM MCAID HEALTHY DUAL 45 A
32170	NM MCAID DUAL NF LOC INF 45 A
32171	NM MCAID DUAL NF LOC PCO 45 A
32187	NM MCAID DUAL NF LOC DBW 45 B
32188	NM MCAID DUAL MI VIA 45 B
32189	NM MCAID HEALTHY DUAL 45 B
32190	NM MCAID DUAL NF LOC INF 45 B
32191	NM MCAID DUAL NF LOC PCO 45 B

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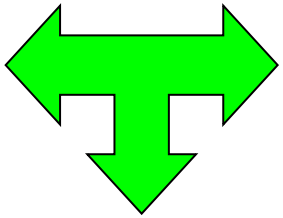
Putting It All Together



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PHASE 1

32100	NM MCAID DUAL NF LOC DBW
32101	NM MCAID DUAL MI VIA
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32174	NM MCAID HEALTHY DUAL B
32175	NM MCAID DUAL NF LOC INF B
32176	NM MCAID DUAL NF LOC PCO B

- Non Dual Mi Via
  - Community NF LOC – HCBS B Services Only

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UHC Community Plan – Customer Service Team

- How to contact and communicate with UHC Community Plan's Customer Service team (for member eligibility, benefit inquiries, PCP assignment, etc):
  - 1-877-236-0826 (follow voice prompts for members – not healthcare professional – and select "Representative")

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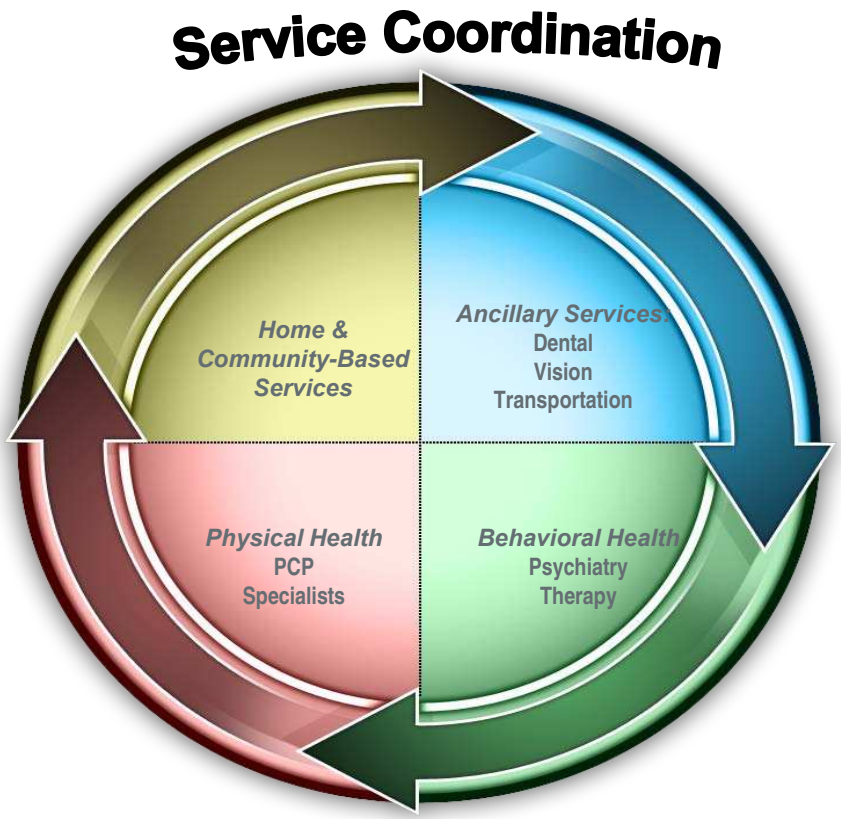
Service Coordination

Service Coordination –
The Cornerstone of the CoLTS Program

Telephonic
Service Coordinator



Field-Based
Service Coordinator

Institutional
Service Coordinator

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Assessment & Service Initiation Timelines

Member Status	Completion of Assessment	Services Initiated
Emergent *(can be any new or transitioning member)*	**7** business days from notification of emergent status	**7** calendar days of assessment
New member to CoLTS	**30** calendar days from notification of enrollment	**14** calendar days from date of completed assessment
Transitioning from another MCO plan	**60** calendar days from notification of enrollment	**14** calendar days from date of completed assessment

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Temporary Notifications during initial assessment period

- *Temporary notifications **are available for new & transferred enrollees** until a new assessment is completed by UHC Community Plan*
  - ***Enrollee must be effective with UHCP.***
- *Provider needs to fax one of the the following to SCA team:*
  - ***Temp auth from Molina for new CoLTS member***
  - ***Amerigroup auth if transitioning into UHCP***
- *Enrollees with temporary approval from Molina that are not effective with a CoLTS MCO would continue to be processed via the Fee for Service model until CoLTS effective date.*

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Telephonic Service Coordination – Member profile:

Member – typically a “healthy dual” may:

- Function independently with ADL (activities of daily living) and IADLs (instrumental activities of daily living)
- Lives with ONE or NO chronic illnesses
- Not on any waiver programs
- Require assistance with some ADL and/or IADLS
- Not at immediate risk for nursing home placement
- Without social/medical interventions the member may decline and be at risk for NH placement
- Typically have 2 or 3 stable chronic conditions
- Need clinical education to manage the conditions
- May apply for a waiver program

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Face to Face Service Coordination – Community Based Member profile:

Member (Full Medicaid or Dual eligible) residing in the community:

- Needs assistance with two or more ADL and IADLs **and**
- **Already** receives 1915 (b) or (c) waiver services
- Certified to be at nursing facility level of care
- At immediate risk for health and functional decline and for nursing home placement
- Typically has multiple chronic conditions & requires clinical education, social supports & services to effectively manage these conditions

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Face to Face Service Coordination – Nursing Facility Member profile:

Member (Full Medicaid or Dual eligible) residing in a nursing facility:

- Needs assistance with two or more ADL and IADLs **and**
- Meets nursing facility level of care
- Receives institutional Medicaid or has both UHC Community Plan Medicare and CoLTS Medicaid plans
- At immediate risk for health and functional decline
- Typically has multiple chronic conditions & requires clinical education, social supports & services to effectively manage these conditions

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When to Contact the Service Coordinator:

Some examples of when contacting a Service Coordinator would be helpful and appropriate:

- **Inability to provide services**
- Change in member's medical condition
- Member unexpectedly leaves place of residence or without notification (AMA)
- Member is admitted to inpatient setting
- Member suffers a fall (CI)
- Member would like information or referral for behavioral health services
- Member needs assistance accessing services such as transportation or DME
- Member needs help finding preventative care or a specialist
- Death of member (CI)

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UHC Community Plan – Service Coordination Team

How to contact and communicate with UHC Community Plan Service Coordination team:

1-877-236-0826;(follow Healthcare Professional voice prompts to Service Coordination)
Fax #: 1-866-751-2448

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Utilization Management

Authorizations

- Attendant Care notifications are issued by the SCA team via a task notification from the Service Coordinator.
- Notifications are based on results of the 2060 assessments for attendant care services. Notification requests are subject to clinical review.
- UHCP Utilization Management team is responsible for Authorizations (inpatient, acute care, non Attendant Care, etc). UM issues authorizations for medically necessary services (acute, inpatient, etc) based on Milliman Care guidelines. Decisions regarding Medical Necessity are based on NMAC guidelines.
- Prior Authorization request forms are available on the UHCP website at: http://www.uhccommunityplan.com/health-professionals/NM/provider-information

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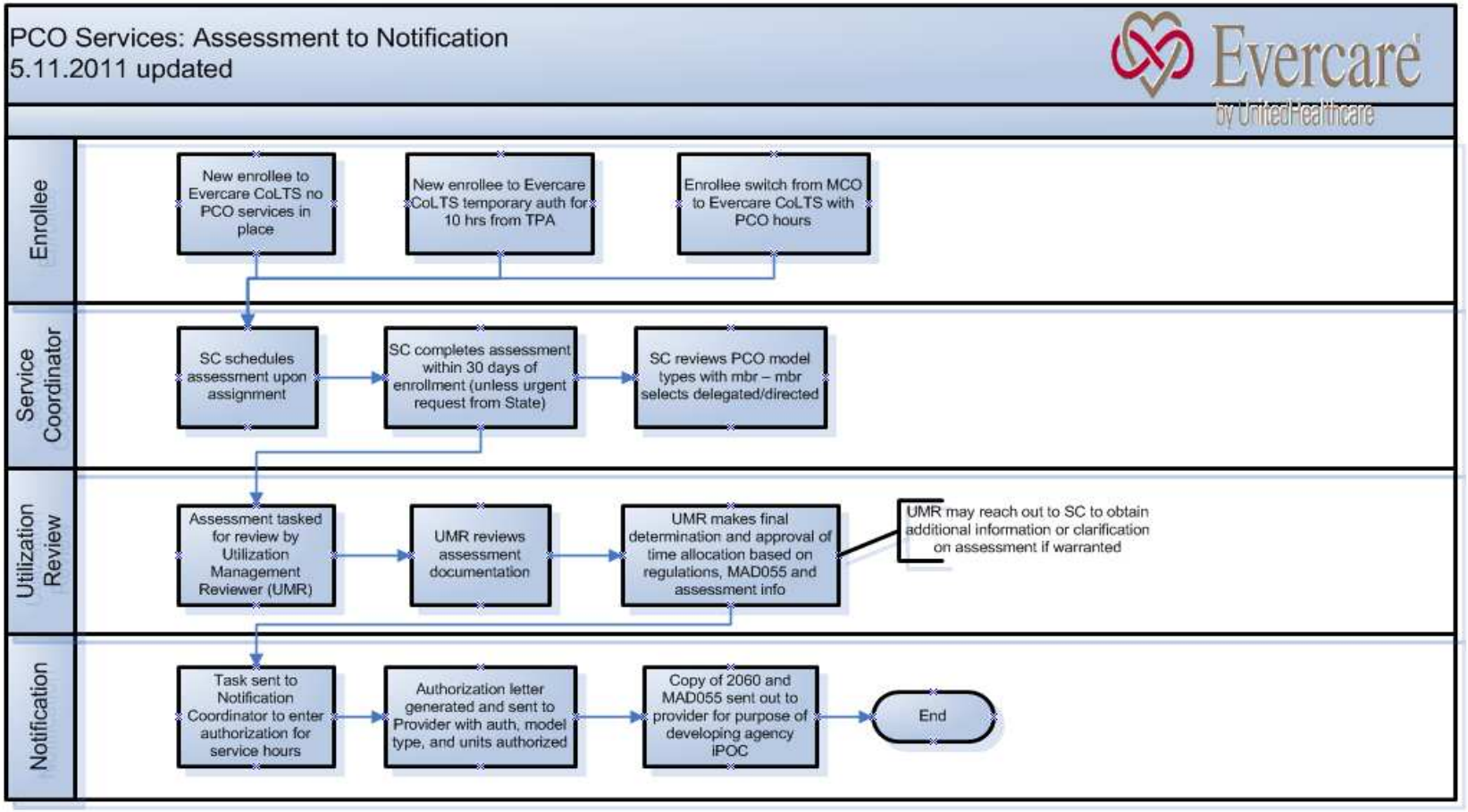
Assessment to Notification Timeline



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Authorization Research Form (ARF)

- Utilize the ARF to request status on Attendant Care notifications.
- DO NOT request status on notifications that are expiring more than 30 days out. **Only utilize the form if the notification is expiring within the next 29 days or less, and you have not received the updated notification.**
- Fax the completed ARF to the SCA team at: 866-751-2448
- To follow up on ARF requests previously sent, contact the SCA team

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Prior Authorization/Notification Guide

UHCP's Prior Authorization/Notification Guide for Contract Providers available online at:

http://www.uhccommunityplan.com/health-professionals/NM/provider-information

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UHC Community Plan – Utilization Management Team

How to contact and communicate with UHC Community Plan Utilization Management team:

1-877-236-0826;(follow Healthcare Professional voice prompts to Prior Authorization)
Fax #: 1-866-968-7582

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Provider Roles & Responsibilities

Eligibility!

- Eligibility determination: Providers must verify eligibility of the member to assure the member is covered on the date the services are provided.
- Eligibility can be verified on UHCOnline, by calling the UHCP Customer Call Center at **1-877-236-0826**, or via the New Mexico Medicaid web portal.

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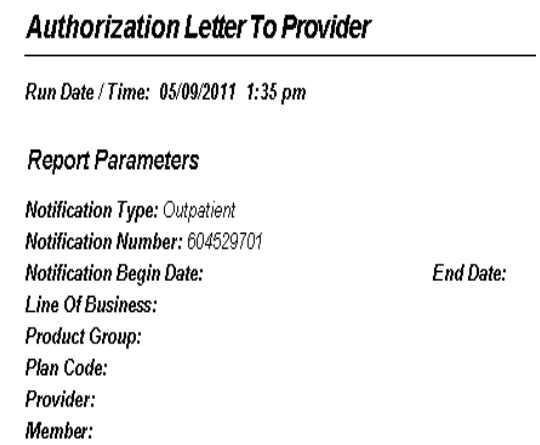
Notifications

- The TPA's temporary auth/approval does not equal a notification from UHCP.
- It is the provider's responsibility to obtain necessary notifications PRIOR to services being rendered.
- It is the provider's responsibility to track/manage the units issued and billed per notification.
- Attendant Care Notifications are issued by the SCA team
- Waiver and Acute Care authorizations are issued by the UM Dept
- Authorization/Notification is not a guarantee of payment.



Authorization Letter To Provider

Run Date / Time: 05/09/2011 1:35 pm

Report Parameters

Notification Type: Outpatient
Notification Number: 604529701
Notification Begin Date: End Date:
Line Of Business:
Product Group:
Plan Code:
Provider:
Member:

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Balance Billing

- **If you know of a member that has been "balance billed" by a provider, please have the member or POA contact the UHCP Customer Service Dept or notify the UHCP Compliance team via the FWA form.**

- **8.302.1.16 ACCEPTANCE OF RECIPIENT OR THIRD PARTY PAYMENTS: A provider may only bill an eligible recipient or accept payment for services if all of the following requirements are satisfied:**
  - A. The eligible recipient is advised by the provider before services are furnished that a particular service is not covered by MAD or that the particular provider does not accept patients whose medical services are paid for by MAD.
  - B. The eligible recipient is provided with information by the provider regarding the necessity, options, and charges for the service, and of the option of going to a provider who accepts MAD payment.
  - C. The eligible recipient still agrees in writing to have specific services provided with the knowledge that he will be financially responsible for payment.

[2-1-95; 2-1-99; 8.302.1.16 NMAC - Rn, 8 NMAC 4.MAD.701.7, 7-1-01; A, 9-15-08]

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Critical Incident Reporting

- Follow the Department of Health - Division of Health Improvement - Incident Management Bureau Incident Management System Guide. Self report as per guidelines by DOH.
  - Please forward a SECURE copy to UHCP via fax to our secure fax at: 866-751-2449 or via SECURE email to qm-nm@uhc.com
- REMINDERS:
  - Provide complete details – including any resolution to the incident.
  - This is a legal document. It should be legible and not contain blank areas
- REQUIRED INFO:
  - Document on page 2, Section 5 which state agencies were notified.
  - In the “other” section document if agency was reported to APS/HSD/DOH and if so, the date.

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Cultural Competency

- UHCP recognizes cultural competency as a necessary component of member rights. It is our desire to integrate cultural competency into all systems of UHCP including quality improvement efforts.
- Physicians and health care providers should be culturally sensitive to the diverse populations they serve. All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the member's cultural heritage and appropriately utilizes natural supports in the member's community.
- For additional details regarding Cultural Competency and resources available, refer to the Provider Administrative Manual.

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Provider Administrative Manual

- Intended to be used as a reference guide for UHCP providers and their office staff.
- Information is current as of the date it was published; may be modified at any time.
- In the event of a conflict or inconsistency between the Provider Agreement and the manual, the provisions of the Provider Agreement will control.
- Available online at:

http://www.uhccommunityplan.com/health-professionals/NM/provider-information

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Regulatory Compliance

- UHC Community Plan Compliance Office
  - Buffie Saavedra, Director
  - Veronica Esparza, Compliance Manager
    - Regulatory Updates
    - Waste, Fraud & Abuse
    - Reporting

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Fraud, Waste & Abuse

Providers requirements are:

- Comply with all applicable federal, state and local laws, rules and regulations,
- Notify UHCP of any credentialing/licensure change,
- Maintain professional standards,
- Maintain and furnish records and documents as required by law, rule, and regulation,
- Abide by contract provisions to avoid termination of the contract,
- Self report errors in which fraud has unknowing been committed,
- Report cases in which members are suspected of fraud,
- Refrain from engaging in kickbacks.

Refer to the Provider Administrative Manual for additional details regarding Fraud & Abuse requirements.

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False Claims Act

- Contracted providers are required by contract to train their staff on the following aspects of the federal False Claims Act provisions:
  - The administrative remedies for false claims and statements;
  - Any state laws relating to civil or criminal penalties for false claims and statements;
  - The whistleblower protections under such laws.
- Refer to the Provider Administrative Manual for additional details regarding False Claims Act requirements.

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Confidentiality

- Providers and their staff are required to adhere to all federal privacy standards, state laws, rules, and regulations regarding the safeguarding and release of confidential member information.
- Providers are required to comply with the HIPAA privacy regulations.
- Refer to the Provider Administrative Manual for additional details regarding Confidentiality requirements.

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Fraud/Waste/Abuse Reporting

Please report allegations of CoLTS fraud, abuse or waste on the UHCP CoLTS FWA Form.

- It is available on the UHCP website
- Confidential email to UHCPcompliance@uhc.com or fax to 1.866.223.5285.
- There are five sections to complete. Please provide as much information as possible (i.e., dates, first and last names, addresses, phone numbers, etc...).
- If there are any allegations against a PCO caregiver please include the name of the PCO agency too.
- Please call Veronica Esparza at 505.449.4156 with any questions.

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When to Use the FWA Form

Examples:

Member:

- Lending UHC Community Plan CoLTS ID card to someone who is not entitled to it
- Making false statements to receive medical or pharmacy services
- Pretending to be someone else to receive services

Provider:

- Providing services to patients that are not medically necessary
- Balance billing a Medicaid member for Medicaid services
- Double billing or improper coding of medical claims
- PCO caregivers falsifying timesheets

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Claims & Reimbursement

Billing UHC Community Plan (NM)

Providers can bill UHC Community Plan CoLTS via paper claims or electronically.

- Electronic claims can be submitted to electronic payer code 87726

- Paper claims can be sent to:

  UHC Commmunity Plan of New Mexico
  PO Box 31350
  Salt Lake City, UT 84131-0350

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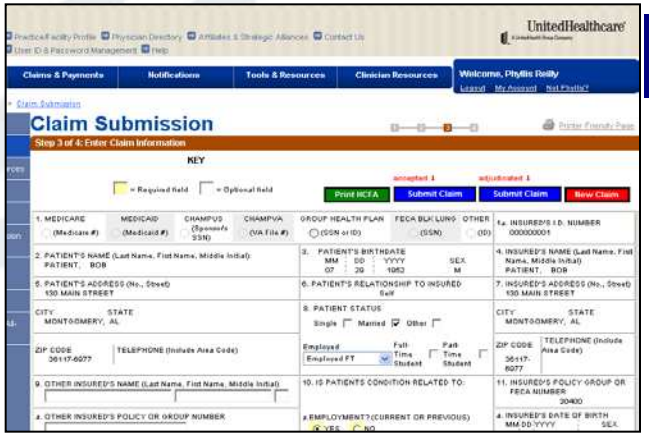
Electronic Claims Submission - No Charge Option

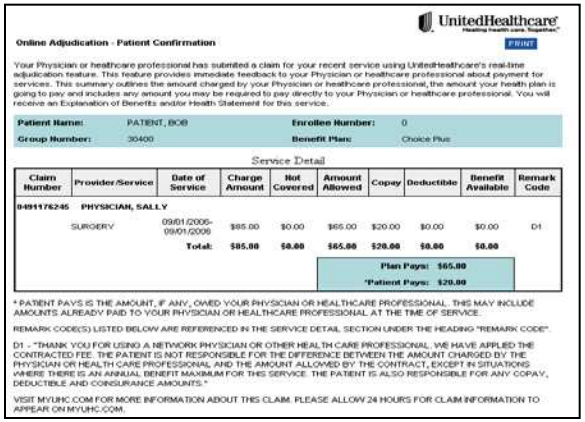
UnitedHealthcareOnline.com – It's FREE!

- Ideal single-payer claim submission option for offices with low claim volume
- Direct data entry & connection with UnitedHealthcare's claim system
- Real-Time Adjudication (RTA) on many claims submitted
  - Patient confirmation – included with RTA
- No Practice Management system needed
- Professional claims only



Online Claim form

Patient confirmation form



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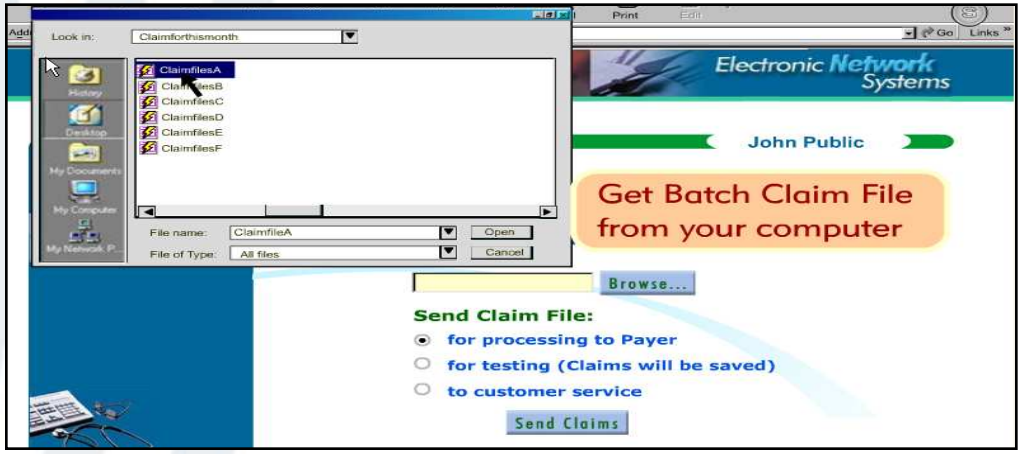
Electronic Claims Submission - Nominal Charge Option

All Payer Gateway from Ingenix *(nominal charge)*



A SINGLE POINT OF CONNECTION
UNITEDHEALTHCARE ONLINE
all-payer gateway

- Discounted multi-payer clearinghouse arrangement
- Web-based application
- Batch and Direct Data Entry options available
- Connections to over 1,700 insurance carriers, managed care companies and governmental payers

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What's the Best Option?

Suite of Tools	Single Payer	Multi-Payer	Free Service	Batch	Direct Data Entry	Real Time Claim Adjudication
UnitedHealthcareOnline All Payer Gateway		✓		✓	✓	
UnitedHealthcare Online®	✓		✓		✓	✓

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Benefits of Electronic Claims Submission

>> Faster

- Reduces claim processing time
- Generates your payment more quickly

>> More Accurate

- Missing or inaccurate claim data can be found at submission
- Increased auto-adjudication means better claim payment accuracy

>> Streamlined … Efficient … Environmentally Friendly

- Eliminate time spent preparing manual claims
- Saves paper/trees and dollars spent on paper

Visit **UnitedHealthcareOnline.com** >Tools & Resources>EDI Education for Electronic Transactions

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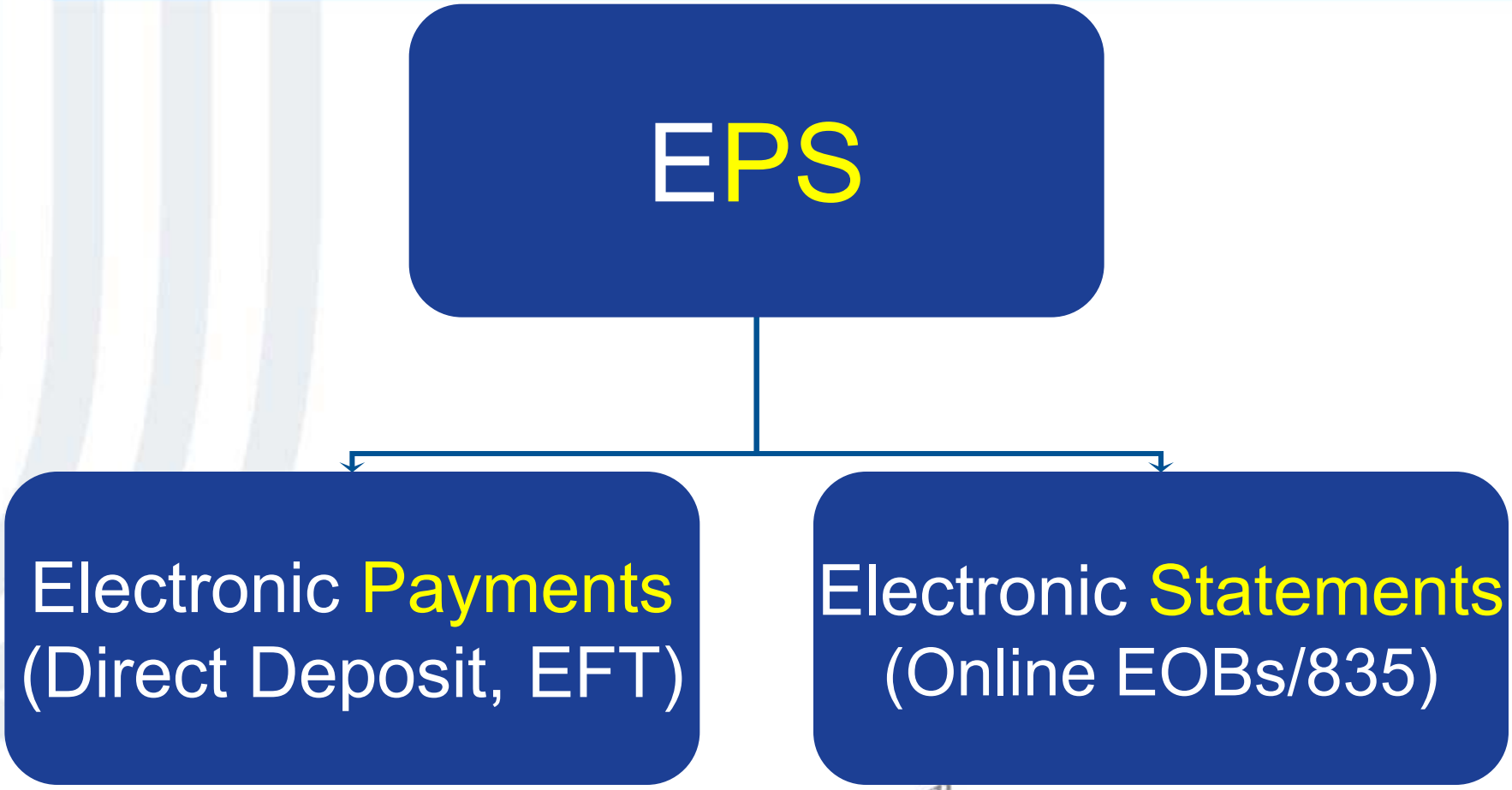
EPS – What Is It?



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Electronic Payments & Statements (EPS)

- ☑ EPS is the standard way for UnitedHealthcare to pay claims
- ☑ EPS reduces administrative costs
  - Reduces postage/paper costs
  - Eliminates lockbox/check deposit fees
  - Reduces manual work
- ☑ EPS is secure

Did you know that one tree can produce 8,333 pieces of paper (16 reams*)?

In 2008 UnitedHealthcare generated 50 million paper EOBs/checks, using 6,000 trees!

*Source: dolphinblue.com

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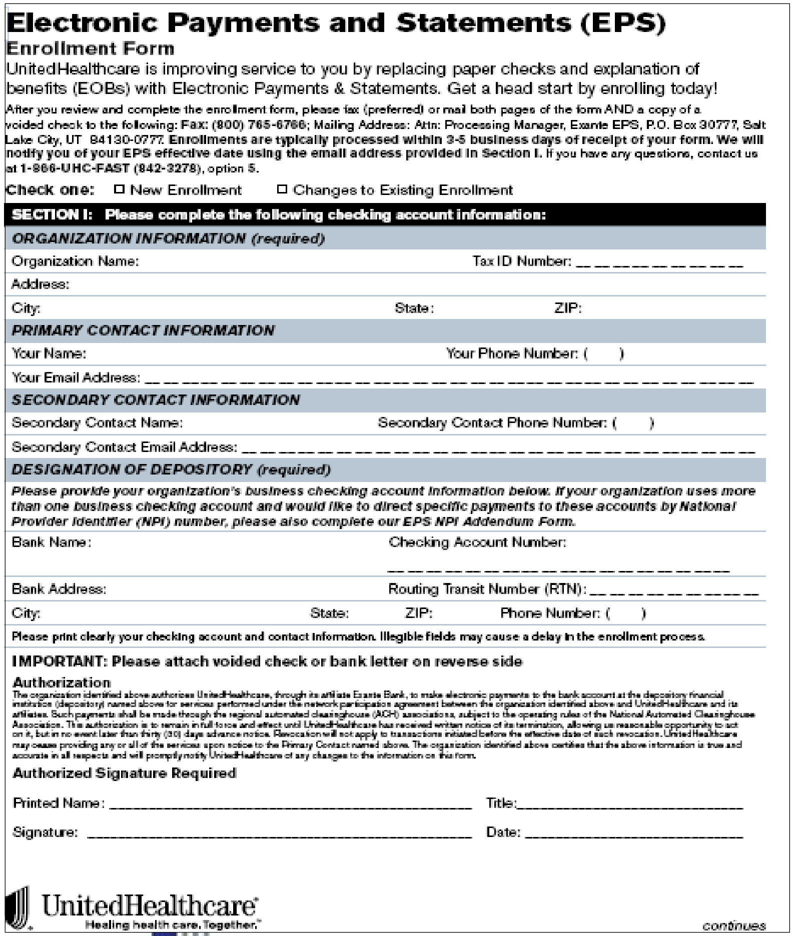
EPS Activation….
Easy as 1-2-3

How to get started:

- Enroll online or complete and fax the paper enrollment form to the fax number located on the top of the form.

- *Be sure to populate the Email Notification field!*



Electronic Payments and Statements (EPS)

Enrollment Form

UnitedHealthcare is improving service to you by replacing paper checks and explanation of benefits (EOBs) with Electronic Payments & Statements. Get a head start by enrolling today!

After you review and complete the enrollment form, please fax (preferred) or mail both pages of the form AND a copy of a voided check to the following: Fax: (800) 765-6766; Mailing Address: Attn: Processing Manager, Exante EPS, P.O. Box 30777, Salt Lake City, UT 84130-0777. **Enrollments are typically processed within 3-5 business days of receipt of your form. We will notify you of your EPS effective date using the email address provided in Section I.** If you have any questions, contact us at **1-866-UHC-FAST (842-3278)**, option 5.

Check one: ☐ New Enrollment ☐ Changes to Existing Enrollment

SECTION I: Please complete the following checking account information:

ORGANIZATION INFORMATION (required)

Organization Name: Tax ID Number: __ __ __ __ __ __ __ __ __

Address:

City: State: ZIP:

PRIMARY CONTACT INFORMATION

Your Name: Your Phone Number: ( )

Your Email Address: __

SECONDARY CONTACT INFORMATION

Secondary Contact Name: Secondary Contact Phone Number: ( )

Secondary Contact Email Address: __

DESIGNATION OF DEPOSITORY (required)

Please provide your organization's business checking account information below. If your organization uses more than one business checking account and would like to direct specific payments to these accounts by National Provider Identifier (NPI) number, please also complete our EPS NPI Addendum Form.

Bank Name: Checking Account Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Bank Address: Routing Transit Number (RTN): __ __ __ __ __ __ __ __ __

City: State: ZIP: Phone Number: ( )

Please print clearly your checking account and contact information. Illegible fields may cause a delay in the enrollment process.

IMPORTANT: Please attach voided check or bank letter on reverse side

Authorization

The organization identified above authorizes UnitedHealthcare, through its affiliate Exante Bank, to make electronic payments to the bank account at the depository financial institution (depository) named above for services performed under the network participation agreement between the organization identified above and UnitedHealthcare and its affiliates. Such payments shall be made through the regional automated clearinghouse (ACH) associations, subject to the operating rules of the National Automated Clearinghouse Association. This authorization is to remain in full force and effect until UnitedHealthcare has received written notice of its termination, allowing us reasonable opportunity to act on it, but in no event later than thirty (30) days advance notice. Revocation will not apply to transactions initiated before the effective date of such revocation. UnitedHealthcare may cease providing any or all of the services upon notice to the Primary Contact named above. The organization identified above certifies that the above information is true and accurate in all respects and will promptly notify UnitedHealthcare of any changes to the information on this form.

Authorized Signature Required

Printed Name: ______________________ Title: ______________

Signature: ______________________ Date: ______________

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continues

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Timely Filing Limits

- UHCP requires that all initial claims must be submitted within 90 days (or per contract language) following the date that the services are rendered or the date of discharge.
- UHCP is always the payer of last resort and thus providers must bill any other insurance, including Medicare, first before submitting claims to us.
- Claims involving coordination of benefits must be submitted within 60 days from the date of the Explanation of Benefits (EOB) from the primary and/or secondary payer. Providers must attach a copy of the payer's EOB with their UHCP claim, even if the claim was originally denied.

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Clean Claim Definition

A clean claim is a claim that has all the required fields filled out correctly and is legible. Claims that are not completely filled out or are illegible will be returned unprocessed to the provider and are not considered as received by UHCP. Claims that have inaccurate or inappropriate information in the fields will be processed and denied. The provider can then resubmit a corrected claim for processing.

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Claim Payment Requirements

UHCP shall pay ninety-five percent (95%) of ***all Clean Claims*** from day activity providers, assisted living providers, and home care agencies including PCO and D&E waiver providers within a time period of no greater than fourteen (14) calendar days and ninety-nine percent (99%) of claims within a time period of no greater than twenty-one (21) calendar days, provided that such claims ***meet the definition of Clean Claims***, are submitted electronically and meet all HIPAA transaction standards.

Date of receipt is the date UHCP receives the claim as indicated by its date stamp on the claim. Date of payment is the date of the check or other form of payment.

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Reimbursement

Reimbursement:

- Based on the provider's contracted rate or State of New Mexico Medicaid reimbursement fee schedule.
- Reimbursement for performing a service or procedure is dependent on the provider obtaining required prior approvals.

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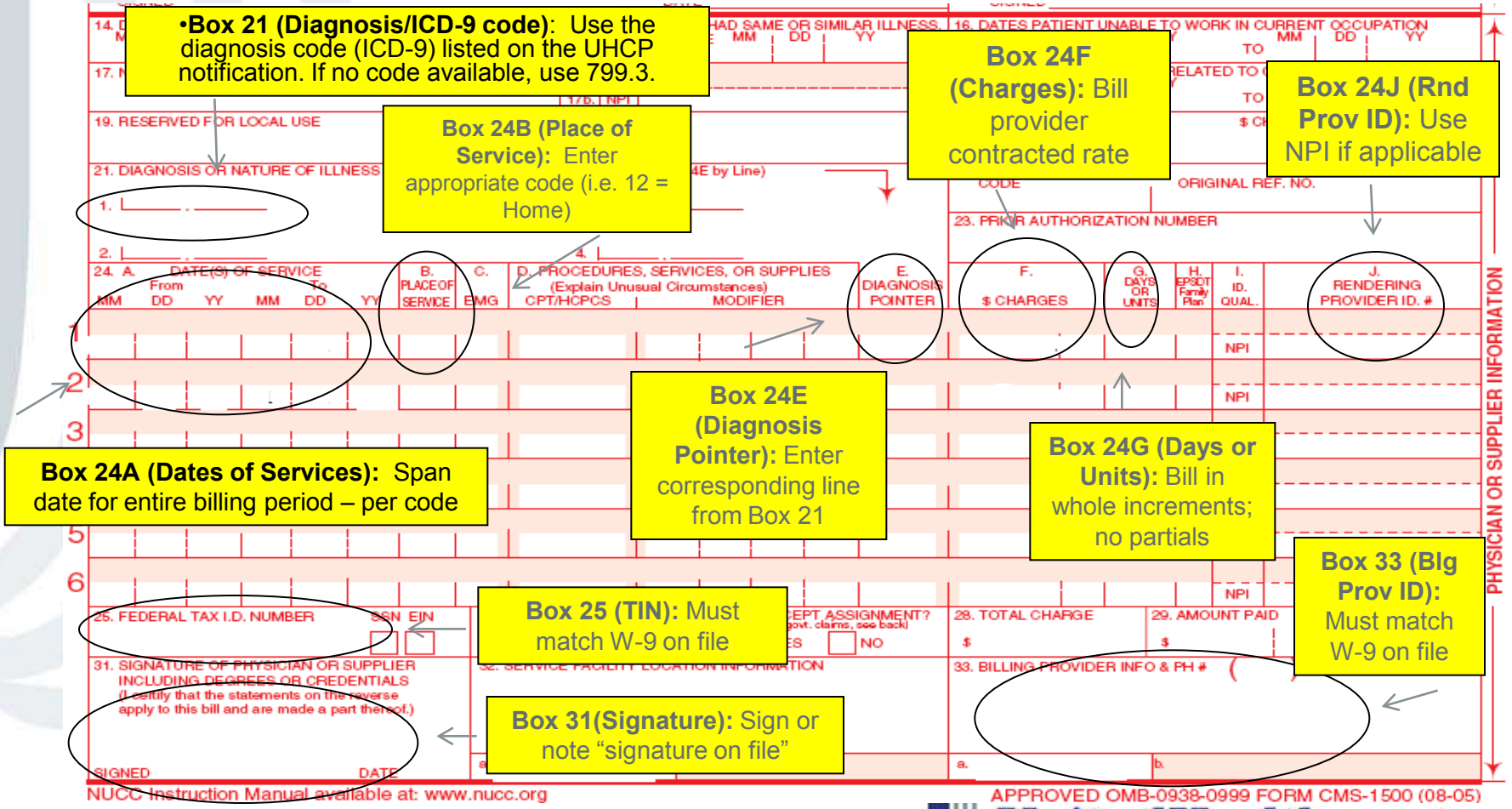
Claims Billing: CMS 1500



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CMS 1500: Instructions/Tips

Box 21 (Diagnosis/ICD-9 code): Use dx code as listed on UHCP Notification; If no code available, use 799.3

Box 24A (Dates of Services): Should match the span date on claim. When billing a single code (i.e. 99509) span date it on one line for the entire billing period. Do not bill the same code on two different lines for two time periods on the same claim. When billing extends past a month end or two notification periods – always create two separate claims.

Box 24B (Place of Service): Enter appropriate Place of Service (i.e. 12 for Home) Refer to the Provider Administrative Manual for complete list.

Box 24E (Diagnosis Pointer): Enter corresponding line from Box 21 (in most cases = 1)

Box 24F (Charges): Bill provider contracted rate

Box 24G (Days or Units): Bill units per code (i.e. 1 unit = 15 minutes for

Box 24J (Rendering Provider ID): Enter NPI if applicable

Box 25 (Federal TIN): Enter provider TIN or SS#; must match W-9 on file

Box 31 (Signature): Complete box 31(real signature or mark signature on file)

Box 33 (Billing provider info): Should always match the name you supplied on your w-9 form. (If you are Joe Smith dba Anonymous Home, Box 33 should reflect this as well.)

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UHC Dual Enrollee

- If you are billing HCBS services for an UHC Dual Enrollee (UHC Medicare primary/UHC Medicaid secondary):
  - Input the Medicaid ID in Box 1a (Insured's I.D. Number) and
  - Input the UHC Group # (32xxx) in box 11 (Insured's Group Number)

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Billing for Gross Receipts Tax

- **IMPORTANT REMINDER:**
  - Billing process for GRT will be based on your current contract status.

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Billing for GRT – Old Contract in Effect

For all DOS billed PRIOR TO the effective date of your new (GRT inclusive)contract:

- Bill GRT as a separate line item – do not "imbed"/include in procedure/HCPCS rate
  - S9999
  - 1 unit
  - 1 line per claim (VERY IMPORTANT)
  - Amount = GRT due for total claim charges (based on provider's city/county rate according to NM GRT rate table)
  - GRT is calculated based on the servicing location - if supplied in Box 32 of the claim – if no address listed in Box 32, GRT will be calculated on billing address in Box 33.

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Billing for GRT – New Contract in Effect

For DOS billed on or after the effective date of the new (GRT inclusive)contract:

- New contract rates are GRT inclusive
- Separate GRT billing (S9999) will no longer be necessary by the provider.
- Billing GRT after the new contract is in effective will result in claim lines being denied (based on contractual agreement)

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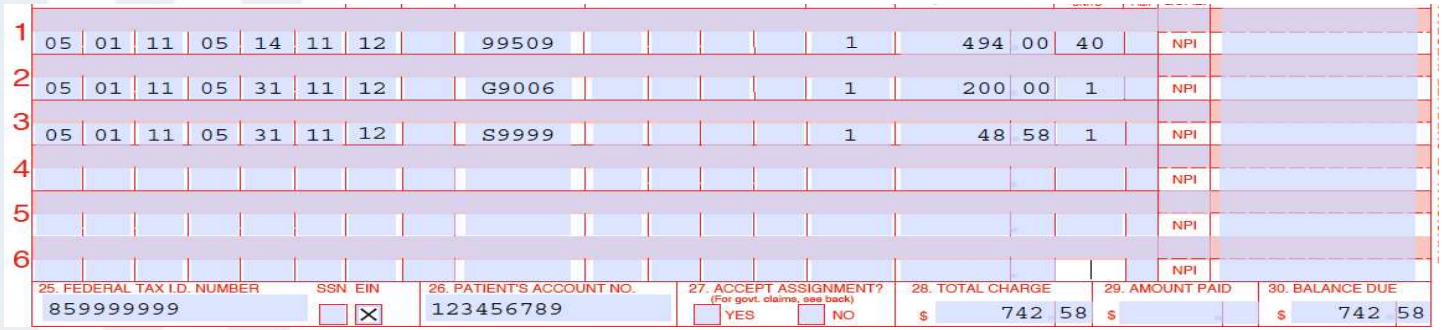
Billing Sample:
multiple codes, DOS span, with GRT

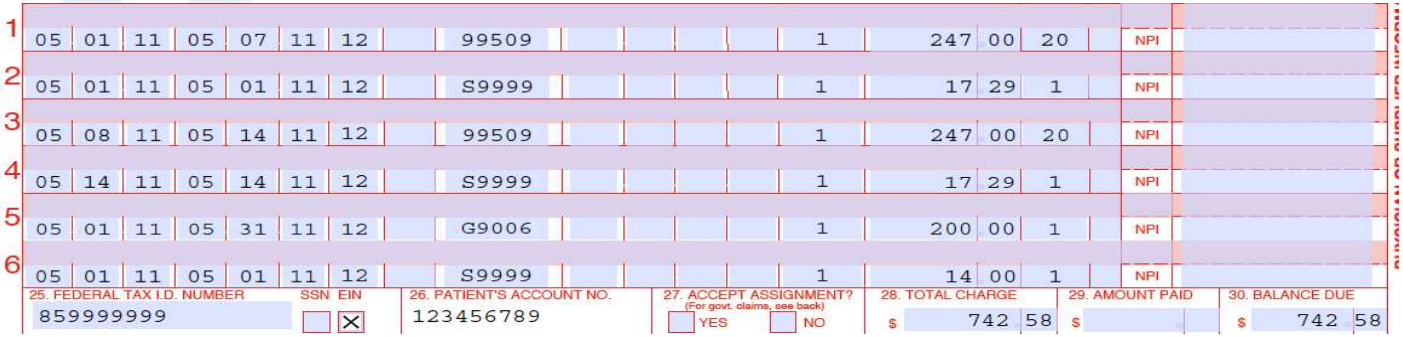
DO THIS:



1	05	01	11	05	14	11	12		99509				1	494 00	40	NPI
2	05	01	11	05	31	11	12		G9006				1	200 00	1	NPI
3	05	01	11	05	31	11	12		S9999				1	48 58	1	NPI
4																NPI
5																NPI
6																NPI

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
859999999		X	123456789	YES NO	$ 742 58	$	$ 742 58

NOT THIS:



1	05	01	11	05	07	11	12		99509				1	247 00	20	NPI
2	05	01	11	05	01	11	12		S9999				1	17 29	1	NPI
3	05	08	11	05	14	11	12		99509				1	247 00	20	NPI
4	05	14	11	05	14	11	12		S9999				1	17 29	1	NPI
5	05	01	11	05	31	11	12		G9006				1	200 00	1	NPI
6	05	01	11	05	01	11	12		S9999				1	14 00	1	NPI

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
859999999		X	123456789	YES NO	$ 742 58	$	$ 742 58

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Billing Sample:

multiple codes, DOS span, GRT inclusive/new contract in effect

DO THIS:

1	05	01	11	05	14	11	12		99509				1	528	58	40	NPI
2	05	01	11	05	31	11	12		G9006				1	214	00	1	NPI
3																	NPI
4																	NPI
5																	NPI
6																	NPI

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
859999999		X	123456789	YES NO	$ 742 58	$	$ 742 58

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Claim Inquiries - Contact Call Center

UHCP's customer service team (877-236-0826) should be the first point of contact for claim inquiries. The Customer Care Professional (CCP) can electronically resubmit claims on behalf of a provider for the following reasons:

Data Entry Error

- Comparison of hard copy claim to processing system shows that a data element of the claim was entered incorrectly
- Incorrect Provider pick-non-par OON provider picked when Par provider is available in system

Processor Error

- Processor did not follow Processing Instructions resulting in incorrect claims payment or denial; example timely filing guidelines not followed or co-pay applied incorrectly

Member Not Effective

- Claim denied for member not effective and research of the member's eligibility indicates that member was effective and claim needs to be reprocessed

Claim Denied for Authorization

- Claim denied for authorization and there is an authorization in the system

Contract Update

- Claim was processed under old contract rate, updated rate is now in the system and claim needs to be adjusted
- Claim denied as Medicaid non-covered code and Provider is stating that it is truly a Medicaid covered code

COB Issues

- Claim was denied requesting primary carrier EOB, Provider stating that member is not covered by any other insurance

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Claim Disputes – Provider Dispute Unit (PDU)

- Provider Disputes encompass 2 levels:
  - Reconsideration (1st level review) and
  - Appeal (2nd level review).
- If you receive reimbursement for a claim that you feel is incorrect and want to submit the claim for reconsideration, please complete the UHCP Reconsideration Form.
- Submit the completed form along with all requested documentation to:

  UHCP of New Mexico
  PO Box 31350
  Salt Lake City, UT 84131-1350
- A physician or health care provider must submit any dispute challenging an adverse determination within 12 months (365 days) from the end date of service or date of discharge.

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Reconsideration Requests

- When completing the Reconsideration Request, please include the original claim # and provide detailed description of what is being requested/desired outcome

- Always bill using the FED TIN that is contracted

- Do not request reconsideration for a code (i.e.GRT) if it was not billed on the original claim (submit corrected claim)

- Check the notification upon receipt to verify complete and correct, then bill the correct code as indicated on the notification

- Bill the one claim line per code for the DOS span (i.e. do not bill same code on multiple lines)

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Corrected Claim Submissions

- If you are aware of a claim that needs to be corrected due to data entry error (i.e. incorrect hours submitted, gross receipts not billed, etc.) You can submit a corrected claim.
- All submissions of corrected claims should include, at a minimum, the following information:
  - Corrected claim form with "Corrected Claim" *written at the top* of the CMS-1500 paper claim form
  - Claim number written in box 22
  - Copy of the remittance advice from the denied or incorrectly paid claim
  - Corrected claims should be sent to:

UHCP of New Mexico
P.O. Box 31350
Salt Lake City, UT 84131-0350

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Refund Process

- Refunds that should be sent to UHCP due to self identified overpayments should be sent to:

UHCP New Mexico/United Healthcare
PO Box 740804
Atlanta, GA 30374-0804

- Be sure to include a copy of the original PRA, original claim #, etc to insure proper application of the refund

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Claim Audit Review

- Claims are subject to post-processing review and audit.
- First letter/recoupment request will initially come from UnitedHealth Group Recovery Services
  - Provider has 90 days to appeal request
  - IMPORTANT NOTE: If you disagree with the assessment, follow the instructions listed in the letter or contact the representative listed on the letter to preserve your appeal rights.

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Claim Audit Review, cont'd

If initial letter from UHG Recovery Services is not responded to or appealed, issue will be escalated to Johnson & Roundtree

- Provider will need to respond to J&R Recovery Agent listed on the letter

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Provider Grievances

•Providers have the right to file a grievance if they are dissatisfied with a component or components of UHCP's service. Provider grievances are not related to claim disputes. To initiate the grievance, the provider should call their Provider Advocate or the Customer Call Center at **1-877-236-0826** to initiate the process.

•The State of New Mexico requires that UHCP attempt to resolve provider grievances or appeals within 30 calendar days. If the provider grievance or appeal is not resolved within 30 calendar days, UHCP is required to request a 14 day extension from the provider

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Common Claim Denials

Notification Required - 026

- Be sure that you received an UHCP Notification or Authorization prior to rendering services that require authorization/notification (Refer to Notification Guide).
- For attendant care hours, call the SCA team. For authorizations, call the UM team.
- UHCP does not issue retro-authorization or notifications.
- If you feel that you have received the denial in error (i.e. notification is on file) contact Customer Service to have the claim electronically resubmitted.

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Member Not Eligible - 051

- Check eligibility with UHCP (via call to Customer Service or via United Healthcare Online website) or via the state portal.
- If member does show UHCP, contact or request that Customer Service resubmit the claim electronically.

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Before Member Eff Date - 041

- Check eligibility with UHCP (via call to Customer Service or via United Healthcare Online website) or via the state portal.
- If member does show UHCP eligibility, contact or request that Customer Service resubmit the claim electronically.

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Eligibility Doesn't Match What to do….

- If NM Medicaid Portal and UHCP Portal do not match on a member's eligibility, contact UHCP Customer Service and notify the rep of the discrepancy. They can initiate the request to Operations to have the issue reviewed and resolved; and deal with any corresponding claim issues.

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Provider Resources & Forms

Get Acquainted with UHCOnline

- Tools & Training
  - Seminars
    - Getting Started with UHCOnline
      - Upcoming dates: 1st Thursday of each month
    - EPS (Electronic Payments & Statements)
      - Upcoming dates: 3rd Thursday of each month
    - EDI 101 – Basics and Beyond
      - Upcoming dates: 2nd Tuesday of each month
  - Tutorials
  - Quick Reference
  - Continuing Education
  - Step by Step Help

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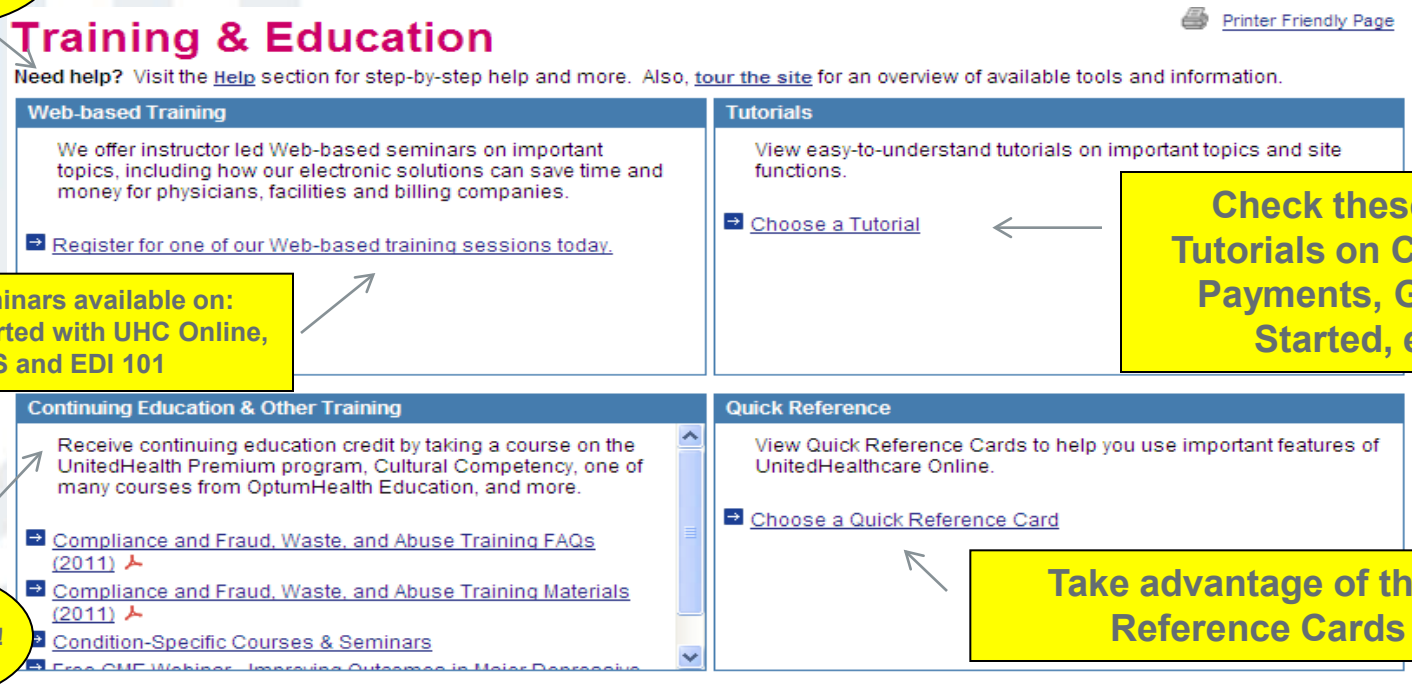
Get Acquainted with UHCOnline

Go to: www.unitedhealthcareonline.com

Tools & Resources > Training & Education

Step by Step Help is available!!



Web seminars available on: Getting Started with UHC Online, EPS and EDI 101

Check these out! Tutorials on Claims & Payments, Getting Started, etc.

CE Training!!

Take advantage of the Quick Reference Cards too!

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UHC Community Plan Website

- Claims, Forms & Manuals
  - Provider Administrative Manual
  - Provider Forms
  - Billing and Reference Guides
  - Training Presentations

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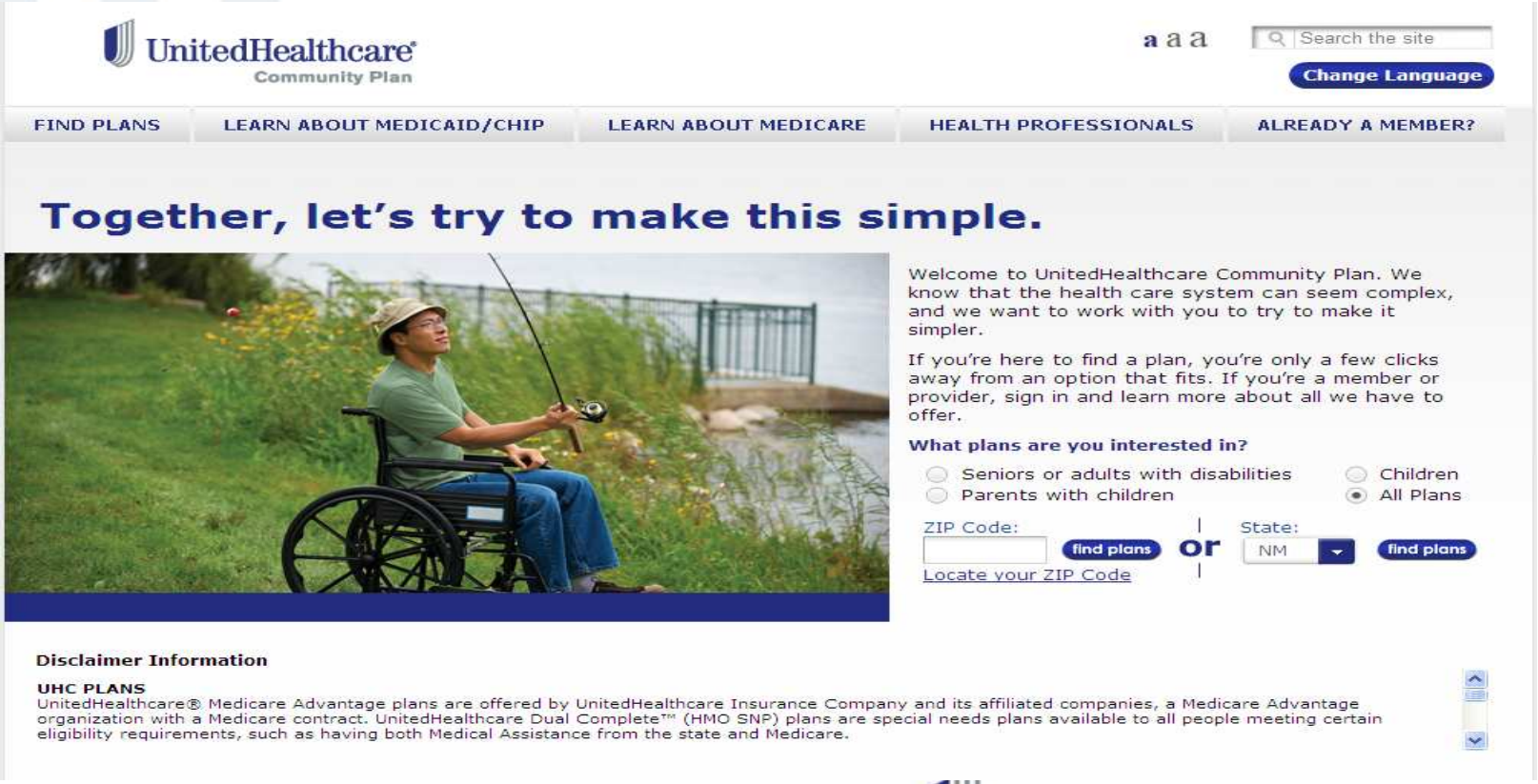
www.uhccommunityplan.com

NEW LOOK!!!!



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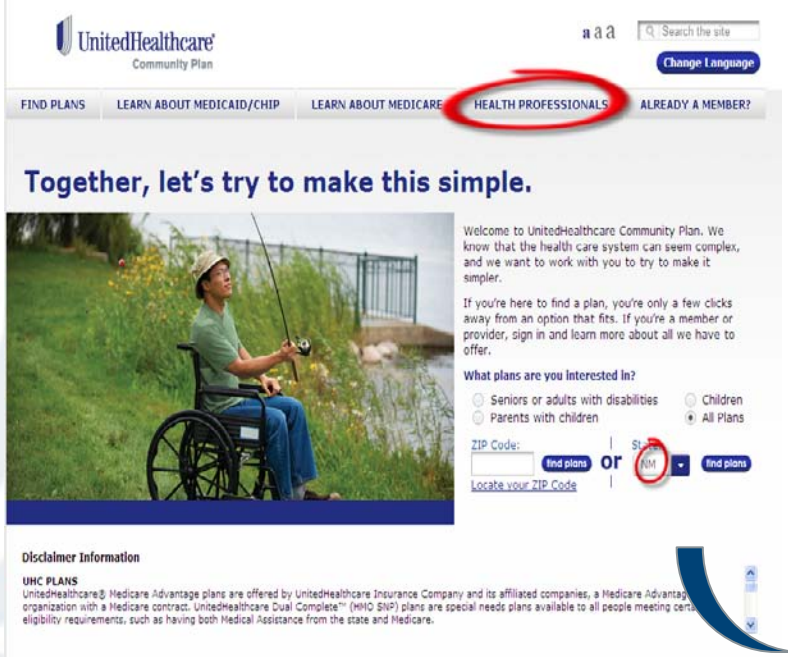
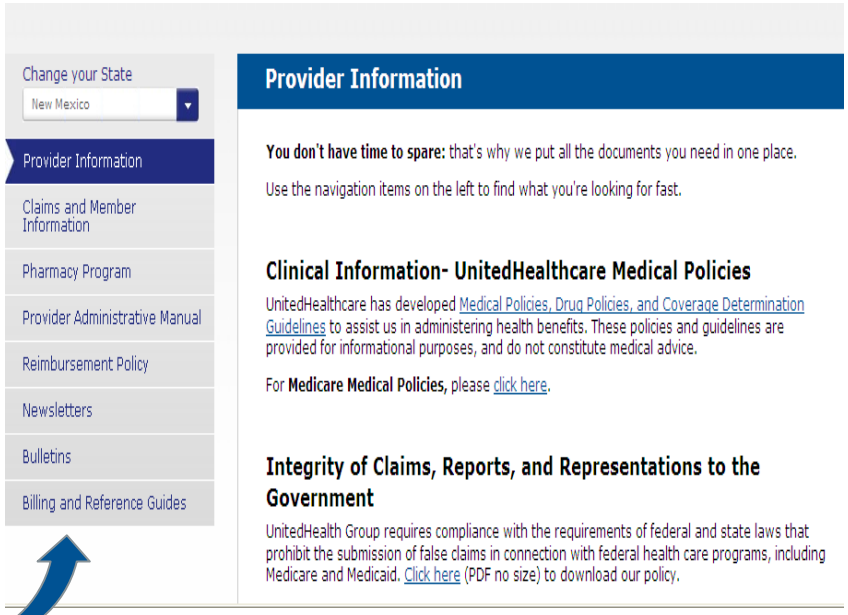
UHCP Website for Healthcare Professionals

Your source for CoLTS specific information: Provider Manual, Forms & QRG:





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Conclusion

We have covered:

- Where to locate changes to the CoLTS program
- UHC Community Plan's Member Benefits
- UHC Community Plan's Service Coordination & Utilization Management
- Provider Role & Responsibilities
- Claim submissions processes and how to work common denial codes
- Where to locate various handouts and resources to assist you in your role.

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What's Next??

- HCBS Billing Training Sessions
  - Monthly via WebEx (4th Tuesday of each month)
- HCBS Quarterly Training by Region
  - Program/Functional information January/February, 2012
    - Stay tuned for additional details, etc

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Thank You for all you do!

(PS: don’t forget to take the survey!!)

“Alone we can do so little; together we can do so much.” Helen Keller

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Q & A

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