Welcome
Optum Alaska

Utilizing Alaska Optum Provider Portal to Submit Adjusted,Corrected, or Voided Claims

Presented by Lisa Brown and Ryan Bender

March 9, 2022

Agenda

1. Optum Payment Cycles
2. Alaska Optum Provider Portal
3. Claim Status Summary
4. How to adjust, correct, and void claims
5. Reading a Provider Remittance Advice
6. Top 5 Trending Denials
7. Questions and Answers

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Optum Pay Cycles

Exciting changes to increase frequency of payments for AK

The Optum Behavioral Health payment schedule changed on February 10, 2022. The current Electronic Fund Transfer (“EFT”) payment schedule pays twice a week.

Direct deposits are moving to four times a week, on Mondays, Wednesdays, Thursdays, and Fridays.

Claim Processed before 5 p.m. on:	Payment data sent to Optum Pay	Optum Pay Processing	Settled in Provider Account/Direct Deposit Date
Tuesday	Tuesday	Wednesday	Friday
Wednesday	Wednesday	Thursday	Monday
Thursday	Thursday	Friday	Monday
Friday	Friday	Monday	Wednesday
Saturday	Monday	Tuesday	Thursday

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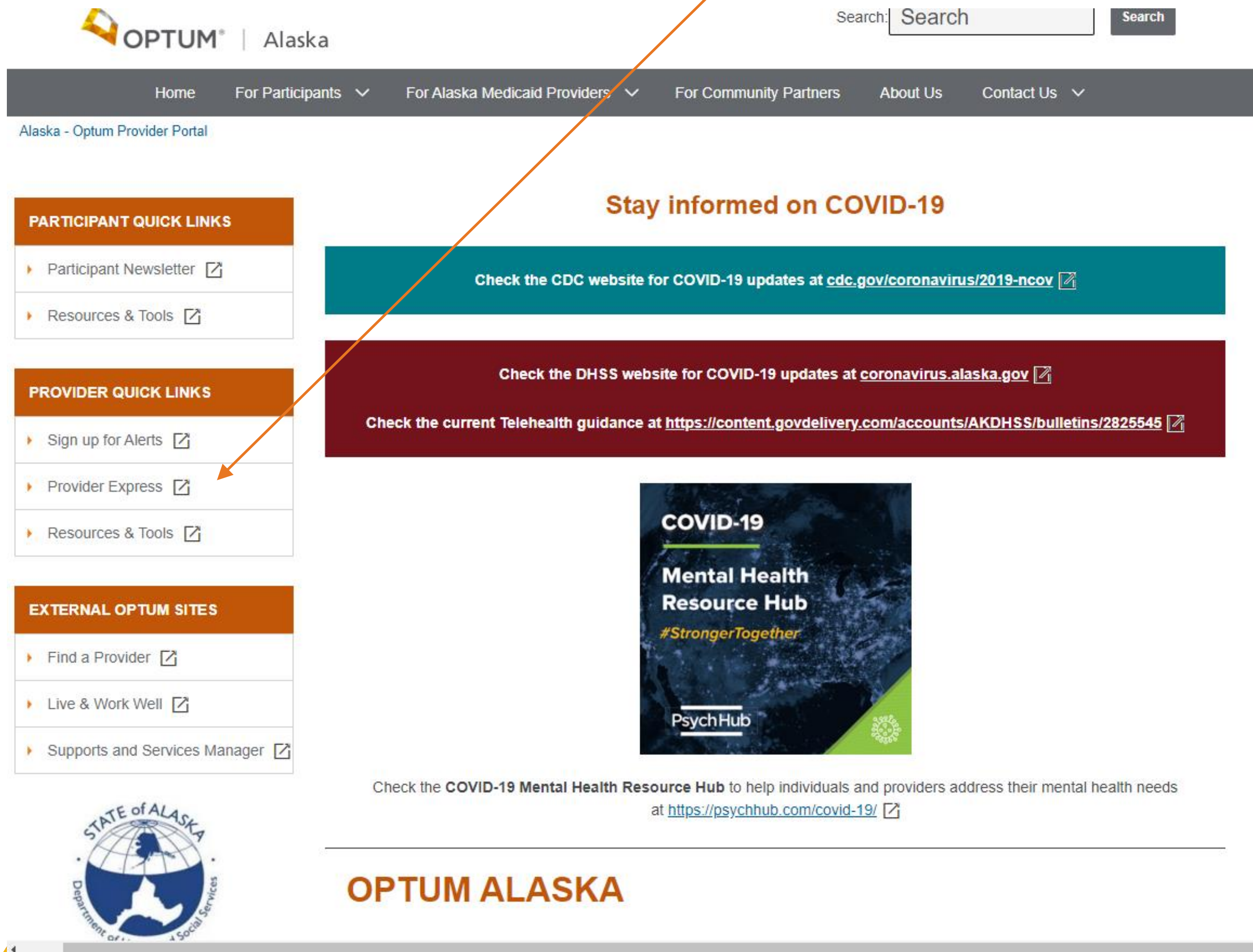
Alaska Optum Provider Portal

Alaska Optum Provider Portal

Alaska - Optum Provider Portal   Click on Provider Express.



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Optum Provider Express

Optum - Provider Express Home

Providers can view claims by clicking on Claims or on Log In.

Log In | First-time User | Global | Site Map

OPTUM® Provider Express

Search: Search [Search]

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Optum - Provider Express Home

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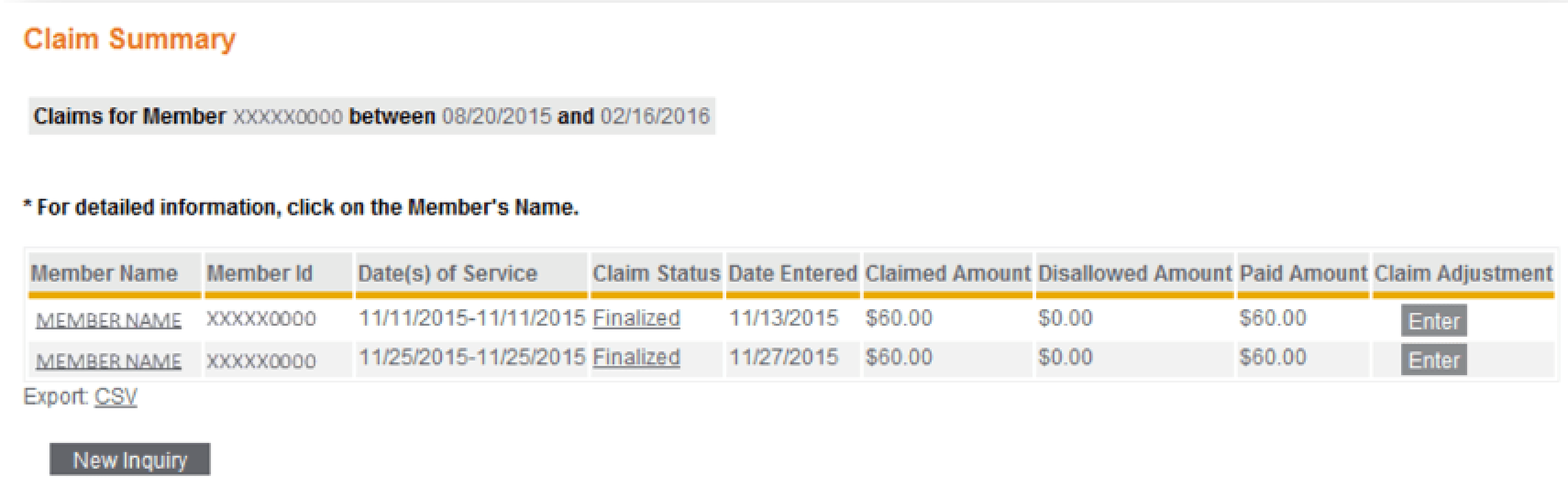
Claim Status Summary

Claim Summary

Claims will display with the parameters of the search criteria entered.

Users have the option to click on the member's name to display a detailed list of that claim.

Claims not fully processed will show Pending in the Claim Status.



*If claim amount is not what is expected, click the {Enter} button

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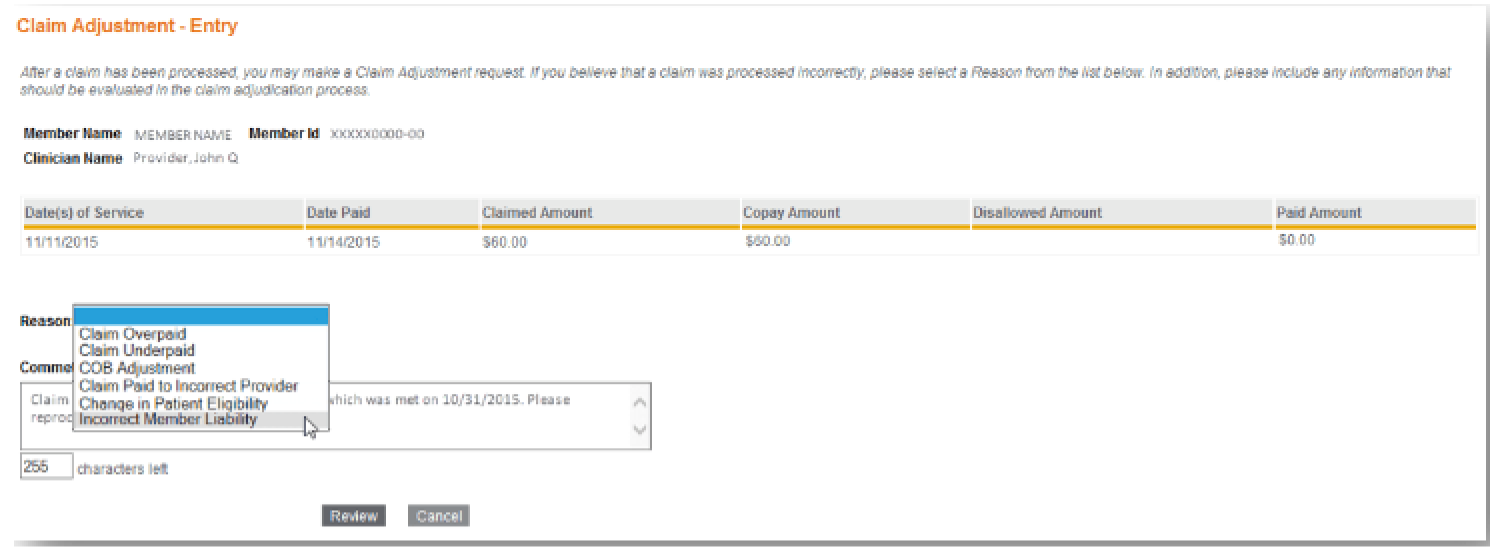
Adjusting a Claim

Claim Adjustment Request

The claims adjustment screen displays the reason for the request and is selected from the drop-down list.



In the comments box, enter a detailed explanation of why the request is being made.

Click the {Review} button to view this request prior to submission.

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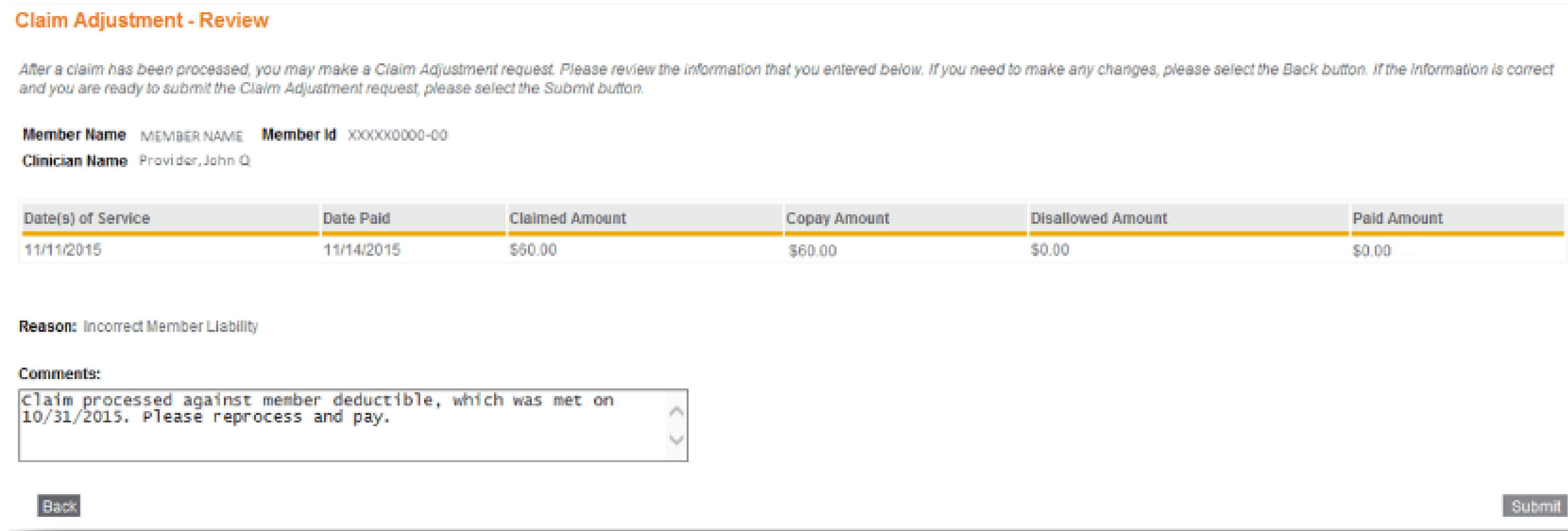
Claim Adjustment Review

Users will review the information they just entered, prior to submitting the claim adjustment.

When the request is complete, click the {Submit} button.



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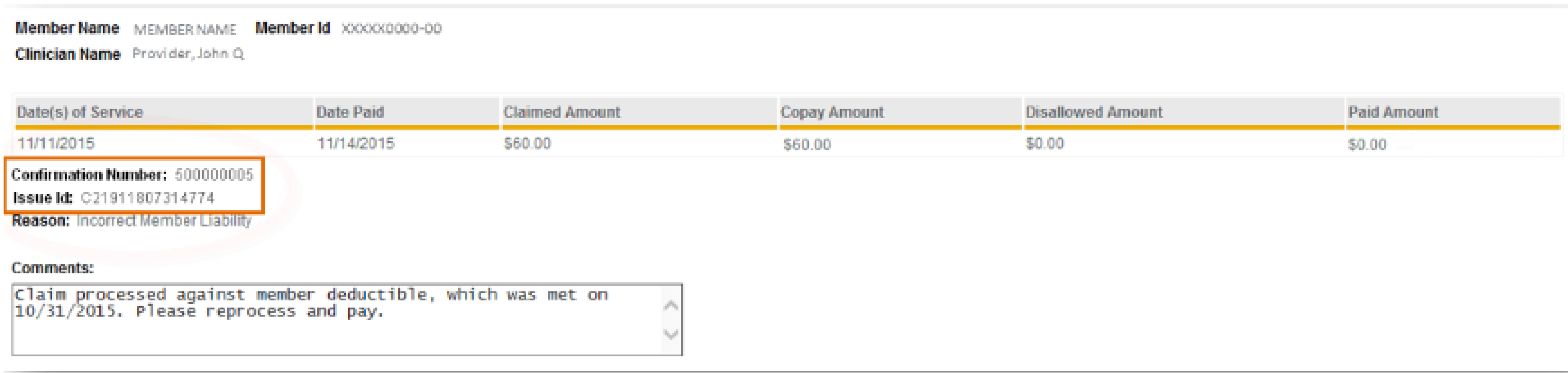
Completed Claim Adjustment Request

Users will receive a Confirmation Number and an Issue ID number for each submission.

- User may use the Confirmation Number to check the status of a request online
- The Issue ID may be given to any claim representative to check the status of a claim by phone



Member Name MEMBER NAME **Member Id** XXXXX0000-00
Clinician Name Provider, John Q

Date(s) of Service	Date Paid	Claimed Amount	Copay Amount	Disallowed Amount	Paid Amount
11/11/2015	11/14/2015	$60.00	$60.00	$0.00	$0.00

Confirmation Number: 500000005
Issue Id: C21911807314774
Reason: Incorrect Member Liability

Comments:

Claim processed against member deductible, which was met on 10/31/2015. Please reprocess and pay.

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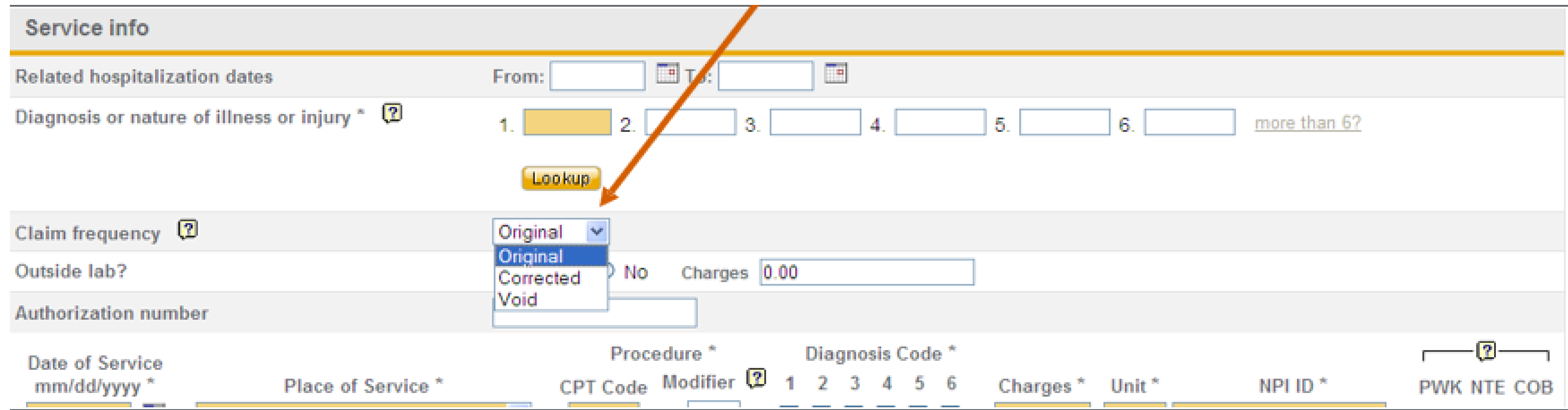
Correcting a Claim

Submitting Corrected Claims

- Regardless of the claim form (short or long), you do have the ability to submit a Corrected claim request as well, when a previously submitted claim had incorrect information on it

- In the Service info section, the “Claim frequency” code is what is used to determine the type of claim you are filing. Provider Express defaults to "Original" but you can change it to "Corrected"



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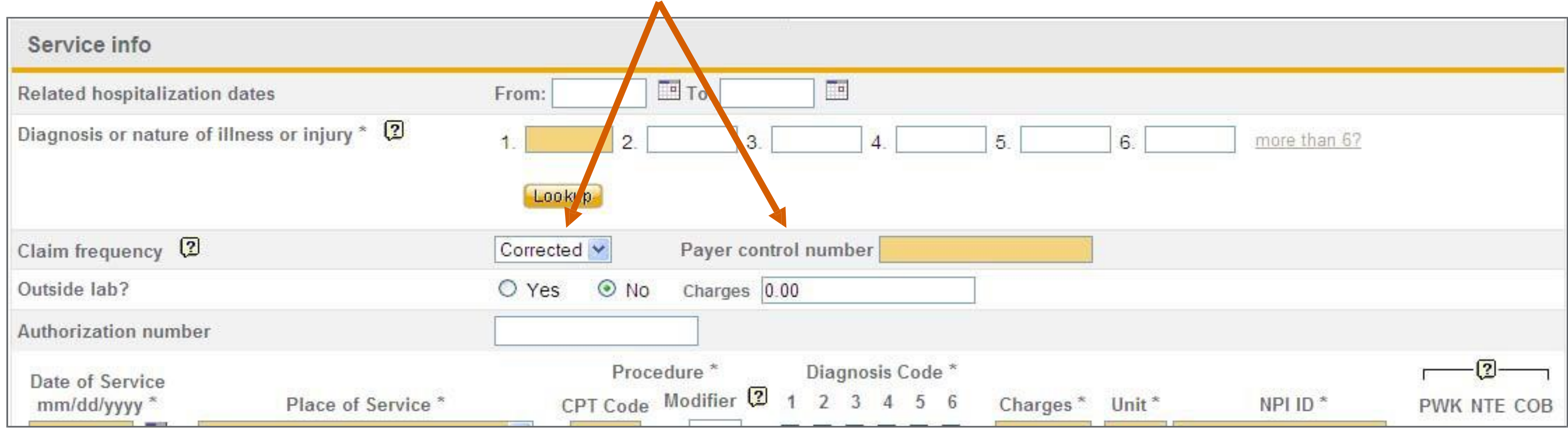
Submitting Corrected Claims (Continued)

Claim frequency - To submit a Corrected claim, you will need to enter the Claim Number found on the claim record in **Claim Inquiry.** The claim number will also be reported on the paper remittance advice or electronic 835 file. You cannot submit a **Corrected** claim until a claim number has been assigned.



"Payer control number" = Claim number

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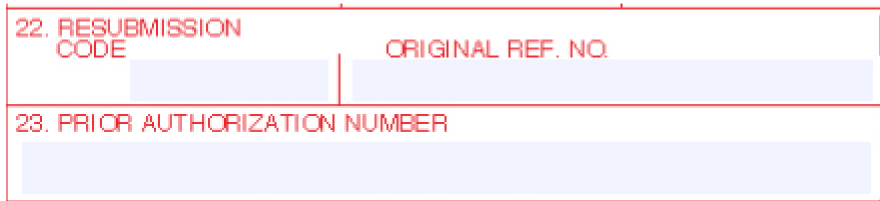
How to submit a corrected paper claim

CMS-1500 (Professional Claims)

Box 22

- Resubmission Code
  - Enter frequency code "7“
- Original Reference Number
  - List the original claim number that you are correcting


22. RESUBMISSION CODE

22. RESUBMISSION CODE	ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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Voiding a Claim

When should you Void a Claim

Utilizing voids is efficient if there are multiple corrections needed on one claim.

A void request will void all paid lines on the original claim form. Every line is reprocessed.

- A paid line has the payment voided and deducted from other payments due
- A denied line remains denied
- A pending line is denied. A void transaction is shown on the Remittance Advice as a payment deduction from payment that may be due. Once the void appears on the Remittance Advice, the services may be resubmitted

If the original claim reference number is not shown in the void request, it will not be processed and will appear on your Remittance Advice as an error. Once a claim has been voided, it cannot be reversed and repaid. You must submit a new claim.

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Provider Remittance Advice

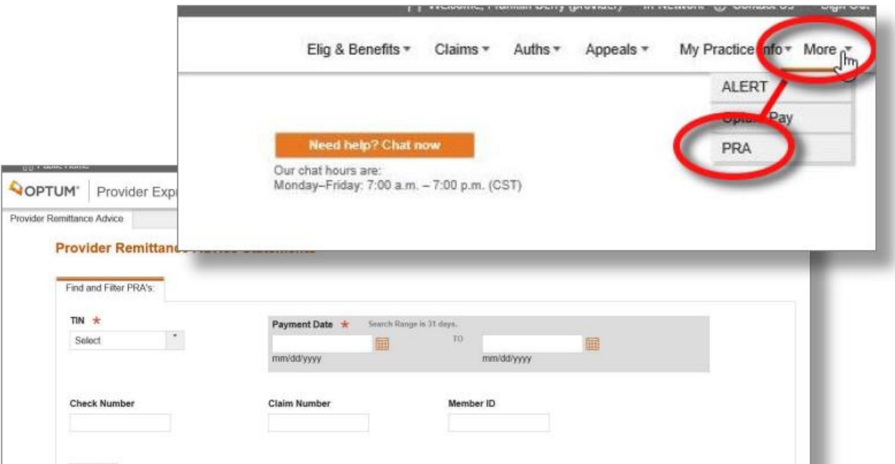
Find a Remittance Advice in Provider Express

Click on the PRA link under "More."

QUICK REFERENCE GUIDE

FINDING PROVIDER REMITTANCE ADVICES (PRA) IN THE SECURE TRANSACTIONS AREA OF PROVIDER EXPRESS

In order to help streamline your financial management and claim reconciliation activities, you can access up to 24 months of payment information at no cost. Below outlines how easy it is to find your PRAs.



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Find a Remittance Advice in Optum Pay

Click on the Payer PRA link. When the PDF icon appears, it is ready to open.

(Click on column hea

835 / EPRA	Payer PRA
835 | PDF	PDF
835 | PDF	PDF
835 | PDF	PDF
835 | PDF	PDF
835 | PDF	[PDF icon]
835 | PDF	[PDF icon]
835 | PDF	[PDF icon]
835 | PDF	[PDF icon]

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Remittance Advice – Claim Summary Information

Claim Summary Information

Pat Ctrl # (1)	Patient Name / Subscriber Name (2)	Pat Rel (3)	Patient ID (4)
		EE	XXXXX

Claim Date (5)	Rend Prov (6)	Claim Numb (7)	Rend Prov ID (8)	Med Rec # (9)
02/15/2020 – 02/22/20				

Auth/Ref # (10)	Clm Chg (11)	Total Line Item Adj Amt (12)	Clm Payment (13)	Pat Resp (14)	Group/ Policy (15)	Contract (16)	DRG/ Wght (17)
	449.1	0.00	449.12	0.00			

#	Field	Description
1	Pat Ctrl #	Patient control number submitted by provider
2	Patient Name/Subscriber Name	Name of participant receiving the service
3	Pat Rel	Patient Relationship (if patient and participant are different)
4	Patient ID	Subscriber ID with first 7 digits masked
5	Claim Date	Date of service
6	Rend Prov	Rendering provider of services
7	Claim Number	System applied claim ID
8	Rend Prov ID	Rendering provider NPI or rendering provider's system ID
9	Med Rec #	Medical record number submitted by provider
10	Auth/Ref #	Service authorization number
11	Clm Chg	Total charge amount at the claim level
12	Total Line Item Adj Amt	Total claim adjustment at claim level
13	Clm Payment	Total claim payment at claim level
14	Pat Resp	Total participant responsibility
15	Group/Policy	Claim system group ID
16	Contract	Provider Agreement ID in Optum system
17	DRG/Wght	DRG and weight code (note: not required on CMS 1500 professional claim form)

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Remittance Advice – #7 Claim Number

<u>Optum Claim Number</u>
20|X|xxxxxxx|00

- Year the claim was received
- Claim submission method
  - X = Electronic
  - 0 = Paper Claim
- Claim document batch, number sequence
- Claim transaction type number
  - 00 = Original
  - 01 = Adjustment

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Remittance Advice – Service Line Information

Service Line Information

Line Ctrl #	DOS	Rev	Adj Prod/ Svc	Mod	Rend Prov ID	Units	Charge	Considered Charge	Adj Amt	Grp Cd	Clm Adj Rsn Cd	Payment	Remark Cd	Auth # / Ref #
1	02[illegible]20 – 02[illegible]20		H0023V1		xxxxx	2.00	56.14	56.14	0.00			56.14		
2	02/16/2020 – 02/16/2020		H0023V1		xxxxxxxxxx	2.00	56.14	56.14	0.00			56.14		
3	02/17/2020 – 02/17/2020		H0023V1		xxxxxxxxxx	2.00	56.14	56.14	0.00			56.14		
4	02/18/2020 – 02/18/2020		H0023V1		xxxxxxxxxx	2.00	56.14	56.14	0.00			56.14		
5	02/19/2020 – 02/19/2020				xxxxxxxxxx									

#	Field	Description
18	Line control #	Claim line sequence number
19	Date of Service	From and through date of service for claim line
20	Rendering Provider ID	Rendering provider NPI or rendering providers facets ID
21	Auth /Ref #	Service authorization number
22	Revenue code	Revenue code (note: not required on CMS 1500 professional claim form)
23	Adjusted Prod/Service	Disallowed amount line level
24	Procedure code modifier	Modifier codes 2 – 4 billed on claim
25	Units	Number of units billed on claim
26	Charge	Total billed charges on claim
27	Considered Charge	Amount approved
28	Adjustment Amount	Disallowed amount line level
29	Group Code	CMS CAGC Claim Adjustment Group Code
30	Claim adjustment Reason code	CMS CARC Claim Adjustment Reason Code
31	Payment	Claim line paid amount
32	Remark Code	CMS RARC Remittance Advise Remark Code

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Provider Level Adjustments

Claim Summary Information

Pat Ctrl #	Patient Name / Subscriber Name	Pat Rel	Patient ID
[redacted]	[redacted]	EE	[redacted]

Claim Date	Rend Prov	Claim Number	Rend Prov ID	Med Rec #
07/15/2021 – 07/15/2021	[redacted]	[redacted]	[redacted]	

Auth/Ref #	Clm Chg	Total Line Item Adj Amt	Clm Payment	Pat Resp	Group/ Policy	Contract	DRG/ Wght
	50.00	50.00	0.00	50.00	15458		

Service Line Information

Line Ctrl #	DOS			Rend Prov ID				Auth # / Ref #			
	Rev	Adj Prod/ Svc	Mod	Units	Charge	Considered Charge	Adj Amt	Grp Cd	Clm Adj Rsn Cd	Payment	Remark Cd
1	07/15/2021 – 07/15/2021			[redacted]							
		T1016GT		0.00	50.00	50.00	0.00			50.00	
				0.00	0.00	0.00	50.00	PR	27	-50.00	N30
TOTALS:					50.00	50.00	50.00			0.00	

Provider Payment Information

Prov Adj Cd	Prov Adj ID	Remark Cd	Prov Adj Amt
		Total Adjustment	[redacted]
		Claim Total	[redacted]
		Prov Pay Amt	[redacted]

REMARK(S) LISTED BELOW ARE REFERENCED IN THE SERVICE DETAIL SECTION UNDER THE HEADING "Remark Cd"

F03 - (F03) We have processed these charges in coordination with Medicare's payment.

M77 - (B08) This place of service is inappropriate for this service.

N130 - (B05) Your Behavioral Health Plan does not cover this expense.

N30 - (SS) Termination via Member-level separation event.

aC8 - (aC8) This charge was originally processed with inaccurate information. This adjustment reverses the original transaction.

United Behavioral Health, operating under the brand Optum

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Provider Level Adjustments

Provider Payment Information

Prov Adj Cd	Prov Adj ID	Remark Cd	Prov Adj Amt
WO	202102911100006 - 20X532200800	OVR	-50.44
FB	202105151030004 - 21X262126600	OVP	470.45
FB	202106161030019 - 21X343022300	OVP	67.30
		Total Adjustment	487.31
		Claim Total	-487.31
		Prov Pay Amt	0.00

REMARK(S) LISTED BELOW ARE REFERENCED IN THE SERVICE DETAIL SECTION UNDER THE HEADING "Remark Cd"

AL3 - (AL3) This charge was originally processed using an incorrect Provider. This adjustment reverses the original transaction.

N30 - (SS) Termination via Member-level separation event.

N522 - (CDD) This claim is a duplicate of a previously submitted claim for this member.

N77 - (B62) Please provide the name, address, degree, license level for this service. If an MD, please include the specialty.

aLA - (aLA) This charge was originally processed with the incorrect claims data. This adjustment reverses the original transaction.

OVR - Overpayment Auto Recovery Amount

PSS - (PSS) Charge exceeds allowable rate for this service or code submitted is not on contracted fee schedule-contact Network Manager for correct code.

aC8 - (aC8) This charge was originally processed with inaccurate information. This adjustment reverses the original transaction.

aL3 - (aL3) This charge was originally processed using an incorrect Provider. This adjustment reverses the original transaction.

OVP - Overpayment Amount

You can save time and reduce paperwork and phone calls by going electronic. Our Site Satisfaction Survey data indicate that online transactions are easy to use and save time. Go to Provider Express today! www.providerexpress.com.

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Overpayment Letters

Submitting corrected or voided claims may result in an overpayment. If an overpayment occurs, you will be sent a letter addressing the overpayment. The letter will include:

- Provider/Member information including patient account and ID number
- Claim number and date of service
- What do I need to do
- How was I overpaid
- Where do I send the refund
- What if I don’t agree with this request

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Alaska Top 5 Trending Denials

1. Timely Filing
2. Duplicate Claim
3. Invalid Procedure Modifier Combination
4. Member Eligibility
5. Place of Service Inappropriate for Procedure

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Timely Filing

Timely Filing

Calculate Timely filing by counting the time between the date the service was rendered and the date the claim was submitted to Optum for payment.

AK Timely Filing of Claims

- All claim types must be filed within 12 months of the date services were provided to the patient
- Third party carrier claims
  - Provider must attach explanation of benefits documentation from the third-party carrier to the Alaska Medical Assistance claim
  - Providers must bill Alaska Medical Assistance within 12 months of the service date

Timely Filing Expired - Acceptable documentation must be attached to the claim upon resubmission. Examples of acceptable documentation include:

- A copy of the remittance advice (RA) page showing claim denial
- A copy of the in-process claims page of an RA
- Provider Express or other electronic claim submission transmission report
- Evidence of previous claim receipt by Optum within the timely filing period

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Timely Filing continues

Acceptable Extensions

- Court orders
- Administrative Hearings
- Good cause – (examples: Fire, Storm, Earthquake)
- Department committed an error on previous claim submission
- Claim was filed timely, but not processed

Filing Limits for Adjustments

Adjustment requests must be submitted within 60 days from the date of payment or within 12 months of the date of service if additional amounts are owed to the provider. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply.

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Duplicate Claim

Duplicate Claim

Definition:
Any claim submitted by a provider for the same service, provided to a covered individual, on a specified date of service, that was included in a previously submitted claim. If you feel a claim is denied a duplicate in error, request a review of the claim in question.
Duplicate claims projects are being completed for frequency 7 and 8 claim types.

When submitting a corrected claim be sure to include the original claim number along with selecting corrected claim type.
Taking the following steps can help you eliminate receiving a duplicate denial:

- Verify the claim has completed processing = (paid/denied)
    - This can be done by checking the remittance advice through Provider Express
- Verify the reason the initial claim did not allow payment
    - Examples of appropriate denials
    - Invalid diagnosis
    - Invalid NPI
    - Invalid Procedure/Modifier combo

A corrected claim will be required if modifications to claim are needed

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Invalid Procedure Modifier Combination

Invalid Procedure Modifier Combination

One of the common reasons your claims may be denied is for missing or invalid modifier combinations (procedure code is not consistent with the modifier you have used).

Although the procedure code is a valid procedure code and the modifier is a valid modifier IF the procedure and modifier combination is not appropriate to be used together, the line item will deny as an invalid modifier combination.

If a claim is denied for an invalid modifier combination, a *corrected claim will be required*. Records also may need to accompany the corrected claim in some situations.

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Primary Modifier Guidance Grids

Entering procedure code modifiers in the correct sequence is necessary for accurate claim payment amounts by Optum.

Entering procedure code modifiers in any other order then shown in the next grid will result in claim denials, underpayments and/or overpayments that must be refunded.

A corrected claim will be required. Records may need to accompany the corrected claim in some situations.

Optum Primary Modifier Guidance for Alaska Medicaid Community Behavioral Health Services as of 7.1.2020

Optum Primary Modifier Guidance for Alaska Medicaid 1115 Waiver Services as of 10.4.2020

Modifier Sequence for 1115 Waiver SUD Services 1/2

Optum Primary Modifier Guidance for Alaska Medicaid 1115 Waiver Services 4.6.2022

Service Title/Description	Service Code	Primary Billed Modifier #1	Modifier #2	Modifier #3	Modifier #4
Outpatient Services ASAM 1.0 - Individual	H0007	V1 - Demonstration			
Outpatient Services ASAM 1.0 - Individual (Telehealth)	H0007	V1 - Demonstration	GT - Telehealth		
Outpatient Services ASAM 1.0 - Group (Adolescent)	H0007	HQ - Group	HA - Adolescent	V1 - Demonstration	
Outpatient Services ASAM 1.0 - Group (Adolescent) (Telehealth)	H0007	HQ - Group	HA - Adolescent	V1 - Demonstration	GT - Telehealth
Outpatient Services ASAM 1.0 - Group (Adult)	H0007	HQ - Group	HB - Adult	V1 - Demonstration	
Outpatient Services ASAM 1.0 - Group (Adult) (Telehealth)	H0007	HQ - Group	HB - Adult	V1 - Demonstration	GT - Telehealth
Intensive Case Management	H0023	V1 - Demonstration			
Intensive Case Management (Telehealth)	H0023	V1 - Demonstration	GT - Telehealth		
Ambulatory Withdrawal Management	H0014	V1 - Demonstration			
Clinically Managed Residential Withdrawal Management	H0010	V1 - Demonstration			
Medically Monitored Inpatient Withdrawal Management 3.7 WD	H0010	TG - High Level	V1 - Demonstration		
Medically Managed Intensive Inpatient Withdrawal Management 4.0 WD	H0011	V1 - Demonstration			
Medically Managed Intensive Inpatient Services 4.0	H0009	TG - High Level	V1 - Demonstration		
Medically Monitored Intensive Inpatient Services 3.7	H0009	TF - Intermediate	V1 - Demonstration		
Community & Recovery Support Services - Group	H2021	HQ - Group	V1 - Demonstration		
Community & Recovery Support Services - Group (Telehealth)	H2021	HQ - Group	V1 - Demonstration	GT - Telehealth	
Community & Recovery Support Services - Individual	H2021	V1 - Demonstration			
Community & Recovery Support Services - Individual (Telehealth)	H2021	V1 - Demonstration	GT - Telehealth		
SUD Care Coordination	H0047	V1 - Demonstration			
SUD Care Coordination (Telehealth)	H0047	V1 - Demonstration	GT - Telehealth		
Peer-Based Crisis Intervention Services	H0038	V1 - Demonstration			
23-Hour Crisis Observation & Stabilization	S9484	V1 - Demonstration			
Mobile Outreach and Crisis Response Services	T2034	V1 - Demonstration			
Crisis Residential Stabilization	S9485	V1 - Demonstration			
Intensive Outpatient ASAM 2.1 - Group	H0015	HQ - Group	V1 - Demonstration		
Intensive Outpatient ASAM 2.1 - Group (Telehealth)	H0015	HQ - Group	V1 - Demonstration	GT - Telehealth	
Intensive Outpatient ASAM 2.1 - Individual	H0015	V1 - Demonstration			
Intensive Outpatient ASAM 2.1 - Individual (Telehealth)	H0015	V1 - Demonstration	GT - Telehealth		
Treatment Plan Development/Review	T1007	V1 - Demonstration			
Treatment Plan Development/Review (Telehealth)	T1007	V1 - Demonstration	GT - Telehealth		
Partial Hospitalization	H0035	V1 - Demonstration			
SUD Residential 3.1 (Adolescent)	H2036	HA - Adolescent	V1 - Demonstration		
SUD Residential 3.1 (Adolescent 18 - 20)	H2036	CG - Adolescent 18-20	HA - Adolescent	V1 - Demonstration	
SUD Residential 3.1 (Adult)	H2036	HF - Substance Abuse	V1 - Demonstration		
SUD Residential 3.3	H0047	HF - Substance Abuse	V1 - Demonstration		
SUD Residential 3.5 (Adult)	H0047	TG - High Level	V1 - Demonstration		
SUD Residential 3.5 (Adolescent)	H0047	HA - Adolescent	V1 - Demonstration	TF - Intermediate	
SUD Residential 3.5 (Adolescent 18 - 20)	H0047	CG - Adolescent 18-20	V1 - Demonstration	HA - Adolescent	TF - Intermediate
Home Based Family Treatment Level 1	H1011	V2 - Demonstration			

Modifier Sequence for 1115 Waiver SUD Services 2/2

Optum Primary Modifier Guidance for Alaska Medicaid 1115 Waiver Services 4.6.2022

Service Title/Description	Service Code	Primary Billed Modifier #1	Modifier #2	Modifier #3	Modifier #4
Home Based Family Treatment Level 2	H1011	TF - Intermediate	V2 - Demonstration		
Home Based Family Treatment Level 3	H1011	TG - High Level	V2 - Demonstration		
Therapeutic Treatment Homes	H2020	V2 - Demonstration			
Assertive Community Treatment	H0039	V2 - Demonstration			
Adult MH Residential Treatment Level 1	T2016	V2 - Demonstration			
Adult MH Residential Treatment Level 2	T2016	TG - High Level	V2 - Demonstration		
Children's MH Residential Treatment Level 1	T2033	V2 - Demonstration			
Children's MH Residential Treatment Level 2	T2033	TF - Intermediate	V2 - Demonstration		
Peer-Based Crisis Services	H0038	V2 - Demonstration			
23 Hour Crisis Stabilization	S9484	V2 - Demonstration			
Mobile Outreach and Crisis Response Services	T2034	V2 - Demonstration			
Crisis Residential Stabilization	S9485	V2 - Demonstration			
Intensive Case Management	H0023	V2 - Demonstration			
Intensive Case Management (Telehealth)	H0023	V2 - Demonstration	GT - Telehealth		
Community & Recovery Support Services - Group	H2021	HQ - Group	V2 - Demonstration		
Community & Recovery Support Services - Group (Telehealth)	H2021	HQ - Group	V2 - Demonstration	GT - Telehealth	
Community & Recovery Support Services - Individual	H2021	V2 - Demonstration			
Community & Recovery Support Services - Individual (Telehealth)	H2021	V2 - Demonstration	GT - Telehealth		
Partial Hospitalization	H0035	V2 - Demonstration			
Intensive Outpatient ASAM 2.1 - Group	H0015	HQ - Group	V2 - Demonstration		
Intensive Outpatient ASAM 2.1 - Group (Telehealth)	H0015	HQ - Group	V2 - Demonstration	GT - Telehealth	
Intensive Outpatient ASAM 2.1 - Individual	H0015	V2 - Demonstration			
Intensive Outpatient ASAM 2.1 - Individual (Telehealth)	H0015	V2 - Demonstration	GT - Telehealth		
Treatment Plan Development/Review	T1007	V2 - Demonstration			
Treatment Plan Development/Review (Telehealth)	T1007	V2 - Demonstration	GT - Telehealth		

Modifier Sequence for 1115 Waiver BH Services 1/2

Service Title/Description	Service Code	Primary Billed Modifier	Modifier #2	Modifier #3	Modifier #4	Fee	Unit of Measure
Intensive Outpatient ASAM 2.1 - Group	H0015	HQ - Group	V2 - Demonstration	-		$9.77	15 Minutes
Intensive Outpatient ASAM 2.1 - Group (Telehealth)	H0015	HQ - Group	V2 - Demonstration	GT - Telehealth		$9.77	15 Minutes
Intensive Outpatient ASAM 2.1 - Individual	H0015	V2 - Demonstration				$29.61	15 Minutes
Intensive Outpatient ASAM 2.1 - Individual (Telehealth)	H0015	V2 - Demonstration	GT - Telehealth			$29.61	15 Minutes
Home Based Family Treatment Level 1	H1011	V2 - Demonstration				$24.16	15 Minutes
Home Based Family Treatment Level 2	H1011	TF - Intermediate	V2 - Demonstration			$24.63	15 Minutes
Home Based Family Treatment Level 3	H1011	TG - High Level	V2 - Demonstration			$27.19	15 Minutes
Therapeutic Treatment Homes	H2020	V2 - Demonstration				$294.65	Daily
Community & Recovery Support Services - Group	H2021	HQ - Group	V2 - Demonstration			$5.63	15 Minutes
Community & Recovery Support Services - Group (Telehealth)	H2021	HQ - Group	V2 - Demonstration	GT - Telehealth		$5.63	15 Minutes
Community & Recovery Support Services - Individual	H2021	V2 - Demonstration				$21.46	15 Minutes
Community & Recovery Support Services - Individual (Telehealth)	H2021	V2 - Demonstration	GT - Telehealth			$21.46	15 Minutes
Intensive Case Management	H0023	V2 - Demonstration				$28.07	15 Minutes
Intensive Case Management (Telehealth)	H0023	V2 - Demonstration	GT - Telehealth			$28.07	15 Minutes
Partial Hospitalization	H0035	V2 - Demonstration				$500.00	Daily
Peer-Based Crisis Services	H0038	V2 - Demonstration				$20.46	15 Minutes
Assertive Community Treatment	H0039	V2 - Demonstration				$30.63	15 Minutes
Treatment Plan Development/Review	T1007	V2 - Demonstration				$135.43	Per Assessment
Treatment Plan Development/Review (Telehealth)	T1007	V2 - Demonstration	GT - Telehealth			$135.43	Per Assessment

Modifier Sequence for 1115 Waiver BH Services 2/2

Service Title/Description	Service Code	Primary Billed Modifier	Modifier #2	Modifier #3	Modifier #4	Fee	Unit of Measure
Adult MH Residential Treatment Level 1	**T2016**	V2 - Demonstration				$601.61	Daily
Adult MH Residential Treatment Level 2	**T2016**	**TG - High Level**	V2 - Demonstration			$480.26	Daily
Mobile Outreach and Crisis Response Services	**T2034**	V2 - Demonstration				$175.64	Per Call Out
23 Hour Crisis Stabilization	**S9484**	V2 - Demonstration				$116.20	Hourly
Crisis Residential Stabilization	**S9485**	V2 - Demonstration				$665.15	Daily

Modifier Sequence for State Plan Services 1/3

Service Title/Description	Service Code	Primary Billed Modifier #1	Modifier #2	Modifier #3
Behavioral Health Screen	T1023			
Behavioral Health Screen	T1023	95 or GT - Telehealth		
Alcohol and/or Drug Assessment	H0001			
Alcohol and/or Drug Assessment	H0001	95 or GT - Telehealth		
Mental Health Intake Assessment	H0031			
Mental Health Intake Assessment	H0031	95 or GT - Telehealth		
Integrated Mental Health & Substance Use Intake Assessment	H0031-HH	**HH**		
Integrated Mental Health & Substance Use Intake Assessment	H0031-HH	**HH**	95 or GT - Telehealth	
Psychiatric Assessment - Diag Eval	90791	XE, XP, or XU		
Psychiatric Assessment - Diag Eval	90791	95 or GT - Telehealth	XE, XP, or XU	
Psychological Testing	96136-HO	**HO**	XE, XP, or XU	
Psychological Testing	96136-HO	**HO**	95 or GT - Telehealth	XE, XP, or XU
Psychological Testing	96137-HO	**HO**	XE, XP, or XU	
Psychological Testing	96137-HO	**HO**	95 or GT - Telehealth	XE, XP, or XU
Psychological Testing	96130-HO	**HO**	XE, XP, or XU	
Psychological Testing	96131-HO	**HO**	XE, XP, or XU	
Neuropsychological Testing	96136-HP	**HP**	XE, XP, or XU	
Neuropsychological Testing	96136-HP	**HP**	95 or GT - Telehealth	XE, XP, or XU
Neuropsychological Testing	96137-HP	**HP**	XE, XP, or XU	
Neuropsychological Testing	96137-HP	**HP**	95 or GT - Telehealth	XE, XP, or XU
Neuropsychological Testing	96132-HP	**HP**	XE, XP, or XU	
Neuropsychological Testing	96133-HP	**HP**	XE, XP, or XU	
Psychotherapy, Individual	90832	XE, XP, or XU		
Psychotherapy, Individual	90832	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Individual	90834	XE, XP, or XU		
Psychotherapy, Individual	90834	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Individual	90837	XE, XP, or XU		
Psychotherapy, Individual	90837	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Family (w/o patient present)	90846	XE, XP, or XU		
Psychotherapy, Family (w/o patient present)	90846	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Family (w/o patient present)	90846-U7	**U7**	XE, XP, or XU	
Psychotherapy, Family (w/o patient present)	90846-U7	**U7**	95 or GT - Telehealth	XE, XP, or XU
Psychotherapy, Family (with patient present)	90847	XE, XP, or XU		
Psychotherapy, Family (with patient present)	90847	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Family (with patient present)	90847-U7	**U7**	XE, XP, or XU	
Psychotherapy, Family (with patient present)	90847-U7	**U7**	95 or GT - Telehealth	XE, XP, or XU

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Modifier Sequence for State Plan Services 2/3

Service Title/Description	Service Code	Primary Billed Modifier #1	Modifier #2	Modifier #3
Psychotherapy, Multi-family group	90849	XE, XP, or XU		
Psychotherapy, Multi-family group	90849	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Multi-family group	90849-U7	**U7**	XE, XP, or XU	
Psychotherapy, Multi-family group	90849-U7	**U7**	95 or GT - Telehealth	XE, XP, or XU
Psychotherapy, Group	90853	XE, XP, or XU		
Psychotherapy, Group	90853	95 or GT - Telehealth	XE, XP, or XU	
Psychotherapy, Group	90853-U7	**U7**	XE, XP, or XU	
Psychotherapy, Group	90853-U7	**U7**	95 or GT - Telehealth	XE, XP, or XU
Comprehensive Medication Services	H2010			
Comprehensive Medication Services	H2010	95 or GT - Telehealth		
Short-term Crisis Intervention Service	S9484			
Short-term Crisis Intervention Service	S9484	95 or GT - Telehealth		
Short-term Crisis Intervention Service	S9484-U6	**U6**		
Short-term Crisis Intervention Service	S9484-U6	**U6**	95 or GT - Telehealth	
Short-term Crisis Stabilization Service	H2011			
Short-term Crisis Stabilization Service	H2011	95 or GT - Telehealth		
Case Management	T1016			
Case Management	T1016	95 or GT - Telehealth		
Therapeutic BH Services - Individual	H2019			
Peer Support Services - Individual	H0038			
Therapeutic BH Services - Group	H2019-HQ	**HQ**		
Therapeutic BH Services - Family (with patient present)	H2019-HR	**HR**		
Therapeutic BH Services - Family (w/o) patient present)	H2019-HS	**HS**		
Peer Support Services - Family (with patient present)	H0038-HR	**HR**		
Peer Support Services - Famly (w/o patient present)	H0038-HS	**HS**		
Peer Support Services - Individual	H0038			
Day Treatment for Children (combined mental health & school district resources)	H2012			

Modifier Sequence for State Plan Services 3/3

Service Title/Description	Service Code	Primary Billed Modifier #1	Modifier #2	Modifier #3
Treatment Plan Review for Methadone Recipient	T1007			
Oral Medication Administration, direct observation; on premises	H0033			
Oral Medication Administration, direct observation; off premises	H0033-HK	**HK**		
Methadone Administration and/or service	H0020			
Ambulatory Detoxification	H0014			
Clinically Managed Detoxification	H0010			
Medically Managed Detoxification	H0011			
Medical Evaluation for Recipient NOT Receiving Methadone Treatment	H0002			
Medical Evaluation for Recipient Receiving Methadone Treatment	H0002-HF	**HF**		
Screening, Brief Intervention, and Referral for Treatment (SBIRT)	99408	XE, XP, or XU		
Screening, Brief Intervention, and Referral for Treatment (SBIRT)	99408	95 or GT - Telehealth	XE, XP, or XU	
Residential Substance Use Disorder Treatment - Clinically Managed; Low Intensity	H0047			
Residential Substance Use Disorder Treatment - Clinically Managed; Medium Intensity	H0047-TF	**TF**		
Residential Substance Use Disorder Treatment - Clinically Managed; High Intensity	H0047-TG	**TG**		

Modifier XE, XP, and XU Guidance

Effective for claims billed with dates of service on and after 7/1/2021, X modifiers are configured in the AK Optum claims system for correct claim reporting.

X modifiers are reported to indicate separate services that are medically necessary to occur on the same date of service as another service.

X modifier definitions:

- **XE Modifier** – Separate encounter, service is distinct because it occurred during a separate encounter
- **XP Modifier** – Separate practitioner, service is distinct because it was performed by a separate provider
- **XU Modifier** – Unusual non-overlapping service, the service is distinct because it does not overlap usual components of the main service

Correcting Invalid Modifier Denial

If a line item is denied for an invalid modifier combination, the claim cannot be adjusted. *A corrected claim will be required*. Records may need to accompany the corrected claim in some situations.

All information requested has to be submitted with the corrected claim in order for the claim to be reconsidered for payment.

Modifier Placement and Payment of claims

It is critical to claims payment accuracy, that modifiers are billed in the appropriate sequence.

Modifier Example for Code H0011- Optum has primary modifier listed as V1 (that is also the only modifier expected by the state).

If a Provider sends a claim to Optum with a V1 Modifier: Claim will pay at the $1500.00 rate.

If a Provider sends claim to Optum with TG and V1 Modifiers: Claim will deny because TG is not Optum's primary modifier.

Code H0010 - Optum has the primary modifier listed as V1 with a $302.25 rate and TG with a $900.00 rate.

If a Provider sends a claim to Optum with V1: Claim will pay at the $302.25 rate.

If a Provider sends a claim to Optum with TG and V1: Claim will pay at the $900.00 rate.

If a Provider sends a claim to Optum with V1 and TG: Claim will pay at the $302.25 rate. This would be an underpayment for Medically Monitored Inpatient Withdrawal Management.

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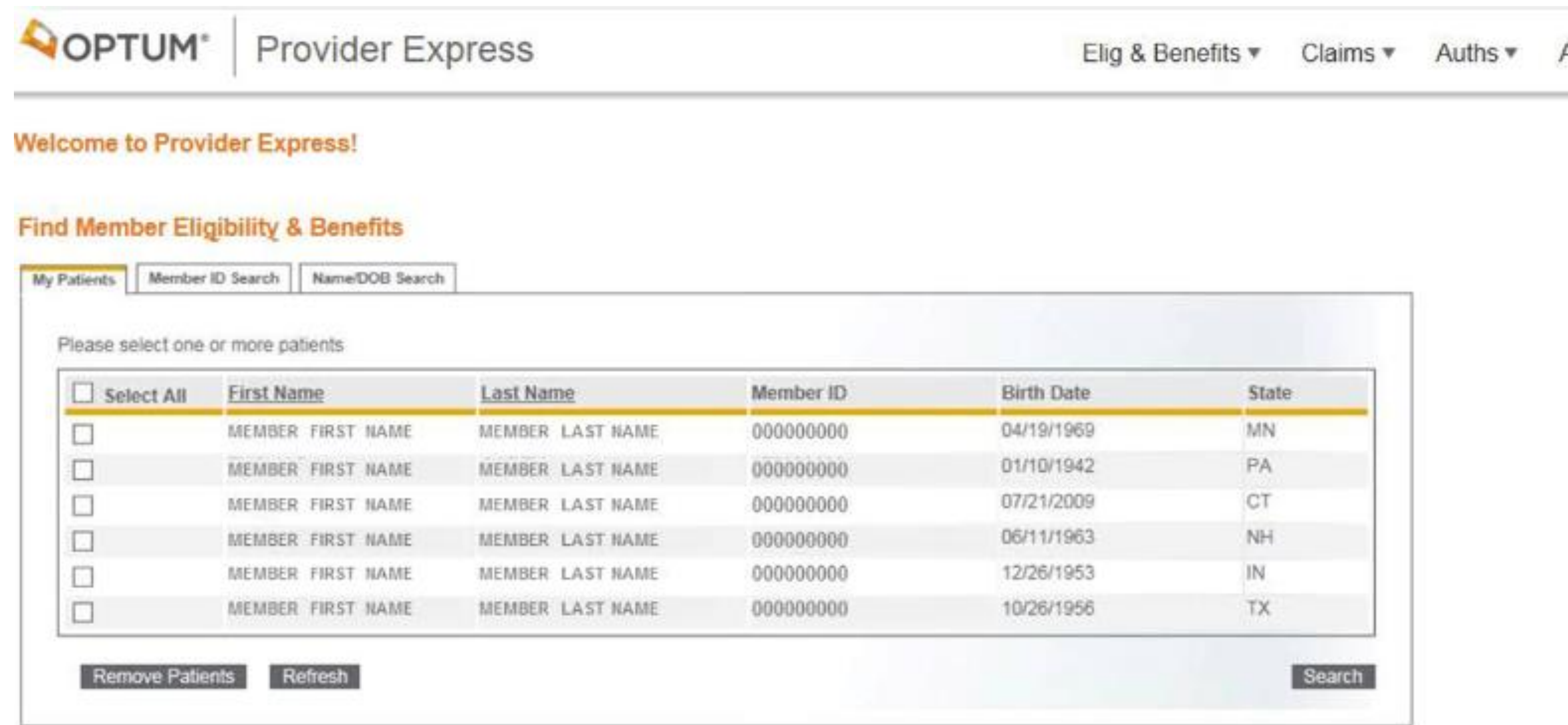
Member Eligibility

Member Eligibility

[Sign In With Your One Healthcare ID - One Healthcare ID]

Note: Members with other insurance is not available in Provider Express only Alaska Medicaid is available.



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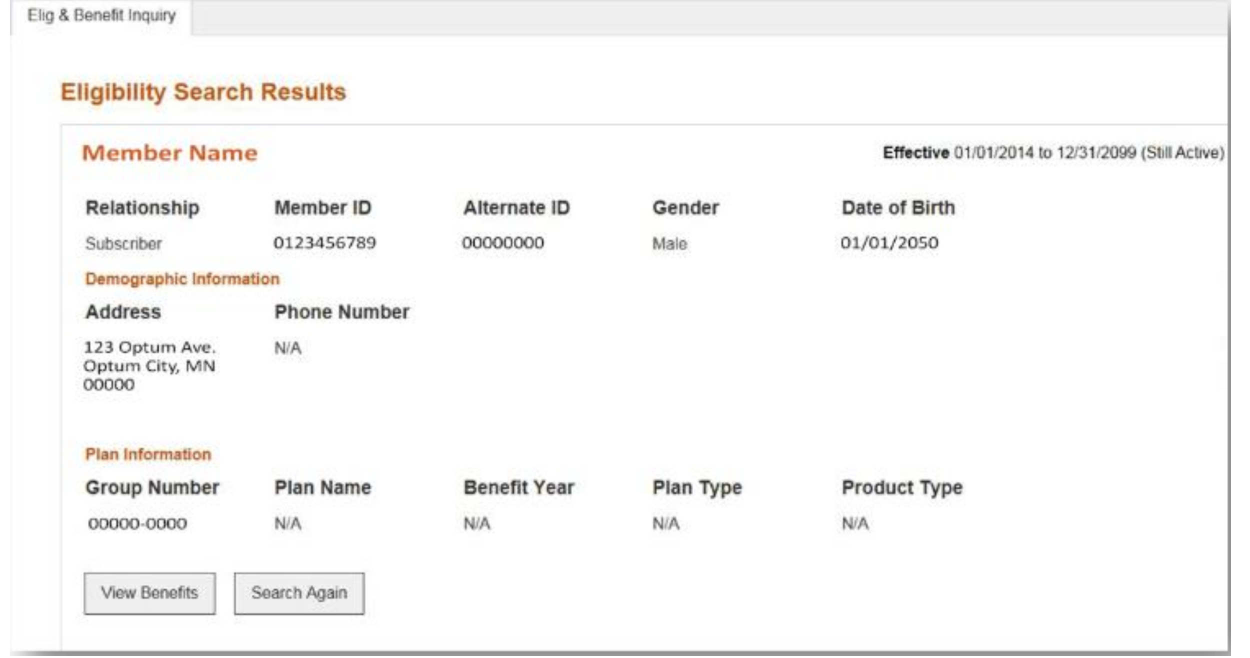
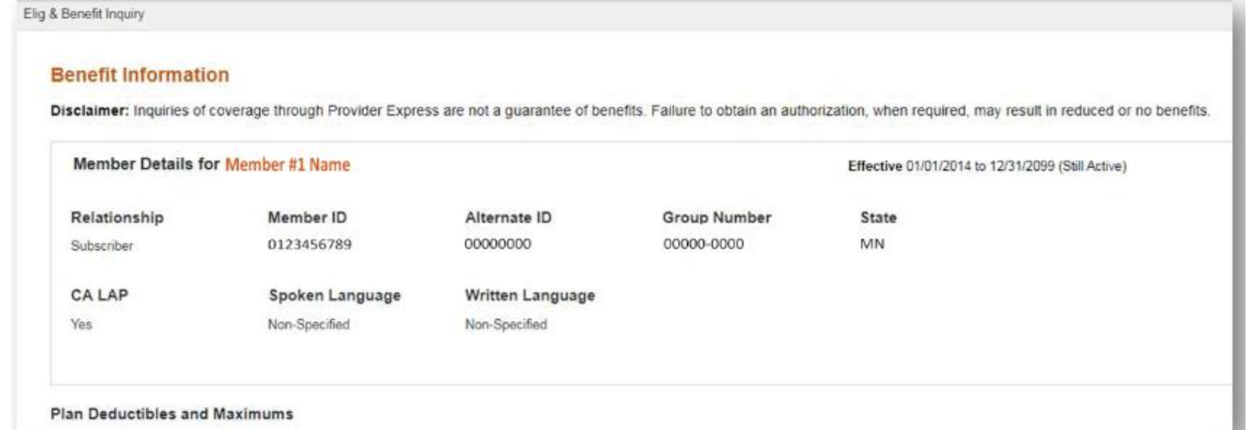
Member Eligibility Continued

The initial search results from any search method you choose. You can view detailed benefits or choose to search again for a different member.





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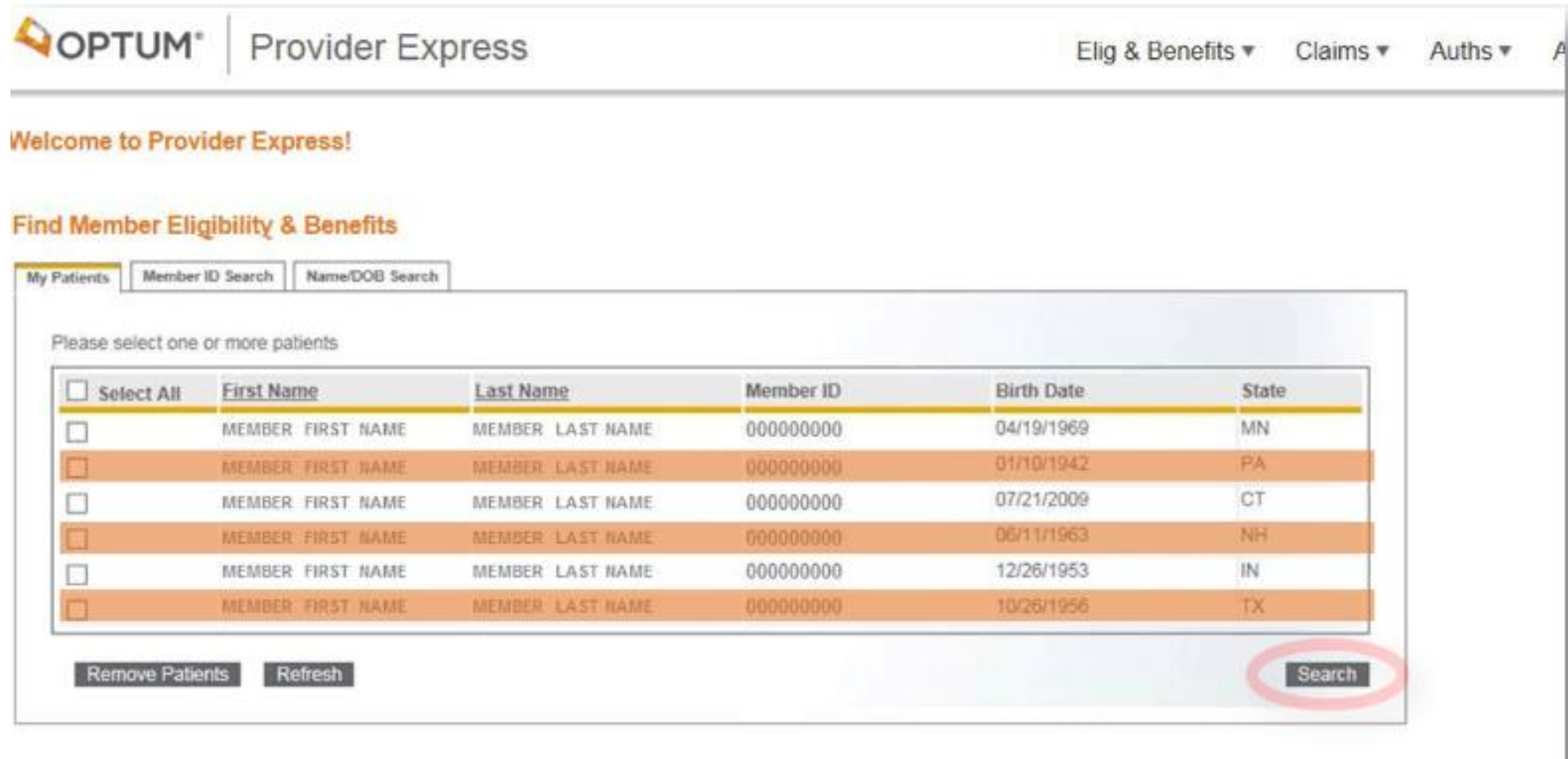
Member Eligibility Continued

New: You can search for multiple members at once. Selecting a multiple-member search is convenient and will save time.



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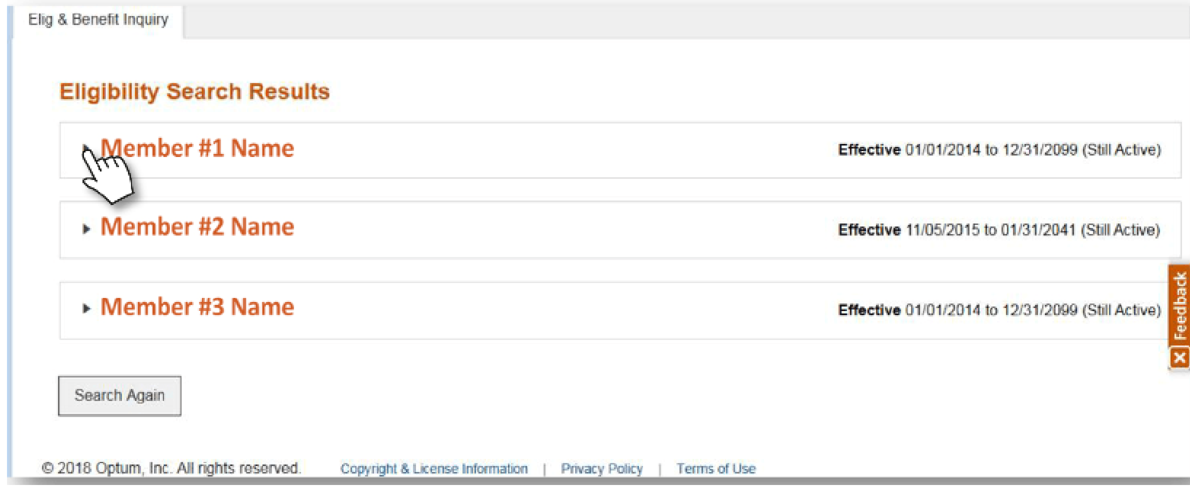
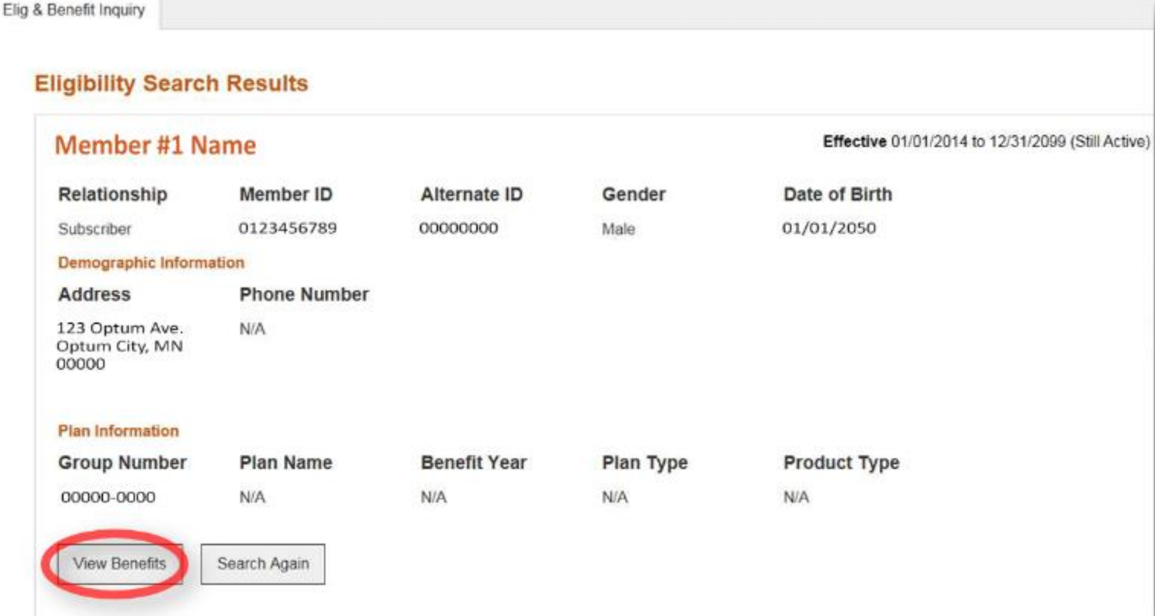
Member Eligibility Continued

Click the triangle arrow left of the name to view details.





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Eligible Alaska Medicaid Behavioral Health Types

Double check patients Medicaid type

On the next page is a table with Alaska Medicaid eligibility types that do not include coverage for Alaska Medicaid covered Behavioral Health Services.

If a claim is denied due to a participant having Medicaid eligibility as an incarcerated person and the person is no longer incarcerated, then providers may work with the participant and the Division of Public Assistance to update the type of eligibility.

If a claim is denied due to a participant having Medicare Premium Assistance only or being approved for a Home and Community Based Waiver assessment only, it is due to the type of Medicaid eligibility the participant received that does not cover Alaska Medicaid Behavioral Health Services.

Medicare Premium Only
The Medicare program provides assistance with the cost of Medicare premiums only. These Medicare assistance categories generally use the financial and non-financial eligibility criteria of the Adult Public Assistance (APA) and Supplemental Security Income (SSI) programs, except that the income and resource limits are higher.

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Ineligible for Behavioral Health

Eligibility Code and Subtype	Denial Reason	Remittance Advice Reason Code (RARC)	Claim Adjustment Reason Code (CARC)
19/WD – Waiver Determination/Waiver Applicant	No Benefit Plan Exists	N30	96
20/AI – Medicaid/Incarcerated Medicaid APA Related	Participant Incarcerated on Date of Service	N103	96
20/MI – Medicaid/Incarcerated Newly Eligible-Expansion	Participant Incarcerated on Date of Service	N103	96
20/XI – Medicaid/Non-Newly Eligible	Participant Incarcerated on Date of Service	N103	96
50/NI – Under 21/Incarcerated non-SCHIP Child/Title 19 funding	Participant Incarcerated on Date of Service	N103	96
50/TI – Under 21/Incarcerated Under 21	Participant Incarcerated on Date of Service	N103	96
66/QD – Qualified Disabled & Working Individuals/Qualified Disabled & Working Individuals	Medicare Premium Only	N30	96
67/QM – QMB-only/QMB	Medicare Premium Only	N30	96
68/SL – SLMB Eligible Part B Payment Only/low income Mcare beneficiary	Medicare Premium Only	N30	96
69/AI – Dual APA/QMB/Incarcerated Medicaid APA Related	Participant Incarcerated on Date of Service	N103	96
78/SL – SLMB Plus Eligible Part B/low income Mcare beneficiary	Medicare Premium Only	N30	96

Medicaid related (alaska.gov). If you have questions or need assistance, please contact Optum at 800-225-8764

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Place of Service Inappropriate for Procedure

Place of Service Inappropriate for Procedure

Overview

Optum will reimburse CPT and HCPCS codes when reported with an appropriate place of service (POS). POS Code set, which are two-digit codes submitted on the CMS 1500 Health Insurance Claim Form or its electronic equivalent to indicate the setting in which a service was provided. Please follow the guidance of Alaska Medicaid. Provider should review Administrative and Billing manuals to assist with POS requirements.

A corrected claim will be required to modify the claim for payment

Example:

B08 – inappropriate place of service and procedure code combination (example: H2015 HQ billed with Place of Service 02 but not with a telehealth modifier).

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Service Authorizations During the Public Health Emergency (PHE)

Service Authorization requirements are currently lifted during the Public Health Emergency.

SFY (State Fiscal Year) service limits will reset when service authorizations do go live.

The Public Health Emergency is currently extended through April 15, 2022.

Check the federal Public Health Emergency for updates on the PHE Declaration at:

https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx

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Let’s Talk - Questions & Answers

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The Provider Relations Team is here to help

The Alaska Provider Relations Team is your local guide to Navigating Optum

The Optum Alaska Provider Relations Team can:

- Act as your Optum Liaison
- Answer important questions
- Facilitate ongoing process improvements
- Keep you abreast of changes that impact your practice
- Provider useful tools and resources

The Optum Alaska Provider Relations Team:

Ryan Bender

Vaoita Puletapuai

Email: akmedicaid@optum.com

Fax: 1-844-881-0959

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Provider Express Technical Support

If you'd like assistance:

Contact support at 1(855)819-5909 or optumsupport@optum.com.

Chat with support (Opens in a new window)

Note: This feature is not advisable for persons with visual impairments and/or who may require audible support.

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Thank you for your time!

Prepared: Wendy Salas Associate Director Network Claims Liaison