Optum's Proposed Remittance Advice

Feedback and Clarifying Questions | April 16, 2020

Thank you for the opportunity to provide feedback on the remittance advice that Optum will use when it relaunches the ASO. The remittance advice will serve as a translator between the provider's system and Optum's to ensure that both systems accurately reflect providers' claims status and will ultimately define the over/underpayment between estimated payments and actual services delivered. To function effectively, the remittance advice must contain complete and accurate information. CBH's questions and concerns about the proposed remittance advice are:

1. Will the Remittance Advice be sent by provider tax ID, by program service or provider type, or by NPI?

2. In the sample Remittance Advice (RA) shared last week, the claim detail indicates that the provider submitted 3 units of 90834 between December 19, 2019 and January 16, 2020. The provider's claim charges of $217.50, reflecting the fee schedule rate of $72.50 for 90834 multipled by three units delivered over the three-week span identified in the claim. A $100 portion of the claim was denied.

    a. Which of the three 90834 submissions in the three-week date span was denied? Which of the three 90834 submissions was partially denied? The provider needs this level of specificity to reconcile the RA with their system.

Serv	Services Dates	Service Code	Units	Charged	Allowed	Denied	Deductible	Copay	Coins	Payment	Explain Codes
100	12/19/2019 - 01/16/2020	90834	3	$217.50	$117.50	$100.00	$0.00	$0.00	$0.00	$117.50	1 45
			Subtotal:	$217.50	$117.50	$100.00	$0.00	$0.00	$0.00	$117.50	

    b. Why was one of the 90834 submissions denied in whole and one in part? The explanation codes indicate that $217.50 exceeds the allowable charge, but $72.50 x 3 units = $217.50. The provider was paid only $117.50. Why? The explanation code does not shed light on which claims were denied and why.

Explanation Code	Description
1	Contract Amount
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)
EP	Advance $500.00 payment offset $190.00; balance $310.00

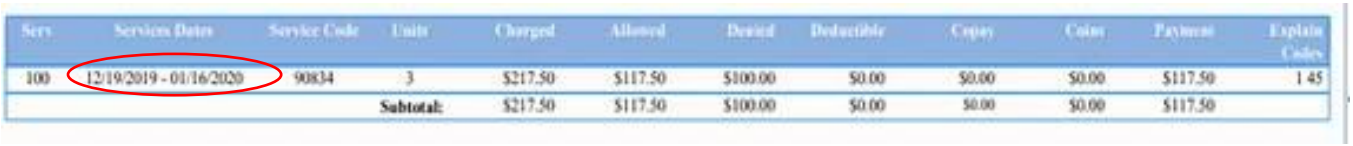
3. How will providers who have not been able to complete set-up in Incedo and/or PaySpan be able to receive remittance advice for all services and be able to submit claims? CBH continues to have members with PaySpan and Incedo set-up issues that haven't been resolved by Optum.

4. Optum's proposed Remittance Advice and workflow for resubmitting claims differs from industry standard in several respects. As reflected in the table below, the RA is missing five data fields that are standard for all payers of behavioral health services in Maryland. In addition, the proposed workflow is missing two elements common to most payers – and particularly critical for publicly-funded services. The absence of this data and operational functionality deprives providers of the ability to effectively line up the remittance advice with their data about services delivered, correct

errors, and arrive at data that matches Optum's in terms of what services were delivered, to whom and when. Without such information, accurate reconciliation will not be possible.

Remittance Advice and Workflow includes:	Medicare	CareFirst	Beacon ASO	Optum ASO
1. Claim date of service	Yes	Yes	Yes	No
2. Provider claim number	Yes	Yes	Yes	No
3. Provider NPI	Yes	Yes	Yes	No
4. Unique patient ID identifiable to provider (such as MA number)	Yes	Yes	Yes	No
5. Actionable denial codes	Yes	Yes	Yes	No
6. Ability to void submitted claim via payer portal and/or website	Yes	Not through website	Yes	No
7. Ability to electronically resubmit corrected claim via payer portal and/or website	Yes	Not through website	Yes	No

a. **Claim date of service**. Claims are submitted with a specific date of service, as required by CMS-1500 format and reflected in Optum's Billing Appendix. Beacon's, Medicare's and CareFirst's remittance advices all include a specific date of service associated with each claim. Optum's remittance advice bundles claims into date ranges. It isn't clear how Optum bundles claims into ranges and whether this will impact same-day service exclusions, encounter case rates, eligibility and other issues keyed to the date of service. The use of date ranges impedes providers' ability to analyze and reconcile claim information with their systems. Can Optum tie each claim to a specific date of service, as Beacon, Medicare and other payers do?



Serv	Services Dates	Service Code	Units	Charged	Allowed	Denied	Deductible	Copay	Coins	Payment	Explain Codes
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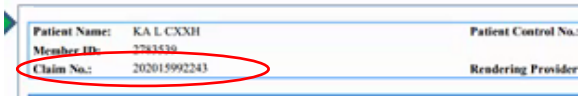
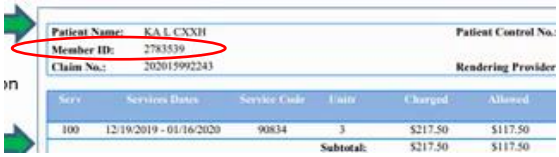
b. **Provider claim number**. Beacon's, Medicare's and CareFirst's remittance advices all include both the payer's claim number and the provider's claim number. The claim number on Optum's remittance advice appears to be an internal Optum reference number? Provider cannot post the remittance advices in their system with Optum's internal reference number. The absence of the provider claim number impedes providers' ability to analyze and reconcile claim information with their systems. Can Optum tie add the provider's claim number to each claim, as Beacon, Medicare and other payers do?



c. **NPI**. Medicare's and CareFirst's remittance advices include both the organization's NPI and the rendering provider's NPI (if associated with the claim). This information is not included on Optum's remittance advice. The absence of this information impedes providers' ability to

analyze and reconcile claim information with their systems. Can Optum tie add the provider's claim number to each claim, as other payers do?

d. **Patient identifier that the provider can use**. What is "Member ID"? It isn't the patient's Medical Assistance number. Other payers routinely include a patient identifier number that can be identified by providers on their RA. Can the patient's Medical Assistance number be on the remittance advice to assist in provider reconciliation of the RA info to their system records?



e. **Void and electronically resubmit capability**. At last week's meeting, CBH asked how a provider could correct and resubmit a denied claim. Optum indicated that providers could submit a corrected 837 or drop a paper claim. *CBH members report that there is no current functionality in Optum's system to void, correct and resubmit claims electronically. Currently, paper resubmission is the only method of resubmitting a claim, and no option to void a claim exists. This is a significant core functionality that needs to be in place prior to the ASO relaunch*. Does Optum intend to have this functionality in place prior to relaunch?

5. **Estimated payment reconciliation**. The last line of the Explanation Code contains, in the EP line, the running log of advance payment, offset of the RA payment, and the balance. Once all claims are processed and denials received, providers then need an opportunity to correct and resubmit any denied claims. Only once the entire revenue cycle is complete can the total tally of estimated payments, actual payments and any balance be addressed. Inclusion of the running "balance" log on the remittance advice does not reflect an actual expected balance.