Compensation and Claims Processing

Compensation

The contracted rate for eligible outpatient visits is reimbursed to you at the lesser of (1) your customary charge, less any applicable co-payments, coinsurance and deductibles due from the Member, or (2) the Optum contracted rate, less any applicable co-payments, coinsurance and deductibles due from the Member.

The contracted rate for Facilities is referenced in the Payment Appendix of the Facility Agreement and defines rates applicable to inpatient and/or higher levels of care rendered at the Facility. When the contracted rates include physician fees, the Facility is responsible for payment of all treating physicians and for notifying the physicians that payment will be made by the Facility and not Optum.

It is important that contracted Providers follow your fee schedule to ensure proper payment of claims. Failure to follow the terms and conditions as set forth on your fee schedule may result in claim denial(s).

Financial records concerning covered services rendered are required to be maintained from the date of service for the greater of 10 years, or the period required by applicable state or federal law, whichever is longer. Any termination of the Agreement has no bearing on this legal obligation.

Co-payments, Coinsurance and Deductible

In most Benefit Plans, Members bear some of the cost of behavioral health services by paying a co-payment, coinsurance, and/or deductible (the “Member expenses”). Deductible amounts and structure may vary from plan to plan. To abide by applicable law including without limitation, parity laws, some deductibles may be combined with medical services. Members should be billed for deductibles after claims processing yields an Explanation of Benefits indicating Member responsibility.

For co-payments, we encourage you to require payment at the time of service. It is your sole responsibility to collect Member payments due to you. Members are never to be charged in advance of the delivery of services.

Benefit Plans often provide for annual co-payment or coinsurance maximums. If a Member states that he or she has reached such a maximum, call the telephone number listed on the back of the Member’s ID card to confirm the amount and status of the Member’s co-payment maximum. If a specific behavioral health number is not listed, call the medical number and follow the prompts for behavioral health.

Balance Billing For Covered Services Is Prohibited

Under the terms of the Agreement, you may not balance bill Members for covered services provided during eligible visits. This means you may not charge Members the difference between your billed usual and customary charges and the aggregate amount reimbursed by Optum and Member co-payment, coinsurance or deductible amounts.

Billing for Non-Covered Services and "No Shows"

In the event that you seek prior authorization of benefits for behavioral health services or authorization for continued treatment, and Optum does not authorize the requested services, the Member may be billed under limited circumstances. The Member may be billed for such services only if a written statement is signed by the Member, subsequent to the non-coverage determination and in advance of receiving such services. Please note that a financial responsibility waiver signed by the Member at the onset of treatment or at the time of admission is not applicable. The signed statement must include:

- That you have informed the Member that Optum is unable to authorize such services for coverage under the Member's Benefit Plan
- The reason given by Optum for not authorizing the services
- That as a result, the Member has been denied coverage for such services under their Benefit Plan and will be financially responsible

In the event a Member exhausts the covered benefits under the benefit contract, you may bill the Member directly for those services. Members may be charged no more than the applicable network fee schedule or Facility contracted rate for such services.

A **Patient Financial Responsibility Form** may be found at **Provider Express** under "Optum Forms – Administrative." We encourage you to use this or a similar form when billing Members for non-covered services.

Optum does not pay for sessions that a Member fails to attend. You may not bill Optum for such sessions or services.

A Member who misses a scheduled appointment may be billed directly, provided you have advised the Member in advance that this is your policy and the Member has acknowledged the policy in writing. The Member should be billed no more than your applicable network fee schedule or Facility contracted rate for such services. Note that some plan designs, including Medicaid and Medicare, prohibit billing Members for no-shows under any circumstance. Members are never to be charged a deposit or advance payment for a potential missed appointment.

Failure to follow this or any other required billing practice may result in referral to the Credentialing Committee for termination.

Claims Submission

Unless otherwise directed by Optum, Providers shall submit outpatient claims using the current 1500 claim form (v 02/12) or Facility-based claims using a UB-04 claim form, (its equivalent or successor) whichever is appropriate, with applicable coding including, but not limited to, ICD diagnosis code(s), CPT, Revenue and HCPCS coding.

Services billed using a CPT or HCPCS code must be billed on a current 1500 claim form and consistent with your fee schedule. Revenue codes or revenue codes with accompanying CPT or HCPCS codes should be billed on a UB-04 claim form. Billing inconsistent with the above or your contracted fee schedule will result in an initial claim denial.

Providers shall include all data elements necessary to process a complete claim including: the Member number, customary charges for the MH/SUD services rendered to a Member during a single instance of service, Provider's federal Tax Identification Number (TIN), National Provider Identifier (NPI), code modifiers and/or other identifiers requested by Optum.

In addition, you are responsible for billing of all Members in accordance with the nationally recognized CMS Correct Coding Initiative (CCI) standards. Please visit the **CMS website** for additional information on CCI billing standards.

Although claims are reimbursed based on the network fee schedule or Facility contracted rate, your claims should be billed with your usual and customary charges indicated on the claim.

Claim Entry through Provider Express: You can file Optum claims at **Provider Express**. This secure HIPAA-compliant transaction feature is designed to streamline the claim submission process. It performs well on all connection speeds and submitting claims on *Provider Express* closely mirrors the process of completing the 1500 claim form (v 02/12). In order to use this feature you must be a network Clinician or Group Practice and have a registered user ID and password for *Provider Express*. To obtain a user ID, click on the **First-time User** link from our home page.

EAP claims are supported through this feature as well. We strongly encourage you to use this no-cost claims entry feature for claims submission at **Provider Express**, which allows claims to be paid quickly and accurately. EAP claims should be submitted through *Provider Express* or on a 1500 claim form using the standard "HJ" code in the modifier field of section 24 D.

The table below reflects the most commonly used EAP service codes:

90832 HJ	90834 HJ	90846 HJ	90847 HJ	90853 HJ

For more information about fast and efficient electronic claims submission, please see Provider Express **"Improve the Speed of Processing - Tips for Claims Filing."**

EDI/Electronic Claims: Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a Payor (Optum). You may choose any clearinghouse vendor to submit claims through this route. Because Optum has multiple claims payment systems, it is important for you to know where to send claims. When sending claims electronically, routing to the correct claim system is controlled by the Payor ID. For Optum claims use Payor ID #87726. Additional information regarding **EDI** is available on *Provider Express***.**

Clinician Claim Forms: Paper claims can be submitted to Optum using the 1500 claim form (v 02/12) or its successor form as based upon your Agreement. The claims should include all itemized information such as diagnosis code (ICD code as listed in DSM), length of session, Member and subscriber names, Member and subscriber dates of birth, Member identification number, dates of service, type and duration of service, name of Clinician (i.e., individual who actually provided the service), credentials, Tax ID and NPI numbers.

Facility Claim Forms: Paper claims should be submitted to Optum using the UB-04 claim form, or its successor, which includes all itemized information such as diagnosis code (ICD code as listed in DSM), Member name, Member date of birth, Member identification number, dates of service, procedure (CPT-4) and/or revenue codes, name of Facility and Federal Tax ID number of the Facility, and billed charges for the services rendered. After receipt of all of the above information, participating Facilities are reimbursed according to the appropriate rates as set forth in the Facility's Agreement. Facilities may file claims through an EDI vendor and can view claim status on **Provider Express**.

Anti - Fraud, Waste and Abuse (FWA): Optum has an Anti-Fraud, Waste and Abuse Program in place. You are required to remain in compliance with Optum's FWA Program. Please review the following Anti-Fraud, Waste and Abuse section of this manual.

Online Claims Help

Information for Claims and Customer Service issues can be found in the **Contact Us** section of *Provider Express*.

To ensure proper processing of claims, it is important to promptly contact Network Management if you change your Tax ID number.

If your practice address changes, it is important that you notify us with the change. You may submit changes to your practice address online. **Log in to Provider Express** and click on "My Practice Info."

Customer Service Claims Help

Optum has dedicated customer service departments with staff available five days a week during regular business hours to assist our network with questions related to general information, eligibility verification or the status of a claim payment. The main Optum

customer service phone numbers are listed below; however various Members may have account-specific customer service numbers. It is best to call the phone number listed on the Provider Remittance Advice.

- Health Plan Groups **1-800-557-5745**
- Employer Groups **1-800-333-8724**
- OptumHealth Behavioral Solutions of California **1-800-333-8724**

Coordination of Benefits (COB)

Some Members are eligible for coverage of allowable expenses under one or more additional health Benefit Plans. In these circumstances, payment for allowable expenses shall be coordinated with the other Plan(s). It is your responsibility to inquire and collect information concerning all applicable health plans available to a Member and communicate such information to Optum.

If Optum is a secondary Plan, you will be paid up to the Optum contracted rate. You may not bill Members for the difference between your billed usual and customary charge and the amount paid by the primary Plan(s) and Optum.

Processing and Payment of Claims

All information necessary to process claims must be received by Optum no more than 90 calendar days from the date of service, or as allowed by state or federal law or specific Member Benefit Plans. Claims received after this time period may be rejected for payment at the discretion of Optum and/or the Payor. You may not bill the Member for claim submissions that fall outside these established timelines. Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim.

Claims should be submitted as directed by Optum. We strongly recommend that you keep copies of all claims for your own records. You permit Optum, on behalf of the Payor, to bill and process forms for third-party claims or for third-party Payors, and execute any documents reasonably required or appropriate for this purpose. In the event of insolvency of the Member's employer or Optum, your sole redress is against the assets of Optum or the applicable Payor, not the Member. You must agree to continue to provide services to Members through the period for which premiums have been paid. Any termination of the Agreement has no bearing on this requirement.

Generally, claims that contain all of the required information and match the authorization, if applicable, will be paid within 45 calendar days after receipt, or as required by state and federal law. This may exclude claims that require Coordination of Benefits (COB) determinations.

Benefits are payable provided coverage is in force at the time expenses are incurred, and are subject to all limitations, provisions and exclusions of the Plan. You will be paid for covered services by Optum and will not under any circumstances seek payment through Optum for Plans for which Optum is not the Payor or administrator.

Optum may make corrective adjustments to any previous payments for services and may audit claims submissions and payments to ensure compliance with applicable policies, standards, procedures, including without limitation, the Manual, the Credentialing Plan, the Agreement, and state and federal law. Optum may obtain reimbursement for overpayments directly or by offsetting against future payments due as allowed by law.

In the event a Provider Agreement with Optum has not been executed timely or a commercially reasonable amount of time is not provided to align Optum systems with a Provider Agreement, Optum will not assign a retroactive effective date or pay claims retrospectively unless federally or state mandated.

In addition, no interest or penalty otherwise required under applicable law will be due on any claim which was initially processed timely and accurately, but which requires reprocessing as a result of the untimely execution of a Provider Agreement or amendment; or the inability to align Optum systems in a commercially reasonable period of time.

The procedure for submitting and processing claims will be modified as necessary to satisfy any applicable state or federal laws.