OPTUM® | Maryland

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

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

Telehealth

1. **Telehealth is expected to end on July 25, 2020, however, with the significant rise of COVID-19 cases, will there be any telehealth extensions to prevent the spread?**
   The Federal Public Health Emergency was extended on July 24 and went into effect on July 25, 2020, for 90 days. To view more information on the telehealth extension, click here.

   You can also find the latest updates on the Federal Public Health emergency, here.

Eligibility/Insurance

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

Authorization

1. **Where can I find information regarding authorization requirements?**
   Providers can access information regarding authorization requirements by viewing the following links:
   - *Authorization Requirements Provider Alert*
   - *Authorization Requirements FAQ*

2. **For authorizations prior to July 1, your alerts state "Providers must be sure to retain all appropriate clinical information documented in each patient file which would have been used for obtaining authorizations." Can you verify what documents an OMHC and PRP program would need to have on file for these authorizations? We were unable to obtain due to the system not being functional.**
   Documentation of their encounters, progress, functional information IRPs, referrals for initial PRP authorizations, just the type of basic information you would have needed to enter for an authorization.
   Per the provider update "For claims with dates of service beginning July 1, 2020, and forward, an authorization will need to be in the system prior to

the date of service for claims to pay." Does this mean we cannot backdate authorization requests? If that is the case, what will happen for those authorizations that face issues in the Incedo Provider Portal (IPP) or for those patients where Medicaid backdated coverage?
Providers do not currently need to submit authorizations for dates of service from January-June 2020, but effective July 1, 2020, authorizations are required. In order to accommodate backlogged entry of authorizations, MDH will permit retro-authorizations through August 31 for dates of service beginning July 1. This is detailed in a Provider Alert, here. For cases with retroactive eligibility, providers can either request an unfunded span at the time of admission to be able to receive a clinical determination at the time of service, or a retro review request can be made outside of the portal.

Example 1:
The participant transferred from another OTP on August 1, 2020. A discharge for that program's authorization was not able to be completed until August 12, 2020, by Optum Maryland staff (of course for the correct discharge date). Should we backdate to obtain the authorization starting August 1, 2020, on August 13, 2020?

If you have confirmed with the participant that they are no longer receiving services elsewhere, you may proceed beyond the warning message and enter the authorization on August 1.

Example 2:
The participant obtained Medicaid mid-August, but that coverage backdated to August 1, 2020. Will we be able to obtain authorization starting August 1, 2020, when it updates in IPP on August 21, 2020?

If the participant is still in treatment, you can call in your request, and based on the eligibility just updating, the authorization can be backdated to August 1 by a care advocate.

3. **I work in a hospital-based outpatient mental health clinic. When I am looking on IPP for outpatient authorizations, it is hard to distinguish the outpatient authorizations from the inpatient authorizations. Will there be any updates to the IPP system to address this?**
This may happen for administrators of a limited number of provider types. You can filter for particular codes in the "service request manager" or a particular member's service request screen. Another option to distinguish authorizations is to export the authorization data into Excel and filter/sort there.

4. **For all patients that started services in June, should we enter authorizations with a start date of July 1?**
   If you did not already enter an authorization in June, you should enter a start date of July 1. If you had already entered an authorization in June, that authorization will still be valid and there is no need to enter a new authorization. The provider only needs to renew authorizations when dates or units are exhausted.

5. **Which authorization number should be used for billing purposes if we use a clearinghouse and which one will IPP pick up if billing from the portal?**
   The SR authorization number should be used for claims regardless of how the claim is submitted.

6. **Do I need to have my team obtain new authorizations based on the changed date spans and modified approved sessions or are you honoring the original date spans and sessions that were approved?**
   Any valid approved authorizations that are in the system already and have units remaining will be honored. Those authorizations have been split into two lines, one for date of service (DOS) prior to June 30 and one for DOS July 1 to the original end date. That line will show the units remaining in the authorization.

7. **In the past, under the prior ASO, providers could enter authorizations for the outpatient level of care (e.g., pharmacy management services) with a grace period of 2.5 months. If your authorization expired on June 30 for instance, you could enter a concurrent authorization which started July 1 through as late as September 15, or thereabout. Is there any grace period in entering authorizations for the outpatient level of care under Optum Maryland? If there is not and there is a gap between when an authorization ends and the patient is then seen again, would this next authorization be considered a new initial authorization or a concurrent authorization?**
   Concurrent authorizations should not be submitted less than 30 days in advance of the continuing authorization period. There is less data entry required for authorization than previously due to required changes related to parity. 30 days for a concurrent authorization for entering MNC data should be adequate. Due to the way Incedo operates, any authorization, even concurrent, is a continuation of an existing "known" patient.

8. **Optum Maryland is instructing providers that authorizations for SUD assessments (H0001) are no longer needed at all. Providers were getting authorization for assessments until mid-April and now authorization is not being provided. If this practice has changed from the prior ASO's requirement of authorizations for these services, can someone confirm and put in writing in the form of a Provider Alert?**
   This is not a change in the policy from the prior to current ASO. An authorization was not previously required for the initial assessments, though initial patient registration is always required. The previous ASO had a "hidden" bundle of services, but in Incedo, these services require selection. When providers did not

see the H0001 selection, they were concerned that the service was no longer available. All billing rules regarding H0001 remain in effect (initial assessment, break in treatment, etc.) and will be denied when used in excess of the billing rules. This was communicated to providers in a Provider Alert release on February 27. The alert explained that assessment codes (90791, 90792, H0001, H0002, and H0016) do not require authorization and are not included in the authorization bundle. Click here to view the alert.

9. **Now that we do not need an authorization for the initial two diagnostic services, we do not know if the client has an outstanding authorization with another agency until we are obtaining the bundle authorization (after we have already initiated treatment with the client). We need a way to find this information out prior to the initial visits with the client.**
   While authorization is not required for the initial assessment visit, it is required for all sessions after. We encourage providers to ask participants when scheduling an appointment if they are in treatment with another provider. The system will also alert you if another authorization is on file when you do attempt to enter authorization.

10. **We can't submit any authorizations because our DLA-20 training certificates have handwritten trainer names.**
    All trainer names that have been received and processed have been added to the drop-down list. The process for getting additional names added to the list is as follows:
    1) *Attend the DLA-20 training offered by the Maryland Department of Health (MDH)*
    2) *Complete the "Train the Trainer" Training for the DLA-20*
    3) *Scan certificate of completion and email to DLA20.Trainer@maryland.gov*

    Once the information provided is validated with MDH, the trainer's name will be added to the "name of trainer" drop-down. Please allow three weeks for the name to appear.

11. **U-codes for RRP do not show on authorization approvals so we have no idea if the U-code requested was approved.**
    Until further notice, you can assume that the U-code is approved if the RRP authorization is approved. When specific U-codes can be chosen when submitting a service request, you will be able to see the approved code.

12. **If we send a claim today for June with no authorization, will it still be paid?**
    Claims for DOS January 1 – June 30 will pay without regard to authorization. For DOS July 1 and forward, an authorization must be in the system for claims to pay.

13. **Should we submit an authorization request in the system for DOS prior to July 1?**
    The Incedo system will not allow authorization requests to be entered for dates prior to July 1, 2020 (date range January 1 through June 30).

14. **For PRP, will code H0002 require an authorization for billing?**
    No authorization is needed for H0002.

15. **What is the Diagnosis for MDRN?**
    MDRN is exempt from the diagnosis requirement. When entering an authorization request, MDRN providers will not be required to enter a diagnosis.

16. **Can you please provide clarity on the combination of service regarding PRP and SUD services?**
    Optum Maryland and MDH are preparing a Provider Alert to provide clarity on this subject.

17. **Will there be an update on the MH combination of the services guide?**
    MDH is currently reviewing this document for updates.

18. **Authorizations cannot backdate after July 31 for July or months going forward, it is only allowed for July?**
    Correct. Until July 31, providers will be able to backdate authorization requests to July 1, 2020. From August 31 forward, preauthorization is required.

19. **Do we need an authorization for each service? For example, the participant sees the provider for 90832. Next appointment, the same participant sees the provider for 90834. Do we need an authorization for both 90832 and 90834, or will one authorization cover both services?**
    Both services will need an authorization. However, you can request both service codes within one authorization request.

20. **If you don't see authorizations being split as they should, what are the recommendations?**
If you believe that too many units were provided on the July 1 and beyond line, those units will be honored as there is an issue where the service detail line displays different units than the service line. If you believe there are too few units, please do the following:

    - *First, verify that the same number of units appear in the service request detail lines. The number of units in the service request detail line is accurate and the other number will be updated shortly.*
    - *If both numbers are incorrect, please fill out an authorization correction form if there are only less than five incorrect authorizations. If there are more than five, please contact customer service at 1-800-888-1965 for assistance.*

21. **Under the prior ASO, we could only get two units of 90846 per authorization term. We have been told by Optum Maryland reps that now we don't need additional units of authorization for additional 90846 services -- please confirm this.**
That is correct and was noted in a Provider Alert on February 27. To view the alert, please click here. CPT code 90846 is now included in the traditional outpatient bundle. While this family therapy code does not need to be requested separately, payment analytics will capture utilization, and outliers will be addressed through clinical outreach and audit mechanisms.

22. **I was informed by a customer representative at Optum Maryland that higher level of care open authorizations (including SUD and IOP) cannot be closed by the patient. They may only be closed by the previous provider. Can you please confirm this?**
This is incorrect. Participants can contact customer service at 1-800-888-1965 to close their authorization.

23. **What date was the Provider Alert for the assessments not needing authorizations?**
That alert was released on February 27, 2020. You can view the alert here.

24. **Were the priority population diagnoses changed for PRP services? Schizotypal and unspecified bipolar were not listed on the information sent out.**
Schizotypal was removed from the priority population list for PRP. Participants not meeting the new criteria will not have to be discharged immediately but should be transitioned to another level of care.

25. **Will the RNBC, LMSW, LGPC referring credential types all be added for PRP/RRP?**
LMSW and LGPC are referring credential types for PRP/RRP. RNBC is not currently a referring credential type.

26. **Will there be an alert regarding the changes in the authorization for OMHC and non-OMHC? For example, only eight units for the E/M levels and 75 for the therapy for the OMHC.**
Yes, an alert regarding this topic is forthcoming.

27. **To clarify about authorizations July 1 and forward, if we were never able to obtain an authorization, January to June will pay but what about July and forward? Will we need to enter an authorization from July 1?**
Yes. For DOS July 1 and forward, an authorization must be in the system. Per the most recent alert, providers will have until August 31 to enter authorizations for DOS July 1 forward.

28. **If we send a claim today for June without an authorization, will it still be paid?**
Yes. Claims for dates of service January 1 through June 30, 2020, will pay without regard to authorization. For details of this, you can view the Status of Authorization Requirements Provider Alert, here, and the Authorization Requirements FAQ, here.

29. **Only 500 authorizations are displayed. It says to export them. That is a very low-viewable amount of practice. How do we view older authorization for appeals, etc.? Is there a plan to expand viewable authorizations?**
If you export your authorizations from the Service Request Manager, you will be able to see all authorizations dated to January 1.

30. **Can we use F99 diagnosis for initial authorizations but not for concurrent requests, correct?**
F99 is used only for 1-2 sessions as a "catch all" until an appropriate diagnosis is confirmed. However, on claims submissions, providers should be using the actual Specialty Behavioral Health diagnosis after the 2nd claims submission. F99 cannot be used on concurrent requests.

31. **Do treatment plans H0032 and 96372 (therapeutic injection) need an authorization?**
No, code H0032 nor 96372 require an authorization.

32. **For SUD providers, is individual counseling bundled in ASAM 2.1 and ASAM 1 services, or will providers have to submit a separate authorization for individual sessions?**
If a patient is in Level 2.1, IOP, no provider can separately bill for Level 1 services. Providers can bill for each day where the minimum number of hours of services is met up to 4 days per week. There has been no change to these services. Please refer to the SUD fee schedule which includes combination of services, if you are uncertain about services co-existing.

33. **RNBC is a mental health provider type. They are an ANCC approved mental health provider. What do we need to do to have this credential type added for referrals?**
While that is an ANCC approved mental health provider, they are not approved to make referrals to PRP.

Claims/Billing

1. **We can submit claims, however, claims are being denied incorrectly.**
Optum Maryland appreciates the support and input from providers who have worked with us to identify when there is a claims rule that has been incorrectly administered resulting in incorrect denials. As these corrections are made, Optum Maryland reprocesses claims from January forward. There may be a delay in the time period in which providers see these changes to their claims. However, if you do have specific claims that you believe incorrectly denied, please call customer service at 1-800-888-1965 to discuss your specific situation.

2. **In the Provider Alert released July 9, regarding fee schedules, there are new fee schedules listed with new increased 4% rates. However, I don't see**

any changes in the new rates. They are the same as what we are getting paid until now. For example, CPT/HCPCs: 80307, G0480, and G0481.
Rate changes are expected to be loaded into the system within the next 30 days and reprocessing will occur as defined in the Provider Alert.

3. **If I'm submitting a backdated claim after the fee schedule increase, am I using the new fees, or do I continue using the old fees up until a certain date of service?**
   The new fee schedules are effective only for dates of service July 1, 2020, and forward. Details can be found in a Provider Alert, here.

4. **Where can I locate the PRP/RRP Cascade Billing Sheet, which is a breakdown of the billing fee schedule?**
   Fee schedules and related documents are posted to the Provider Information page, under the Behavioral Health Providers Tab, at maryland.optum.com. Click here to view the PRP Billing Cascade.

5. **If our normal fee schedule is lower than your allowable (i.e., $100), will we be paid the new fee schedule rate? Is it okay to bill Optum Maryland at their allowable rate even if it is higher than our usual fee schedule?**
   Yes, claims will be processed according to the published Optum Maryland fee schedule providing the billed charges are equal to or in excess of the fee schedule allowable.

6. **Has the IPP system been updated to provide specific denial reasons?**
   Yes. Specific denial reasons will now display in IPP. To view the list of MD ASO - Common Claim Denial Reasons And Descriptions, click here.

7. **Where can providers find a comprehensive list of modifiers?**
   Modifiers can be found within the CPT Book for CPT codes and in the HCPCS book for HCPCS codes. State-specific modifiers are communicated within State policy documents. CMS websites also offer information on modifiers.

8. **For PRP, providers do not have to use H2016 any longer, only the final billing code of 2018 with the modifier?**
   That is incorrect. H2016 is required and indicates that the visit occurred. Claims submitted with H2018 without any associated encounters will deny. The payment cascade for PRP is dependent on the number of encounter visits in conjunction with the U2 through U7 modifiers that are used to support the level of service rendered and associated amount of payment.

As further reviewed during the meeting, H2016 should not be billed in conjunction with the U2 thru U7 modifiers as those are reserved for H2018.

9. **Some of the denial reasons in PRP case rates are not correct (the service is from February). How will this affect reconciliation?**
   Optum Maryland is conducting a full audit of all previous PRP denials. Review of claims processed through June is complete and should be included in overall reconciliation. We would recommend calling customer service at 1-800-888-1965 to discuss your specific situation and a claims research ticket can be created.

10. **Will all claims be paid from DOS January 1- June 30, 2020, regardless of authorization status?**
    Yes. Covered services for dates of service January 1 through June 30, 2020, will pay without regard to authorization. Providers must keep in their documentation the MNC and all associated notes that would be necessary for an approval of a service had the authorization system been live. These may be audited at a future date. For details of this you can view the Status of Authorization Requirements Provider Alert, here, and the Authorization Requirements FAQ, here.

11. **Where do you place the GT modifier on the CMS-1500 form? Is it placed in front of the code or in the modifier box, and do you put 02 as the place of service for telehealth?**
    Modifiers are to be placed in the modifier box. Although Medicare uses Place of service 02, Maryland Medicaid opted to use the GT modifier in lieu of the place of service 02. Telehealth claims submitted to Medicaid should be submitted with the usual place of service as if the service was not telehealth and with the appropriate GT or UB modifier. Please note: GT and UB modifiers should never be used together, on the same service line. Claims submitted with both modifiers will be denied and the provider will need to submit a new claim.

12. **When you have a system fault denial issues for provider type, who resubmits these claims? Will Optum Maryland automatically resubmit claims or is the provider responsible for resubmitting?**
    Claims only need to be resubmitted if a correction is being made. We would recommend calling customer service at 1-800-888-1965 to discuss your specific situation and a claims research ticket can be created.

13. **How do we correct claims that were submitted since the new rates were just released? Should we void the prior claims and resubmit?**
If the billed amount is less than the new rate, you will need to submit a corrected claim using the new rates to allow for reprocessing. Resubmitted, corrected claims must be clearly marked as "corrected" using the appropriate resubmission code. However, if billed/charges are equal to, or greater than the new rate, Optum Maryland will reprocess the claim and no provider action is necessary. Details of the fee schedule update can be found in a Provider Alert, here.

14. **How can estimated payments stop before all the provider types are fully functional (Crisis, Capitation, and SE)?**
Great strides have been made in managing the various provider types, but we acknowledge there remain some outstanding issues and implementations in process. MDH and Optum Maryland continue to assess system functionality and these issues will be taken into consideration when making a final decision about estimated payments.

15. **Will there be any issue with PRP encounter claims entered before the cut off of July 12 and then the case rate billed after July 13. Will the system count the supporting data?**
*Yes, the system will continue to count the supporting encounters. *Post the Provider Council Meeting, MDH announced that estimated payments will continue through August 6, in order to account for the providers with monthly billing processes.*

16. **I have a participant that has had numerous inpatient hospitalizations during the last several months. I have been treating her for individual therapy in between her hospitalizations. Will I be paid for those services once I submit the claims? Primarily because a clinician cannot bill while their participants are in inpatient care.**
Claims are processed based on the date of service and will process correctly. The dates of service for individual therapy should not overlap the dates of an inpatient stay.

17. **Can a Provider run a report of all categories: denial reasons, payment, rejections (the reason why), completed, etc.?**
Currently, there is no functionality within IPP to allow for the export of claims reports. We are working with our technology partners on a possible future enhancement.

18. **In submitting claims, my provider info is linked to the client. Why do I have to reenter the ID number and my NPI and Tax ID?**
The entry of the identifying information is a validation point to ensure claims are being attributed to the correct participant and provider site.

19. **Can we bill claims where Medicaid is the secondary payer on the website? I need to submit an explanation of payments from the primary payer.**
Claims can be submitted on the website if there is another carrier paid amount. Paper claims are only required if the Primary carrier paid $0.00 and the provider is submitting via the provider portal. Primary carrier paid amounts in excess of $0.00 can be entered into the CMS-1500 form on the Incedo Provider Portal. There is currently no functionality to support the upload of EOB's.

20. **How should we be submitting ER Petition claims? Everyone I paper billed is either not on file or is denied for not being eligible.**
ER Petition claims should continue to be mailed in. For denials or missing claims, we would recommend calling customer service at 1-800-888-1965 to discuss your specific situation and a claims research ticket can be created.

21. **I had some denied claims that I resubmitted with a change to the POS service, but some of these were still denied as duplicates. Is that an error?**
We would recommend calling customer service at 1-800-888-1965 to discuss your specific situation and a claims research ticket can be created.

22. **As can be done with the authorizations tab, can a download be provided to create an Excel file with the claims tab to allow the same so we can keep track of claims denied with the reasons?**
Currently, there is no functionality within IPP to allow for the export of claims reports. We are working with our technology partners on a possible future enhancement.

23. **What do we do if our rendering providers have not been loaded into the IPP? Are we able to bill online or do we have to submit claims manually? Who do we contact to rectify this issue?**
Yes, claims can be submitted via the IPP system. The Rendering Provider NPI needs to be populated in the "rendering provider" field, Box 24 J on the CMS-1500 form.

Reconciliation

1. **Has Phase 1 of the reconciliation process started yet? I still have not received our reconciliation report.**
   Yes, Phase 1 of reconciliation started the week of July 20. To view the Reconciliation Process and Timeline, click here. Providers can also view all up-to-date reconciliation information such as the reconciliation survey, schedule of backlogged claims, FAQs and more, by visiting the dedicated webpage, here.

Payment

1. **Will the claim ID be listed in the 835 file format once we start receiving them? The 835 files we received back in January did not have this information listed and we were not able to electronically post payments into our EHR.**
   The patient control number will be included and returned on the 835 file. Additionally, the claim ID number generated by the IPP system will also be included.

PRP

1. **The PRP changes effective July 1, 2020 state that clients cannot be in PRP and several other types of services, specifically SUD-IOP. SUD-IOP services are short term, specific solely on sobriety and are not specific to independent living whereas PRP encompasses independence. With that in mind, will there be any provisions and/or exceptions for clients to be able to be in both SUD-IOP and PRP since the services are entirely different?**
   This is currently being reviewed by Optum Maryland. Please continue to submit requests for PRP, we are looking at participants transitioning out of different LoC, so they are not in both at once. We will allow time for this to happen, more info to follow in a Provider Alert.

General

1. **Why do we get random reference numbers for our calls when speaking to customer service? Many representatives that I encounter do not give out reference numbers at all.**
   Reference numbers should always be given for each call. We will investigate this matter to resolve this problem. If you are not given a reference number, please ask your representative for the number before the end of your telephonic interaction.

2. **Will there be an updated Provider Manual uploaded on the website? The current manual is from January 2020 and may be out of date?**
   Optum Maryland reviews and updates the Provider Manual on a monthly basis, which can be found on the Optum Maryland website, under the "Behavioral Health Providers" tab.