HCBS Provider Billing Guide

Revision 2.8.18

Claim Submission Options

All information necessary to process a claim must be received no more than 180 days from the date of service; however, this can vary by contract. Please refer to your United Healthcare Participation Agreement for your specific requirement. Providers may submit claims through a variety of channels:

- **Electronically** through an established claim clearinghouse – our electronic payer ID is 96385
- **Electronically** through KanCare Front End Billing (KMAP): https://www.kmap-state-ks.us/public/homepage.asp
- **Electronically** through UHCOnline web portal: https://www.unitedhealthcareonline.com
  - Once the provider receives their UHC Provider ID, create a user ID/password to access Claim Submission option.
- **Paper**: Must use original red and white CMS 1500. Mail paper claims to United Healthcare, P.O. Box 5270, Kingston, NY 12402.
- **Electronic Visit Verification (EVV)**: Most HCBS services require the use of EVV. Claims are billed via AuthentiCare.
  - https://www.authenticare.com/kansas/KSAuthentiCareUserManual.pdf

NPI Billing Requirements

- National Provider Identifier (NPI) is required for most KS providers. All provider identifiers must be valid group NPI numbers.
- Atypical providers are not required to have an NPI; however, if a group NPI is on record with UHC, it must be submitted on claims.

Client Obligation

- The HCBS client obligation is the payment amount the KanCare Clearinghouse determines HCBS participants must contribute toward the services they receive from contracted HCBS providers.
- Providers receive monthly reports listing the members and the amount of the client obligation to collect from each member.
- The client obligation amount is withheld from paid provider claims and published on the remittance as coinsurance.
- Members are also notified of their client obligation amount.

Avoiding Common Claim Errors

- Avoid billing address denials by always submitting the billing address provided on the credentialing paperwork in box 33 of the CMS 1500. To verify the billing address on file with UnitedHealthcare, please contact your HCBS Provider Advocate.
- When using Place of Service 11, include the group NPI in the rendering provider NPI field.
- Providers must bill date spans consistent with the authorization date spans to avoid claim payment issues.
- Best practice is to not overlap calendar months or years when billing claim dates of service.

Third Party Liability (TPL)

- Effective with dates of service **on and after July 1, 2016**, most HCBS codes are considered noncovered regardless of health insurance carrier and will not require proof of noncoverage prior to billing UHC. For a complete list of codes see the Third-Party Liability Noncovered Procedure Code List posted on the KMAP Provider page: https://www.kmap-state-ks.us/Public/TPL%20Noncovered.asp.

Electronic Payments & Statements (EPS)

- With Electronic Payments & Statements (EPS), providers can use a single tool to receive electronic funds transfer (EFT) and electronic remittance advice (ERA). By enrolling in EPS, providers receive claims payments by direct deposit and can access Explanations of Benefits (EOBs)/Provider Remittance Advices (PRA) online or via 835 ERA files.
- Users receive payments and remittance advices 5 to 7 days faster than with paper.
- Receive email notifications when payments are deposited to your designated bank account(s).
- View the amount of the deposit and all remittance advice associated with that deposit by logging on to EPS.
- View or print remittance advice and post payments manually to your practice management system, or auto-post using the 835 ERA file
- Online enrollment process is accessible at https://myservices.optumhealthpaymentservices.com/registrationSignIn.do

Self-identified Overpayment or Refund Requests

- Providers, who wish to refund an overpayment on any UnitedHealthcare Community and State account for the KanCare program, may do so by submitting a check to the following address: United HealthCare, PO Box 5230, Kingston NY 12401.
- To ensure the refund is accurately credited, checks should be accompanied with the following information: member's full name; member's Medicaid ID; date of service; amount original paid by UHC; amount overpaid (must match check); reason amount is considered overpaid; claim number; UID from recovery letter (if applicable); copy of UHC remit; provider's Tax ID# and name/number of person submitting refund.
- Information to accompany refund checks can be found here: http://www.uhccommunityplan.com/health-professionals/ks/provider-forms.html

Claim Correction

If it is determined that an error was made on the original claim either based on an internal review or how the claim was processed, providers have 365 days from the remittance date to submit a corrected claim.

- To file a corrected claim **Electronically** through **Link: claimsLink Application**:
  - Follow steps outlined in the Link: claimsLink Claim Reconsideration/Corrected Claims Quick Reference Guide. .
  - Choose Reason Request = Submission of a corrected Claim
  - Follow the next steps as prompted, ie. New Comment, Attachments, etc.
  - Use the Comments field to clearly explain in detail what you are expecting with the corrected claim.
  - Attach a corrected CMS 1500 to the request. Write "CORRECTED" on the face of the claim. Add Resubmission code "7" and the United original claim number in Box 22.
  - Monitor the status by following the steps outlined in the claimsLink - Claim Reconsideration/Corrected Claims Quick Reference Guide
- To file a corrected claim **Electronically** through the **KMAP Front End Billing** option:
  - Create a new blank professional claim on KMAP. Cannot edit the existing incorrect claim.
  - Enter the United original claim number (from the UHC remittance advice) in the Timely Filing Override ICN Field.
  - Provide all the correct claim information and submit as a new claim.
- To file a corrected claim via **Paper**:
  - Original red and white CMS 1500 must be used.
  - Write "CORRECTED" on the face of the claim. In box 22, enter resubmission code "7" (replacement request) or "8" (void request) and the UHC original claim number in the Original Ref. No. field.
  - Mail corrected claims to: United Healthcare, P.O. Box 5270, Kingston, NY 12402.
  - Allow up to 30 days for corrected claim to be processed when submitted by paper.
- To correct an **EVV/AuthentiCare** claim:
  - If the EVV claim was already released, providers should follow one of the above corrected claim processes.

Claim Reconsideration

If the claim was filed correctly but did not pay as expected, providers may submit a Claim Reconsideration to request a review of the claim.

- Providers have 120 calendar days, plus 3 calendar days if the notice is mailed, from the remittance date to submit a reconsideration.
- Reconsideration is an optional process available to providers prior to submitting an appeal.
- Reconsideration requests can be submitted through various means:
  - **Electronically**: UnitedHealthcare portal (uhcprovider.com) using the Link: claimsLink Application. Follow steps outlined in the Link: claimsLink Claim Reconsideration Quick Reference Guide.
  - **Phone**: 877-542-9235
  - **Paper**: Use the Claim Reconsideration Request Form (available on uhccommunityplan.com) sending request to UnitedHealthcare Community Plan, PO Box 31350, Salt Lake City, UT 84131-0350
- Monitor the status by following the steps in the claimsLink - Claim Reconsideration/Corrected Claims Quick Reference Guide.
- Providers may terminate the reconsideration process and submit a formal appeal request within 60 calendar days of the original remittance notice of action, plus 3 calendar days if the notice is mailed.
- If you disagree with a claim reconsideration decision, you have the right to file a formal claim appeal within 60 calendar days of the reconsideration notice of action.

Claim Appeal

- Appeals must be filed in writing within 60 calendar days of the date of the provider remittance or notice of action, plus 3 calendar days if the notice is mailed.
- Request must state in the document this is a "formal appeal". State the specific reason for denial as stated on the remittance or notice of action. Enclose all relevant documentation with the appeal request.
- Filing an appeal is final. Providers cannot submit a reconsideration following the appeal decision.
- Send written request via regular mail to: UnitedHealthcare, Attention: Formal Grievances and Claim Appeals, PO Box 31364, Salt Lake City, UT 84131-0364
- If you disagree with the appeal outcome, you can file a State Fair Hearing.

Online Resource: **www.uhcprovider.com** is the provider's single source for everything from UnitedHealthcare administrative guides and policies to Link self-service.

- **Link** is the gateway to online self-service tools: claimsLink; eligibilityLink; Prior Authorization & Notification; UHC on Air; etc.
- **Claims, Billing and Payment:** Manage your practice's submission of claims and receipt of payments via claimsLink.
- **Eligibility and Benefits:** Tools to verify member eligibility, determine benefits, view care plans and more.
- **Prior Authorization & Notification:** Check the status of HCBS prior authorizations.
- **Health Plans by State**: Access UHC Community Plan – KS Providers, select "*Kansas*" from the drop down and then click "*Go to UHCCommunityPlan.com*". Fine information such as the KanCare Program Administrative Guides, Claim and Member Information, Newsletters, Bulletins, Provider Forms, Value Added Benefits for members, etc.
- **Resource Library:** Links to the latest UnitedHealthcare news, information on joining our network, helpful tips for using Link Self-Service Tools and training resources available including live instructor-led sessions or recorded webinars.
- **Latest UnitedHealthcare Provider News**