UnitedHealthcare
Community Plan

HCBS Provider Billing Guide

Revision 4.20.17

Claim Submission Options

All information necessary to process a claim must be received no more than 90 days from the date of service. 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.

Date Span Billing

- 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.

Client Obligation

- The HCBS client obligation is the payment amount the KanCare Clearinghouse determines HCBS recipients 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.

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 bulletin Third-Party Liability Noncovered Procedure Code List posted on our website www.uhccommunityplan.com> For Health Care Professionals> Kansas> Bulletins. The list will be updated on an annual basis.

Avoiding Common Claim Errors

- Avoid billing address mismatch 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.

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.
- 835s and PDF versions of the remittance advice documents are available online the same day the payment is made, making reconciliation easy.
- EOBs are easy to view or save to your computer. Claims and payment histories are available on the EPS website for up to 13 months.
- Print a consolidated file (less paper) of EOBs or Provider Remittance Advices that are identical to the EOBs received in the mail.
- Online enrollment process is accessible at www.optumhealthfinancial.com.

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: UnitedHealthcare Insurance Company, PO Box101760, Atlanta, GA 30354-1705.
- To ensure the refund is accurately credited, checks should be accompanied with the following information: member's full name, member's Medicaid or UHC subscriber ID#, provider's Tax ID#, claim ID number, dates of service, billed amount, refund amount (must match check) and detailed reason for overpayment. Providing the EOB is also very helpful.
- If the refund is due to the receipt of an overpayment/recovery letter, please include the UID number from the letter or a copy of the letter.

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 Link: claimsLink Quick Reference for corrected claims.
  - Choose Reason Request = Submission of a corrected Claim
  - Select Corrected Claim Reason = Attach Copy of 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 Claims Reconsideration Status & Update/Resubmit Quick Reference.
- To file a corrected claim **Electronically** through the **KMAP Front End Billing** option:
  - Start with 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 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. Add Resubmission code "7" and the United original claim number in Box 22.
  - 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.

- For claims processed on or after 5.1.17, providers have 120 calendar days, plus 3 calendar days if the notice is mailed, from the remittance date to submit reconsideration.
- For claims processed prior to 5.1.17, providers have 365 calendar days from the remittance date to submit reconsideration.
- Reconsideration is an optional process available to providers prior to submitting an appeal.
- Reconsideration requests can be submitted through various means:
  - **Phone**: 877-542-9235
  - **Electronically**: UnitedHealthcare portal (uhconline.com) using the Link: claimsLink Application. Follow steps outlined in the Link: claimsLink Quick Reference
  - **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 outlined in the Claims Reconsideration Status & Update/Resubmit Quick Reference.
- 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.

Website Resources

- www.uhccommunityplan.com: Public site. Click "For Health Care Professionals", select "Kansas" from the drop down box to access provider information such as Provider Administrative Guides, Claim and Member Information, Newsletters, Bulletins, Provider Forms, Value Added Benefits for members, etc.
- www.uhconline.com
  - Non-secure section: user name/password not required. Current News and Quick Links on home page. Help and Tools & Resources to access training/education resources, quick reference guides and tutorials.
  - Secure section - user name/password required. Includes access to claim submission, checking claim status, accessing electronic payments and statement, submitting claim reconsiderations, etc.