UHC Status update:

1. **<u>Taxonomy Codes required on Claims:</u>**

- June 11, 2015 update – UHC suspended its taxonomy billing requirements on May 18, 2015.
- While our goal in collecting taxonomy codes was to provide accurate Encounter data to DHH, we do not want to impose an additional burden on our Provider network to reach that goal. We will continue our pursuit of taxonomy information in the future, re-informing providers of requirements prior to implementing a claims edit.
- Claims denied solely for missing Taxonomy code(s) are being reprocessed.

2. **<u>Drug Codes billed under Revenue Codes 250/636 on UB04 claims:</u>**

- UHC transitioned from a Shared to Pre-paid MCO on 2/1/15, implementing Outpatient UB04 reimbursement utilizing the DHH/Molina "Outpatient Hospital Non-Ambulatory Surgery Schedule" as written
    - All drug codes documented on the Fee Schedule were activated as "covered" codes when billed on an Outpatient Non-Ambulatory Surgery claim
    - All drug codes not specifically listed on the Fee Schedule were active as non-covered codes, denying when billed on an Outpatient Non-Ambulatory Surgery claim
- UHC received feedback from providers that the these codes had been reimbursed in FFS Medicaid, even though they were not specifically listed on the Outpatient Non-Ambulatory Surgery Fee Schedule
- DHH confirmed in May that these codes were reimbursed historically
- UHC established a small, cross-functional team to review the drug codes currently set to deny when billed on a Hospital Outpatient Non-Ambulatory UB04, with the intent to approve most if not all of the codes so they're payable when billed.
    - Determination has been made and the system updated for the majority of the known high-volume codes. Evaluation of the remaining codes continues.
    - Note – it may be determined that some codes are truly not covered, and others require Prior Authorization.
    - UHC will communicate any new PA requirements to providers

3. **<u>FQHC/RHC Claims billed with non-FQHC/RHC Place of Service</u>**

- UHC initially built FQHC/RHC providers to bill their T1015 PPS rate with POS 3, 50 or 72
- We've recently modified our system logic to allow FFS reimbursement for non-PPS services billed with POS 21, 22, etc.
    - Previously denied claims billed with valid POS are being reprocessed.
    - Note – FQHCs and RHCs should not utilize POS 11

4. **<u>TPL</u>**

- It was brought to our attention that some of our Provider Call Center team members are providing TPL information relevant to our <u>former pre-2/1/15 Shared Savings contract</u>, where Molina was the primary owner of TPL verification. We realize the TPL process changed drastically under our new contract, and we're working to ensure all Call Center team members are reminded of these important changes:
    - Effective 2/1/15, UHC became responsible for all TPL processes for our members; including services they may have received prior to 2/1/15. This responsibility includes, but is not limited to:
        - Receiving and verifying TPL from the following sources -
            - Weekly TPL files from Molina
            - Monthly and Quarterly COB files from HMS, Optum, and other vendors contracted to identify and verify third-party coverage
            - Primary Carrier EOBs/RAs submitted with claims
            - Primary Carrier leads phoned in to Provider Call Center
            - Primary Carrier documentation submitted by provider offices via Fax
            - Primary Carrier documentation received by DHH/Molina and sent via paper to relevant MCOs
        - Confirming TPL coverage and loading it into our system to ensure accurate claims processing

- Submitting files of verified TPL information to Molina so they can update MEVS for easy provider reference

5. **Paper RAs with no Check or documented Check #**

- RAs for UHC's 5/8/15 check date were erroneously generated with no corresponding checks or check #s
  - This impacted only non-EFT providers
- Impacted Providers can destroy these RAs
- New RAs with check #s and corresponding checks have been generated

6. **Vision Screenings, Circumcisions – payment in addition to Evaluation and Management service**

- Providers are encouraged to review the CMS definition and utilization recommendation for Modifier -25 for possible use with E&M codes billed with Vision Screenings, Circumcisions, etc.

7. **39-Week Initiative**

- UHC follows the process established by the Administrative Simplification Committee, requiring all delivery CPT codes be billed with 1 of 3 established modifiers that define the delivery:

Modifier	Description	Claim Process Rules
GB	Delivery is **39 weeks or more**	Claim will be adjudicated
AT	Delivery is *less than 39 weeks* and medically indicated/spontaneous	Claim will be adjudicated
GZ	Delivery is *less than 39 weeks* and **NOT** medically indicated	Claim will be adjudicated (Deny)
None	Claim will Deny for incomplete information	Claim will Deny

- All Physician delivery claims are subject to retrospective review to confirm Modifier utilized matches LEERS documentation.
- If Modifier does not match LEERS documentation, claim is ultimately subject to recoupment.
- Related facility claims would also be recouped
- Note – pre-2/1/15 OB Claims for our former Shared members are subject to Molina's FFS 39-week processes. These delivery claims will not be paid until LEERS data is accurate.

8. **Newborn Birth Weight**

- Not related to 39-week Initiative
- UHC requires that a newborn's birth weight, in grams, be submitted via Value Code 54 on the newborn's initial UB04 claim

9. **Enteral Feeding supplies – claim submissions**

- Please ensure historical DOS range on claim covers entire period during which the member will utilize the supplies. Future DOS will not be reimbursed.