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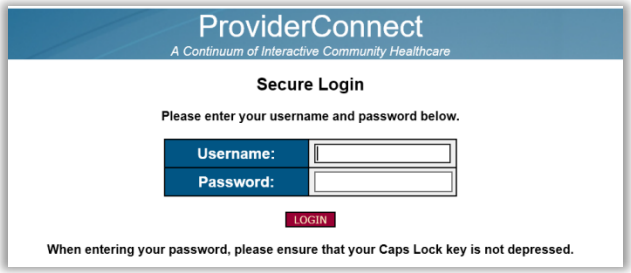
What is ProviderConnect?

Often referred to as PCONN, ProviderConnect is a secure web-based tool that interfaces directly with Optum's business system. It allows providers to submit client reporting data, create treatments, submit billings and view claim adjudication results.

Login

- ProviderConnect is accessed using the link below:
  - Copy and paste this link into your web browser: *https://providerconnect.netsmartcloud.com/saltlake/*

- Once PCONN has been accessed, you will be required to enter your username and password.
- Optum Network will provide you with your username and a temporary password.

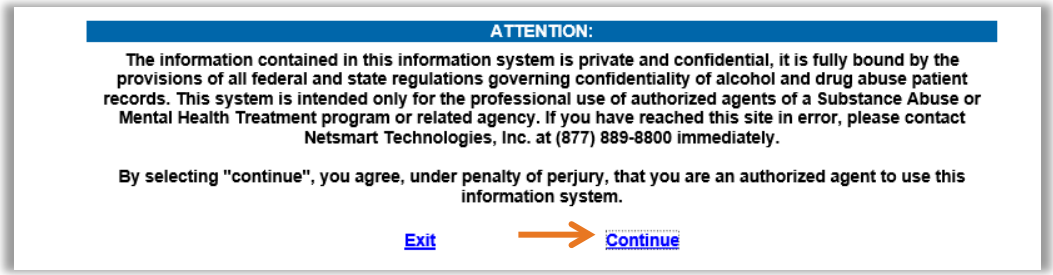


Helpful Tips:

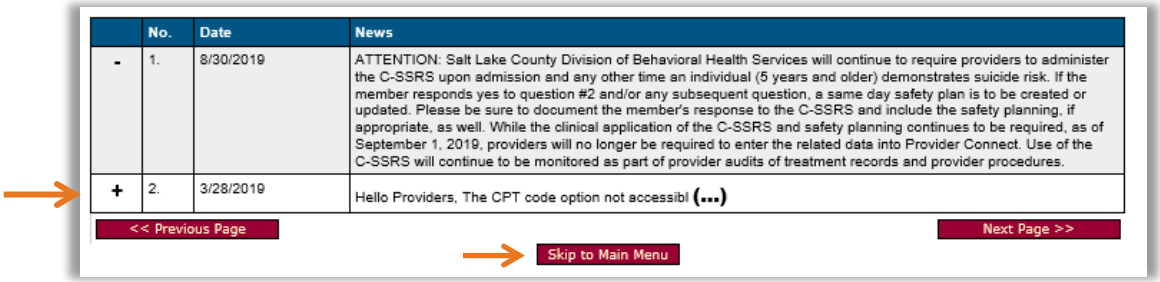
- ✓ *When accessing PCONN the first time, you will be prompted to set your own password. Passwords are assigned to individual staff, not to the facility.*
- ✓ *Usernames and passwords are not to be shared. Please contact Optum Network if a user needs access to ProviderConnect.*
- ✓ *User profiles are set to inactive if the log-in credentials have not been used in 45-days.*
- ✓ *When creating your password, please keep the following requirements in mind:*
  - *Password cannot be "password"*
  - *Passwords must be between 6 and 30 characters.*
  - *Passwords are case-sensitive.*
  - *Passwords cannot be the same as your username, or your username backwards.*

Navigation

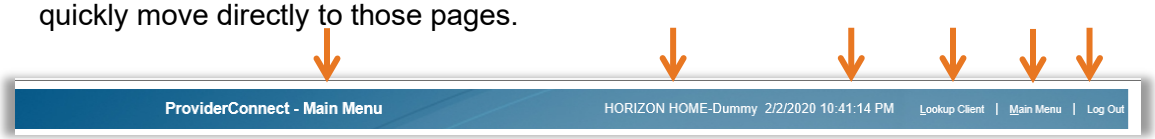
- Once logged in, you are required to attest to the confidentiality of the data. Select 'Continue' to agree and to proceed to the next page.



- The 'News' section below is a tool used by Optum to communicate directly with providers. In this section we will communicate planned system outages or breaks. Please be sure to check this section regularly.
- Select the plus sign to read full text.
- Select 'Skip to Main Menu' to proceed.

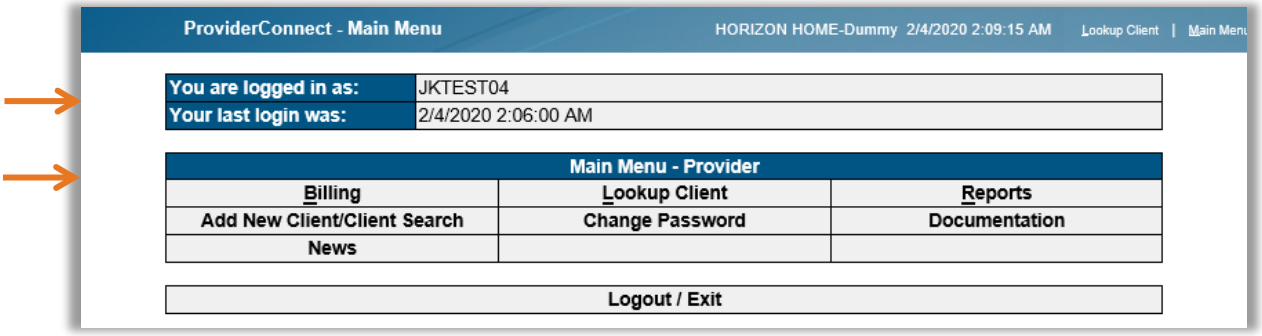


- ProviderConnect ribbon shown below is present at the top of each page. It includes form/page name, provider/agency name, current date and time. In addition, the links presented in the right corner for 'Lookup Client', 'Main Menu' and 'Log Out', allow you to quickly move directly to those pages.



Main Menu

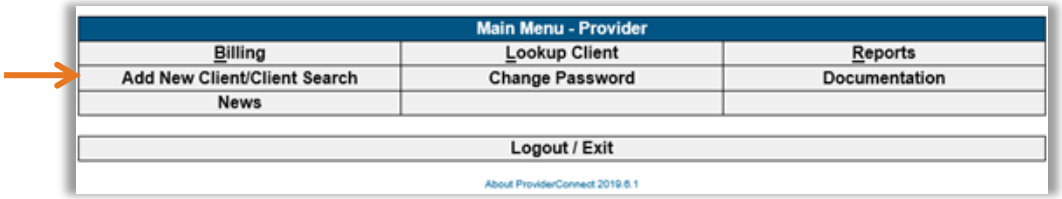
- In addition to displaying the navigation bar at the top described above, the Main Menu also displays the following:
  - Login username and last login date and time.
  - Navigational links to the forms/pages.



- The following is a high-level summary of each section:
  - **Billing:** Allows user to submit bills to Optum.
  - **Lookup Client:** Used to search for clients who have been assigned a client specific authorization for your agency.
  - **Reports:** Ability for the user to run reports regarding authorizations and claims submitted via ProviderConnect.
  - **Add New Client/Client Search:** Used to search for clients already in the Optum system or to add a new client to the system.
  - **Change Password:** Allows the user to update their password.
  - **Documentation:** Contains a link to a Netsmart ProviderConnect website for general product information.
  - **News**: This link will take you to the same page previously viewed during login.
  - **Logout / Exit:** Used to log out of ProviderConnect

Client Admission – Add New Client/Client Search

- In the Main Menu, click on “Add New Client/Client Search”



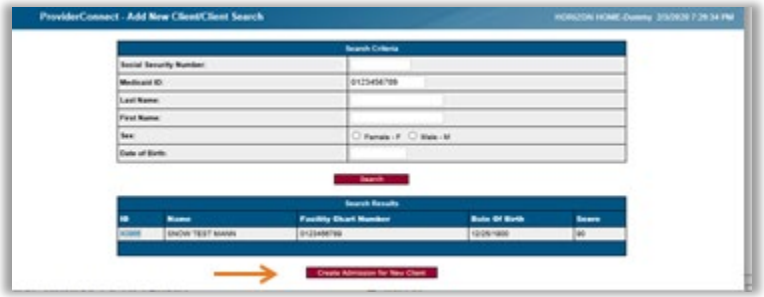
- Enter clients Medicaid ID (Required Field)
  - *Medicaid numbers are 10 digits in length and always have a leading zero*
  - *Ensure there are no spaces before or after the 10-digit number*
  - *Leave all other fields blank to ensure accurate search results.*
- Select the ‘Search’ button.

- If the member is found, click on the blue hyperlink member ID to open the Client Record.
  - *Verify the name, Medicaid Id number and DOB to validate if the member is the same as your member.*

Helpful Tip:

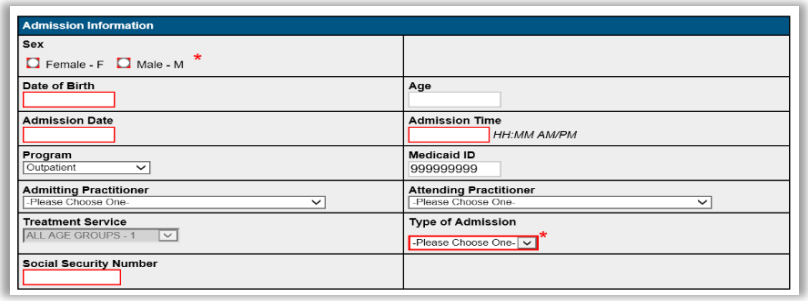
✓ *If you see a member with a middle name of ‘**DONOTUSE**’, that means the client record is not available for use and should not be selected.*

- If the member is not found, select “Create Admission for New Client”

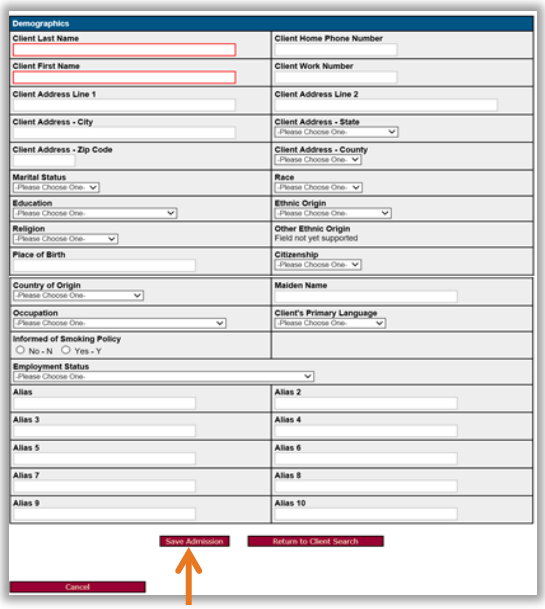


In the Admission information, enter client's data:

- Sex. *This must match the client's legal gender with Utah Medicaid.*
- Date of birth
- Admission Date
- Admission Time
- Program Will *this will default to 'outpatient'.*
- Medicaid ID will prefill based on entry on previous page.
- Admitting Practitioner *LEAVE AS IS*
- Attending Practitioner *LEAVE AS IS*
- Treatment Service *LEAVE AS IS*
- Type of Admission
- Social Security Number *if unknown, enter 999-99-9999*



- In the Demographics section, enter client's data:
  - Client Last Name *cannot contain any spaces or special characters, including apostrophes.*
  - Client First Name *cannot contain any spaces or special characters, including apostrophes.*
  - All remaining fields can be populated if the data is available.



Helpful Tips:

✓ *Client name must be entered as it appears on their Utah Medicaid ID card.* ***Do not solely rely on a member's self-reported name.***

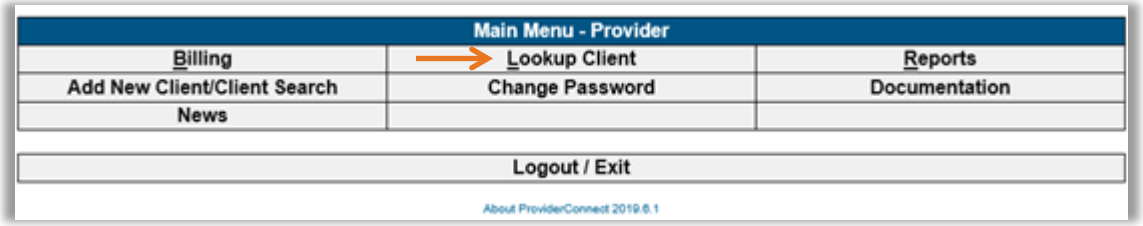
✓ *All fields in* ***red*** *are required and must be completed before saving the record.*

- Once all fields have been entered, click 'Save Admission'. The system will return to the Main Menu upon saving.

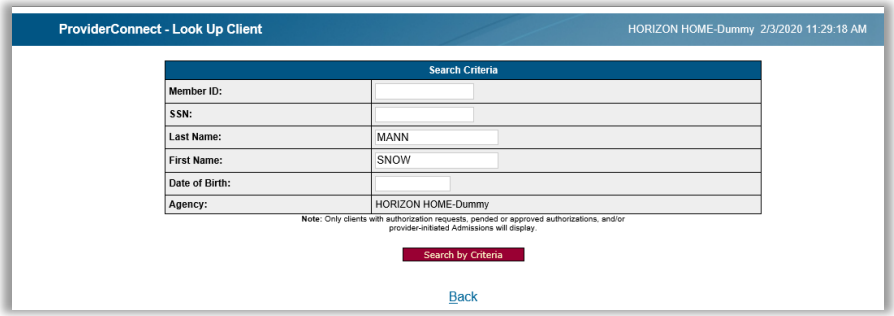
Lookup Client

SEARCHING FOR CLIENTS ALREADY ADDED TO YOUR PRACTICE

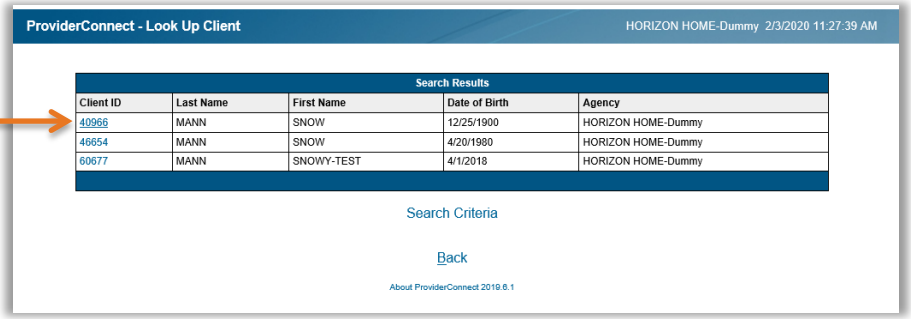
- In the Main Menu, click “Lookup Client”



- Enter client data into the form, then click ‘Search Criteria’



- Click the blue Client ID number to view the consumer’s Demographic information.



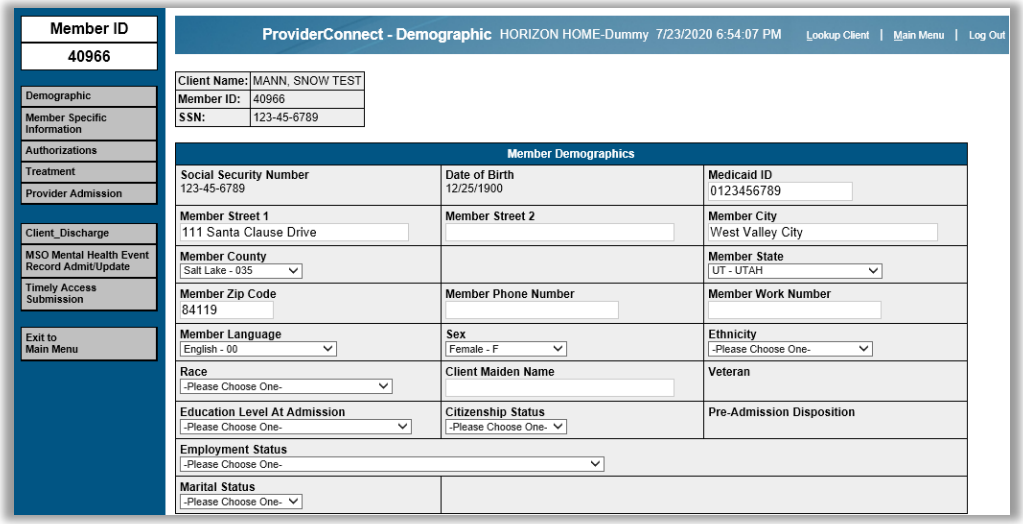
Helpful Tip:

✓ *Make note of the Client ID number generated by the ProviderConnect system in your agency’s medical record for future reference*

Client Record

UNDERSTANDING THE CLIENT RECORD

- The page below is the client's 'home page'.



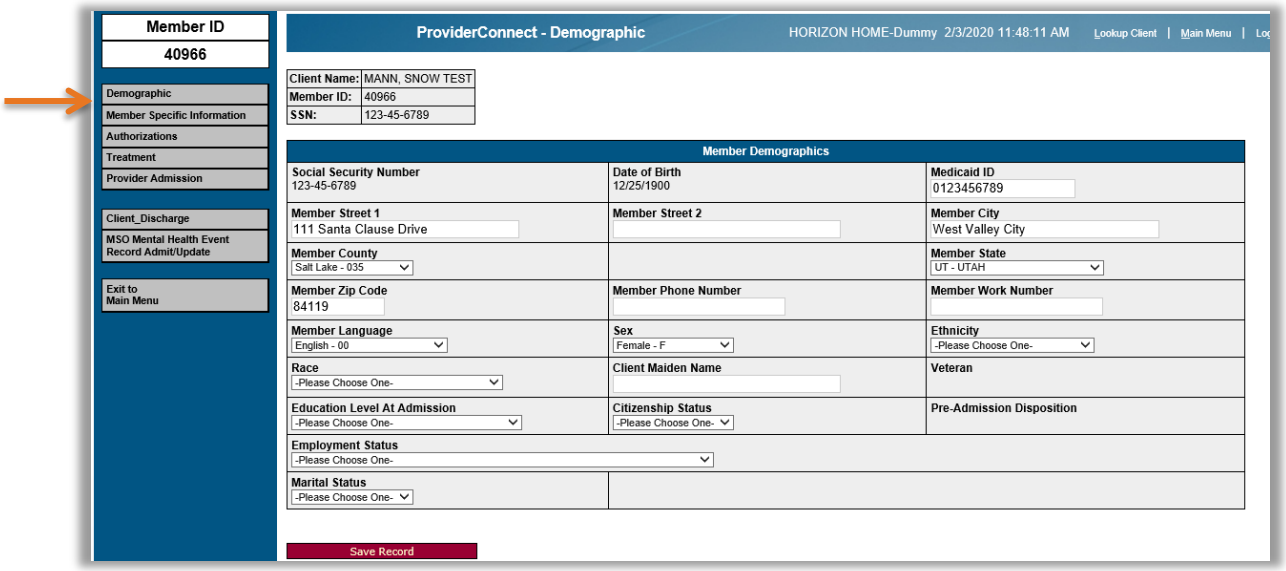
- The navigation bar on the left includes the following information. The following is a high-level summary of these functions:

- **Demographic**
  - **Member Specific Information**: This is the client's eligibility record. Optum updates the eligibility records weekly and monthly. No user data entry is required.
  - **Authorizations**: All services require an authorization. This form will allow you to view higher level of care authorizations that have been created for the client.
  - **Treatment:** This is the first step in billing. It is where you go to enter the details associated with each service provided to the client.
  - **Provider Admission**: All clients are assigned an episode in Optum's system; this tab shows a summary of the episodes. No user data entry is required.
  - **Client Admit/Discharge:** This form is used admit and discharge clients to and from your practice.
  - **MSO Mental Health Event Record Admit/Update:** Required for all mental health services, this form allows you to create new and update existing records.
  - **Timely Access Submission:** This form is a Medicaid Quality Requirement for reporting timely service delivery. This form allows you to report access to care data.

Helpful Tips:

✓ *The form above is a snapshot of what the form could look like if full access has been granted to ProviderConnect. You may not have access to all options. Please check with Optum Network if there is a question about access.*

Demographics

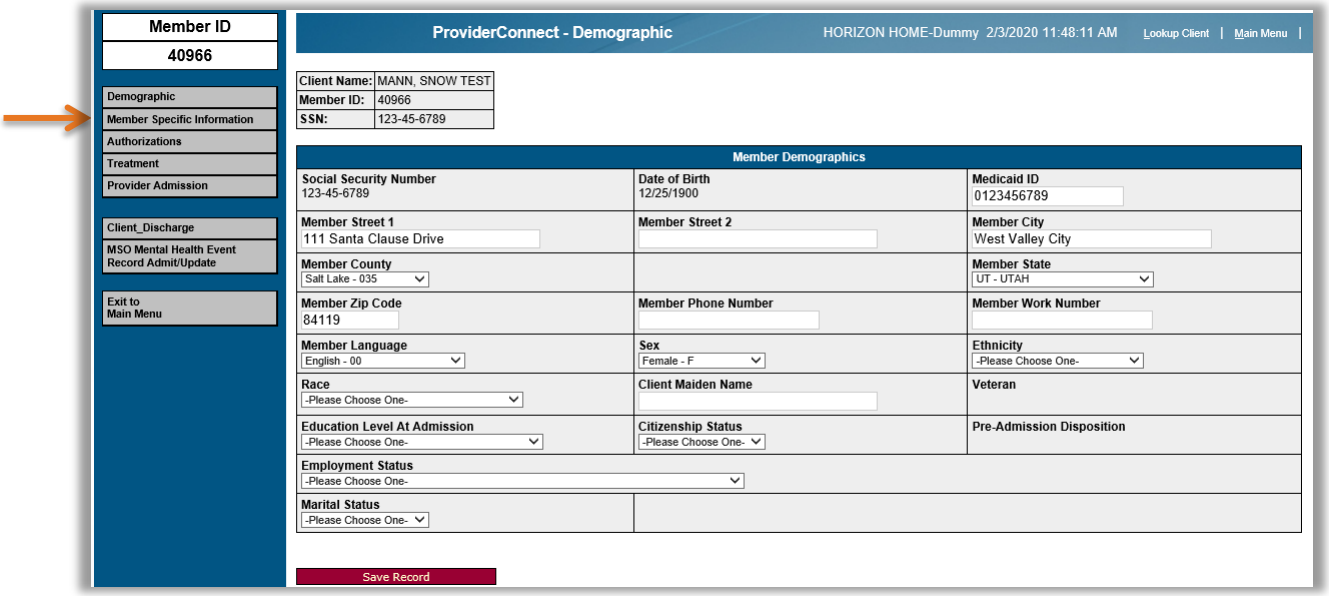


The fields listed below are locked down after initial entry must match the client's record in Utah Medicaid's system. If a field doesn't match, please contact Optum Network to update the client's record:

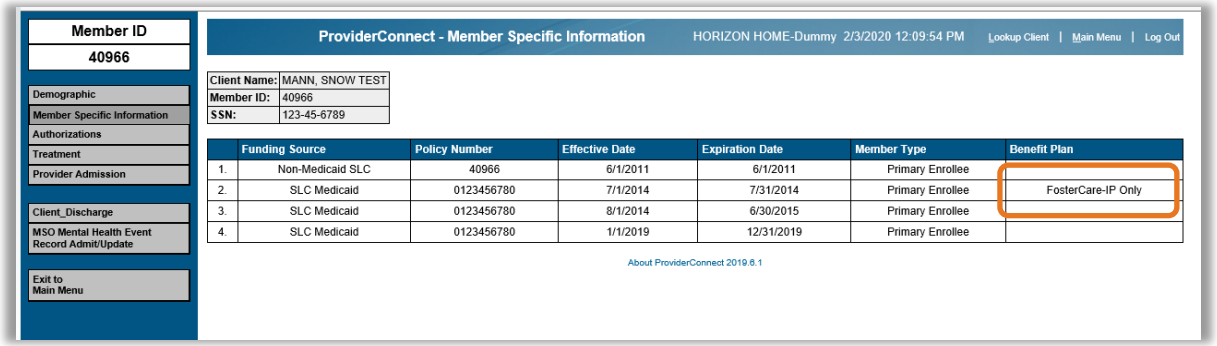
- Client name
- Social Security Number
- Date of Birth
- Medicaid ID *must be 10 digits beginning with a zero*

- The remaining fields can be updated as new data becomes available.

Member Specific Information



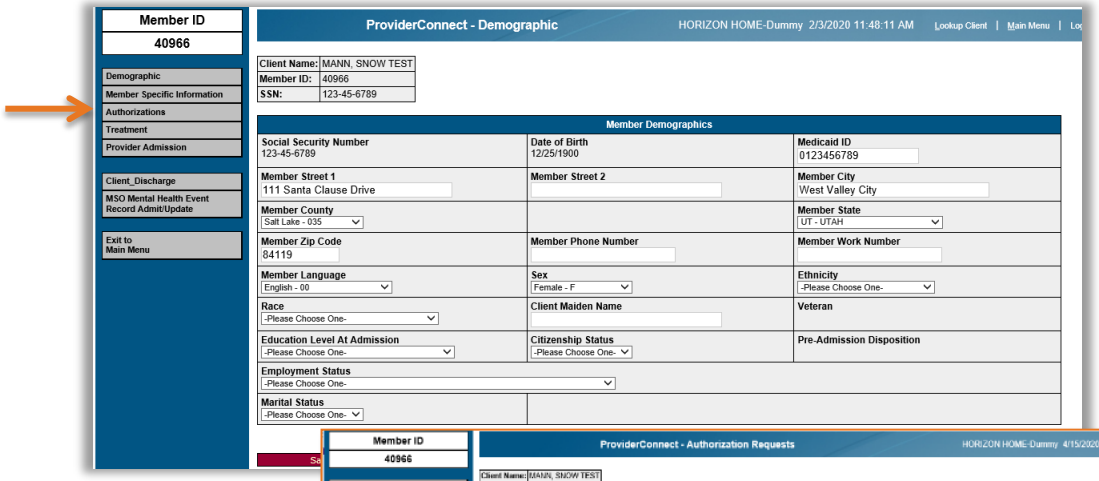
- Member Specific Information records are added/updated by Optum. They cannot be created or modified by users directly in PCONN.
- Each record will show the client's Medicaid ID, along with the effective and expiration dates for each timespan.
- Clients with 'FosterCare-IP Only' listed in the benefit plan column are ineligible for all services except inpatient.

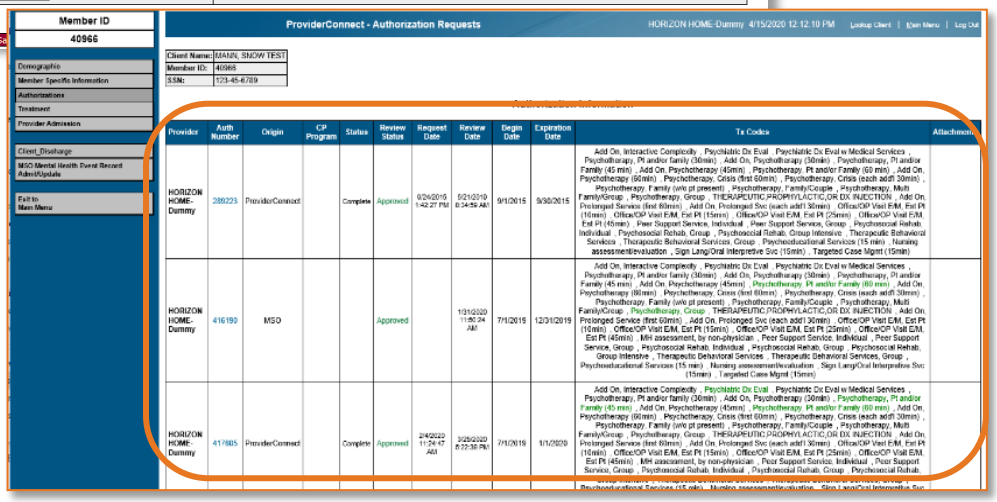


Authorizations

Client specific higher level of care authorizations are viewable in this form. Blanket authorizations are not viewable here.

Accessing the Authorization form in Provider Connect





- When selecting 'Authorization' from the left navigation bar, the following page will be displayed:

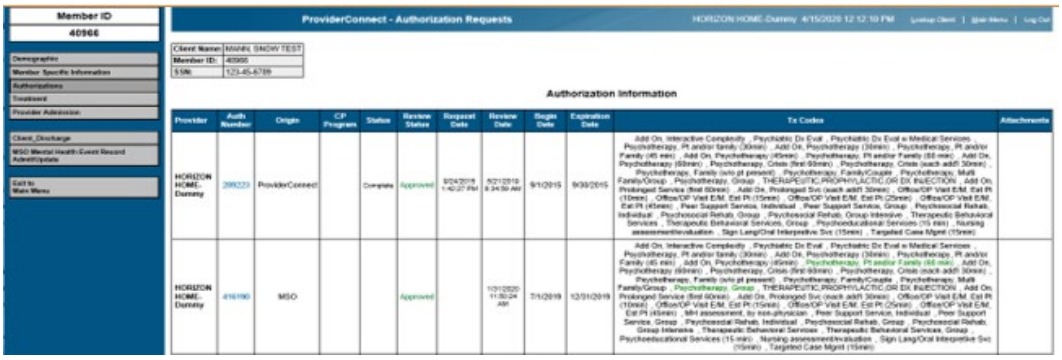
- The form contains the following columns of data:
  - Authorization number
  - Status – will show the current status of the authorization
  - Review Status – *Actual authorization status. Possible statuses are as follows:*
    - Approved *treatments can be created using this auth*
    - Denied *treatments cannot be created using this auth*
    - Pending *treatments cannot be created using this auth*
  - Request Date – *Date auth was created*
  - Review Date – *Date auth determination was made*
  - Begin Date – *Current authorization start date*
  - Expiration Date – *Current authorization end date*
  - TX Codes – *Procedure codes currently assigned to the authorization*

Optum utilizes two types of Authorizations

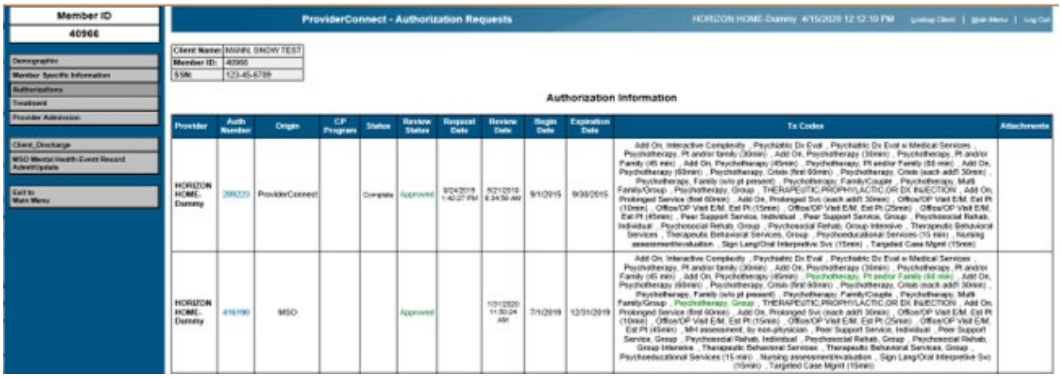
- **Outpatient Level of Care** - for standard outpatient level services and does not include IOP, Day Treatment, or Psych Testing. *Created by Optum's Operations team.*
- **Higher Level of Care** - *Created by Optum Care Advocates.*

Outpatient Level of Care - Optum issues Contracting Provider Service Authorizations, also referred to as "blanket auths" for standard outpatient level services for in-network providers.

- The provider is issued blanket authorizations numbers, unique to the provider (*not client*) and fund source (i.e. County) and service type (i.e. mental health vs. substance use).
- Includes:
  - **Mental health outpatient (MH_OP**) - Created for standard mental health outpatient services performed telephonically or in person.
  - **Substance use 1.0 (SA10)** - Created for standard substance use outpatient services performed telephonically or in person.
  - **Telehealth (TELEHEALTH)** - Created for standard mental health and substance use outpatient services performed via telehealth, using HIPAA compliant technology.
- The authorization numbers begin with 'P' and are typically followed by 3 to 4 digits.
- ***Please Note: Blanket authorizations are NOT*** viewable in client's authorization form in ProviderConnect.



Higher Level of Care Authorizations - Member specific authorizations are used when billing higher level of care services and display in this screen.



MH_OP Authorization Group

The following is a list of the codes included in the MH_OP authorization group.

- ***IMPORTANT NOTE**: **The following codes will be visible and will allow the user to select any code within the group but does not guarantee payment. Payment of specific codes is based on each provider's individual contract**. If you have questions about what codes you are contracted to provide, please contact Optum Network.*

Code	Description	Code	Description
90785	Add On, Interactive Complexity	99214CG	Office/OP Visit E/M, Est Pt (25min)
90791	Psychiatric Dx Eval	99215CG	Office/OP Visit E/M, Est Pt (45min)
90792	Psychiatric Dx Eval w Medical Services	99417	Add On, prolonged Svc, E/M (each add'l 15 min)
90832	Psychotherapy, Pt and/or family (30min)	H0031	MH assessment, by non-physician
90833	Add On, Psychotherapy (30min)	H0038	Peer Support Service, Individual
90834	Psychotherapy, Pt and/or Family (45 min)	H0038HQ	Peer Support Service, Group
90836	Add On, Psychotherapy (45min)	H0046	Personal Care, MH NOS
90837	Psychotherapy, Pt and/or Family (60 min)	H0046U1	Personal Care, MH NOS per diem
90838	Add On, Psychotherapy (60min)	H2014	Psychosocial Rehab, Individual
90839	Psychotherapy, Crisis (first 60min)	H2017	Psychosocial Rehab, Group
90840	Psychotherapy, Crisis (each add'l 30min)	H2017U1	Psychosocial Rehab, Group Intensive
90846	Psychotherapy, Family (w/o pt present)	H2019	Therapeutic Behavioral Services
90847	Psychotherapy, Family/Couple	H2019HQ	Therapeutic Behavioral Services, Group
90849	Psychotherapy, Multi Family/Group	H2027	Psychoeducational Services
90853	Psychotherapy, Group	S5150	Unskilled Respite (non hosp svc)
96372	Therapeutic, Prophylactic or DX Injection	T1001	Nursing Assessment/evaluation
99354	Add On, Prolonged Service (first 60min)	T1013	Sign Lang/Oral Interpretive Svc
99355	Add On, Prolonged Svc (each add'l 30min)	T1017	Targeted Case Mgmt
99212CG	Office/OP Visit E/M, Est Pt (10min)	T2002	Non-Emergency Transportation per diem
99213CG	Office/OP Visit E/M, Est Pt (15min)	T2002HX	Non-Emergency Transportation

Please Note: This information is based on CMS and Medicaid regulations and is subject to change.

SA10 Authorization Group

The following is a list of the codes included in the SA10 authorization group.

***IMPORTANT NOTE**: **The following codes will be visible and will allow the user to select any code within the group but does not guarantee payment. Payment of specific codes is based on each provider's individual contract.** If you have questions about what codes you are contracted to provide, please contact Optum Network.*

Code	Description
90785	Add On, Interactive Complexity
90791	Psychiatric Dx Eval
90792	Psychiatric Dx Eval w Medical Services
90832	Psychotherapy, Pt and/or family (30min)
90833	Add On, Psychotherapy (30min)
90834	Psychotherapy, Pt and/or Family (45 min)
90836	Add On, Psychotherapy (45min)
90837	Psychotherapy, Pt and/or Family (60 min)
90838	Add On, Psychotherapy (60min)
90839	Psychotherapy, Crisis (first 60min)
90840	Psychotherapy, Crisis (each add'l 30min)
90846	Psychotherapy, Family (w/o pt present)
90847	Psychotherapy, Family/Couple
90849	Psychotherapy, Multi Family/Group
90853	Psychotherapy, Group
96372	Therapeutic, Prophylactic or DX Injection
99354	Add On, Prolonged Service (first 60min)
99355	Add On, Prolonged Svc (each add'l 30min)
99212CG	Office/OP Visit E/M, Est Pt (10min)
99213CG	Office/OP Visit E/M, Est Pt (15min)
99214CG	Office/OP Visit E/M, Est Pt (25min)
99215CG	Office/OP Visit E/M, Est Pt (45min)
99417	Add On, Prolonged Svc, E/M (ea add'l 15 min)
H0006	Substance Abuse Case Management
H0031	MH assessment, by non-physician
H0038	Peer Support Service, Individual
H0038HQ	Peer Support Service, Group
H0046	Personal Care, MH NOS
H2014	Psychosocial Rehab, Individual
H2017	Psychosocial Rehab, Group
H2017U1	Psychosocial Rehab, Group Intensive
H2019	Therapeutic Behavioral Services
H2019HQ	Therapeutic Behavioral Services, Group
H2027	Psychoeducational Services
S5150	Unskilled Respite (non hosp svc)
T1001	Nursing Assessment/evaluation
T1013	Sign Lang/Oral Interpretive Svc

Please Note: This information is based on CMS and Medicaid regulations and is subject to change.

TELEHEALTH Authorization Group

The following is a list of the codes included in the TELEHEALTH authorization group.

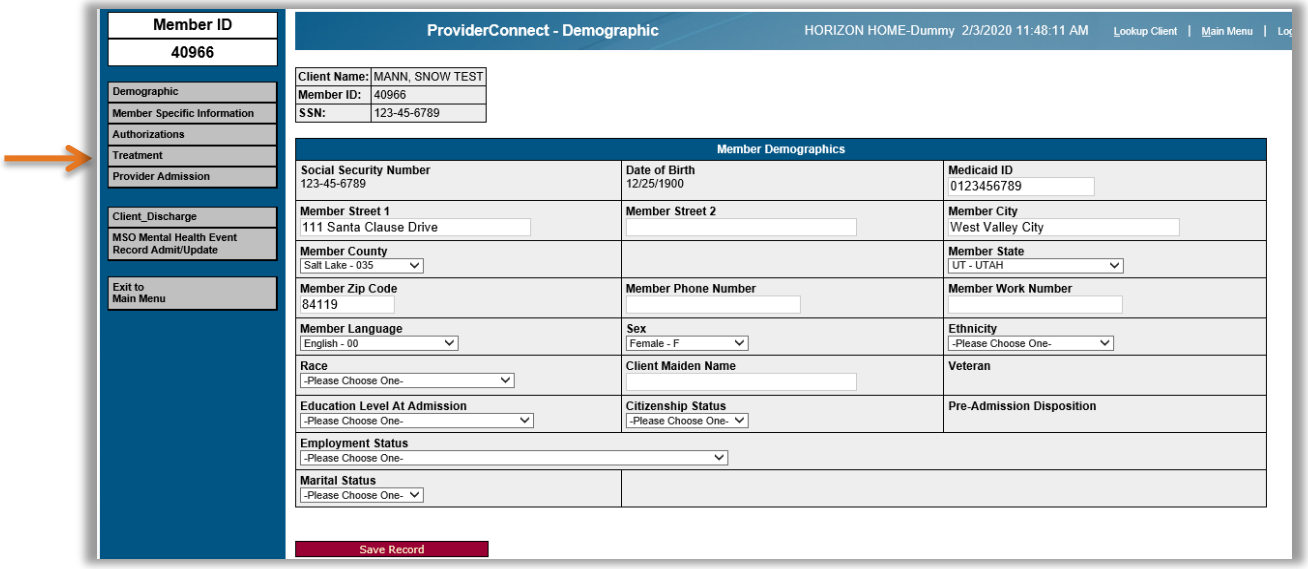
***IMPORTANT NOTE**: **The following codes will be visible and will allow the user to select any code within the group but does not guarantee payment. Payment of specific codes is based on each provider's individual contract.** If you have questions about what codes you are contracted to provide, please contact Optum Network.*

Code	Description	Code	Description
90785GT	Add On, Interactive Complexity (Tele)	99215CGGT	Office/OP Visit E/M, Est Pt (45min) (Tele)
90791GT	Psychiatric Dx Eval (Tele)	99354GT	Add On, Prolonged Svc (first 60min) (Tele)
90792GT	Psychiatric Dx Eval w Medical Services (Tele)	99355GT	Add On, Prolonged Svc (each add'l 30min) (Tele)
90832GT	Psychotherapy, Pt and/or fam (30min) (Tele)	99417GT	Add On, Prolonged Svc (each add'l 30min)(tele)
90833GT	Add On, Psychotherapy (30min) (Tele)	H0006GT	Substance Abuse Case Management (Tele)
90834GT	Psychotherapy, Pt and/or Fam (45 min)(Tele)	H0031GT	MH assessment, by non-physician (Tele)
90836GT	Add On, Psychotherapy (45min) (Tele)	H0038GT	Peer Support Service, Individual (Tele)
90837GT	Psychotherapy, Pt and/or Fam (60 min)(Tele)	H0038HQGT	Peer Support Service, Group (Tele)
90838GT	Add On, Psychotherapy (60min) (Tele)	H2014GT	Psychosocial Rehab, Individual (Tele)
90839GT	Psychotherapy, Crisis (first 60min) (Tele)	H2017GT	Psychosocial Rehab, Group (Tele)
90840GT	Psychotherapy, Crisis (each add'l 30min) (Tele)	H2017U1GT	Psychosocial Rehab, Group Intensive (Tele)
90846GT	Psychotherapy, Family (w/o pt present) (Tele)	H2019GT	Therapeutic Behavioral Services (Tele)
90847GT	Psychotherapy, Family/Couple (Tele)	H2019HQGT	Therapeutic Behavioral Services, Group (Tele)
90849GT	Psychotherapy, Multi Family/Group (Tele)	H2027GT	Psychoeducational Services (Tele)
90853GT	Psychotherapy, Group (Tele)	T1001GT	Nursing Assessment/evaluation (Tele)
99212CGGT	Office/OP Visit E/M, Est Pt (10min) (Tele)	T1013GT	Sign Lang/Oral Interpretive Service (Tele)
99213CGGT	Office/OP Visit E/M, Est Pt (15min) (Tele)	T1017GT	Targeted Case Mgmt (Tele)
99214CGGT	Office/OP Visit E/M, Est Pt (25min) (Tele)		

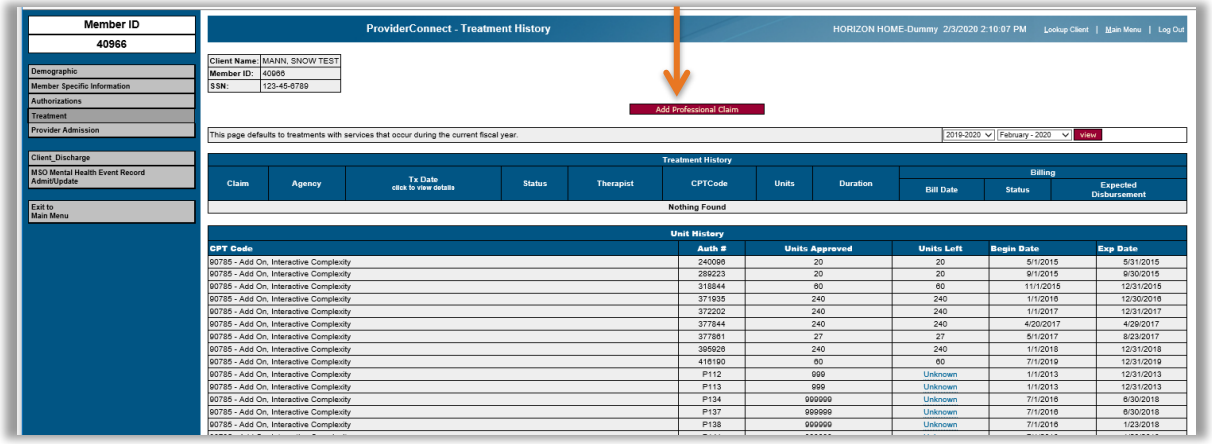
Please Note: This information is based on CMS and Medicaid regulations and is subject to change.

Treatment

This is the first step in billing. It is where you go to enter the details associated with each service provided to the client.

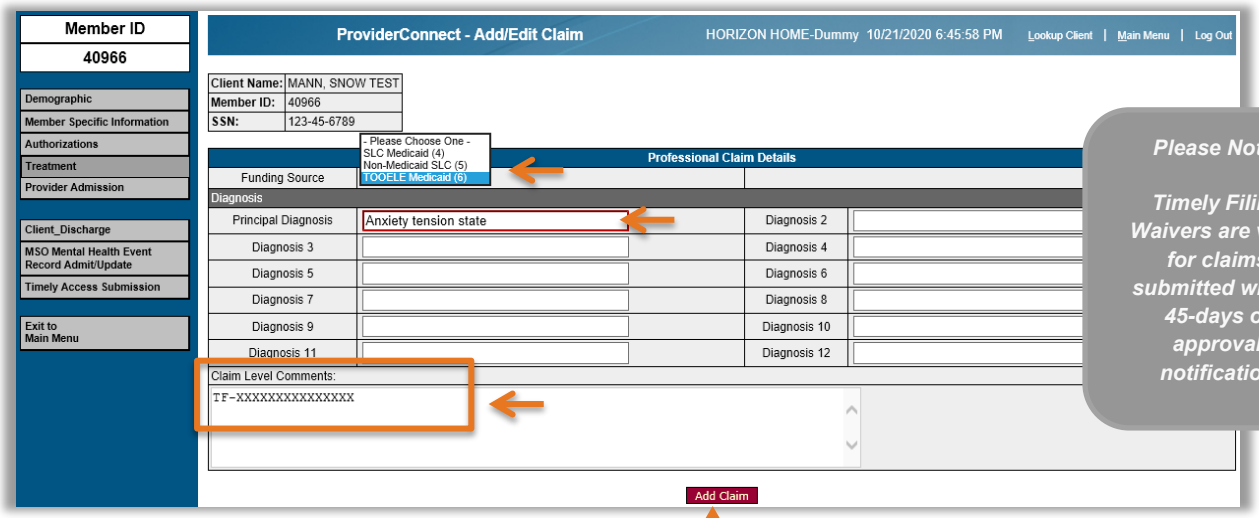


- When the treatment form is open, the page will allow you to create new treatments as well as view the status of previously created treatments.



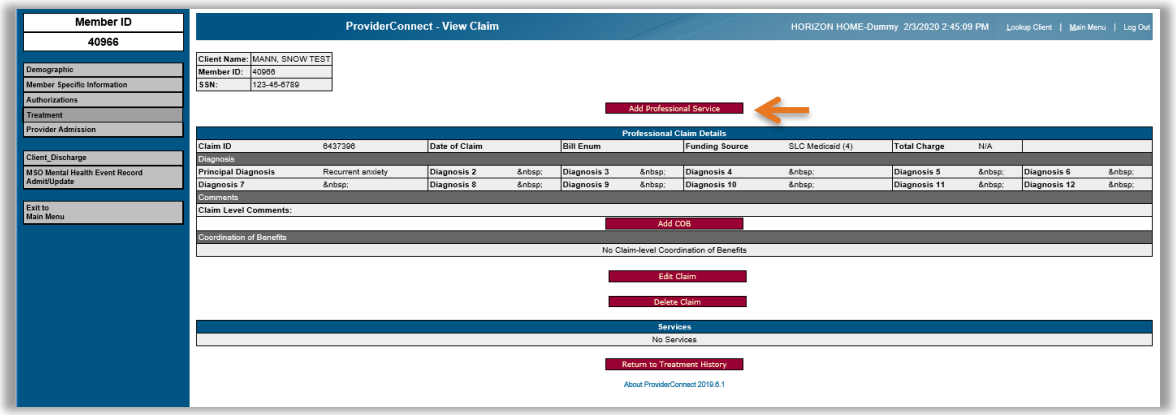
- Create a new Treatment by clicking ‘Add Professional Claim’.

- The Add/Edit Claim form will open, please populate the fields as follows:
  - Funding Source *select one of: SLC Medicaid (4) or TOOELE Medicaid (6)*
  - Principal Diagnosis *enter code or description, then select appropriate code from drop-down.*
  - Remaining Diagnosis fields *optional – populate if available*
  - Claim Level Comments *if prior TF approval has been granted, enter timely filing waiver ID*



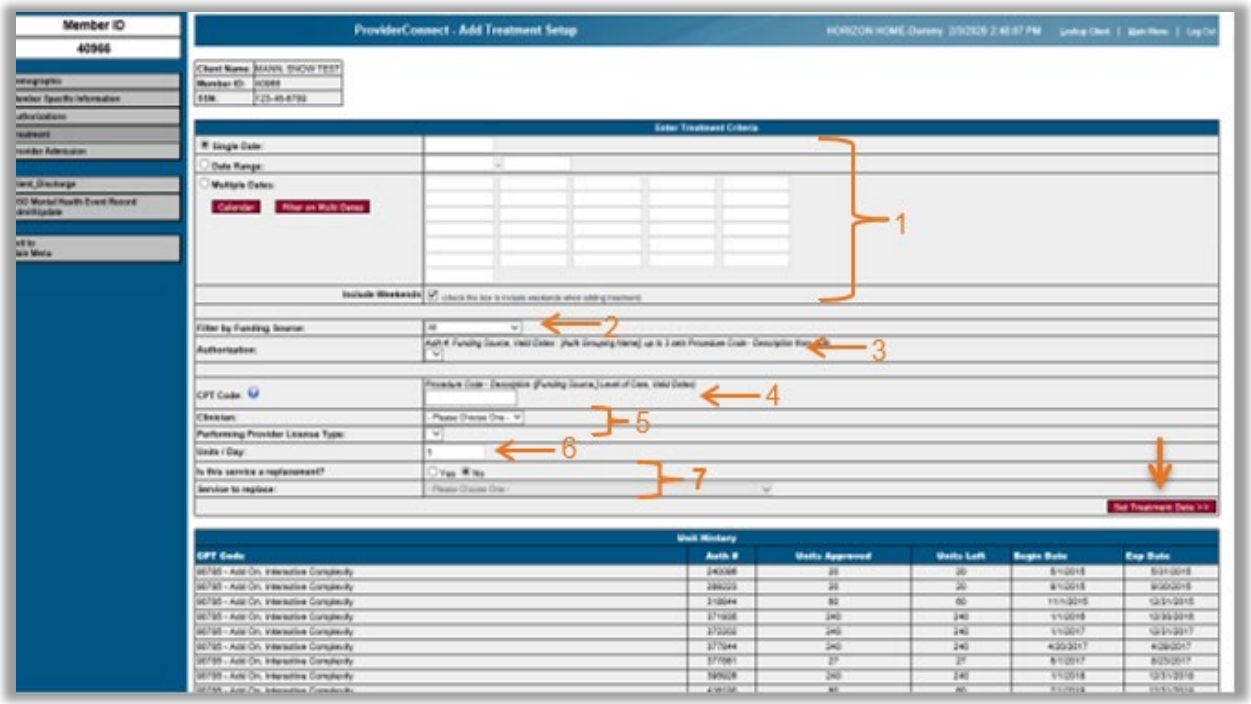
- Select 'Add Claim' button.

  - The View Claim form will open. Select 'Add Professional Service' and this will launch



the 'Add Treatment Setup' form as shown below.

- On the ‘Add Treatment Setup’ form the fields below are available. Please note: these fields need to be populated in order to ensure data populates properly.



1. Date – enter single date, date range or multiple dates. *Please note: Individual dates must be selected if this treatment is a replacement of a previously submitted record.*

2. Filter by Funding Source – *Select ‘4 - SLC Medicaid’ or ‘6 - TOOELE Medicaid’*

Helpful Tip:

✓ *The date range and multiple dates options assume that all other data points are identical - auth number, CPT code, Clinician, and units per day.*

3. Authorization – *the authorization drop-down will filter to only show authorizations that are valid on the date(s) selected in #1.*

4. CPT Code – *The CPT Code search box will filter to only show the CPT codes that are included in the authorization selected in in #3.*

5. Clinician and Performing Provider License Type – *Select performing provider from the drop-down menu. If the individual that provided the service is not present in the drop-down, please contact Optum Network to complete the registration process.*

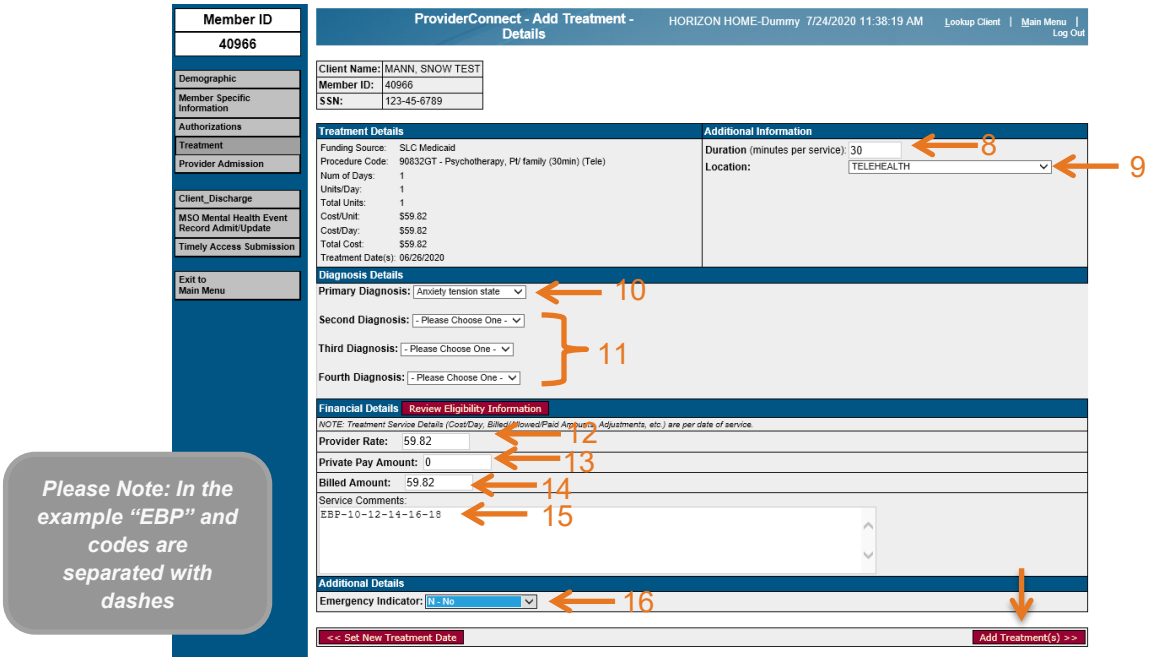
6. Units – *Total unit count for all services billed. If multiple dates are entered in #1, the unit entry should be the sum total of all units.*

7. Is this service a replacement and Service to replace – *Select ‘yes’ if you are replacing a service that was previously submitted and adjudication. Please Note: Services can only be replaced one time. The replacement claim drop-down menu will filter and only display services that are available to be replaced.*

- Once the fields have been populated. Select the ‘Set Treatment Date’ button.

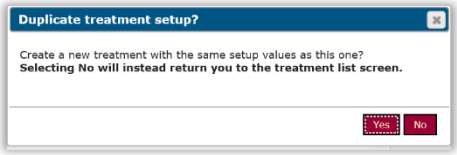
- On the Add Treatment - Details form, please populate the following fields:

8. Duration – enter the total minutes for the service.
9. Location – *All available locations are present in the drop-down. Please Note: Some codes have limitations on available location codes. Please contact Optum Network for specifics.*
10. Primary Diagnosis – *Drop-down populates from entries selected during Add/Edit claim step.*
11. Second, Third and Fourth Diagnosis – *Not required, but can be populated if codes avail.*
12. Provider Rate – *This field defaults to the provider's fee schedule rate for the service code/date. The amount can be increased if the provider chooses to.*
13. Private Pay Amount – *Enter 0*
14. Billed Amount – *this field will auto populate to align to the provider rate field.*
15. Service Comments - *Enter Evidence Based Practice (EBP) codes that were offered/delivered during the session(s). A complete list of the EBP codes has been included at the end of this document.*
16. Emergency Indicator – *select 'No' or 'Yes' from drop-down.*



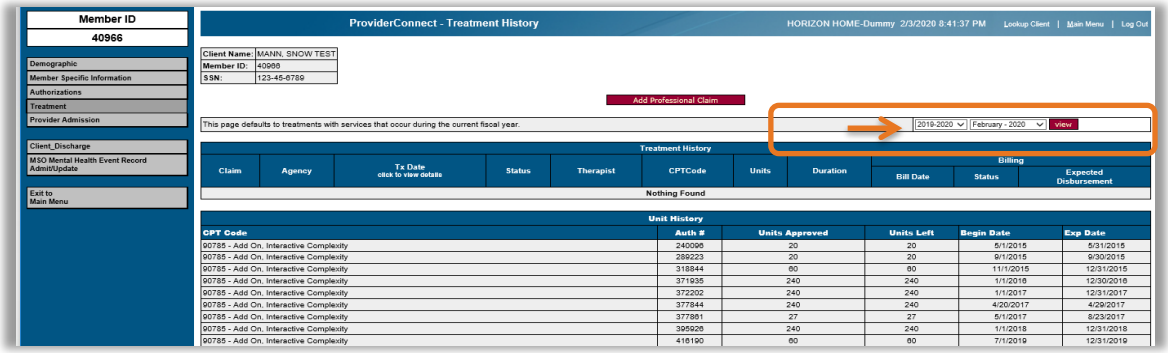
Please Note: In the example "EBP" and codes are separated with dashes

- Select the 'Add Treatment' button.
- The system will then display a popup message: Duplicate treatment setup?

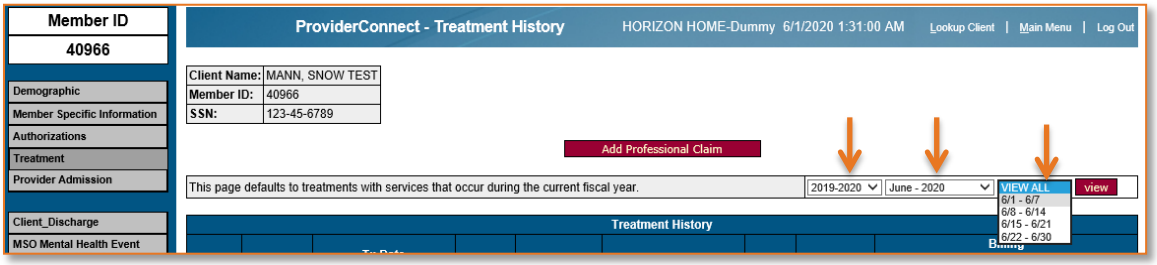


  - Select "Yes" if you would like to add another treatment to the claim.
    - Once selected, PCONN will return you to the 'Add Treatment' form.
  - Select 'No' if no additional services need to be added to the claim.
    - Once selected, PCONN will return you to the 'Treatment History' form.

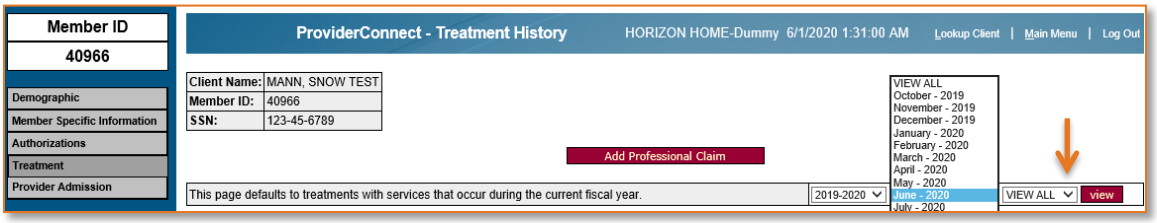
View Treatment History is available after completing the treatment creation process or by selecting 'Treatment' from the left-hand navigation bar.



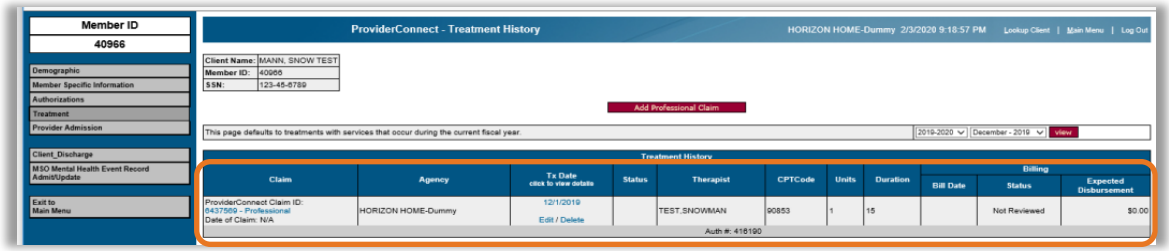
- *To view previously created treatments, set the filters for year, month and week located towards the top of the form.*
  - *Click the down arrow to expand the window to allow for all months (in the fiscal year) or weeks (in the selected month).*



  - *Select 'VIEW ALL' to see all records for the fiscal year.*



- *For Example: To view the treatment created in this example for December 2019, select 2019-2020 in the year drop-down and December 2019 in the month drop-down, then select 'View'.*

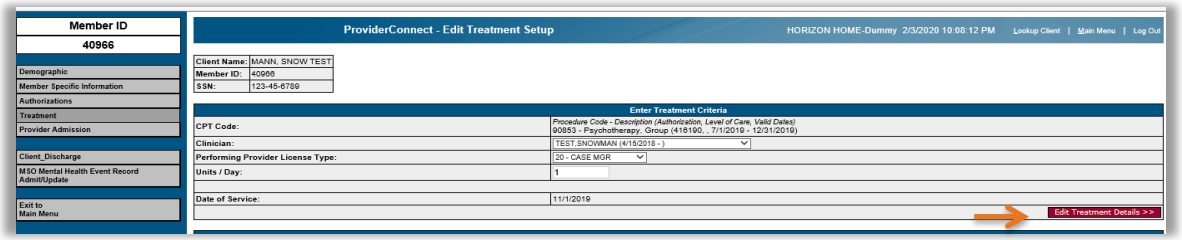


  - Bill date will remain blank until the treatment has been billed and submitted.

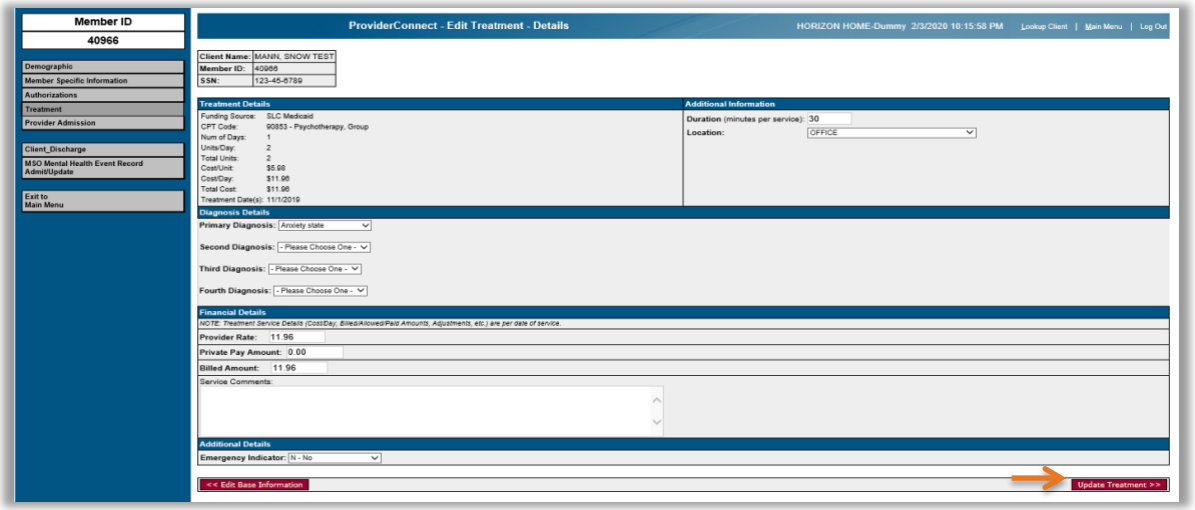
- Billing Status will remain as ‘Not Reviewed’ until the claim has been adjudicated and an EOB has been issued.

- *To edit an existing claim that has not been billed, click ‘Edit’ in the TX Date field.*

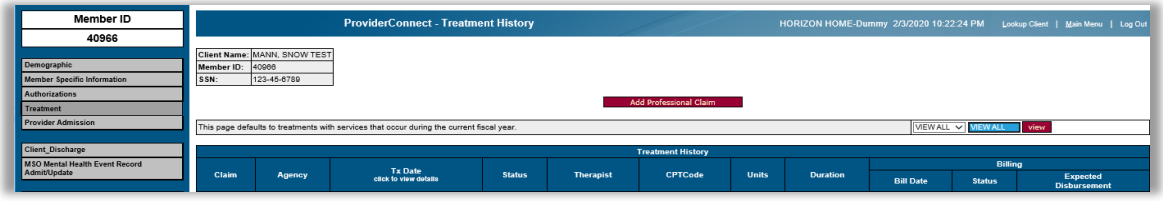
- *Enter changes for clinician, license type and units per day then select ‘Edit Treatment Details’ button.*



- *Enter remaining changes in the Edit Treatment Details form, then select ‘Update Treatment’.*



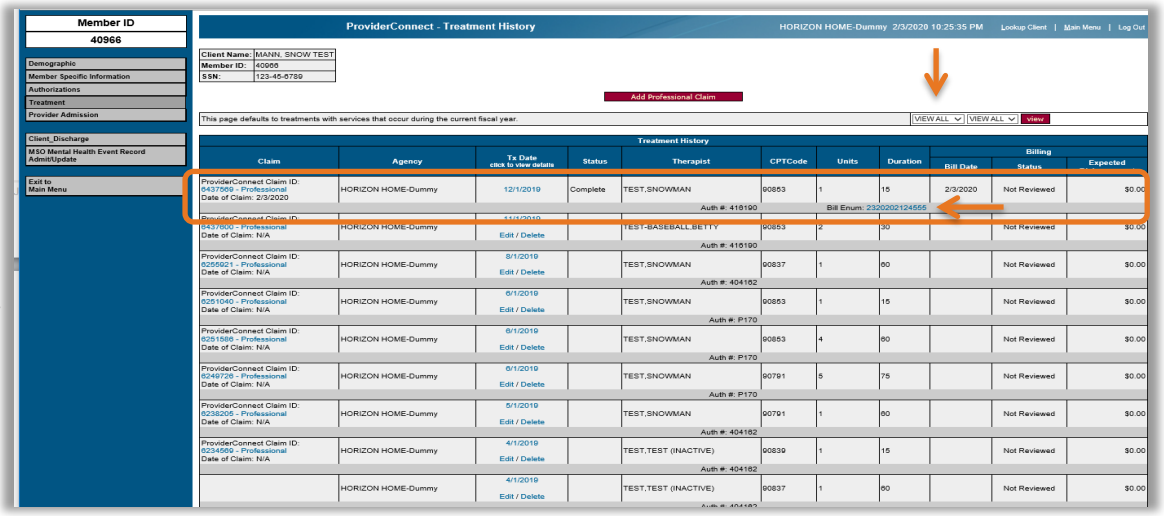
- *To View a full treatment history, select ‘View All’ in the year drop-down as well as the month drop-down, then select ‘View’.*



- *The result of a view search produces a full list of all treatments created in ProviderConnect.*

Helpful Tip:

- ✓ *Data is organized by a fiscal year October thru September.*
- ✓ *Additional CPT codes or dates of service are added to the Professional Claim through the Treatment History screen.*



- *Please note: The top record has been billed, whereas the other records shown have not.*
- *Once billed the Bill Date field will populate, as well as a 'Bill Enum' number.*

Special Instructions for Telephonic and Telehealth Billing

Due to the COVID-19 pandemic, Optum has authorized the use of telephonic services for treating clients during this crisis. The following is a breakdown of what is considered telephonic vs. telehealth.

- Telephonic services are defined as a standard telephone call or video conference using a non-HIPAA compliant technology, between the treating provider and the client.
  - Use non-telehealth authorization group.
  - Procedure code should NOT include GT modifier.
  - Location code '02' (Telehealth) is required.
- Telehealth services are provided using a HIPAA compliant technology to conduct a video treatment session.
  - Use telehealth authorization group.
  - Procedure code MUST include GT modifier.
  - Location code '02' (Telehealth) is required.

For complete instructions please refer to the Telehealth provider training.

Treatment – Coordination of Benefits (COB) Third Party Liability (TPL)

Coordination of benefits, often referred to as COB or TPL applies to a person who is covered by more than one health plan, in addition to Utah Medicaid.

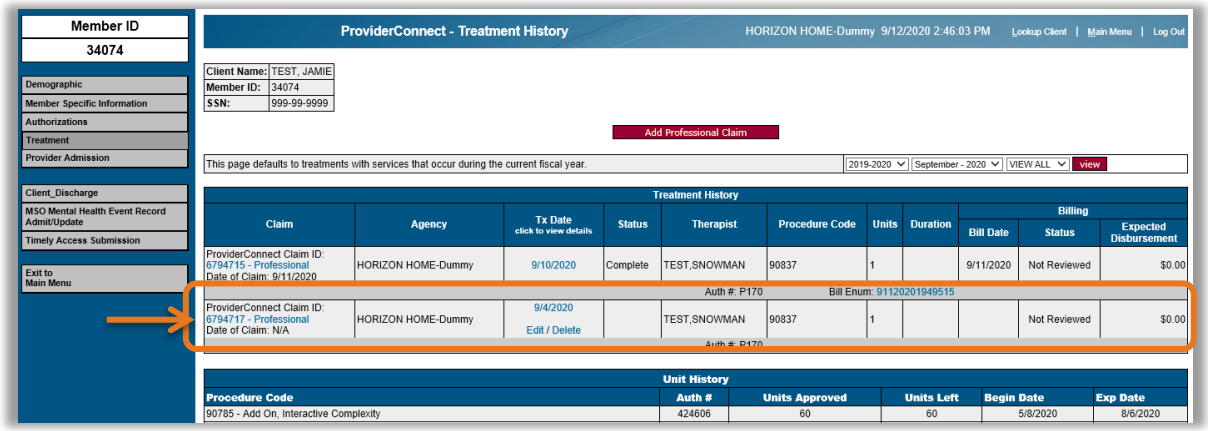
The COB regulations, as well as the HIPAA Privacy Act, permit Medicaid to coordinate benefits with other health plans and payers to reduce administrative burden and enable patients to obtain payment of the maximum benefit they are allowed.

Optum's claim adjudication system manages these at the service level only. All claims submitted with claim level TPL will be denied.

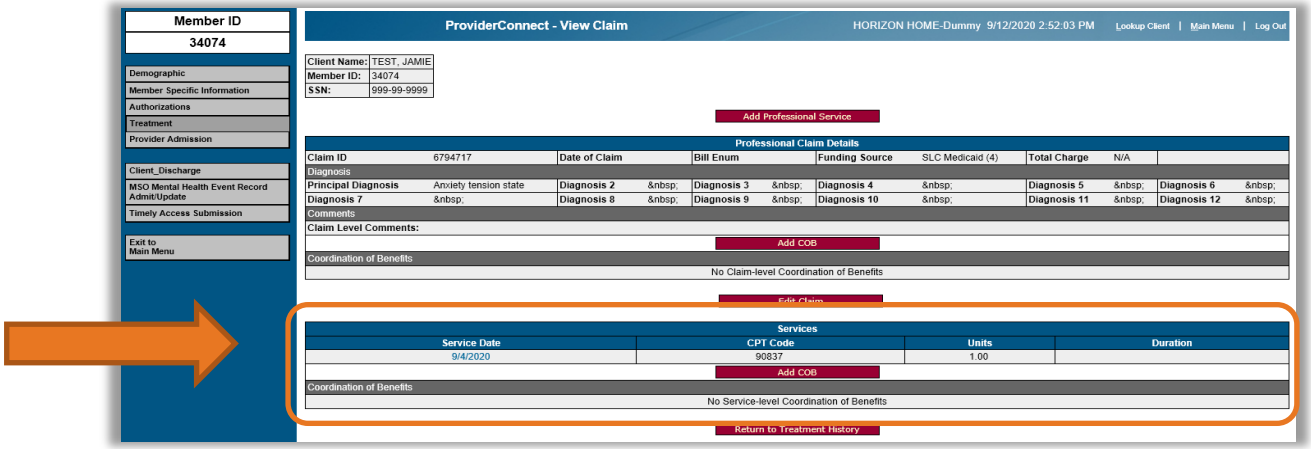
Creating a claim with COB requires the creation of a treatment first. Once completed, the COB data is then added.

Add COB (Coordination of Benefits) / TPL (Third Party Liability)

- Navigate to claim previously created.
- Find claim and click on the blue hyperlink.

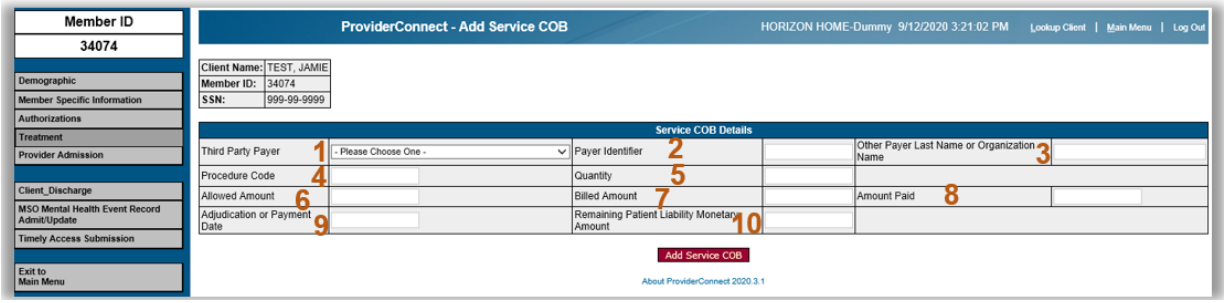


- In the Service detail section, click 'Add COB'

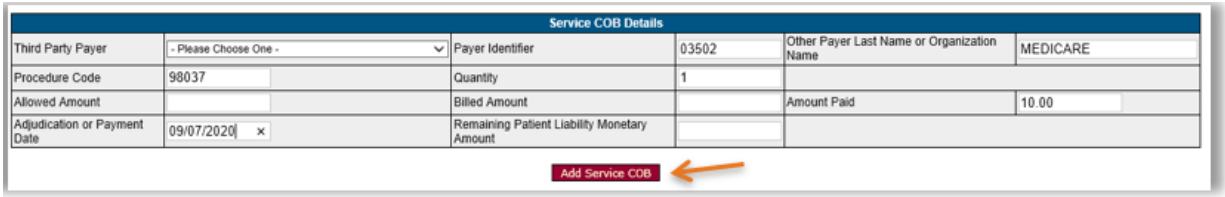


- Upon selecting the 'Add COB' button, the following form will open. You MUST enter the third-party data ***exactly*** as presented on the Primary EOB.

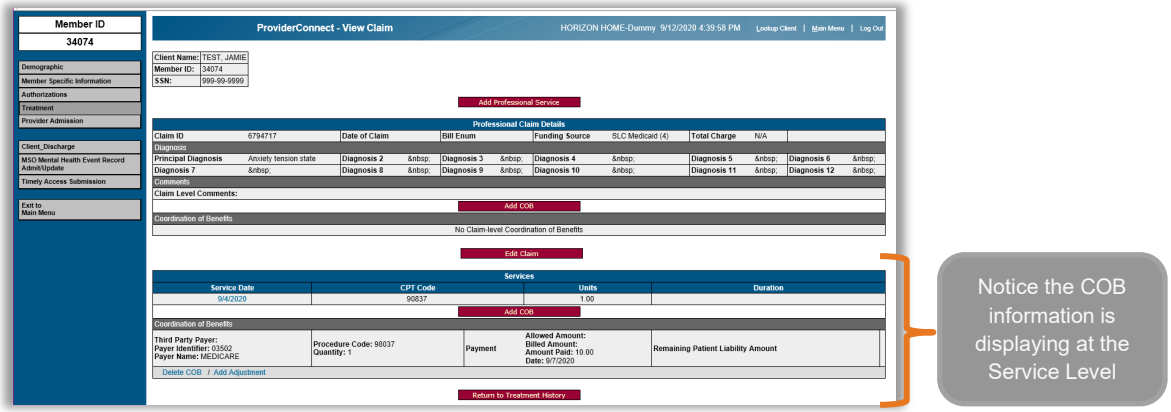
1. Third Party Payer - *Leave blank.*
2. Payer identification - *Enter the other payer primary identifier.*
3. Other Payer Organization Name - *Enter the primary payer name.*
4. Procedure Code - *Enter the procedure code including any modifier(s).*
5. Quantity - *Enter billed units/days from the primary EOB.*
6. Allowed Amount - *Leave blank.*
7. Billed Amount - *Leave blank.*
8. Amount Paid - *Enter the amount paid by primary payer.*
9. Adjudication or Payment Date - *Enter the date of the primary EOB.*
10. Remaining Patient Liability Monetary Amount - *Leave blank.*



- Click 'Add Service Cob' when entry is complete.

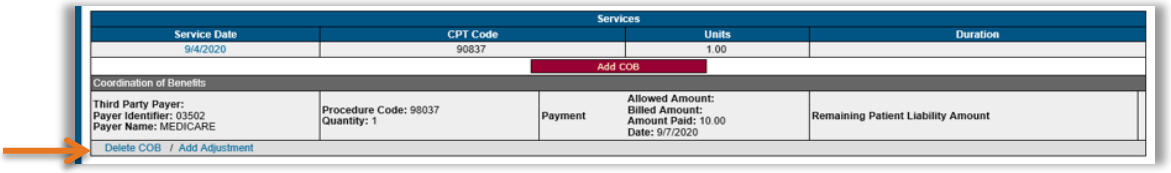


- Upon completion of entering the primary payer information, please review details to ensure they are accurate.

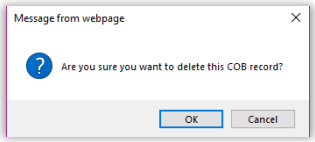


- If needed, you can delete the COB previously entered using the Delete COB option.

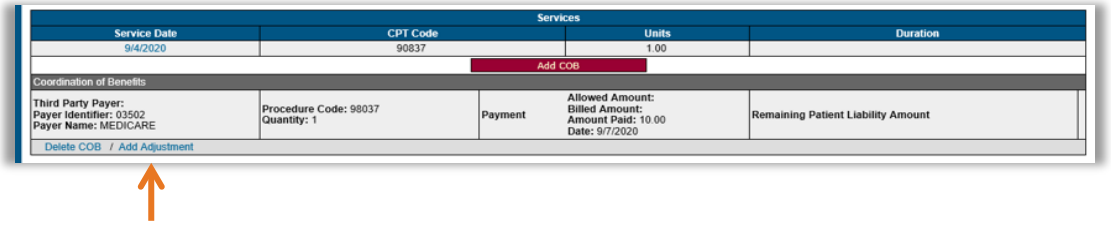
Click ‘Delete COB’ to delete.



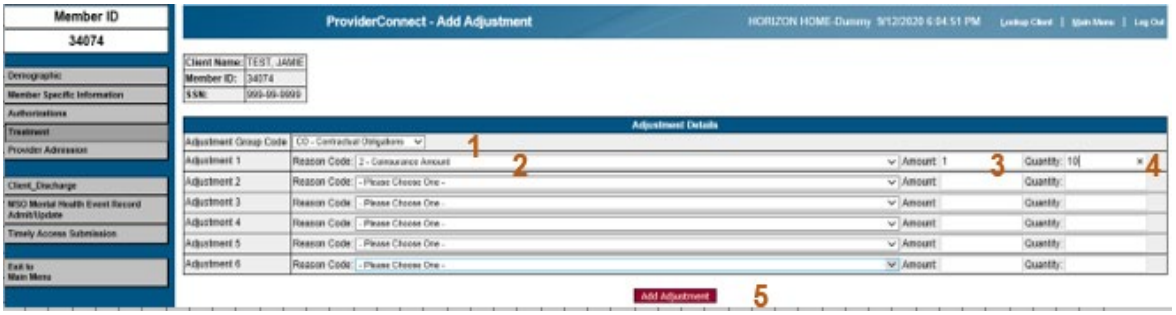
- You will be prompted ‘Are you sure you want to delete this COB record?’ Click OK to delete, or cancel



- If no additional changes are needed, click ‘Add Adjustment’



- Enter all adjustments present on the primary payer EOB
- The screen accommodates up to six adjustment records per service



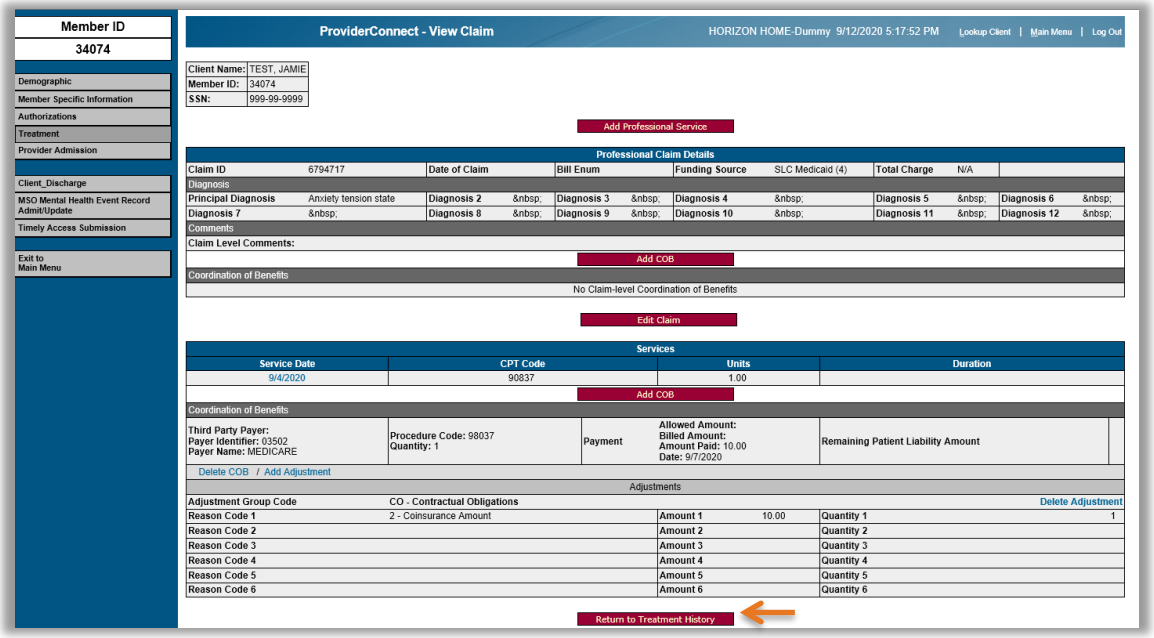
1. **Adjustment Group Code** *Displays the CAS group code dictionary.*
   CO – Contractual Obligation
   OA – Other Adjustment
   PI – Payor Initiated Reduction
   PR – Patient Responsibility
2. **Reason Code** *Displays the reason code dictionary. Select the code(s) displayed on the primary payer EOB.*
3. **Amount** *Enter the amount associated to the reason code selected from the primary payer EOB.*
4. **Quantity** *Enter billed units/days from the primary payer.*
5. **Add Adjustment** *Click 'Add Adjustment' button to save.*

- Once all adjustments have been entered, click ‘Add Adjustment’.

Please Note: There must be at least one adjustment per service.

- Once the adjustments have been saved, you will be returned to the ‘View Claim’ form.

- Use the appropriate options to add or delete records.



- In the event there are additional COB's to enter, follow the instructions within this documentation, otherwise Click 'Return to Treatment History' to exit.

Helpful Tips:

✓ *If data was entered in error, it can be deleted and then added again as needed.*

- *Use the appropriate options: 'Delete COB' or 'Delete Adjustment' to delete.*
- *Use the appropriate option: 'Add COB' or 'Add Adjustment' to add.*

Treatment – Replacement/Void Claim Submissions

Optum's claim adjudication allows for the submission of void and replacement claims via provider connect. For a service be eligible for void or replacement, the following rules must be met:

- Original claim must be fully adjudicated, including the issuance of an EOB
- Original claim cannot have been previously voided or replaced.
- Replacement claim must be for the same contracting provider/agency as the original claim.
- Replacement claim must be for the same client ID as the original claim.

Providers are encouraged to submit replacement claims using the same submission method as the original claim.

Optum's system limits replacement submissions to one time per unique claim ID. In the event a claim needs to be replaced a second time, please keep this logic in mind:

Claim A – Original claim submitted

Claim B – Replaces claim A

When submitting claim B, the payer claim control number (issued by Optum) for claim A should be referenced.

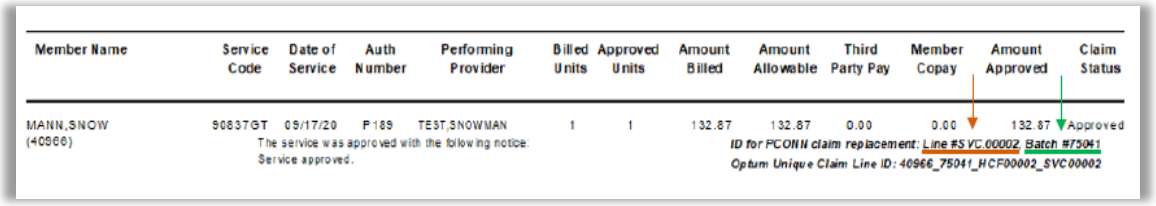
Claim C – Replaces claim B

When submitting claim B, the payer claim control number (issued by Optum) for claim A should be referenced.

Please Note: In this example, if claim C is submitted with the payer claim control number for claim A instead of claim B, the claim will be rejected because the claim has already been replaced.

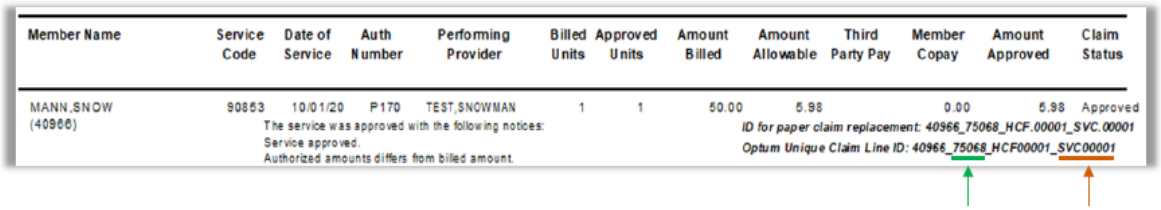
The first step in the replacement claim process is to identify the claim to be replaced. This can be done by reviewing your EOBs.

- Claims originating from PCONN will include the service ID and batch number, shown below with the **orange** and **green** lines below the data.



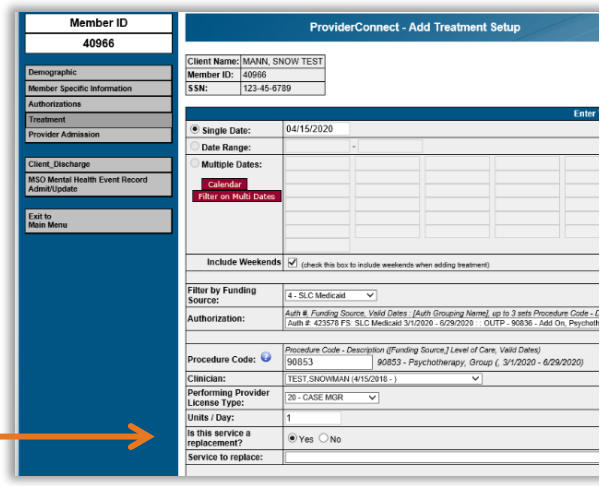
Member Name	Service Code	Date of Service	Auth Number	Performing Provider	Billed Units	Approved Units	Amount Billed	Amount Allowable	Third Party Pay	Member Copay	Amount Approved	Claim Status
MANN,SNOW (40966)	S0837GT	09/17/20	P189	TEST,SNOWMAN	1	1	132.87	132.87	0.00	0.00	132.87	Approved
The service was approved with the following notice: Service approved.												
ID for PCONN claim replacement: Line #SVC00002, Batch #75041												
Optum Unique Claim Line ID: 40966_75041_HCP00002_SVC00002												

- Claims originating from paper or EDI, can be replaced via a PCONN transaction. The value underlined in **orange** is the SVC number and the field underlined in **green** is the batch number.

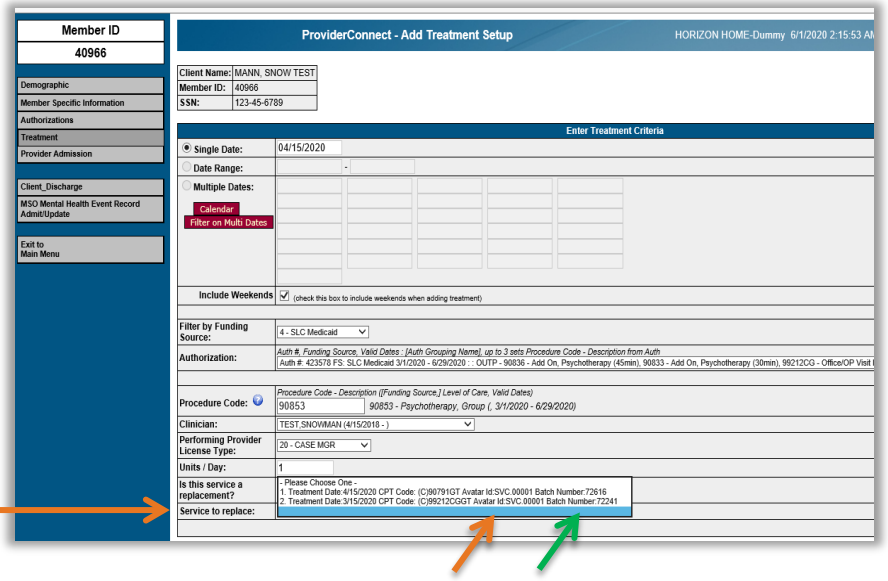


Replacement Claim Creation

Claims that have been fully adjudicated (including issuance of EOB) and have not been previously voided or replaced are eligible for replacement.



- Select 'Yes' on "Is this a replacement?"

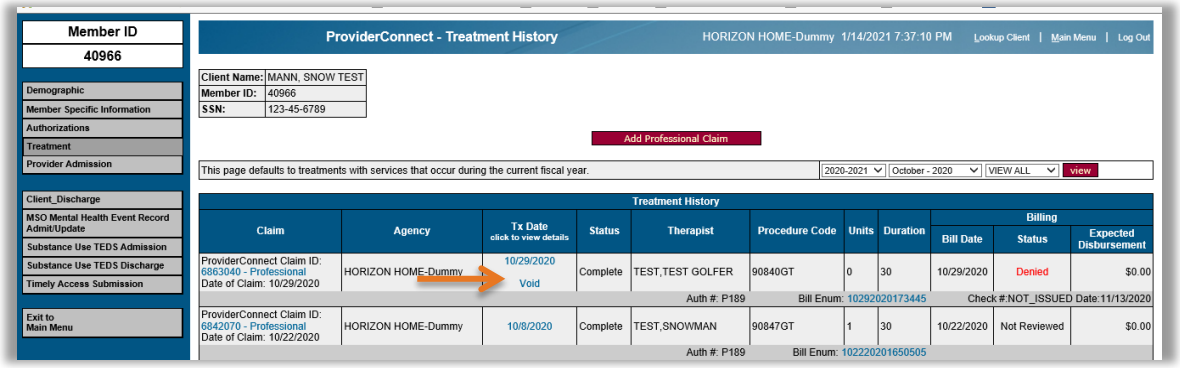


- Select the appropriate service to be replaced by matching **SVC. ID number** and **batch number** from the EOB.

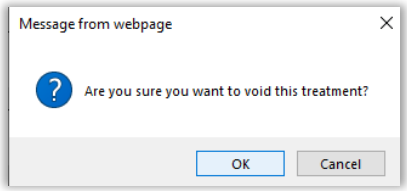
- Continue steps to complete the treatment creation and submit to save.

Void Claim Creation

- To void a service, begin by navigating to the client treatment form in ProviderConnect.



- Find the service to be voided, then select 'Void'. A dialogue box will then open to confirm the void.



- Once 'OK' is selected, the void record is ready for submission from ProviderConnect to Optum's billing system. ***Please Note: This action cannot be undone.***

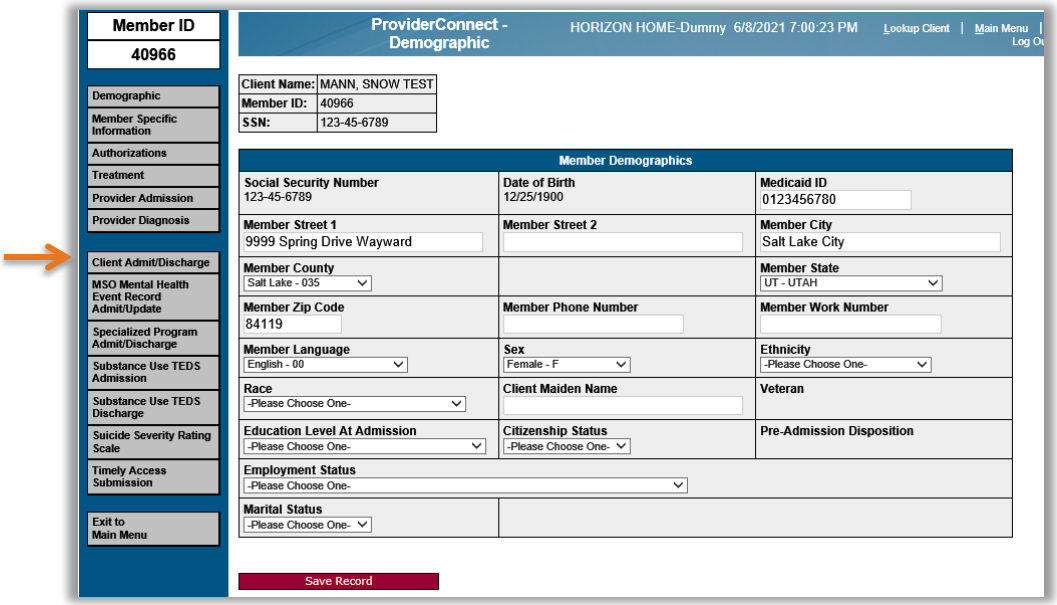
Client Admit/Discharge

Effective July 1, 2021, the ‘client_discharge’ form in ProviderConnect will be replaced with a ‘Client Admit/Discharge’ form. We are requiring the admission date (in addition to the discharge date) in order to improve communication and coordination for members for whom we do not have a current member-specific authorization.

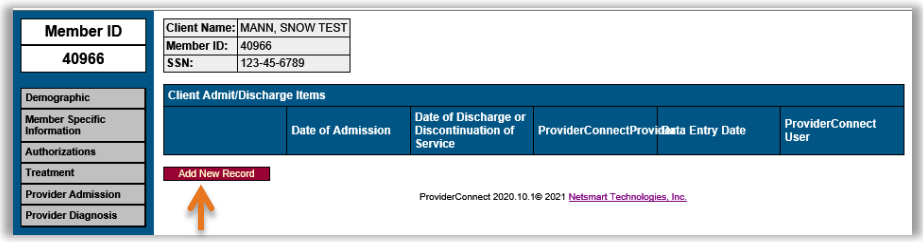
For all clients admitted on or after 07/01/21 for whom you are billing with blanket authorizations, please create an initial record within 7 days of admission. The record should then be updated with the client’s discharge date, when they leave your care.

Please do not enter discharge records when a client is changing levels of care.

- To access the form, select ‘Client Admit/Discharge’ from the left navigation bar.

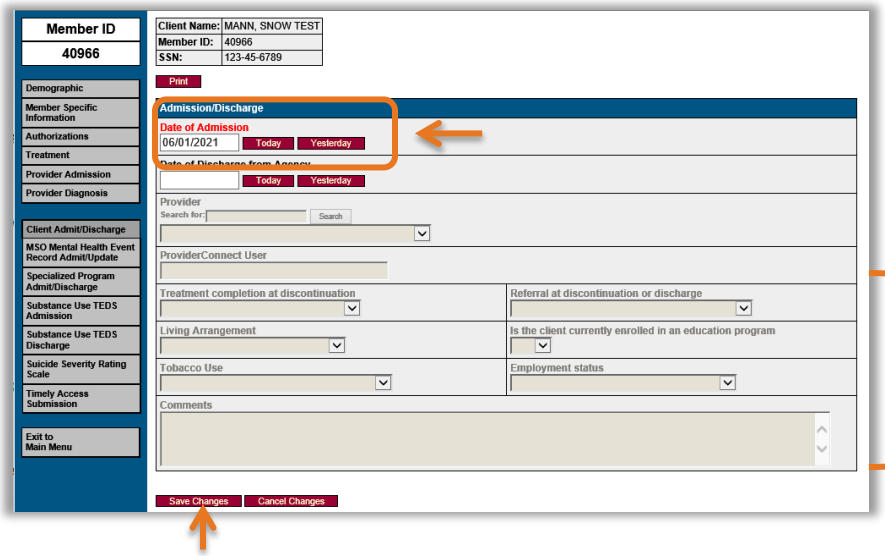


- Select “Add New Record”



Client Admit

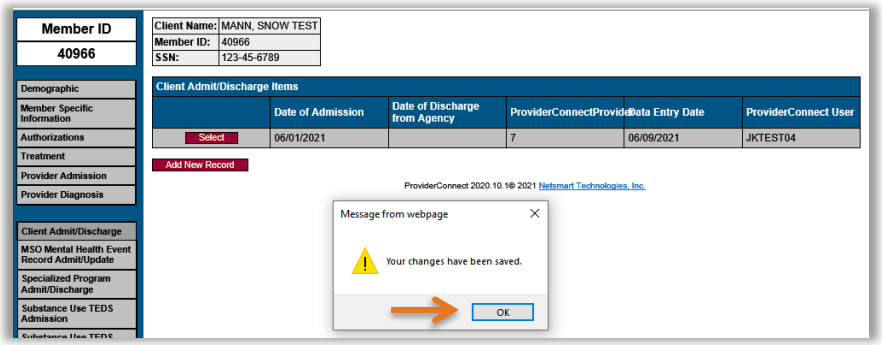
- Enter the actual date the client admitted to your practice in 'Date of Admission' field (regardless of how old), then click 'Save Changes' button at the bottom of the form.



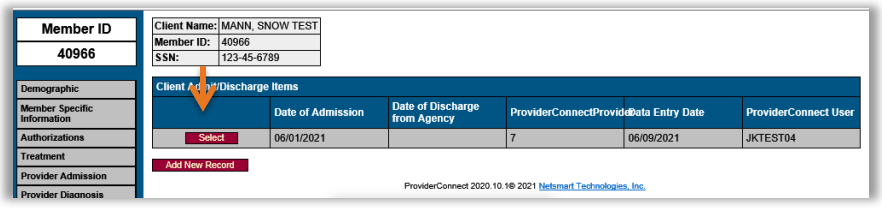
Please note:

The fields on the bottom of the form are disabled as they are only populated on client discharge.

- Once the record has saved, a confirmation popup will appear. Click 'OK' to dismiss the message.



- In the event a client's admission date requires correction, click on the 'Select' button on the left-hand side of the admit/discharge timeline to open the record. Proceed with updating the admission date, then save the record.



Please note:

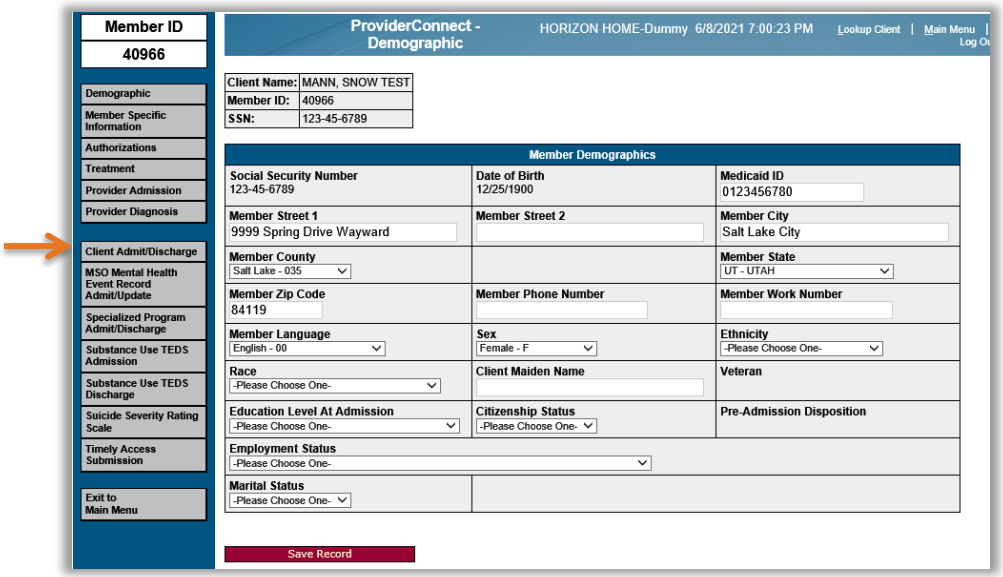
Each timeline should mirror the client's actual episode of care at your agency. It should not be used to identify changes in level of care within your agency.

- Admission records should be created within **7** days from the date the client admitted to your practice.

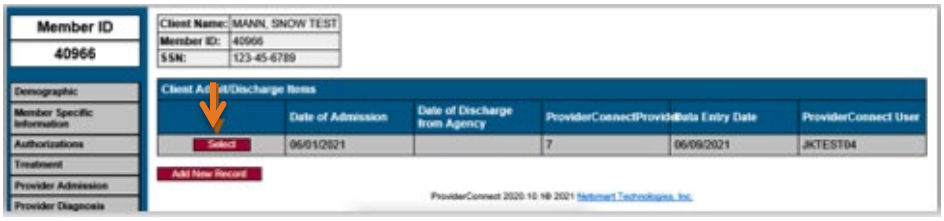
Client Discharge

Once a client has left your care, please add the client's discharge date to the 'Client Admit/Discharge' timeline previously created. To enter the client's discharge record, please complete the following steps:

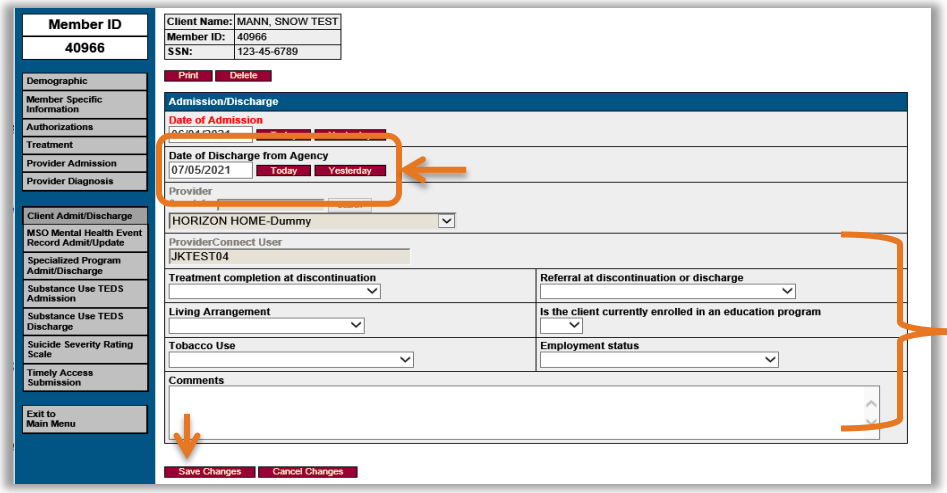
- Click 'Client Admit/Discharge' button from the left navigation bar.



- Click on the 'Select' button on the left-hand side of the admit/discharge timeline to open the record.



- Enter the date the client left your agencies care into the ‘Date of Discharge’ field.



These optional fields will engage once a discharge date is entered.

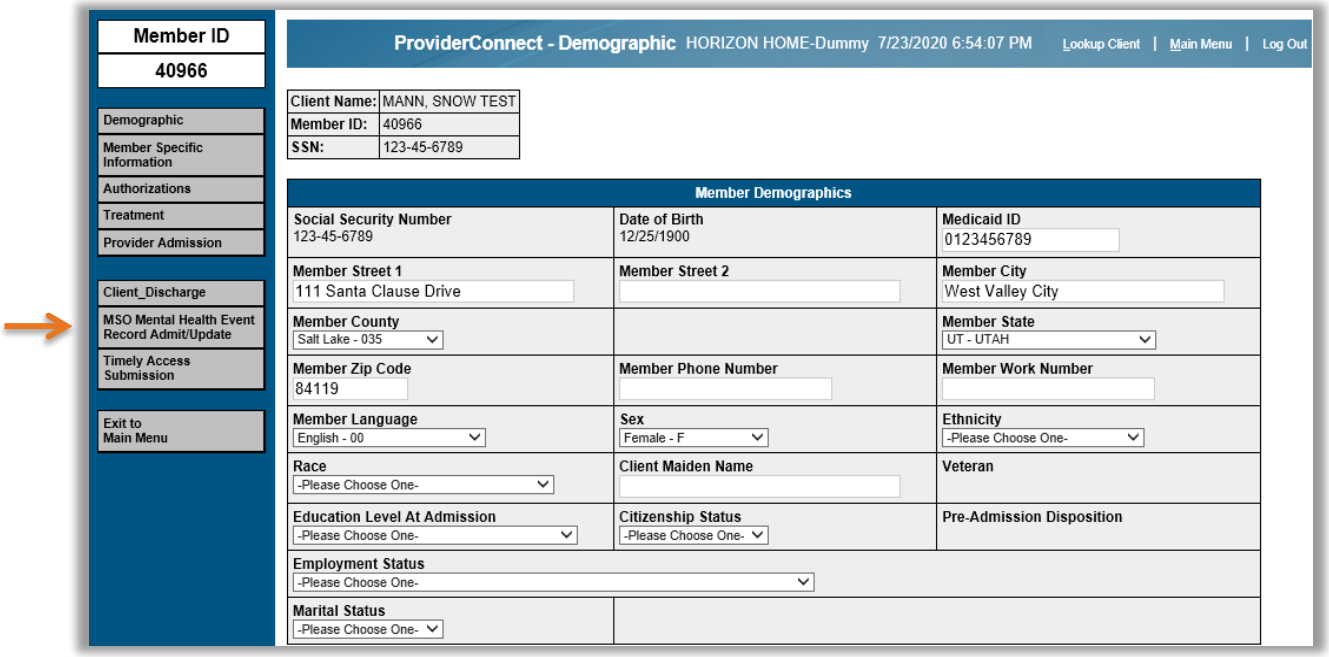
- The fields above are optional, but you are encouraged to answer the questions if the data is available:
  - Treatment completion at discontinuation
  - Living Arrangement
  - Tobacco use
  - Comments
  - Referral at discontinuation or discharge
  - Is this client currently enrolled in an education program
  - Employment status
- Select ‘Save Changes’ at the bottom of the form, once entry is complete.

PLEASE NOTE:

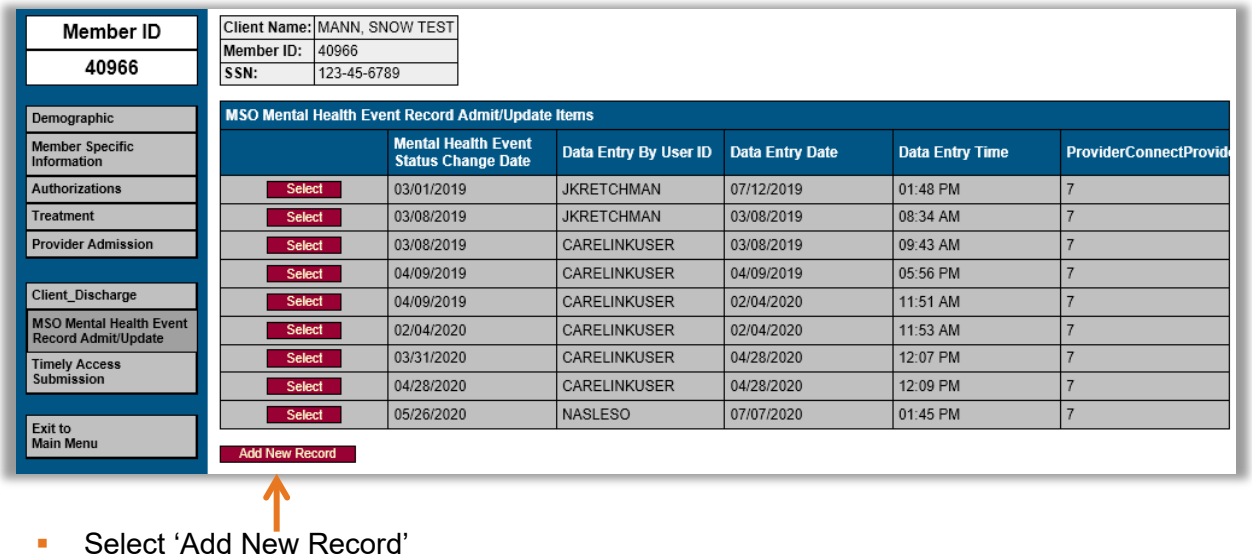
For clients admitted prior to July 1, 2021, an admission record is not required at this time. At the point of discharge, you will be required to create a Client Admit/Discharge record – entering in the client’s actual admission date, in addition to the discharge date.

Mental Health Event Record

The Mental Health Event Record (MHER) data set is used at the state level to collect and report the types and amounts of mental health services provided to persons served. This data set is a critical component of the Substance Abuse and Mental Health Information System (SAMHIS) for linking persons served to services, providers, costs, and outcomes



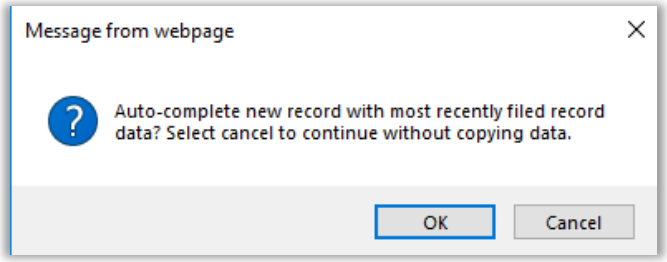
- To access the form, select 'MSO Mental Health Event Record Admit/Update' from the left navigation bar.

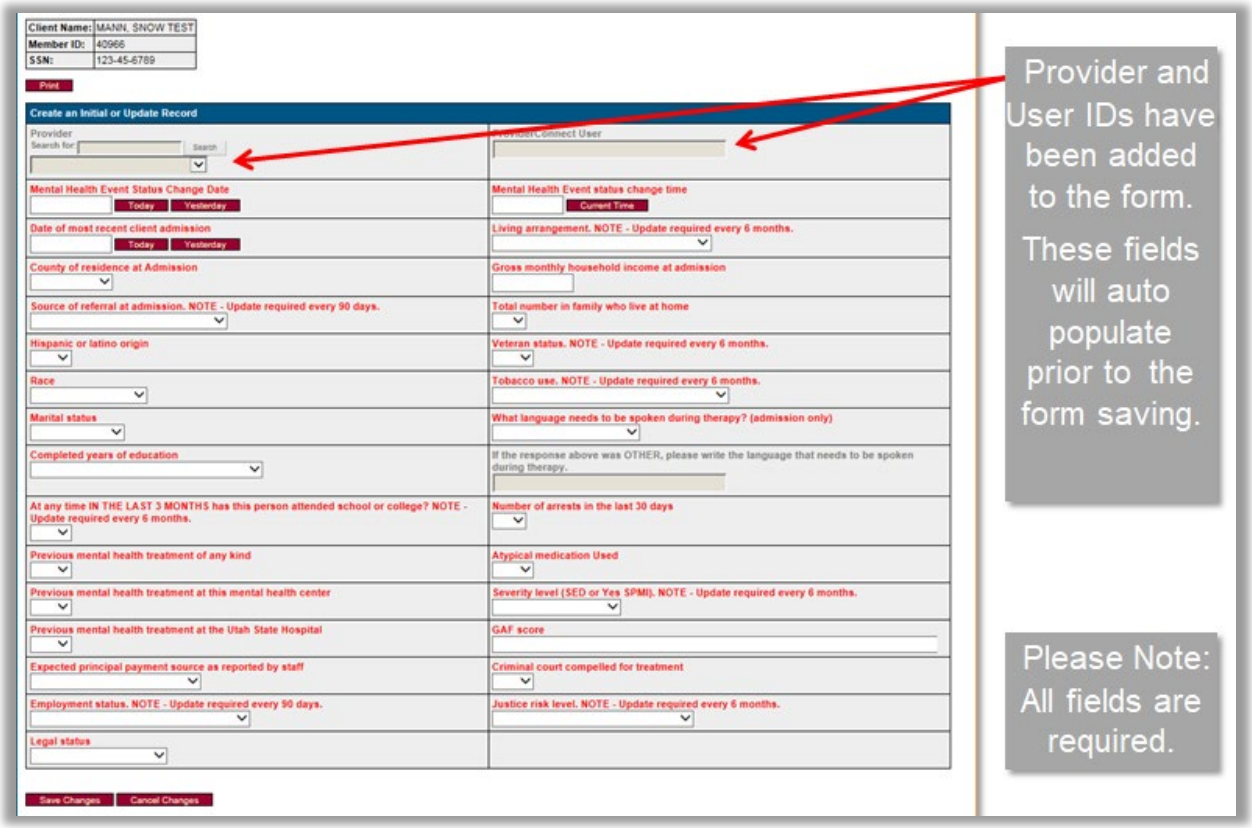


- Select 'Add New Record'

- If there are existing records the system will prompt if you would like to Auto-complete the new record (prefilled) with the most recently filed record data.

- Select OK to Auto-complete or Select Cancel if you would like to fill in the form from scratch.



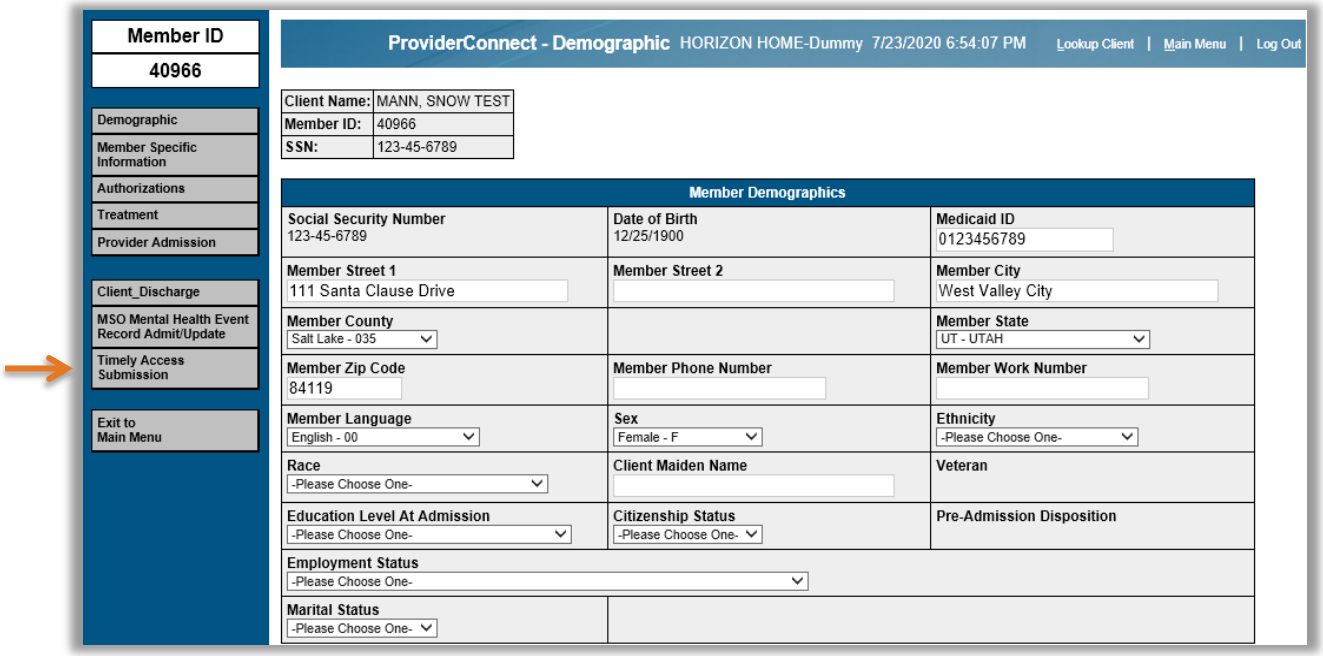


- MHER records must be created within 30-days of initial service date, for all new or returning clients.
- All clients actively in treatment must have a current MHER record. This includes a review and update every 90 days. or if there is a change in their status or level of care.
- All providers will be required to update/refresh their client's MHER at least every 6 months, at a minimum. Update requirements have been added to the MHER form in PCONN.
- Additional training documentation is available on "Mental Health Event Record 20190606" and "MHER_provider training_20190412"

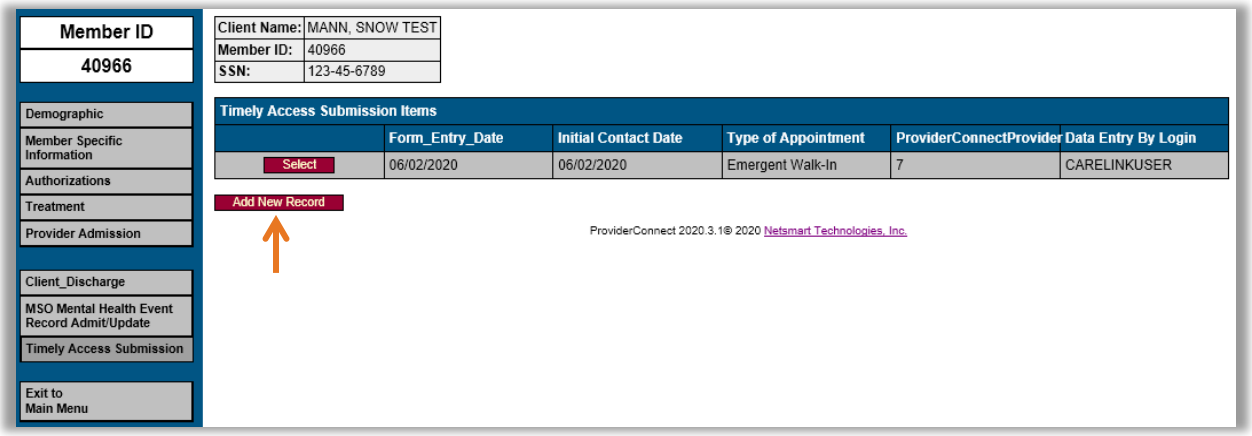
Timely Access Submission

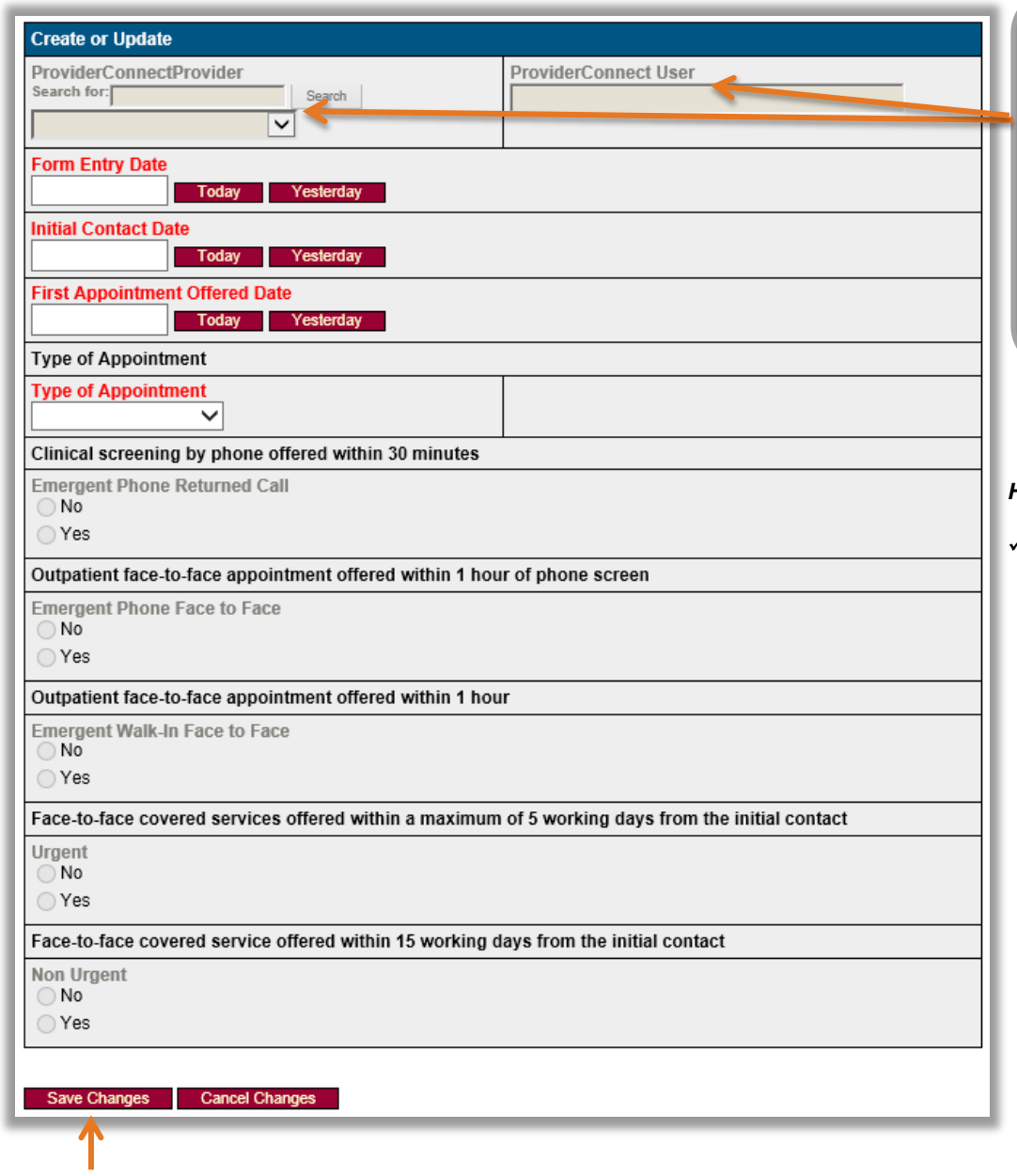
Medicaid Timely Access to Care: Medicaid outlines the expectations for timely service delivery based on the member's presentation when requesting services.

Entries are only required for Optum Medicaid members who are new to your practice, or who are requesting services after they have previously discharged from your care.



- To access the form, select 'Timely Access Submission' from the left navigation bar.
- Click "Add New Record"





Provider and User IDs have been added to the form. These fields will auto populate prior to the form saving.

Helpful Tip:

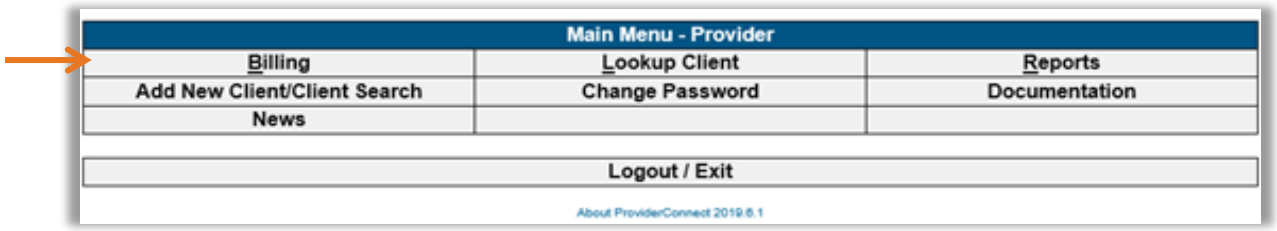
✓ *First Appointment Offered Date cannot be prior to the Initial Contact Date*

- Complete all questions in Red.
- After selecting the Type of Appointment from the dropdown list, the respective questions will become red and must be completed to submit the entry.
  - *Emergent Phone*
  - *Emergent Walk-In*
  - *Urgent*
  - *Non Urgent*
- When all items in red are complete, select the 'Save Changes' button at the bottom of the page.

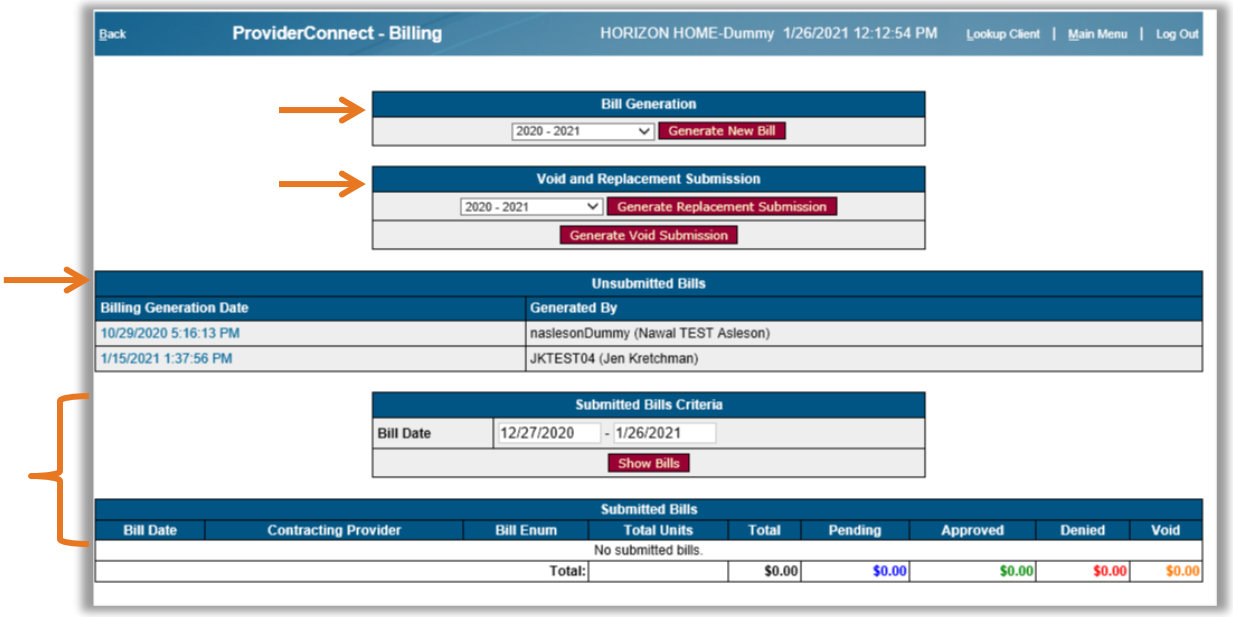
Billing

UNDERSTANDING THE BILLING SECTION

- From the Main Menu, select 'Billing'.



- The page below is the Billing section. The following is a high-level summary of these functions:



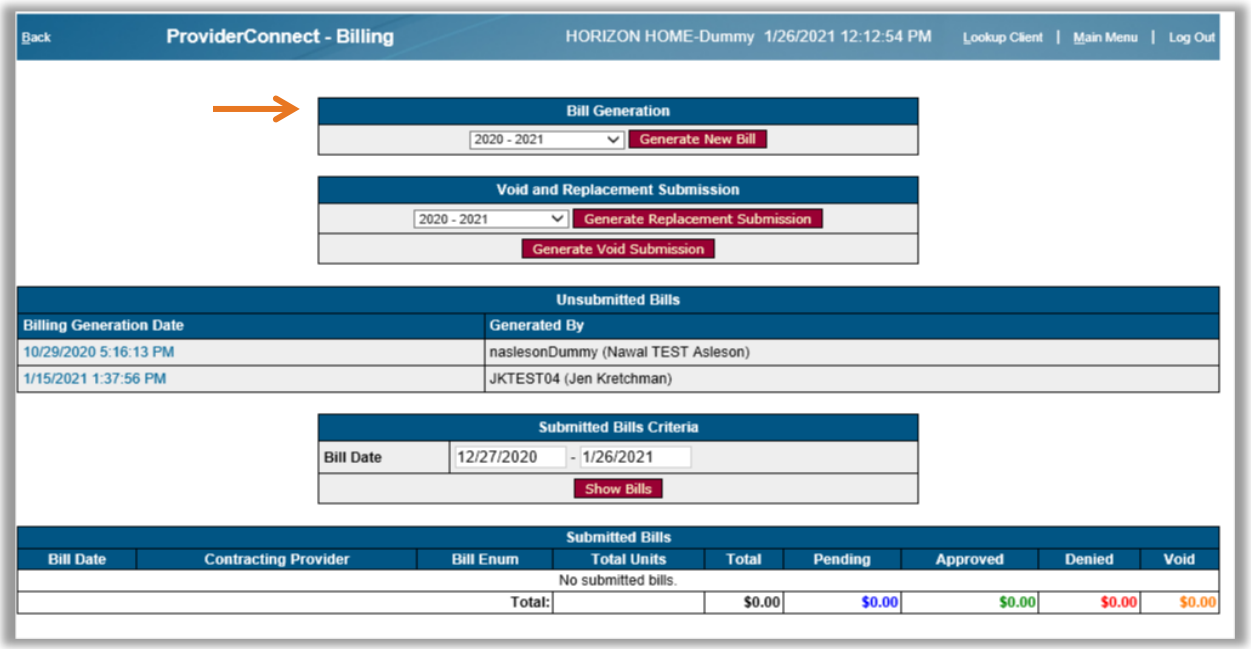
  - **Bill Generation:** This section creates a bill for all treatments in a specified fiscal year range; the fiscal year in ProviderConnect is defined as October 1st to September 30th.

  - **Void and Replacement Submission:** This section creates a bill for treatments that have been marked to be voided or replaced.

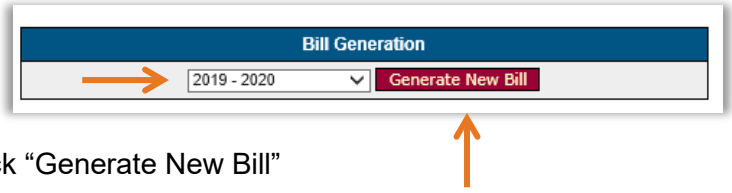
  - **Unsubmitted Bills:** This section shows bills that were created but *NOT* submitted because the user did not complete the bill submission.

  - **Submitted Bills Criteria and Submitted:** These sections work in tandem to show bills that have been submitted by bill date. Bills that have not been through an adjudication cycle will have dollar amounts reflected in the Pending column.

Bill Generation

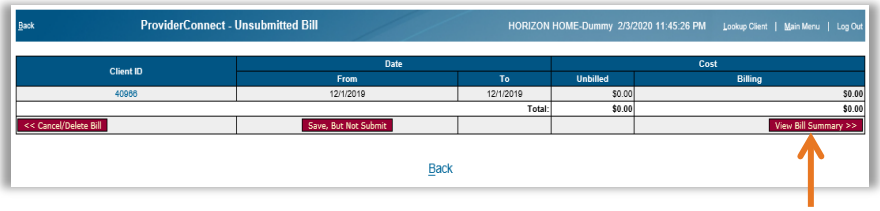


- Set the filter for the applicable fiscal year for the (services/treatments) being billed (fiscal year = service dates 10/1 – 9/30).



- Click “Generate New Bill”

- Treatments that have not yet been assigned to a bill will be compiled and displayed here. Multiple clients can be billed together.



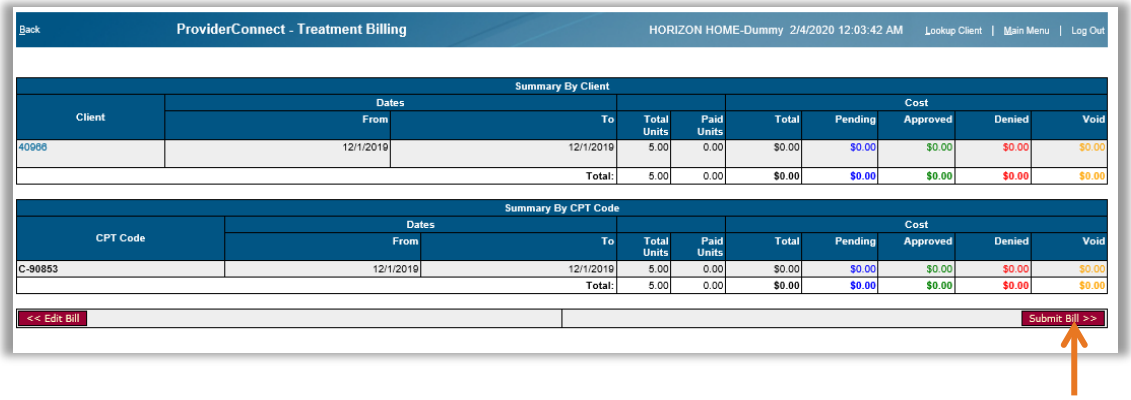
- Select ‘View Bill Summary’ to proceed with billing submission process.

Helpful Tip:

✓ *If all treatments have previously been assigned to a bill, the system displays the following message:*

✓ *If you believe this to be incorrect, please check the Unsubmitted Bills section to see if treatments were assigned to a bill already and have not been submitted for payment.*

- The Treatment Billing form will appear with a summary of treatments about to be submitted.

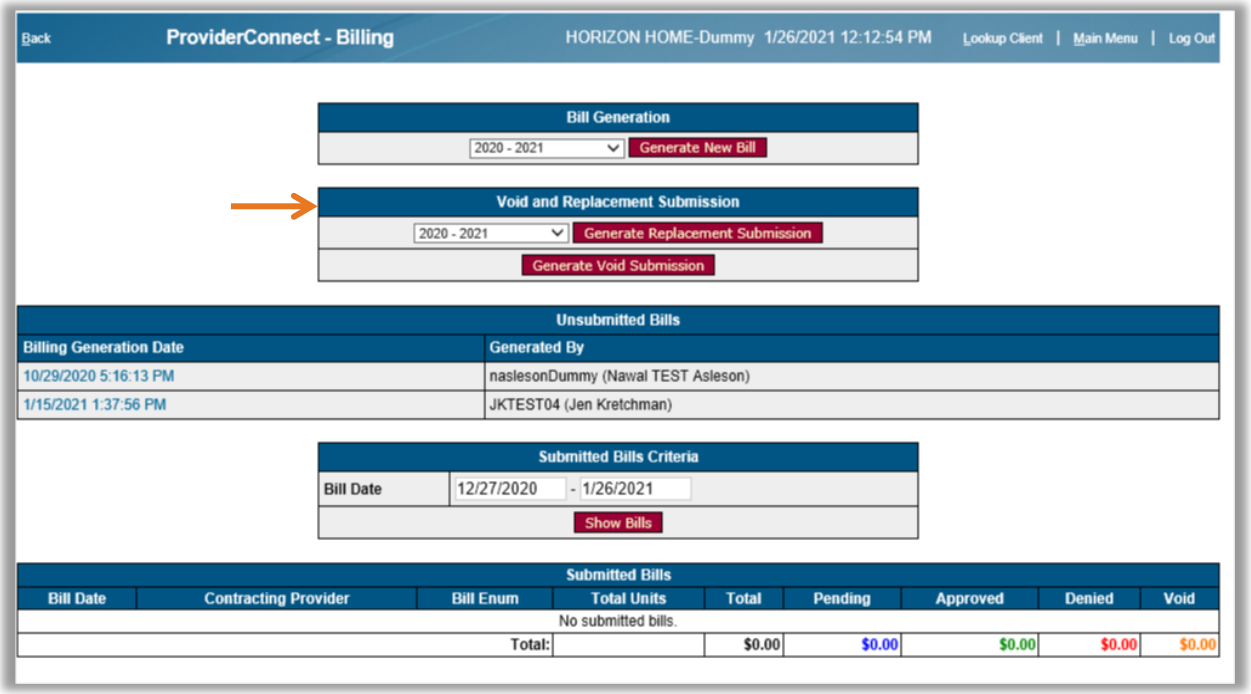


- Select 'Submit Bill' to complete billing submission process. The bill submission is now complete

Helpful Tip:

✓ *We recommend including numerous treatments per Bill Enum to reduce the number of data transmissions and thereby reduce data transmission errors.*

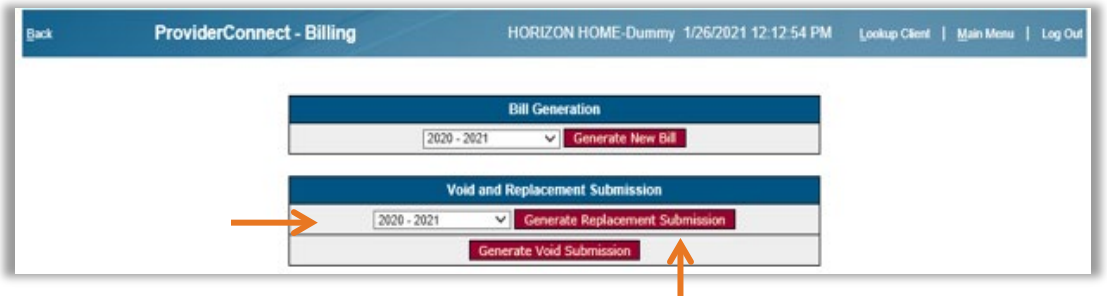
Void and Replacement Submission



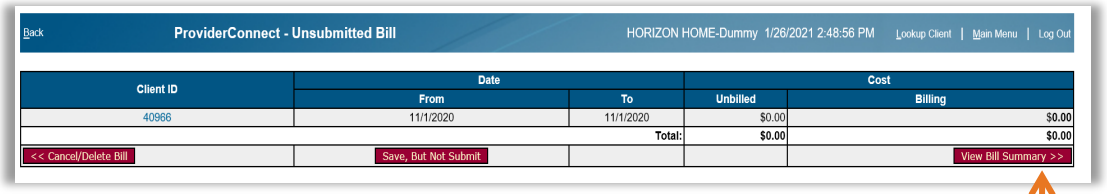
- **Generate Replacement Submission**
  - Only treatments created with the Replacement radio button set to Yes will be included.
  - Set the filter for fiscal year that contains the service to replace. Please note: This is based on the date of service.

Helpful Tip:

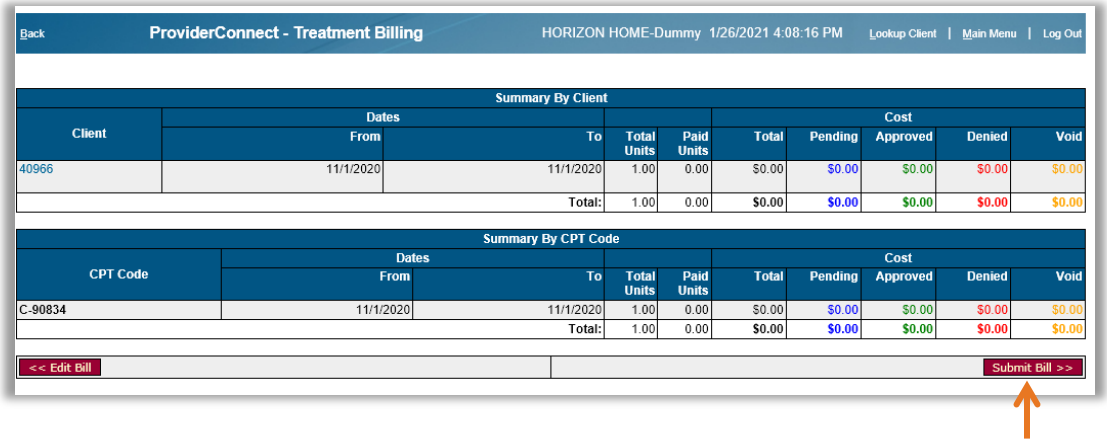
✓ *The fiscal year in ProviderConnect is defined as October 1st to September 30th*



  - Upon selecting the 'Generate Replacement Submission' button, the form for submission will open. This functionality is very similar to the forms for original billings.



  - Click 'View Bill Summary'

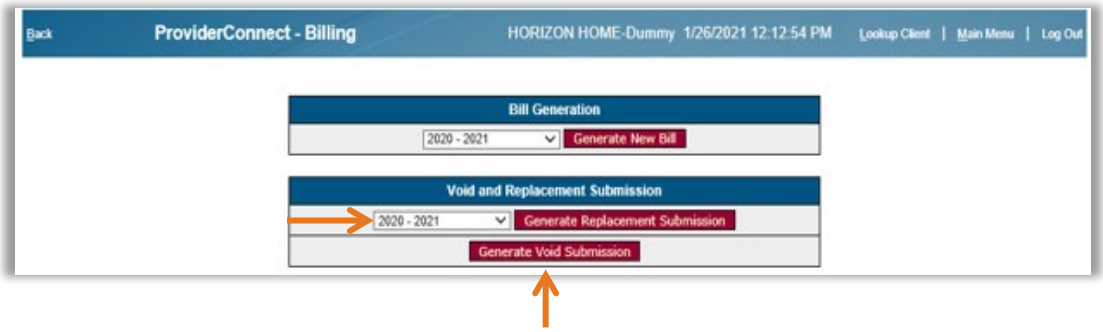


- After reviewing the data, if all records are correct, select the 'Submit Bill' button to bill.

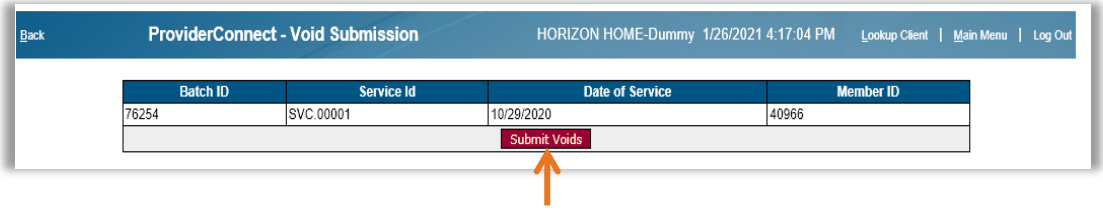
- **Generate Void Submission**
  - Only treatments which have been voided will be included.
  - Set the filter for fiscal year that contains the service to void.

Helpful Tip:

✓ *The fiscal year in ProviderConnect is defined as October 1st to September 30th*



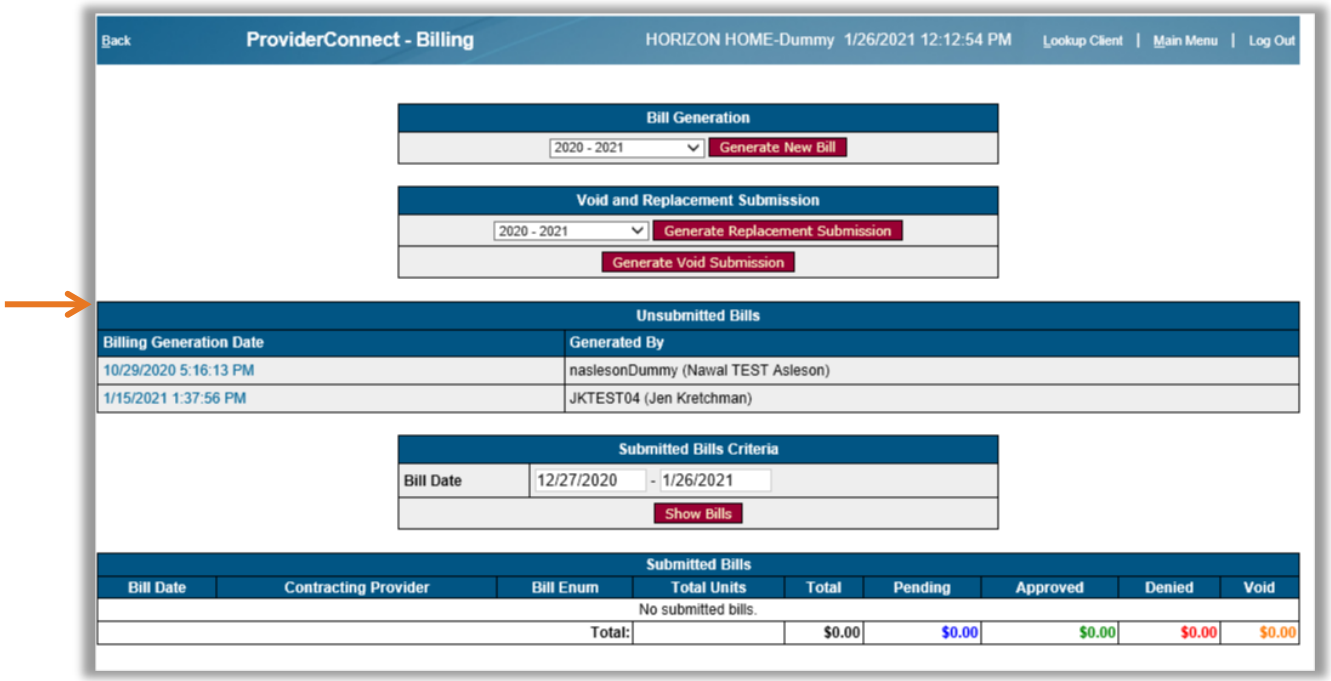
  - Upon selecting the 'Generate Void Submission' button, the form for submission will open.



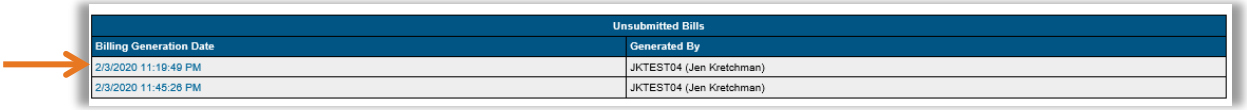
  - After reviewing the data select the button to 'Submit Voids'.

  - Upon completion of this step, the void treatment(s) will immediately pass into Optum's system and retro adjustments will be created to zero out the dollars and units of the voided services.

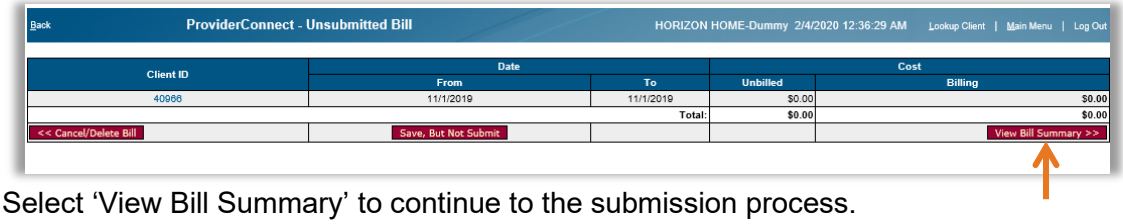
Unsubmitted Bills



- This section contains treatments that were previously assigned to a bill but the submission process was not completed.
- *These services will appear as if they have been billed when viewing the client's treatment history and so it is important to ensure that this section is worked and all unsubmitted bills are submitted!*
- To complete the submission process, click on the date/time hyperlink in blue.

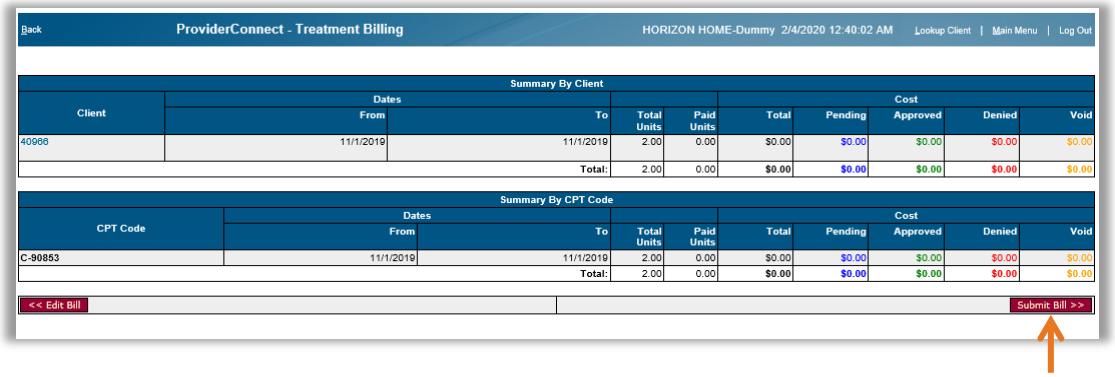


- Once selected, PCONN will display the records contained in the bill.



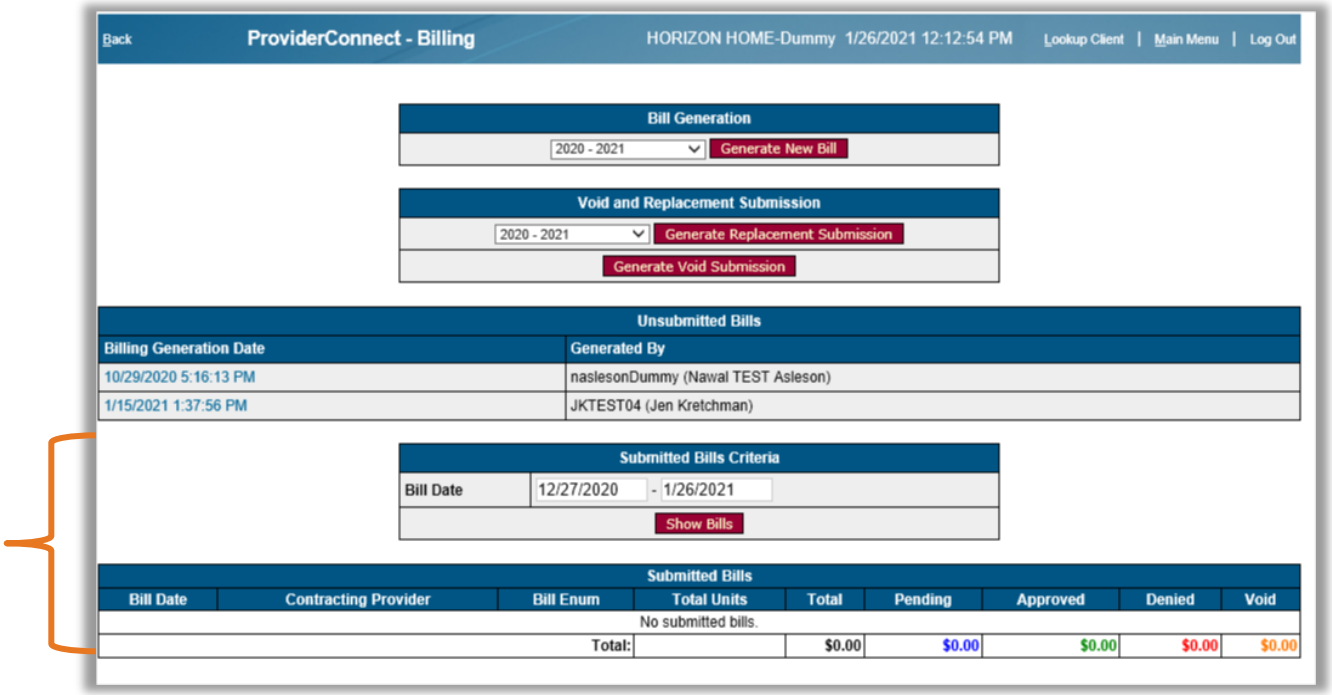
- Select 'View Bill Summary' to continue to the submission process.

- Review treatment details and select ‘Submit Bill’, if all records are correct.

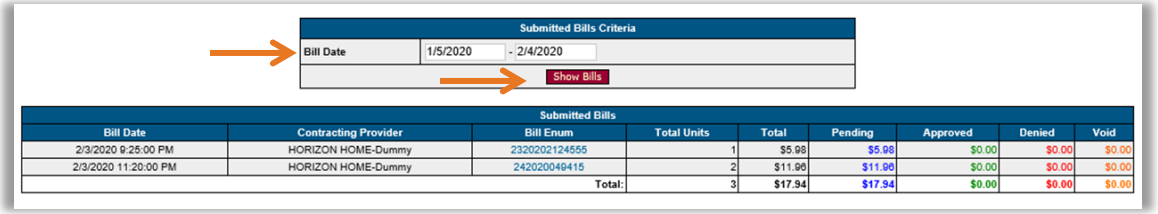


- The bill submission is now complete.

Submitted Bills Criteria and Submitted Bills



- Enter bill date range then select 'Show Bills.'

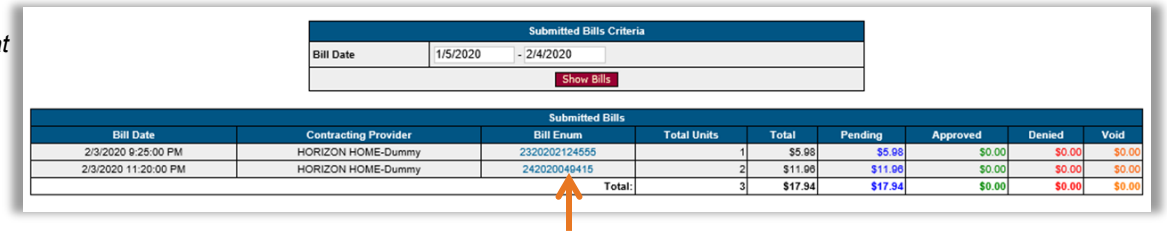


  - The total charge for each Bill Enum will remain in 'Pending' (blue) until the services are fully adjudicated, including EOB issuance.

  - Once adjudication is complete, the amount in 'Pending' will move to 'Approved', 'Denied' or 'Voided.'

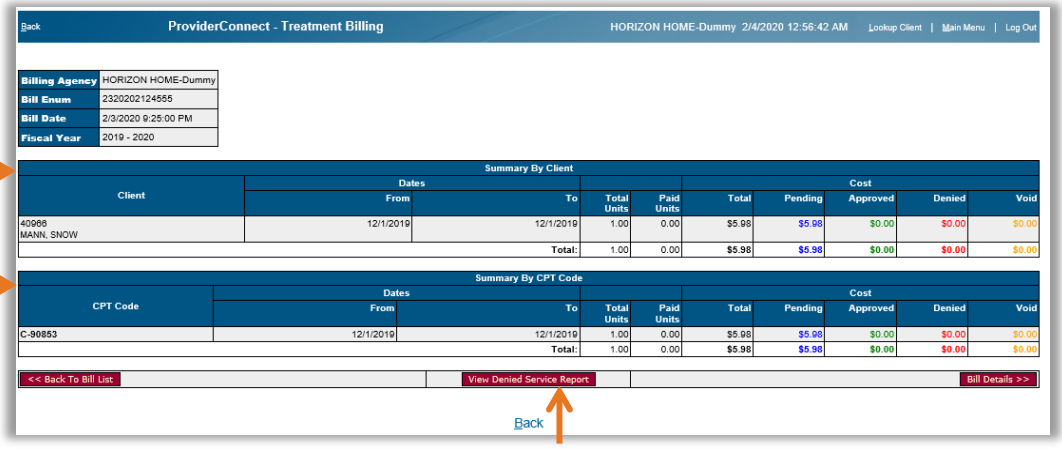
Helpful Tip:

✓ *Please note that Voided Bill Submissions will not appear in this section.*

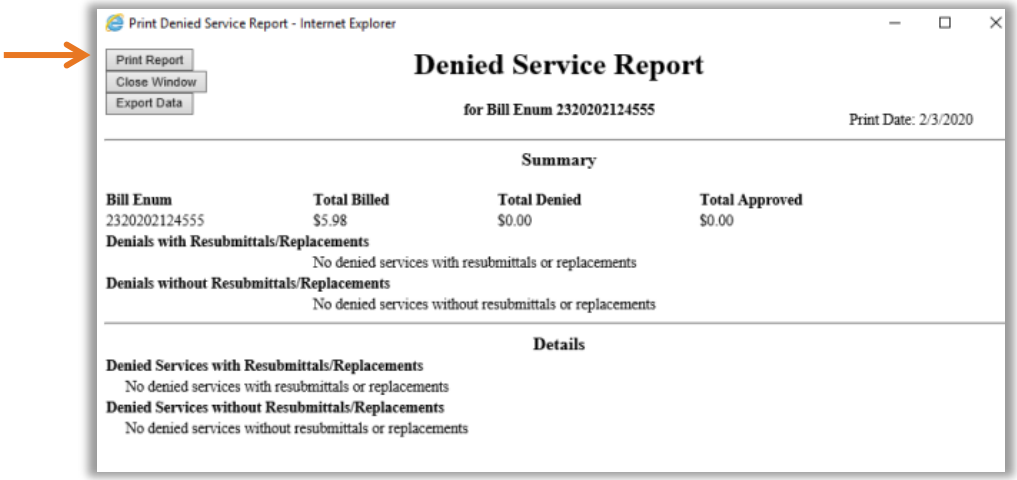


  - Select the hyperlink in 'Bill Enum' to see the details for each bill.

- Data is organized into two sections: ‘Summary by Client’ and ‘Summary by CPT Code.’



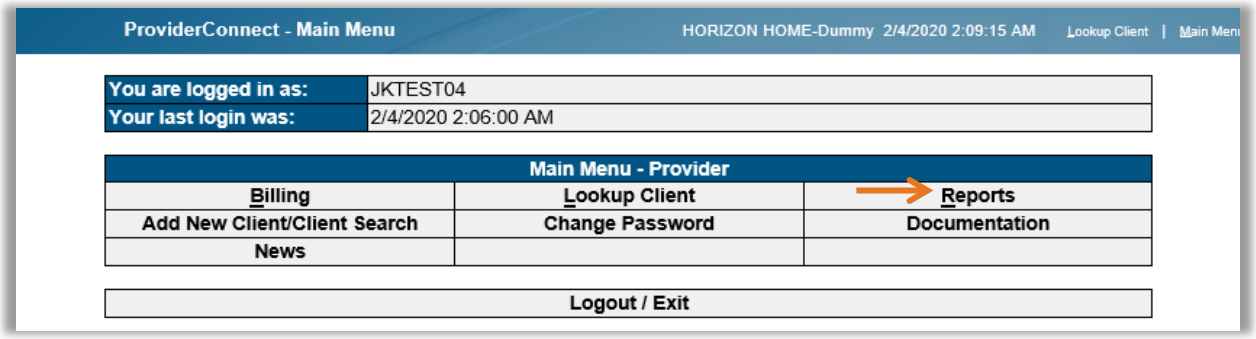
- Below the ‘Summary by CPT Code’ section, a link ‘View Denied Service Report’ will provide specifics on those services that were denied during the claim adjudication process.



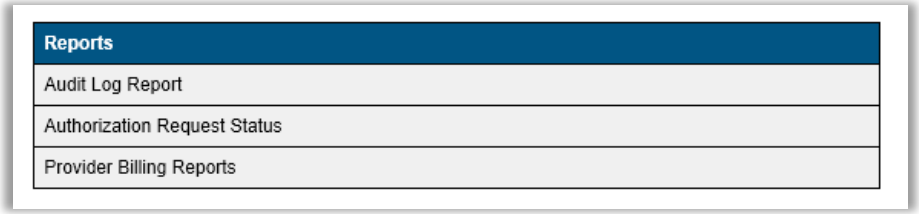
- Please Note: In the upper left corner, options to print the report or export the data are available.

This completes the Billing section in ProviderConnect.

Reports



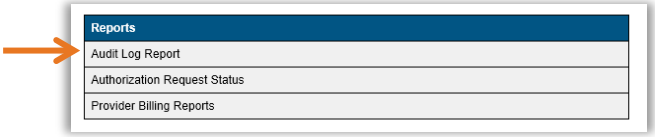
- From the Main Menu, click on “Reports”
- ProviderConnect features several reports. Below find detailed instructions for the Authorization Request Status and Provider Billing Reports.



Audit Log Report

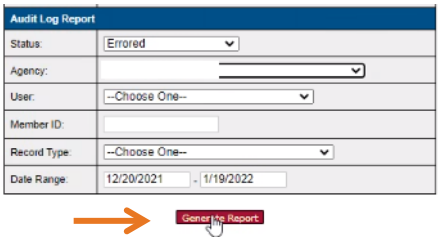
This report provides details on records passing from PCONN to Optum’s billing system.

- Select ‘Audit Log Report’ from the report menu.

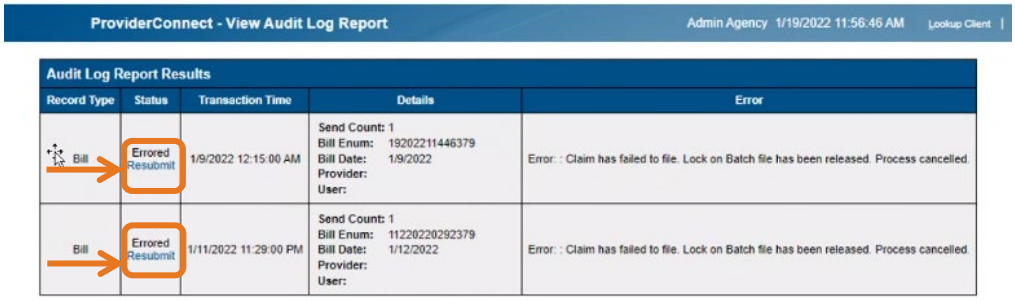


- Set the report filters as desired in the popup.
  - Status – Set to Errored to see transmission errors.
  - The date range section is based on record submission date (as opposed to auth date or service date).

- Click ‘Generate Report’ to run the report



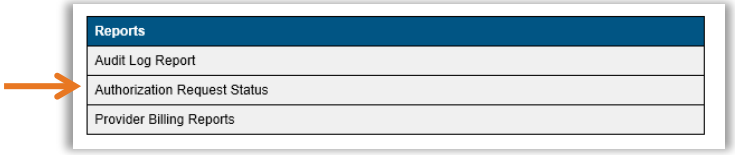
- Audit Log Report Results Example:
  - For **Record Type** of Bill - If the **Status** shows 'Errored / Resubmit', this means a Bill sent to Optum failed to transmit successfully and must be resent. Click the Resubmit hyperlink to resend the Bill to Optum.



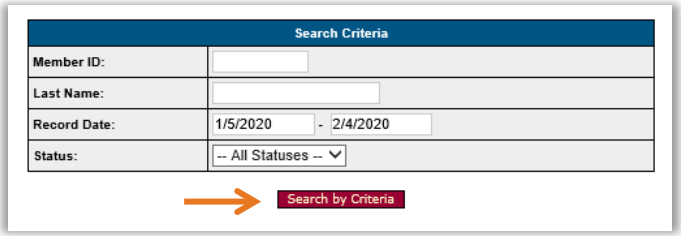
Authorization Status Report

This report provides details about authorizations.

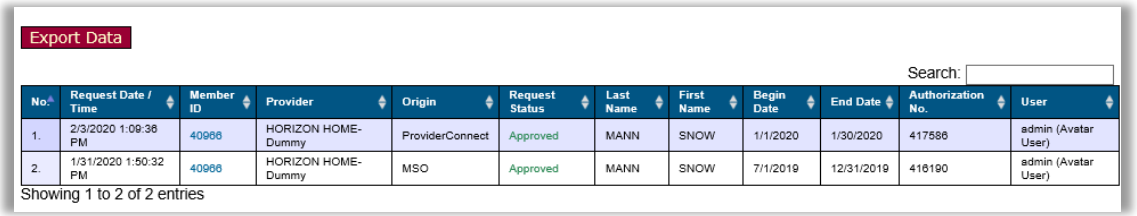
- Select 'Authorization Request Status' report from the report menu.



- Set the report filters as desired in the popup. The date range section is based on record submission date (as opposed to auth date or service date).



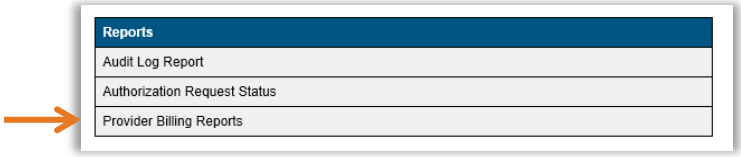
- Click 'Search by Criteria' to run the report
- Report Example:



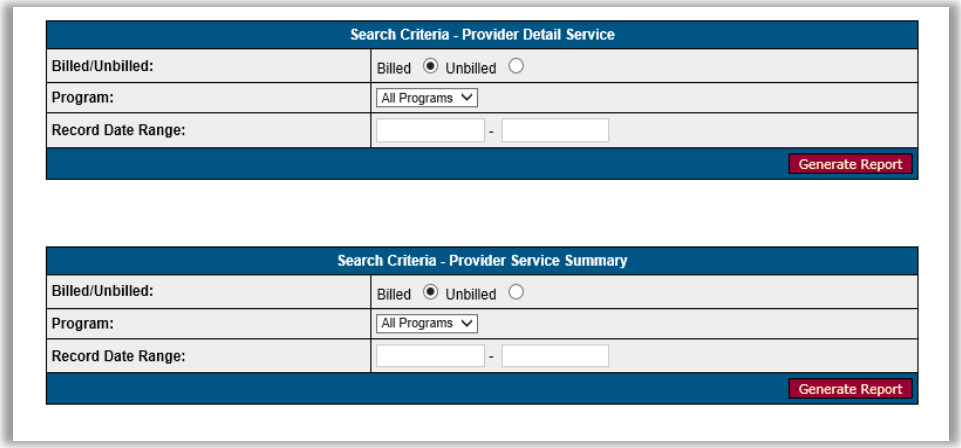
Provider Billing Report

This report provides details on Billed and Unbilled treatments.

- Select ‘Provider Billing Reports’ report from the report menu.

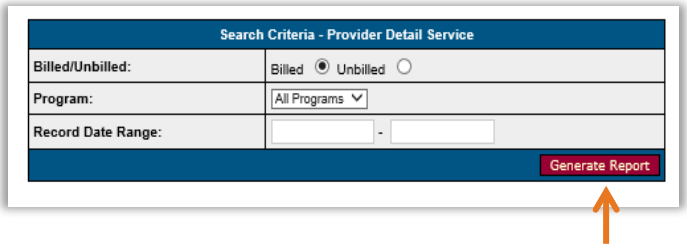


- There are two reports available:
  - Provider Service Detail
  - Provider Service Summary



Provider Service Detail:

- Select ‘Billed’ or ‘Unbilled’
- Take the default of All Programs
- Set the date range
- Click ‘Generate Report’ to run the report



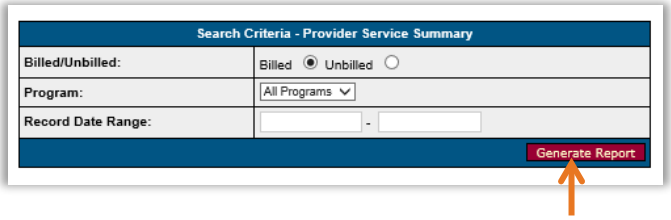
- Report Example

Export Data

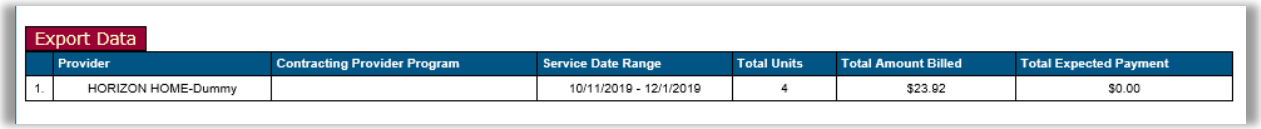
	Provider	Contracting Provider Program	Client ID	Client Name	Authorization Number	Date of Service	CPT Code	Units	Duration	Location	Clinician	Amount Billed	Expected Payment	Status
1.	HORIZON HOME-Dummy		40966	MANN, SNOW	416190	11/1/2019	Psychotherapy, Group	2	30		TEST-BASEBALL,BETTY	$11.96		Billed
2.	HORIZON HOME-Dummy		40966	MANN, SNOW	416190	12/1/2019	Psychotherapy, Group	1	15		TEST,SNOWMAN	$5.98		Billed
3.	HORIZON HOME-Dummy		62754	TEST-BELLDUMMY, TINKER	412825	10/11/2019	Psychotherapy, Group	1	60		TEST,SNOWMAN	$5.98	$0.00	Billed

Provider Service Summary:

- Select ‘Billed’ or ‘Unbilled’
- Take the default of All Programs
- Set the date range
- Click ‘Generate Report’ to run the report



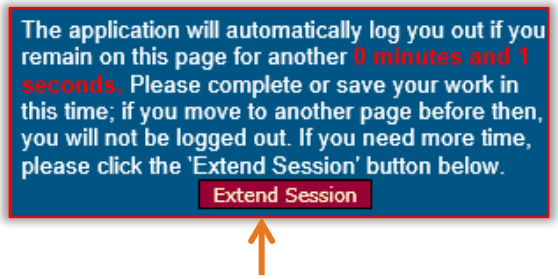
- Report Example



	Provider	Contracting Provider Program	Service Date Range	Total Units	Total Amount Billed	Total Expected Payment
1.	HORIZON HOME-Dummy		10/11/2019 - 12/1/2019	4	$23.92	$0.00

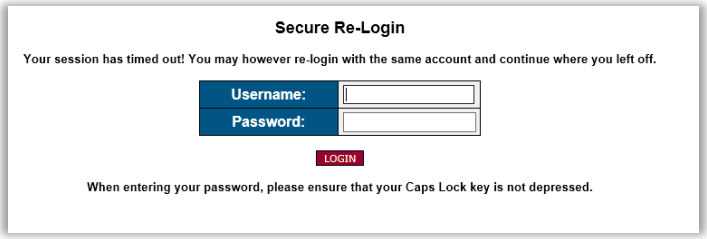
System Timeout

- *PCONN* is configured with a two-minute timeout warning.
- The system will prompt to “Extend Session” as you approach the idle timeout threshold
- Select “Extend Session” to stay logged in.



Secure Re-Login feature

- If the session has reached the idle timeout threshold the system “Secure Re-Login” pop-up message will appear:
  - “Your session has timed out! You may however re-login with the same account and continue where you left off.”



Client Eligibility Check

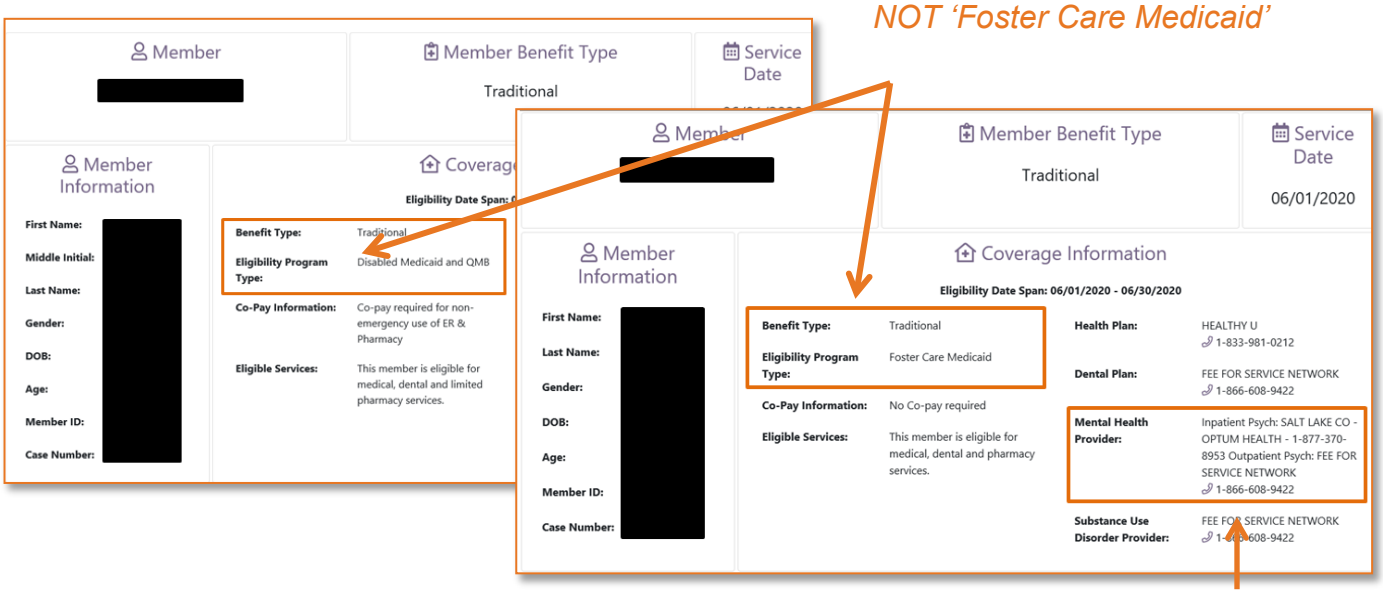
It is the Providers responsibility to ensure that eligibility is confirmed prior to administering treatment.

- Eligibility can be checked using Utah Medicaid's eligibility lookup tool:

https://medicaid.utah.gov/eligibility

- Utah Medicaid grants client eligibility on a month by month basis. It is the provider's responsibility to verify eligibility on all clients each month.

Confirm Eligibility program is NOT 'Foster Care Medicaid'



Helpful Tips:

✓ *Upon confirming eligibility, please print copy of confirmed eligibility and save in the client's file.*

Confirm Mental Health Provider is Optum Health.

Clients Assigned New Medicaid ID

Optum has implemented a new procedure to manage clients who are assigned multiple Medicaid ID numbers.

- For clients with higher level of care authorizations:
  - Contact your Optum Care Advocate and notify them that a new Medicaid ID has been issued.
  - A Care Advocate will discharge the old client record and create a new client record (including a new patient ID number), authorization and Mental Health Event Record.

- For clients with outpatient level of care authorizations:
  - Create new client record in ProviderConnect.
  - Create a client discharge record on old client ID. Please be sure the discharge date aligns to the expiration date listed in Utah Medicaid's system.

Evidence Based Practice (EBP) Codes

Code	Description
1	Medication Management
2	Outcome Questionnaire (OQ) / Youth Outcome Questionnaire (YOQ)
3	Wraparound to Fidelity
4	Assertive Community Treatment
5	Supported Employment
6	Supported Housing
7	Family Psychoeducation
8	Illness Self-Management and Recovery
9	Multisystemic Therapy (MST)
10	Therapeutic Foster Care
11	Functional Family Therapy (FFT)
12	Wellness Recovery Action Plan (WRAP)
15	Integrated Treatment for Co-occurring Disorder (Mental Health Substance Abuse)
16	Motivational Interviewing
17	Medication-assisted Treatment
18	Trauma Recovery & Empowerment Model (TREM)
19	Helping Women Recover
20	Seeking Safety
21	Matrix Model
22	Helping Women Recover and Beyond Trauma
23	Clubhouse
24	Dialectical Behavioral Therapy (DBT)
25	Motivational Enhancement Therapy (MET)
26	Prime for Life-Treatment
27	Peer Support
28	Relapse Prevention Therapy (RPT)
29	Eye Movement Desensitization and Reprocessing (EMDR)
30	Individual Placement and Support (IPS) (Grant)
31	Individual Placement and Support (IPS)
32	Attachment, Self-Regulation, and Competency (ARC)
33	Moral ReconationTherapy (MRT)
34	Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
35	Team Solutions (TS) and Solutions for Wellness (SFW)
36	Aggression Replacement Training (ART)
37	Adolescent Community Reinforcement Approach
39	Second Step Elementary School Program
40	The Seven Challenges
41	Assisted Outpatient Treatment (AOT)

42	Columbia Suicide Severity Rating Scale (C-SSRS)
43	Collaborative Assessment and Management of Suicidality (CAMS)
44	Psychoeducational Multifamily Groups (PMFG)
45	Acceptance and Commitment Therapy (ACT)
46	Cognitive Processing Therapy
47	Assisted Outpatient Treatment (AOT - Grant)
48	Prevention and Recovery from Early Psychosis (PREP - FEP Grant)
49	PRIME for Life - Prevention and Early Intervention
50	DIMENSIONS
51	Child Parent Relationship Therapy
52	Parent-Child Interaction Therapy
53	Cognitive Behavioral Therapy (CBT) - Beck Institute
54	Attachment Based Family Therapy (ABFT)
55	Child Parent Psychotherapy
56	Modified Therapeutic Community (MTC)
57	TCU-Mapping Enhanced Counseling
58	Solution Focused Brief Therapy (SFBT)
59	Cognitive Behavioral Therapy for Psychosis (CBTp)
60	Mind Body Bridging
98	Not Applicable