Achieving a Functional ASO

Necessary ASO Performance Standards | May 11, 2021

The Maryland Department of Health (MDH), in consultation with the providers in the Public Behavioral Health System, is required to identify the necessary reports and features required for a fully functional ASO. MDH's report should be filed with the Maryland General Assembly by July 1, 2021. Quarterly reports thereafter should identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date(s). This document seeks to define the core functionality necessary in an ASO vendor.

Standard 1: Claims Processing. ASO vendor's claims processing system includes all functionality necessary to support providers' revenue cycle management and is consistent with industry-standard practices.
1A: If a claim is submitted with all required information, it will be timely and accurately paid by Optum without additional intervention by the provider. Performance includes: a. Optum will publish and maintain a companion guide as referenced by 42 CFR §§ 162.1203, 162.1403, and 162.1603 that includes required information such as payer testing, EDI contacts, payer-specific business rules and limits; b. Claims will be paid or denied within clearly defined contractual expectations, which has historically been 14 days from submission, but was re-interpreted under Optum to be 21 days from submission; c. System will generate an accurate 835 that fully describes the status of every encounter, claim, and payment adjustment, and deliver it to provider *at the same time* as the claim payment, retraction, or payment adjustment; d. If claims are not paid within 30 days, Optum will automatically include interest payment on such claims without provider demand, as required by Maryland law; e. Upon an update in service fee schedules, Optum will pay claims at the updated rate within 30 days of the effective date of the rate change; and f. MDH defines evidentiary requirements and reporting mechanism for providers to report non-compliance with deadlines by Optum to the Department.
1B: If a claim fails to process and/or pay in Optum's system, providers will receive timely automated reports at each step in the process that identify the reason for the failure and the information needed to correct the claim. Performance includes: a. System will generate accurate 999 reports for all claims batches that fail to upload; b. System will generate accurate 277 reports (claim response on front-door edits) that accurately identifies rejected claims and contains all necessary data required to submit a clean claim without requiring supplementary reports; c. System will generate an accurate 835 on every encounter, claim, and payment adjustment, and deliver it to provider *at the same time* as the claim payment, retraction, or payment adjustment; d. System will use industry standard denial codes *and* denial explanations. Each denial code will identify a singular and distinct denial reason and its correlating denial explanation will accurately and completely describes the reason for the claim denial and offer sufficient information for the provider to correct the claim; and e. If there are multiple reasons for a claim denial, the system will include each of the distinct denial reasons and their correlating industry standard explanations on the 835.

1C: If a claim is in any status other than full payment (including but not limited to fails, rejects, pends, remains "in process," underpayments, partial payments, zero payments, or denials) due to a failure or error in Optum's claims processing, Optum will identify, correct and pay the claim within 30 days of claim submission without additional provider intervention.

a. Failures or errors in Optum's claims processing system include but are not limited to non-payment statuses arising from:
   - i. Client naming convention errors;
   - ii. Insurance indexing errors (i.e. selecting incorrect primary insurance or displaying inactive insurance);
   - iii. Secondary payer processing errors;
   - iv. Denials of add-on codes when underlying code is appropriately authorized;
   - v. Duplicate client records;
   - vi. Erroneous duplicate claims denials;
   - vii. Unfunded spans without end dates;
   - viii. Service portal and data errors including incorrect NPI numbers;
   - ix. All errors caused by manual processing by Optum;

b. If a provider reports claims denied or underpaid due to Optum errors, Optum will correct and pay each claim within 30 days of original submission date;

c. If claims are not corrected and paid within 30 days, Optum will automatically include interest payment on such claims without provider demand, as required by Maryland law; and

d. MDH offers mechanism for providers to report noncompliance to MDH; and upon validation, MDH applies requisite monetary penalty for contractual noncompliance.

1D: Incedo will include necessary functionality to enable providers' revenue cycle management activities, including:

a) Full export and download capacity for claims and authorizations (not max of 500);
b) Void and resubmit capacity for individual and batch claims;
c) Reporting and search capacity that meets basic industry standards and includes eligibility statuses; uninsured requests; claims data by processed dates, service dates, and claims status; search capability should identify the full array of client and/or claims data present in the system at any and all times;
d) Full and accurate reporting capacity on claims' processing history including dates of each reprocessing, check numbers and check dates associated with every reprocessing of a claim;
e) Capability to save draft/in progress authorizations; and
f) When applying retroactive funding switches for eligibility changes, the system will remit retraction and repayment info for a single claim simultaneously and on the same 835.

1E: Optum will provide prompt and adequate notice to providers of planned and unplanned system outages, including:

- For unplanned outages:
  - Within 30 minutes of a reported outage of authorization or claims processing functionality by more than two providers, Optum will release a notice to the provider community;
  - Once the scale and duration of a system outage is reasonably identified, Optum will release an update to provider community;
  - Within 30 minutes of an outage resolution, Optum will release an update to the provider community;

- For planned upgrades:
    - Optum will provide 48-hour advance notice to provider community of planned upgrades that may result in system outages or reduced functionality, including date, duration and functions impacted.

Standard 2: Eligibility and Authorizations. Uninsured eligibility decisions and authorizations are accurately and timely processed.

2A: Timeframes and Workflows.

a. Authorization requests for crisis services are approved accurately on first review and responded to within 24 hours of request;
b. Authorization requests for non-crisis services are approved accurately upon first review and within 14 days; If additional documentation is requested by Optum, approval is made within 3 calendar days of provider submission of requested documentation;
c. if auth is pended for reasons other than routine approval (i.e. for overlapping dates spans), provider should receive notification of the pended authorization within 5 days of submission as well as justification for the pend;
d. Requested uninsured spans are approved or renewed within 5 days of submission;
e. Requested unfunded spans are approved within 3 days; and
f. Split authorizations are appropriately identified and approved; conflicting authorizations are appropriately identified and prevented.

2B: Transparency and Accountability. In consultation with the provider community, Optum will report monthly on the average time from request to decision for uninsured eligibility and authorization requests--by provider type-- to ensure that:

g. Authorization process for every provider type matches the workflow and clinical requirements described in the provider manual; and
h. MDH clearly defines evidence necessary to document non-compliance with time standards and provides a mechanism to report it.

Standard 3: Provider relations. Performance standards for the ASO's provider relations are accurately defined, measured, and actionable.

3A: The ASO RFP requires Optum to respond to provider inquiries within one business day (p. 16, 2.3.2.4.A), resolve claims problems and open tickets within same week, or report to Contract Monitor (p. 16, 2.3.2.4.A.5). Evaluating compliance with these requirements can ensure that MDH is able to hold Optum accountable for retaining sufficient staff to handle provider complaints and needs; and otherwise meeting contractual performance standards.

a. Optum will track timeframe for provider problem resolution and share with MDH;
b. MDH will have a reporting mechanism for providers to submit evidence to MDH of Optum's noncompliance with the contractual performance standards in terms of timeframes and/or issue resolution; and
c. MDH will report this data to the provider community monthly.

Standard 4: ASO demonstrates the ability to identify and mediate security and privacy violations in a timely manner.

4A: The ASO issues payments only to those providers who have billed the ASO for providing treatment to a patient.

a. A clear avenue for providers to report misdirected payments is established and communicated to the provider community;
b. Optum identifies a root cause for ongoing misdirected payments;
c. Implementation of appropriate corrective action is reported; and
d. Efficacy of corrective actions is evaluated by MDH through monitoring of ongoing reports from provider community.