PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

Provider Notice

To: **All PerformCare Network Providers**

From: **Scott Daubert, PhD, VP Operations**

Date: **November 2016**

Subject: **AD 16 106 Information System Update and Timeline**

All PerformCare Network providers should note the following important process changes and transition dates related to PerformCare's change of information systems and related provider functions.

Please see Table 1 on page 2 of this Notice for a summary of changes.
As noted in our earlier communications, the main change affecting providers is that the current eCura ® ProviderConnect provider portal will be replaced by a new single log-in provider portal powered by NaviNet, America's largest real-time healthcare communications network. The following Workflows will be available in NaviNet:

- Eligibility & Benefits Inquiry
- Claim Status Inquiry
- Claim Submission (connection to Emdeon Provider WebConnect)
- Report Inquiry (reserved for later use)
- Provider Directory (connection to PerformCare on-line Provider Directory)
- Pre-Authorization Management (connection to PerformCare's Jiva care management system)
- Forms and Dashboards (includes BHRS and Family-Based Provider Capacity entry)

The following general processes are not changing:

- Electronic Claims Submission via Change Healthcare (formerly Emdeon) clearinghouse
- EFT/ ERA information via Change Healthcare
- Paper claim submission via Source HOV, Kentucky address

The following are important dates of transition of note for providers:

November 29, 2016 – Security Officers of new offices / registrants in Navinet will be able to add Users
December 1, 2016 – NaviNet PerformCare Plan Central page will be available to all registered NaviNet users
December 9, 2016 (close of business 4pm) – Submission of documents via CabinetShare is de-commissioned.
eCura® ProviderConnect functions related to clinical data entry, including Critical Incident Reporting, Provider Capacity for BHRS, FBMHS, ISPT Meeting Invite, and Service Prescription Events end.
December 12, 2016 – PerformCare Care Management begins in Jiva information system.
December 19, 2016 (close of business 4pm) - eCura® ProviderConnect single claims entry ends.
eCura® ProviderConnect view Claims Status function remains open but ends as of 12/31/16.
December 20, 2016 – On all claims submitted (paper/ electronic), taxonomy codes will be required.
The modifier additions in Table 2 will be required. See additional claims notes in this Notice below.

Table 1: Summary of Changes

Current Process	Moving to NaviNet	Moving to Fax
eCura ProviderConnect		
Critical Incident Reporting		X
Single Professional Claims Entry & Submission	X Workflow: Claims Submission, Emdeon Provider WebConnect	
Upload professional and institutional claims in an 837 5010 format*	X Workflow: Claims Submission, Emdeon Provider WebConnect*	
Provider Capacity for BHRS/ FBMHS	X Workflow: Forms & Dashboards	
ISPT Meeting Invite	X Workflow: Pre-Authorization Mgmt, Jiva system	
Service Prescription Events	X Workflow: Pre-Authorization Mgmt, Jiva system	
Check Open Authorizations	X Workflow: Pre-Authorization Mgmt, Jiva system	
Check Claim Status / Eligibility	X Workflow: Claims Submission	
CabinetShare		
Submit prior authorized / registered Partial/IOP/OP Requests		X
Submit Children's Service packets (e.g., RTF, CRR-HH, BHRS, FBMHS)	X Workflow: Pre-Authorization Mgmt, Jiva system	

* PerformCare previously has offered two methods for submission of HIPAA compliant 837 transactions: Submitting through the Change Healthcare (previously Emdeon) Clearinghouse, or Direct Submit to PerformCare.

- The providers who were directly submitting 837 transactions to PerformCare are being transitioned to the submission of files through Emdeon Provider WebConnect.
- Additional providers may also choose to use the 837 submission process through Emdeon Provider WebConnect. (Setup and associated fees with Change Healthcare apply).
- If providers or their vendors are currently sending electronic claims files via Change Healthcare as a clearinghouse, that process is unchanged.
- The current EFT/ERA processes through Change Healthcare are unchanged.

SCHEDULED TRAININGS:

Clinical information submission training, using Jiva care management system (via NaviNet workflow), will occur on November 21st and November 30th. Multiple times are scheduled for both Evaluators and Children's Services Treatment providers. Contact your Account Executive for registration and any additional needed information.

Claims entry training, using Emdeon Provider WebConnect (via NaviNet workflow), will occur December 12, 1pm and December 13, 10am. Contact your Account Executive for registration information.

For general NaviNet users and security officers, NaviNet has extensive training documents, video tutorials, FAQs, and User Guides available on their website under their Help section. In addition, a PerformCare NaviNet User guide will be available in late November offering step-by-step instruction and screen shots. In addition, support options include Live Chat, telephonic support, and online submission. If you are a new NaviNet Security Officer, the Help section also includes a dedicated section for Security Officers.

PROVIDER SETUP AND CLAIMS CHANGES:

Check Runs:
Check runs in December 2016 will continue to be on Thursdays throughout the month, with the last one 12/29/16. This will be the final check run from the current eCura platform. First scheduled check run from the new claims system (Facets) will be Wednesday, January 4, 2017. Beginning in 2017, checks runs will be Wednesdays.

Paper Claims Submission:
ALL paper claims must be submitted to:
PerformCare
P.O. Box 7308
London, Kentucky 40742

This is not an address change, but this now will include claims tied to administrative appeal approvals and out of network claims. No paper claims should be sent to our Harrisburg address, beginning 12/20/16.

Third Party Liability (TPL) Claims Submission:
Secondary claims will now be able to be accepted electronically. In the past providers had to submit secondary claims with the primary EOB attached on paper, but with the change of platform this is an upgrade to our current process.

Taxonomy Codes:
Beginning on December 20, 2016 for all claims submissions (electronic and paper), taxonomy codes will be required. This is a HIPAA requirement that was not previously enforced by PerformCare. Taxonomy will now be required to be reported on all claims in the following HIPAA-compliant manner:

837P

- Billing Provider - Loop 2000A PRV Segment

- Rendering Provider Loop – Loop 2310B PRV Segment (This is primary, if PerformCare receives. If not received, PerformCare will use the billing provider taxonomy.)

837I

- Billing Provider - Loop 2000A PRV Segment

SourceHOV CMS1500 (paper)

- Billing Provider – Box 33b
- Rendering Provider – Box 19 (ZZ qualifier is required. If box 19 is blank, the taxonomy should be listed in box 24J above the provider NPI. Rendering provider taxonomy is primary, if PerformCare receives. If not received, PerformCare will use the billing provider taxonomy.)

SourceHOV UB04 (paper)

- Billing Provider – Form Locator 81 (ZZ qualifier is required)

Provider Setup and Payments:

Basic provider setup and payments will be according to license type. Each license type will correspond to a primary master mailing address and payment (check/EFT). If an entity has the multiple licenses of MH Outpatient, Family-Based, and/or MH Partial, internally those will be combined in our system into one "outpatient / MH clinic" facility type. (This includes BHRS payments tied to those licenses).

Modifier Additions:

Please see Table 2 on the following page for modifier additions that were needed to resolve CPT-Modifier combination conflicts between programs and/or providers.

Claim Edit Updates:

Please see Table 3 and Table 4 on subsequent pages to updates that are being made to specific claims edits on electronic files and paper claims. Questions on specific claims edits or rejections can be directed to the PerformCare Provider Claims Helpline at 888-700-7370.

Table 2: Modifier Additions (effective on all claims submitted on or after 12/20/16)

Level of Care Description	PROC_CODE & Modifer(s)	Notes
MH--BHRS--Behavioral Specialist Consultant - Brief Treatment Model	H0032U2	U2 modifier added
MH--BHRS--Mobile Therapy - Brief Treatment Model	H2019U2	U2 modifier added
MH--BHRS--CRR ITP (Intensive Treatment Program)	H0019HE HK	HK modifier added. HY is third modifier when member in C&Y Custody.
MH--BHRS--Exception Program - SITE program (Kidspeace)	H0046U5 U1	U1 modifier added
SA--NH--Detox - DUAL	H0013HE	HE modifier added
SA--NH--Drug-Free Halfway House - DUAL	H2034HE	HE modifier added
SA--NH--Drug-Free Residential, Short Term (3B) DUAL	H0018HF HE	HE modifier added
SA--NH--Drug-Free Residential, Long Term (3C) DUAL	T2048HF HE	HE modifier added
SA—NH--Drug-Free Halfway House - ADOLESCENT	H2034HA	HA modifier added

Table 3: Electronic Claim Edits (effective on all claims submitted on or after 12/20/16)

Edits for electronically submitted claims
Member # must be less than 17 alpha/numeric characters or claim will reject.
All claims containing any form of Post Office Box, will be rejected by Emdeon/Change HealthCare, when received in the 2010AA loop, Billing Provider Address, either the N301 or the N302. This would include but not be limited to POBOX, P0BOX, PO Box, P0 Box, POB, PO B, Lock Bin, Lock Box, Post Office Box etc.
ICD-10 EDIT 1 # Base EDIT – If the qualifier indicates ICD-9, then the code must be a valid ICD-9 code. If the qualifier indicates ICD-10 then the code must be a valid ICD-10 code. If not, claim will reject.
ICD-10 EDIT 2 # Date EDIT - If the date of service on the claim is prior to 10/1/2015, it must be a valid ICD-9 code. If the date of service on the claim is on or after 10/1/2015 it must be a valid ICD-10 code. If not, claim will reject.
Inpatient claim that spans over a calendar month will reject. These Claims are to be for services within the month. Each month should be billed on its own claim. This is applicable for Bill Types of 11X, 12X, and 086X only.
If 837I and bill type 11X, 12X, or 086x, if the Inpatient Admission Date (DTP*435) is after the Statement begin date (DTP*434 – first date) claim will reject
Bill types 11X, 12X, or 086X require an admission date on the 837 claim (DTP*435); else claim will reject
If 837I and if Admit Type does not contain 1, 2, or 3 (CL101),claim will reject
If claim type 837I and If bill type not in 11X, 12x, or 86X, and DTP segment for date of service is not present, reject claim
If claim type 837I and If bill type 11X, 12X, or 086X, and contains a DTP segment for date of service, claim will reject
If 837I, claim will reject if the dates of service are outside the statement period (DTP*434)

Table 4: Paper Claim Edits (effective on all claims submitted on or after 12/20/16)

CMS1500 = C; **UB04 = U; Both = B**	**Form Locator Validation Field**	**Rejection Reason/Paper Claims**
U	74	Principal Procedure Code is invalid
	74 A-E	
B	C: 24A; U:45	Date of Service prior to 10/1/2001 - Please submit to correct carrier
		Note: applicable to any detail line
B	C: 26	Patient Account/Control Number is missing or illegible.
	U: 3A	
B	C:2	Member name is missing or illegible (SAME or "SAME AS INSURED" is acceptable and should not reject)
	U:8B/58	
C	C: 4	*Insured name missing or illegible* (SAME or "SAME AS PATIENT" is acceptable and should not reject)
C	24E	Diagnosis Pointer is required on Line(s) %Line%
C	C:27	Assignment acceptance must be indicated on the claim
U	14	Valid Admission Type is required
U	50	Payer name is required
U	53	Valid Assignment of Benefits Certification Indicator is required
B	U: 59; C: 6	Valid Patient's relationship to insured is required
U	12	Admission Date is missing or illegible (Use Bill Type table to identify Inpatient and Outpatient claim; If OP - do not reject claim; If IP and a valid date is not billed, reject claim)
U	13	Admission Hour is required (Use Bill Type table to identify Inpatient and Outpatient claim; If OP - do not reject claim; If IP and bill type is anything except 21x and a numeric value is not billed on the claim, reject claim)
U	15	Point of Origin for Admission or Visit missing (If claim has any bill type except 14x and field is blank, reject claim)
U	16	Discharge Hour is required (Use type if bill table to determine IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, reject claim)

U	69	Admitting diagnosis code is missing or illegible (Use TOB table to identify OP and IP bill types. If IP and field is blank or illegible, reject claim)
U	70	Patient's Reason for Visit is missing (Use TOB table to identify OP and IP bill types. If *OP* and field is blank, reject claim)
U	76	Attending Provider Qualifier is missing/ invalid (Reject claim if the 'Other Provider ID' is present and either: 1.) the 'Qualifier' box is blank or 2.) A qualifier other than 0B/1G/G2 is present
U	76	Attending Provider Other ID# Missing (Reject claim if qualifier is present and Other ID box is blank)
U	6	Inpatient claim that spans over a calendar month will reject. These Claims are to be for services within the month. Each month should be billed on its own claim. This is applicable for Bill Types of 11X, 12X, and 086X only.
U	14	If Admit Type does not contain 1, 2, or3), claim will reject
U	45	If Bill Type **not** in 11X, 12x, or 86X, and date of service is not present, claim will reject.
U	45	If Bill Type 11X, 12X, or 086X, and contains date of service, claim will reject.
U	12	If Bill Type 11X, 12X, or 086x, and the Inpatient Admission Date is after the Statement begin date (locator field 6) claim will reject