Claims Submission Overview

Provider / Biller Training

This Training Includes:

- Timely Filing Guidelines
- General Information and Resources
- Submitting Original and Corrected Claims: CMS-1500 & UB-04
- Primary Insurance Updates
- Appeals

PerformCARE

Presented by: PerformCare Claims

Timely Filing Guidelines

Timely Filing - Initial Claim Submissions

- **Capital Area Behavioral Health Collaborative (CABHC):** The initial claim submission must be received *within* **60** days from the date of service. This includes Cumberland, Dauphin, Lancaster, Lebanon, and Perry Counties.

- **Tuscarora Managed Care Alliance (TMCA):** The initial claim submission must be received *within* **60** days from the date of service. This includes Franklin and Fulton Counties.

Timely Filing Guidelines

Timely Filing - Secondary Claim Submissions

- **Capital Area Behavioral Health Collaborative (CABHC):** Secondary claim submission must be received *within* **60** days from the date of the primary insurance eob *and* the DOS is less than 365 days.

- **Tuscarora Managed Care Alliance (TMCA):** Secondary claim submission must be received *within* **60** days from the date of the primary eob *and* the DOS is less than 365 days.

Timely Filing Guidelines

Timely Filing - Corrected Claim Submissions

- Must have resubmission code “7” in Field 22 of the 1500 form along with the original claim #
- Must have the correct Bill Type on UB-04 form (117, 867) along with original claim # in box 64A

Replacement of a claim that denied in full = 365 days from the date of service.

Replacement of a claim that overpaid= 365 days from the date of service.

Replacement of a claim that underpaid= 365 days from the date of service.

- Replacement of a claim that *overpaid* after 365 days = Provider must send a refund check with detailed documentation (a replacement claim should *not* be sent).
- Replacement of a claim that *underpaid* after 365 days = Past corrected claim / admin appeal timely filing guidelines, cannot be paid.
- **Void Requests** (with resubmission code “8” in Field 22 of the 1500 form, or Bill Type 118, 868 on the UB-04 form)
- There is no time limit on a void claim request.

PLEASE NOTE: **A claim that is returned or rejected electronically is not entered into our system, therefore it is considered an original claim and NOT a correction. The provider must submit the returned / rejected claim following the original claim submission guidelines**.

General Information

Provider Claims Services 1-888-700-7370 Option #1, 8am to 4:30pm M—F

Authorization Questions, Care Managers, Pre-Certs, AE's = 1-888-700-7370, Option #2 or follow the prompts.

TPL (Third Party Liability) Claims can be submitted electronically or mailed in, one sided, claim first then EOB, and mailed to:

PerformCare
PA Health Choices
PO Box 7308
London, KY 40742

OON (Out of Network) Agreements must be attached to the submitted paper claim.

Administrative Appeals must be mailed to:

PerformCare
PA Health Choices
PO BOX 7301
London, KY 40742

Resources

- **CMS-1500 Professional Claim Form Version 02/12**: http://www.nucc.org/
- **UB-04 Institutional Claim Form**: http://www.nubc.org/
- **PerformCare website**: http://pa.performcare.org/
- **Sign up for Network News for Important Provider Updates**: http://pa.performcare.org/apps/icontact-networknews/index.aspx#signup
- **Location of Online Presentations**: http://pa.performcare.org/providers/training-education/performcare-presentations.aspx
- **NaviNet Enrollment Guide**: http://pa.performcare.org/pdf/providers/resources-information/navinet/navinet-enrollment-guide.pdf

Network News = Provider Memos!

2019:

AD 19 100: Service Location Enrollment Deadline (05/01/19)
AD 17 104: Ordering, Referring, and Prescribing Providers (Revised 03/01/19)

2018:

BHRS 18 100: Differential Reimbursement of TSS with the RVT Credential (07/01/18)

2017:

AD 17 107: New NaviNet Electronic Claim Inquiry Enhancement
AD 17 106: Clarification of Rejected and Corrected Claim Rules (12/15/17)
AD 17 105: NaviNet Authorization and Claims Reports for Providers
AD 17 104: Ordering, Referring, and Prescribing Providers (Revised 12/01/17)

2016:

BHRS 16 102: CPT Codes & Modifiers for ABA Services (11/14/16)
AD 16 102: Additional Pre-Payment Claims Edit for Duplicate / Disallowed Services (04/01/16)

Locating Provider Memos

Go to our website http://pa.performcare.org and select 'Provider Forms'

Provider forms

Providers: Find the forms you need for any level of care or service.

Along the left-hand side (under Providers), select 'Latest Updates'

Providers

- Claims and billing
- Self-service tools
- Forms
- Latest updates
- Training and education
- Resources and information
- Quality improvement
- Member wellness resources
- Complaints and grievances

Submitting CMS-1500 Claims

Important Fields for the CMS-1500 Form 02/12

Refer to the Provider Manual for a complete list of required fields
http://pa.performcare.org/pdf/providers/resources-information/provider-manual.pdf

1 - Medicaid

1a - Insured's I.D. (Member's MAID)

9a - Other Insured's Policy or Group number
IMPORTANT! If 11d has **YES** checked off, then this must be filled out!

9d - Insurance Plan Name or Program Name
IMPORTANT! If 11d has **YES** checked off, then this must be filled out!

11d - Is there another health benefit plan?
IMPORTANT! If **YES**, then you must fill out fields 9a and 9d.
If **NO**, then fields 9a and 9d must be left **BLANK**!

17b - National Provider Identifier (NPI) of the attending, prescribing, or supervising physician (if required for your provider type)

19 - ZZ qualifier and Rendering Taxonomy (if different from Billing Taxonomy in 33b)

21 - Diagnosis Code(s) ICD-10

22 - Medicaid Resubmission Code and Original Claim # --used for corrected claims (7) and voids (8) + Claim #

23 - Authorization Number—if the service requires an authorization, then this field is required.

24A-G - Dates of service, Place of service, CPT code, Modifiers, Diagnosis Pointer(s), Charges, # of units

24I - ZZ qualifier

24J - The rendering taxonomy code (unshaded area) if different from billing provider and not listed in field 19. The rendering NPI if rendering NPI is different from the billing NPI (from box 33a)

25 - Federal Tax ID (must match billing information)

26 - Patient Account number

27 - Accept Assignment? Check off "yes" or "no" (see back of form or the CMS website for explanations)

32 - Name / address of facility where services were provided if other than home or office, must be MA enrolled

33 - Billing Information 33a = NPI; 33b = ZZ qualifier and Billing Provider's Taxonomy Code.

CMS 1500 claim form completion guidelines for paper submissions are available on our website.

Under Providers / Self-Service, click on the Provider Manual (PDF) and refer to pages 101 - 103 for required fields.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Submitting UB-04 Claims

Important Fields for the UB04 Form

Refer to the Provider Manual for a complete list of required fields
http://pa.performcare.org/pdf/providers/resources-information/provider-manual.pdf

1 - Provider Name and Address

3 - Patient Control Number / Medical Record #

4 - Type of Bill (examples: 111, 112, 113, 114, 117, 861, 862, 863, 864, 867)

5 - Federal Tax No.

6 - Statement Covers Period (From & Through)

12 through 15—Admission Information

16 - Discharge Hour (leave blank if member is still a patient)

17 - Discharge Status (ensure that this status matches the Bill Type in box 4)

42 - Revenue Code

45 - Service Date (**ONLY** used for OP facility claims, example: Bill Type 13x)

46 - Service Units (days member was Inpatient MINUS the discharge day)

47 - Total Charges

50a - Payer Name

52 & 53 - Must have either a “Y” or “N”, please refer to your UB04 provider manual for explanations

54a - Prior Payments

56 - NPI #

58 through 60 - You MUST have the member’s MAID in 60

63 - Authorization #

64 - Original claim # (required for corrected claims or voided claim requests)

66 - Diagnosis and Procedure code qualifier (ICD version indicator)

67 - Principal diagnosis codes and Present on Admission (POA) indicator(s)

69 - Admit Diagnosis code

71 - PPS code (DRG) if necessary

76 - In the appropriate boxes, enter the NPI of the provider; the 2-digit qualifier of G2 (optional); the 9-digit MA number (optional); and the Last Name and First Name. This can be the provider that ordered the admission or the provider who is responsible for determining the diagnosis or treatment of the patient.

81 - B3 qualifier plus the Taxonomy code (no spaces)

UB 04 claim form completion guidelines for paper submissions are available on our website.

Under Providers / Self-Service, click on the Provider Manual (PDF) and refer to pages 103—105 for required fields.

Submitting a Corrected Claim

Important Information—

Refer to the Provider Manual for an explanation between returned / rejected claims and corrected claims
http://pa.performcare.org/pdf/providers/resources-information/provider-manual.pdf

Submitting a Corrected Claim on the CMS-1500 02/12 Form

- Enter the correct code in Field 22: Resubmission code can be either of the following:
  - "7" for a Replacement of a prior claim
  - "8" for a Void of a prior claim
- Enter the PerformCare Original Claim Number in Field 22- (Original Ref. No.)

Submitting a Corrected Claim on the UB-04 Form

- Enter the correct Bill Type in Field 4– Please note the last digit of the four-digit Type of Bill is used to determine a replacement or void / cancel request. For example, Bill Type 0117 indicates a replacement claim whereas Bill Type 0118 indicates a void request.
- Enter the PerformCare Original Claim Number in box 64A (Document Control Number)

Remember: Corrections are timely when submitted within 365 days from date of service.

Common Billing Errors

Common billing errors

- **Paper claims must be submitted on original pink and white CMS 1500 forms. Hand writing these forms is strongly discouraged to avoid unnecessary delays in payment processing.**
- **NPI** is not registered with the PROMISe Medicaid Enrollment Number (see OMAP Bulletin Number 99-06-14 titled Instructions for Registering Your National Provider Identifier to DHS, Issued November 22, 2006).
- Pay to **federal tax ID** is not up to date with the PROMISe Medicaid Enrollment Number.
- **Insured's ID number** — Member's MAID/recipient number.
- **Diagnosis** (ICD-10 diagnosis codes only) diagnosis should match the service you are billing (SA versus MH).
- **Place of service code** (must be valid for the service and Provider type/specialty for the **rendering** Provider).
- **Rendering Provider** — The rendering NPI and taxonomy code if the rendering Provider is different from billing and holds the license with the state to perform the service.
- **Billing Provider:**
  - **CMS 1500**
    - The billing NPI must always be provided in box 33a; the qualifier ZZ and billing taxonomy code must be in box 33b.
  - **UB-04**
    - The billing NPI must always be provided in box 56; the qualifier B3 and taxonomy code must be in box 81.
- **Qualifier** — The appropriate qualifier for a taxonomy code is ZZ for CMS 1500 and B3 for UB 04 claims.
- **Multiple CPT/revenue codes** — Separate claim forms are required when billing different CPT or revenue codes. Claims with multiple codes on the same form will be denied. Example: H2021EP and H0032HO cannot be on the same claim. The only **exceptions** are **facility lab fees** and **family-based services**.
- **Multiple-year claims** — Providers must bill separate claims when the dates of service span over a calendar year. This rule applies to medical and hospital claims.

As a reminder, per the November 2016 Provider Notice (AD 16 106 Information System Update and Timeline), all claims both CMS 1500 and UB 04, submitted electronically or on paper, MUST have a taxonomy along with the qualifier, in the appropriate boxes.

Common Denial Codes

Ultra Blue	Meaning	Resolution
Z99	Code not payable for Provider Specialty or there is no Provider agreement on file	May be due to invalid CPT, modifiers, POS, diagnosis, provider type / spec, provider agreement on file for the service being billed? (ex. SA dx for MH service)
ZH0	Duplicate, disallowed, or unbundled service	Is the member in a treatment episode for MH-PH, RTF, IOP, etc.? (see AD 16 102)
ZK1	Invalid / Deleted Code, Modifier, Description	Is the billed modifier valid for service? (ex. 90791)
ZR2	Please submit the correct original claim #	Reference numbers from returned claim letters are not valid claim #'s and cannot be used in box 22.
X96	EOB (Explanation of Benefits) attached illegible or incomplete	Member may have multiple active TPLs
ZH4	Code Mod not valid for Provider Type or MAID	Is the modifier valid? Does it match / agree with the POS being billed?
ZH6 / N17	Invalid place of service	Is the billed POS valid for service / provider?
Z48	Not a final denial	What was the primary insurance denial reason?

Common Denial Codes

Ultra Blue	Meaning	Resolution
073	Deny All Claim Lines	This is not a stand-alone denial code. There will be an additional denial code listed on your remittance advice for a more detailed explanation (see example below)

Date of Service	Proc/Rev DRG	Mod	Description	Qty	Charged Amount	Allowed Amount	OIC	Coins	COB	Deductible	Amount Paid	Adj/ Den
09/06/18-09/06/18	90837		Psychotherapy, 60 minutes w	001	150.00	0.00	0.00	0.00	0.00	0.00	0.00	073
09/06/18-09/06/18	90837		Psychotherapy, 60 minutes w	001	150.00	0.00	0.00	0.00	0.00	0.00	0.00	073
										Interest Payment	0.00	
										Prior Payment	0.00	
Claim Denial Code: ZR2			Claim Total		300.00	0.00	0.00	0.00	0.00	0.00	0.00	

Messages

073 Deny All Claim Lines

ZR2 Please submit the correct original claim number for consideration

Primary Insurance Updates

ACT 62 Denial Letters / EOB's

- Providers must submit one denial / non-covered letter per CPT / per calendar year.
- Denials can either be submitted with paper claim forms and mailed to London, KY or faxed directly to us at 888-296-4002 or 888-987-5828 Attention: ACT 62 Updates
- After the denial is submitted and is on file, providers can submit directly to PerformCare as primary.

TPL Updates

- Providers can submit TPL updates via NaviNet. When the policy is confirmed to be terminated, claims impacted will be reprocessed.
- Weekly TPL Underpayment jobs are run every Thursday to reprocess denied claims.
- If unable to submit via NaviNet, providers can submit termination information either attached to the claim and mailed to London, KY or faxed to 888-296-4002 or 888-987-5828 Attention: TPL Updates

Appeals

- This process is based on the **PerformCare Policy *FI-027 Appeals of Administrative Denials.***
- Administrative appeals are the process by which claim denials that are not approved because they do not meet contractual or administrative requirements are reviewed. Providers may appeal TFO (submitted after plan filing limit) denials.
- An Administrative Appeal Request Form *must* be included with every submission (available on our website).
- ALL providers (In-Network and OON) must submit an Administrative Appeal Request Form within **60 days** of the claim denial date with all the requested information completed or the appeal *will* be rejected for insufficient information.
- Before submitting an appeal request to PerformCare, provider *must* have billed a claim and received a claims denial notification. The request will not be processed without a specified claim number included on the request form.

Appeals

- Administrative appeals should be mailed to:

  PerformCare Admin Appeals
  P.O. Box 7301
  London, Kentucky 40742

- Each appeal request should be specific to only one member and one service / CPT code, but can include multiple dates of service.
- Providers must utilize the Multiple Administrative Appeals spreadsheet (available on our website) when appealing ten (10) or more claims related to the same denial issue. Be sure to include the timeframe for the dates of service of all claims. The dollar value (must be PerformCare's contracted amount, not the billed amount) and the # of units of all claims must be listed. The completed template, the appeal request form, and all supporting documentation must then be securely emailed back to your Account Executive.
- Appeal decisions are made within 30 days of receipt by PerformCare.
- The process allows only a one-time submission. PerformCare does not offer second-level appeals. Therefore, completed information and all appropriate supporting documentation must be included with the first submission. **All decisions are final**.

Appeals

- Appeals submitted within 365 days of the dates of service and valued at less than $10,000 are reviewed and decided by the Administrative Appeals Committee. This committee is comprised of the Account Executives as well as management representation from the Claims, Care Management, Quality Improvement, and Contracting Departments.

- Appeals submitted beyond 365 days of the dates of services will automatically be denied.

- Issues considered in decision-making may include: length of time Provider has been with PerformCare network as well as the Provider’s authorization and/or billing history.

Where do I find the appeal form?

Providers

- Claims and billing
- Self-service tools
- Forms
- Latest updates
- Training and education
- Resources and information
- Quality improvement
- Member wellness resources
- Complaints and grievances

Claims and Billing

For complete claims instructions, view the Claims and Claims Disputes chapter in our Provider Manual (PDF).

Use these resources for prompt payment for services provided to members.

- Administrative appeals
- Claims submission overview (PDF)
- Electronic billing services
- NaviNet Claims Investigation Guide (PDF)
- Paper claims submission
- Paper claims submission FAQ

Admin Appeal Form

PerformCARE® | P.O. Box 7301 London, KY 40742

ADMINISTRATIVE APPEAL REQUEST

Date: ____________

Member Information

Member name: ________________________________

County of residence: ______________ MAID number: ______________

Primary insurance: ______________ Secondary insurance: ______________

Provider Information

Provider name: ________________________________

Provider site address: ________________________________

Contact person's name: ________________________________

Contact person's address: ________________________________

Phone number: ______________

Appeal Information

Date(s) of service to be reviewed: ________________________________

Type of service: ____________ CPT code: ____________ Modifier: ____________

Authorization number: ______________ Claim number: ______________

Total dollar amount requested: ________________________________

Provider's requested action:

____

____

Reason for denial:

____

____

Steps taken to correct and prevent future occurrences:

____

____

____

____

Additional Information

Please submit additional documental of services rendered, such as EVS verification or any other documentation that will support the request. Please include a typed narrative of additional supporting documentation to justify the request.

Providers: 1-888-700-7370 • http://pa.performcare.org

Required Documentation for AA's

FOR ISSUES RELATED TO RETRO ELIGIBILITY:

- Always include Eligibility Verification System (EVS) documentation from the start date of service with your appeal request.
- Possibly include the exception report which includes the Member's name and is dated (must be submitted within 60 days of the date on the exception report).
- If appeal is related to substance abuse services, please include the member's American Society of Addiction Medicine (ASAM) criteria.
- If appeal is related to IP services, please include the Member's medical record.
- If appeal is related to BHRS, please submit the Member's complete BHRS request packet.
- If appeal is related to FBMHS, please include all progress notes for one month before the dates of service and specify the exact number of additional units requested for each date of service.

FOR ALL AA REQUESTS INVOLVING SERVICES REQUIRING PRE-AUTHORIZATION:

- Member's medical records or clinical notes must be submitted.
- MNC criteria must be met.
- Authorization from primary insurer must be included, if applicable.

FOR ISSUES RELATED TO PRIMARY CLAIMS DENIALS:

- EOBs or denial letters from the primary insurer must be included (must be submitted within 60 days of the date on the EOB / denial letter).

Why was my appeal rejected?

Rejection reasons may include but are not limited to the following:

- The claim was not billed and/or the denial notice was not received before submitting the appeal.
- The Provider failed to include the claim number on the request.
- The Provider submitted incorrect and/or insufficient information.
- The claim was paid already.
- The Member was ineligible for PerformCare coverage on the requested dates of service.
- The volume (number) of claims requires the submission of the multiple appeal template.
- For medical necessity denials, please follow the Complaint and Grievance process — a grievance must be requested by a Member or a Member's guardian/personal representative (if the Member is less than 14 years of age). The Member has 45 days from the date of the original denial to file a grievance.
- Rejected appeals may be resubmitted for review, if instructions noted on the decision letter are followed by the Provider and resubmissions are received **within 30 days** from the date of the rejection letter.
  If the resubmission is past 30 days, the appeal will be denied.

Why was my appeal denied?

Denial reasons may include but are not limited to the following :

- Failure in authorization management by the Provider.
- Failure in claims and billing management by the Provider.
- Failure to provide documentation of eligibility check prior to service delivery.
- Submission of the request for review beyond 60 days of denial notice or the service delivery date (if claim was never billed).
- Untimely filing - claims that are 365 days old or older will not be considered for payment.
- Denied appeals may not be resubmitted for review. These decisions are final.

Why was my appeal approved?

Approval reasons may include but are not limited to the following:

- Documentation of eligibility verification issues beyond the control of the Provider.
- Documentation of MNC concurrent review issues beyond the control of the Provider.
- Documentation of processing errors by PerformCare beyond the control of the Provider
- Unavoidable delay caused by another provider (i.e., BHRS evaluations)
- Timely notification and resolution of the issue —If all PerformCare protocols were met **and** the appeal was submitted timely, appeal will be approved.

Appeals

- The Administrative Appeals Request form can be found on our website at www.pa.performcare.org.

- PerformCare Policy and Procedure *FI-027 Appeals of Administrative Denials* can be found on our website www.pa.performcare.org.

- PerformCare Provider Manual can be found on our website www.pa.performcare.org.

- PerformCare Account Executives (AEs) are available to answer questions about administrative appeals at **1-888-700-7370, option 3.** Dial this number and request to speak with your Account Executive.

- PerformCare Claims Department is available to answer questions about administrative appeals at **1-888-700-7370, option 1.**

Thank you!

We sincerely thank you for attending this Claims Training Session.

We admire and appreciate your ongoing dedication to offer improved services to our Members.