

Claims Submission Overview

Presented by PerformCare

Agenda

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- Methods for Claims Submission
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Resources

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

Review of PerformCare Website and Navinet

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

General Information – Addresses

- **Paper Claims**

PerformCare
PA HealthChoices
PO Box 7308
London, KY 40742

- **TPL (Third Party Liability) Claims** can be submitted electronically or mailed, one sided, claim first then EOB (DO NOT USE STAPLES).

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PO Box 7308
London, KY 40742

- **OON (Out of Network) Claims** OON (Out of Network) Claims can be submitted electronically or mailed via paper. If submitted via paper, an OON agreement must be attached to the claim and mailed here.

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PO Box 7308
London, KY 40742

- **Administrative Appeals** must be mailed to (or sent via **secure** email to: PerformCareAppeals@Amerihealthcaritas.com):

PerformCare
PA HealthChoices
PO Box 7301
London, KY 40742

PerformCare strongly recommends that all correspondence mailed to PerformCare be sent via certified mail

General Information – Phone Numbers

- **Provider Claims Services** - 1-888-700-7370 Option #1, 8am to 4:30pm Monday-Friday.
 - For Authorization questions, Care Managers, Pre-Certs call 888-700-7370, Option #2 or follow the prompts.
- **Connect Center** - 877-363-3666
- **EDI (837 submissions)** - 877-363-3666
 - *If you are submitting 837 files and having issues with getting claims submitted, please work with your clearinghouse to resolve.*
- **ECHO (Payment)** - 888-834-3511

Timely Filing Guidelines

- **All initial claims** must be received within 60 days from the date of service. This includes both CABHC and TMCA counties.
- **Secondary claim** submissions must be received within 60 days from the date of the primary insurance EOB and the DOS must be less than 365 days. This includes both CABHC and TMCA counties.
- **Corrected Claim Submissions:**
 - Must have resubmission code of “7” in Field 22 of the 1500 form along with the original claim number.
 - Must have the correct Bill Type on the UB-04 form with the frequency code of “7” along with the original claim number in box 64A.
 - Only use the claim number, any additional words or letters will cause the claim to reject.
- **Any replacements of a claims that denied in full, overpaid or underpaid must be submitted within 365 days from the date of service.**

Timely Filing Guidelines (Continued)

- Replacement of a claim that *overpaid* after 365 days = Provider must send a refund check with detailed claim documentation (a replacement claim should *not* be sent).
- Replacement of a claim that *underpaid* after 365 days = these claims cannot be paid as they are beyond 365 days for corrected claims or admin. appeals.
- **Void Requests** are submitted with resubmission code “8” in Field 22 of the 1500 form, or Bill Type with frequency code of “8” on the UB-04 form.
 - There is no time limit on a void claim request.
- Please note: A claim that is returned via a letter noting that the enclosed claim(s) could not be entered into our system is considered a Rejected claim. Corrected claims cannot be submitted for rejected claims. Resubmission of the claim to PerformCare is required and must be submitted as an original claim (no original claim number should be included on the claim). These rejection letters are applicable for electronic or paper claims.

Methods for Claim Submission

- Paper
 - Professional claims – 1500 claim form
 - Institutional claims – UB04 claim form
- Electronic
 - Single claim entry in ConnectCenter
 - Can be Professional or Institutional Claims (previous platforms did not allow for electronic submission of Institutional Claims)
 - 837 Files

Submitting CMS-1500 Claims

Important Fields for the CMS-1500 Form 02/12

Refer to the PerformCare 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)

Submitting CMS-1500 Claims (Continued)

- 21 -Diagnosis Code(s) ICD-10
- 22 -Medicaid Resubmission Code and Original Claim number --used for corrected claims (7) and voids (8) + Claim number
- 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.

Submitting UB-04 Claims

Important Fields for the UB04 Form

Refer to the PerformCare 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: For Inpatient claims: 111, 112, 113, 114, 117; For RTF claims: 861, 862, 863, 864, 867).

Bill types 11X:

111-Admit through discharge
112-Interim-First claim
113-Interim-Continuing Claims
114-Interim-Last claim
117-Replacement for prior claim
118-Void/Cancel of prior claim

Bill types 86X:

861-Admit through discharge
862-Interim-First claim
863- Interim-Continuing Claims
864-Interim-Last claim
867-Replacement for prior claim
868-Void/Cancel of prior claim

- 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)

Submitting UB-04 Claims (Continued)

- 17 -Discharge Status (ensure that this status matches the Bill Type in box 4)
- 39-41 Value codes and amounts (if applicable):
 - 80-Covered Days (the number of days covered by the primary payer as qualified by the payer.
 - 81-Non-covered Days (Days of care not covered by the primary payer).
- 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
- 48 – Non Covered Charges (as reported by provider, if there is an amount listed the claim will be denied)
- 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)

Submitting UB-04 Claims (Continued)

- 66 -Diagnosis and Procedure code qualifier (ICD version indicator)
- 67 -Principal diagnosis codes and Present on Admission (POA) indicator(s)
Valid POA indicators:
Y: Yes, present at the time of inpatient admission.
N: No, not present at the time of admission.
U: Unknown, documentation is insufficient to determine if condition was present at time of inpatient admission.
W: Clinically Undetermined, provider is unable to clinically determine whether condition was present at time of inpatient admission or not.
Null Value - leave the POA field blank: Exempt provider/diagnosis.
- 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)

ConnectCenter

- **ConnectCenter** provides the ability to upload a file of claims created in an EMR, Practice Management System, Hospital Information System or similar application. To be processed, claims files must use the ANSI 837 5010 EDI format. This document provides some guidance on how to construct a compliantly formatted file but it is not a replacement for the ANSI 837 Implementation Guideline.

<https://www.changehealthcare.com/solutions/medical-network/connectcenter>

- **. Plan Identifiers**

- The payer IDs (CPIDs) below should be used in the 2010BB NM1 segments to identify which plan is being billed. Please note that a different ID should be used for Institutional claims then for Professional claims. Be sure to select the **CPID** from the column appropriate to the type of claims you are creating. As additional reference information, the 5-character payer IDs that are more commonly used to identify these plans are included in this table but these **must not** be used in the 2010BB NM1.

Plan Name	Plan Payer ID	CPID for Professional Claims	CPID for Institutional Claims
PerformCare-HealthChoices	65391	6183	4657

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 99-0614 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-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.

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 <u>not</u> 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 Denials (Continued)

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	

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(enter only the claim number) in box 64A (Document Control Number)
- **Remember: Corrections are timely when submitted within 365 days from the date of service.**
- **Writing or stamping “correction” or “corrected claim” on the claim form is not permitted – providers must follow the instructions above when submitting corrected claims**

Primary Insurance Updates

ACT 62 Denial Letters/EOB's

Denials can be submitted with paper claim forms and mailed to:

PerformCare
PA HealthChoices
PO Box 7308
London, KY 40742

For electronic claims, providers have the option to add primary payment/information. The denial reason code must be submitted with each claim.

After the denial is submitted and is on file, providers can submit directly to PerformCare as primary. Provider's should reference IBHS 21 103 Memo – <https://pa.performcare.org/assets/pdf/providers/resources-information/ibhs-21-103-ibhs-tpl-eob.pdf>.

Primary Insurance Updates (continued)

TPL Updates

Providers have 3 options to report TPL changes when a provider discovers a Member no longer has primary insurer coverage and PerformCare should be primary payer.

- 1. Claim submission** – providers can send a paper claim with documentation attached (EOB, denial letter, eligibility printout) or electronic option with the appropriate denial reason code. Claim examiners will route claim to TPL department for verification and to update our system.

PerformCare
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PO Box 7308
London, KY 40742
- 2. Navinet submission** – inquiry can be sent advising PerformCare of the TPL discrepancy. Information to include is carrier name, policy number and details of the discrepancy. Claims staff will copy the provider's inquiry into a service form (SF) and send to the TPL department for verification and to update our system.
- 3. Call Provider Claims Services (PCS) contact center** – providers can call PCS and advise of a TPL discrepancy. PCS will complete a service form (SF) and send to the TPL department for verification and to update our system.

PerformCare has a TPL Underpayment automated process that runs every Thursday to reprocesses claims previously denied with reason code EOB required where the primary insurance is now termed.

Administrative 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.

Administrative Appeals (Continued)

- **Administrative Appeals** must be mailed to (or sent via **secure** email to: PerformCareAppeals@Amerihealthcaritas.com):

PerformCare
PA HealthChoices
PO Box 7301
London, KY 40742

- Each appeal request should be specific to only one member and one service / CPT code, but can include multiple dates of service (Multiple members can submitted via the multiple appeal spreadsheet).
- 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 to: PerformCareAppeals@Amerihealthcaritas.com.
- 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.**

Administrative Appeals (Continued)

- 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 that are more than \$10,000 will go to the Executive Management Committee for review.
- 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.
- 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 Customer Service is available to answer questions about administrative appeals at **1-888-700-7370, option 1.**

Where do I locate the appeal form?

Providers

Coronavirus disease (COVID-19)

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](#)

Administrative 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 (if applicable):

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 Appeals

- **FOR ISSUES RELATED TO RETRO ELIGIBILITY:**
- Always include Eligibility Verification System (EVS) documentation from the start date of service with your appeal request.
 - Recommend including 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 Inpatient services, please include the Member's medical record.
- If appeal is related to BHRS/IBHS, please submit the Member's complete BHRS/IBHS 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.
- Out of network (OON) appeals must include submission of the applicable request form (i.e. prior authorization for MH OON)
- **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 the 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 maybe 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 the 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.

Questions?

Thank you!