PerformCARE®
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PERFORMCARE CLAIMS FAQ

CLAIMS

- Can secondary claims be sent electronically?
  - Yes
- Does the ZZ qualifier need to go in box Box 32B and Box 33B?
  - Yes, the ZZ qualifier must be used in box 32 and 33 with the taxonomy code.
- Do claims need to be on the pink and white forms?
  - Yes, they need to be completed on the pink and white form.
- When should telehealth POS 02 or 10 be used?
  - Please reference provider notice AD 22 106 Telehealth Place of Service and Audio Only Modifier Updates
  - https://pa.performcare.org/content/dam/amerihealth-caritas/performcare-pa/pdf/providers/resources-information/ad-22-106-telehealth-place-of-service.pdf.coredownload.inline.pdf
- What information is needed in box 24J
  - The rendering taxonomy code if different from billing provider and not listed in field 19. The rendering NPI if rendering NPI is different from the billing NPI (Box 33a). *For MH-OP groups only.
- Should provider put EOB and the number of pages following the secondary claims?
  - No, not permitted.
- If the member has multiple diagnoses, should the provider list all diagnoses or just the primary?
  - Provider should list all but be aware that the primary diagnosis should line up with what type of service is being provided. (Example- MH diagnosis for a MH service or SA diagnosis for a SA service.)
  - If a member is dual diagnosed and the facility is a MH facility the primary diagnosed needs to be submitted as a MH diagnosis to pay.
- When should a TPL termination be submitted through Navinet?
  - Submission of a TPL termination through Navinet should be submitted after a claims denial is received.
- For TPL claim submission, do providers need to include an EOB and final denial letter?
  - The claims denial must be a final denial.
- How long does certified mail of claims take to process?
  - PerformCare processes claims within 30 days.
- If a provider is not a Medicare facility, does PerformCare override Medicare in this situation?
  - PerformCare is the payer of last resort. Member should find a provider that is in network with Medicare.
- For inpatient claims, is the 60 days from day of admission or discharge?

    - Timely filing goes by each date of service, not admission of discharge.
- Provider received a final denial letter from a 2nd level appeal with a primary payer for inpatient services, can we start billing PerformCare immediately after the final denial letter is received or bill the primary first and receive an EOB with denial code before billing PerformCare?
    - Provider will have to submit the final denial letter from the primary with each claims.
- Are there additional fees to use features within Navinet?
    - No additional fees.
- If a POS code is incorrect and the claims denies; does the provider have 60 days from DOS or 365 days from DOS to submit a correct claim?
    - 365 days
- Is the referring/ordering provider required on claims?
    - It depends on your provider type and specialty. See Provider Notice AD 17 104.
    - https://pa.performcare.org/assets/pdf/providers/resources-information/policies/admin/ad-17-104-ordering-providers.pdf
- Corrected claims are set up with a new claim number, why?
    - Each corrected claim is given a unique claim number for tracking purposes.