PerformCare Claim Submission Instructions

This document provides an overview of the claims process for PerformCare. The claims payment process was designed to ensure prompt and accurate payment for services provided to members of the PerformCare HealthChoices program. Our goal is to make billing and claims payment as simple for providers as possible. In this spirit, PerformCare has developed a Claims Help Desk. This service is available at **1-888-700-7370**, Monday through Friday from 8 a.m. to 4:30 p.m., to assist provider staff with claims questions.

Completing and Submitting Claims Forms

PerformCare will accept the two existing claims forms, the UB-04 for hospital claims and the CMS-1500 for medical claims.

Inpatient Admissions Over 30 Days

PerformCare has removed this requirement and claims will no longer reject if the claim spans a calendar month. Providers will need to keep timely filing in mind and bill accordingly. Timely filing for primary claims is based on date of service, and not based on discharge date. However, remember that claims cannot span a calendar year. This rule is for medical and hospital claims. Providers must bill separate claims when the date of service span over a calendar year.

Timeliness of Claims and Claims Involving Third-Party Liability

Original claims must be received within 60 days for the Capital Area contract (Cumberland, Dauphin, Lancaster, Lebanon, Perry) and TCMA contract (Franklin, Fulton). Claims involving third-party liability must be received within 365 days of the date of service and no more than 60 days after the EOB date. At least one level of appeal is required to the primary insurance when the primary insurer refuses to pay for a service due to a medical necessity denial before PerformCare will pay, regardless of how long it takes the primary insurer to respond. The EOB from the primary insurance must be attached to the claim (one claim to one EOB). Each claim must have an EOB attached. Providers are not permitted to send multiple claims with one EOB attached. If billed this way, the first claim will process with the EOB, and the other will deny for the missing EOB. Secondary claims are now accepted electronically (see Provider Notice AD 16 106). For questions regarding electronic submissions of secondary claims, contact your claims clearinghouse.

Authorization Number

An authorization number is required for any service that requires prior authorization. See Appendix B for a full list of authorization requirements by service. If appropriate, the claim forms must reflect the appropriate authorization number written clearly in the space indicated on the form. Claims that are missing the appropriate authorization number may be subject to delay to allow for proper matching of service to payment.

Electronic Billing

On January 16, 2009, CMS published its final rule adopting updated versions of the standards for electronic healthcare and pharmacy transactions originally adopted under the Administrative Simplification subtitle of HIPAA. The mandatory compliance date to adopt ANSI version 5010 for all covered entities was January 1, 2012. All claims submitted electronically through an electronic data exchange (EDI) must meet requirements outlined in 5010. If you submit individual claims through NaviNet or paper claims, these processes are unaffected.

PerformCare has a trading partner agreement with Change Healthcare, formerly known as Emdeon, for electronic

claims to provide a more positive experience for our providers. **PerformCare's Change Healthcare Payer ID is 65391.** Change Healthcare is the EDI services leader in health care and is already used by a majority of providers as well as other payers. PerformCare accepts electronic claims via Emdeon or any clearinghouse that trades with Change Healthcare. Change Healthcare provides EDI services based on individual needs, giving flexibility to providers for testing and submitting claims.

Providers may contact Change Healthcare for provider solutions by calling **1-866-369-8805** or visiting **Change HealthCare Connect Center.** ConnectCenter **Change HealthCare Uploading an 837 Batch Claim File** allows users 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.

Uploading an 837 Batch claim file:

- **All 837 claims should be compliant with SNIP level 4 standards, with the exception of provider secondary identification numbers (provider legacy, commercial, state ID, UPIN, and location numbers).**
- **SNIP 4: validates inter-segment value relationships: if element A has the value "X," then element B must have the value "Y"**
- **All 837 claims with Claim Attachments should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.**
- To submit completed 837 claim files, use the ConnectCenter file upload feature. This feature is found within the **Mailbox** menu.
- If you create claim files through a third-party application such as a PMS, HIS, or EMR system, work with your software vendor for any modifications needed to create properly formatted batch claim files.
- If you are not familiar with the ANSI 837 transaction format and not able to engage your software vendor for assistance, you should use the claim data entry tool provided in ConnectCenter to create claims online. Refer to the **Keying Institutional Claims** and **Keying in Professional Claims** for more information about online claim creation.
- File names can contain alpha and numeric characters. You can use underscores, periods, and hyphens. Do not use spaces or any special characters other than underscores, periods, and hyphens.
- Please do not submit claims on the same day that you create a new ConnectCenter submitter account. An overnight configuration process must be executed before claim files can be correctly associated with your account.

Submit a 275 claim attachment transaction

PerformCare is accepting ANSI 5010 ASC X12 275 unsolicited attachments via Change Healthcare. Please contact your Practice Management System Vendor or EDI clearinghouse to inform them that you wish to initiate electronic 275 attachment submissions via payer ID: 65391

There are three ways that 275 attachments can be submitted.

- Batch — You may either connect to Change Healthcare directly or submit via your EDI clearing house.
- API via JSON — You may submit an attachment for a single claim.
- Portal — Individual providers can register at Change Healthcare to submit attachments.

The acceptable supported formats are pdf, tif, tiff, jpeg, jpg, png, docx, rtf, xml, doc, and txt. Providers can view an instructional video of the 275 claims attachment process with detailed instructions here. Using this link: https://player.vimeo.com/progressive_redirect/playback/813387387/rendition/1080p/file.mp4?loc=external&signature=48b9ebe7ae66c5f768f080b79f55ba64280beb56b8ac7157d8c95c5535fb9c36

When submitting an attachment, use the applicable code in field number 19 of the CMS 1500 or field number 80 of the UB04.

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 than 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 five-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 Professional Claims
PerformCare-HealthChoices	65391	6183	4657

Acknowledgement and Claim Reports

Claims files typically complete the first phase of processing within 10 to 15 minutes, which means that within 15 minutes newly uploaded claims should be visible in the **Claim Health Vitals, Work List,** and **Claim Search** views. In addition, a claim acknowledgement report will be delivered to your mailbox with information regarding any claims or batches that could not be successfully processed.

If you do not see claims or reports within 15 minutes of uploading your files, there may be a problem with your file configuration. Please contact support if this happens.

Batch reports can provide additional insight about the status of files uploaded. These reports are typically returned with one minute of file upload. To access these reports, choose **Mailbox** from the main menu. Change the **Directory** field to **All** to access reports. If you have a lot of reports, use additional filters such as date to shorten the list of reports returned.

The reports returned in this fashion can be challenging to understand. The most important thing to look for is the file status, which will be given in the first few lines of the report. Look for "**** TRANSFER OF FILE" followed by the name of your file. Immediately after the file name the report should say either "SUCCESSFUL" or "FAILED." If your file has a FAILED status, please contact either your vendor or Change Healthcare customer support for help correcting the problem.

Next Steps/Getting Started

Visit ConnectCenter:

- **Change HealthCare Connect Center**
- Scroll down to the **Getting Started** section and click the **Sign-Up** button to create an account.
- After logging in for the first time:
- Go to **Admin/Provider Management** to add information about providers for whom you bill.
- Go to **Payer Tools/Enrollment** to sign up to receive ERAs in ConnectCenter.

Need more help?

Call **1-800-527-8133**, **option 2** for questions about:

- Submitting new claims
- Eligibility
- Claim status
- Remits
- Enrolling for remits

Call **1-877-667-1512**, **option 2** for questions about:

- The status of old claims or old remits
- Access to reporting and analytics

Electronic Funds Transfer (EFT)

PerformCare has arranged for provider payment services, consisting of virtual credit card (VCC), automated clearing house (ACH)/electronic funds transfer (EFT), and paper check payments as well as electronic remittance advice (ERA) provided through ECHO Health, Inc., a partner of Change Healthcare. This payment platform offers an easy method of signing up for electronic funds transfer (EFT), medical payment exchange (MPX), and paper checks. Providers can review options and get enrollment information here: **https://pa.performcare.org/assets/pdf/providers/claims-billing/echo-provider-payments-portal-quick-reference-guide.pdf**
For all claims payment options and assistance, visit
https://pa.performcare.org/assets/pdf/providers/claims-billing/echo-eft-provider-enrollment-guide.pdf

EFT Enrollment Instructions

Enrollment with ECHO for ACH/EFT payment is a fast, one-time process. Simply follow the instructions outlined in the following section to begin receiving electronic payments and remittance advices today.

New EFT customers

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by VCC or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices (ERAs) for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to download from the Echo provider portal at **www.providerpayments.com**. If you are new to EFT, you will need to enroll with ECHO Health for EFT from PerformCare.

Please note: Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO." To sign up to receive EFT from PerformCare, visit
https://enrollments.ECHOhealthinc.com/efteradirect/enroll. There is no fee for this service.

To sign up to receive EFT from all of your payers processing payments on the Settlement Advocate platform, visit **https://enrollments.ECHOhealthinc.com**. **A fee for this service may be required.** If you have questions regarding how to enroll in EFT, please refer to the PerformCare EFT enrollment guide:
https://pa.performcare.org/assets/pdf/providers/claims-billing/echo-eft-provider-enrollment-guide.pdf If

you have additional questions regarding VCC, EFT, or ERAs, please call the Echo Health Support team at **1-888-492-5579** or reference our FAQ: **ECHO EFT Provider FAQ.pdf**

Electronic Remittance Advice (ERA)

PerformCare now also offers ERAs (also referred to as an 835 file) through Change Healthcare/ECHO Health. To receive ERAs from Change Healthcare and ECHO, you will need to include both the Change Healthcare PerformCare payer ID (**65391)** and the ECHO payer ID (**58379**).

All Change Healthcare/ECHO HEALTH generated ERAs and a detailed explanation of payment for each transaction is accessible to download from the ECHO provider portal:
www.providerpayments.com/Login.aspx?ReturnUrl=%2f.

If you are a first-time user and need to create a new account, please reference Echo Health's provider Payment Portal Quick Reference Guide for instructions. **echo-provider-payments-portal-quick-reference-guide.pdf**

Contact your practice management/hospital information system for instructions on how to receive ERAs from PerformCare under Payer ID 65391 and the ECHO Payer ID 58379. If your practice management/hospital information system is already set up and can accept ERAs from PerformCare, then it is important to check that the system includes both PerformCare and ECHO Health Payer ID 58379 for ERAs.

If you are not receiving any payer ERAs, please contact your current practice management/hospital information system vendor to inquire if your software has the ability to process ERAs. Your software vendor is then responsible for contacting Change Healthcare to enroll for ERAs under PerformCare and ECHO Health Payer ID 58379.

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

For enrollment support, please contact ECHO Health, Inc. at **1-888-834-3511**.

Paper Claim Submission

PerformCare recommends that providers mail claims certified mail.

- Note that since the mailing address is a PO Box, FedEx and UPS deliveries are not accepted.

Paper claims should be mailed to:
PerformCare
PA HealthChoices
P.O. Box 7308
London, KY 40742

Paper claims must be submitted on original pink and white CMS 1500 forms. Handwriting these forms is strongly discouraged for better, more accurate processing.

CMS 1500 form and UB-04 form

Each claim form must indicate the member's diagnosis using ICD-10-CM diagnosis codes, as well as the procedures performed. When billing for professional services, there will be a CPT and HCPCS procedure code associated with the service. When billing for inpatient stays, there will be a DRG or a revenue code as appropriate. Reimbursement will be based on the PerformCare fee schedule provided through the contracting

process or most recent update. The following section provides instructions for completing each accepted form.

Please be aware this instruction template has been updated compliant with SNIP Level 4 and 275 attachments for 837P and 837I.

All 837 claims should be compliant with SNIP level 4 standards, with the exception of 2010BB loop REF segment with G2 qualifier (Provider legacy id).

All 837 claims with Claim Attachments (via 275) should be sent only with Claim Attachment Report Type codes (PWK01) listed under Field #19 for CMS-1500 Claim Form and Field # 80 for UB-04 Claim Form.

Should any questions arise regarding the completion of these forms, please contact the PerformCare Claims Help Desk for assistance.

CMS 1500 claim form completion guidelines paper submission

Block #	Required (R) Notrequired(N) Situational(S)	Instructions
1	R	Check applicable program (Medicaid)
1a	R	Recipient Medicaid ID number
2	R	Patient's name (last name, first name, middle initial, as shown on the access card)
3	R	Patient's birth date (MMDDCCYY) and sex (check the box)
4	R	Insured name (SAME or "SAME AS PATIENT" is acceptable)
5	R	Patient's mailing address and phone number, including area code
6	R	Enrollee's relationship to insured (check box for self, spouse, child, other)
7	N	Enrollee address (number, apartment number, street, city, code, phone number with area code)
8	N	Enrollee's status (check boxes for single, married, other, employed, full-time student, part-time student)
9	S	Other enrollee name (last name, first name, middle initial) Refers to someone other than the patient. Enter the complete name of the insured. If Item Number 11d is marked, complete fields 9, 9a, and 9d, otherwise leave blank
9a	S	Other enrollee policy or group. Required if # 9 is completed.
9b	N	Reserved for National Uniform Claim Committee (NUCC) use
9c	N	Reserved for NUCC use
9d	S	Insurance plan name or program name. (**Do not list any Medicaid plans, schools, or county programs. This field is used only if the member has a primary Medicare or commercial carrier**.) Required if #9 is completed. List name of other health plan, if applicable. Required when other insurance is available. Complete if more than one other medical insurance is available, or if 9a completed

Block #	Required (R) Not required (N) Situational (S)	Instructions
10a – c	R	Enrollee's condition related to employment, auto accident, and other accident
10d	S	Claim codes (designated by NUCC)
11	S	Insured policy, group or FECA number (if applicable). Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to 10a, b, and c. Enter the policy group or FECA number.
11a	S	Insured date of birth. Same as # 3. Required if 11 is completed.
11b	S	Other claim ID (designated by NUCC)
11c	S	Insurance plan name or program name (if applicable) Enter name of Health Plan. Required if 11 is completed.
11d	R	Is there another health benefit plan indicates that the patient has insurance coverage other than the plan indicated in Item Number 1. (**Only select yes if there is a primary Medicare or commercial carrier.**) If marked "YES", complete 9, 9a, and 9d. Only one box can be marked.
12	R	Patient's or authorized person's signature (All invoices must have either the recipient's signature or the words "Signature exceptions" or "Signature on file.)"
13	N	Insured or authorized person's signature
14	S	Date of current illness
15	S	Date of same or similar illness
16	S	Date client unable to work in current occupation
17	R	Enter the name of the attending, prescribing or supervising physician (if required for your provider type)
17a	N	**Enter the 9-digit MA provider number of the attending, prescribing or supervising physician** (if required for your provider type)
17b	R	National Provider Identifier (NPI) of the **attending, prescribing or supervising physician** (if required for your provider type)
18	S	Hospitalization dates related to current services

Block #	Required (R) Notrequired(N) Situational (S)	Instructions
19	R	ZZ qualifier and rendering taxonomy (if different from billing taxonomy 33b) **Additional Claim Information for 837P,** **Loop ID 2300** **Segment PWK01** Claim Attachment Report Type codes in 837P defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet
20	S	Required when billing for diagnostic tests
21	R	Diagnosis or nature of illness or injury (ICD-10-CM diagnosis code)
22	S	Medicaid resubmission code 7 corrected claim; 8 void claim/original claim number (must be billed if submitting a corrected claim or void)
23	S	Prior authorization number
24a	R	Dates of service (note the start and end date — use one line per service per day)
24b	R	Place of service (refer to the CMS 1500 manual at **www.nucc.org**)
24c	N	EMG
24d	R	Procedures, service, or supplies Enter the applicable procedure codes and modifiers from PerformCare's fee schedule.
24e	R	Diagnosis code Enter the diagnosis reference number as shown in block 21 to correlate the diagnosis code to the procedure or service performed
24f	R	Charges
24g	R	Number of days or units
24h	S	EPSDT family plan
24i	R	ZZ qualifier (if billing rendering taxonomy in 24j)

Block #	Required (R) Not required (N) Situational (S)	Instructions
24j	R	The rendering taxonomy code (unshaded area) if different from billing provider and not listed in field 19
24j	R	The rendering NPI If rendering NPI is different from billing NPI
25	R	Federal tax ID number
26	R	Patient's account number
27	R	Accept assignment
28	R	Total charges Enter the total sum of 24f lines 1 – 4 in dollars and cents
29	R	Amount paid by other insurance (if applicable) Enter the total sum of 24k lines 1 – 4 in dollars and cents
30	N	Reserved for NUCC use
31	R	Signature of physician/supplier of service and invoice date
32	R	Name and address of facility where services were provided (refer to the CMS 1500 manual at **www.nucc.org**)
33	**R**	**Supplier's billing name, address, ZIP code, and phone number**
33a	**R**	**Billing NPI**
33b	**R**	**ZZ qualifier and billing provider's taxonomy code**

UB 04 claim form completion guidelines paper submission

Block #	Required (R) Not required (N) Situational (S)	Instructions
1	R	Provider name, address, phone number
2	R	Pay-to name and address
3a	R	Patient control number
3b	S	Provider medical/health record number
4	R	Type of bill (refer to the UB-04 manual at **www.nubc.org**)
5	R	Federal tax number
6	R	Statement covers period (note a beginning and end date)
7	N	Reserved for assignment by NUBC
8	R	Patient name/identifier
9	R	Patient address
10	R	Patient birthdate
11	R	Patient's sex
12	R	Admission date (MMDDYY)
13	R	Admission hour (refer to the UB-04 manual at **www.nubc.org**)
14	R	Admission type (refer to the UB-04 manual at **www.nubc.org**)

Block #	Required (R) Not required (N) Situational (S)	Instructions
15	R	Point of origin for admission or visit (indicates referral source)
16	R	Discharge hour (refer to the UB-04 manual at **www.nubc.org**)
17	R	Patient status (refer to the UB-04 manual at **www.nubc.org**)
18 – 28	S	Condition codes
29	R	Accident state
30	N	Reserved for assignment by the NUBC
31 – 34	R	Occurrence codes and dates
35 – 36	R	Occurrence span codes and dates
37	N	Reserved for assignment by the NUBC
38	N	Responsible party name and address
39 – 41	R	Value codes and amounts (if applicable)
42	R	Revenue code (see PerformCare's fee schedule)
43	R	Revenue code description
44	S	HCPCS/rate
45	S	Service date (required for outpatient billing only; cannot be used for inpatient billing)
46	R	Service units
47	R	Total charges
48	S	Non-covered charges
49	N	Reserved for assignment by the NUBC
50	R	Payer identification Enter the name of each payer organization from which you may anticipate payment.
51	R	Health plan identification number (if applicable)
52	R	Release of information certification indicator
53	R	Assignment of benefits certification indicator
54	S	Prior payments — amount paid by other insurance (if applicable)
55	N	Estimated amount due from patient. **The amount up to two decimal places.**
56	R	Billing NPI
57	N	
58	R	Insured's name (if applicable)
59	R	Patient's relationship to insured
60	R	Patient recipient number (10-digit Medical Assistance number)
61	S	Insurance group name (if applicable)
62	S	Insurance group number (if applicable)
63	R	Treatment authorization number

Block #	Required (R) Not required (N) Situational (S)	Instructions
64	S (required when billing a corrected or void claim)	Original claim number
65	N	Employer name (of the insured)
66	R	Diagnosis and procedure code qualifier (ICD version indicator)
67	**R**	**Principal diagnosis code and present on admission indicator**
67 A – Q	R	Other diagnosis code — secondary diagnosis (if applicable) (ICD-10-CM diagnosis code)
68	N	Reserved for assignment by the NUBC
69	R	Admission diagnosis code (ICD-10-CM diagnosis code)
70 A – C	S	Patients reason for visit (required for outpatient)
71	S	Prospective payment system code (DRG)
72	S	External cause of injury (ECI) code
73	N	Reserved for assignment by the NUBC
74	S	Principal procedure code and date
74 A – E	S	Other procedure codes and dates
75	N	Reserved for assignment by the NUBC
76	**R**	In the appropriate boxes, enter the NPI of the provider; the two-digit qualifier of G2; the nine-digit MA number; and the last name and first name. This can be the provider who ordered the admission or the provider who is responsible for determining the diagnosis or treatment of the patient.
77	R	Operating physician name and identifiers (including NPI) (if applicable)
78 – 79	S	Other provider names and identifiers (including NPI)

Block #	Required (R) Not required (N) Situational (S)	Instructions
80	N	Remarks
	R	**Additional Claim Information for 837I,** **Loop ID 2300** **Segment PWK01** Claim Attachment Report Type codes in 837I defines the following qualifiers 03 - Itemized Bill M1 - Medical Records for HAC review 04 - Single Case Agreement (SCA)/ LOA 05 - Advanced Beneficiary Notice (ABN) CK - Consent Form 06 - Manufacturer Suggested Retail Price /Invoice 07 - Electric Breast Pump Request Form 08 - CME Checklist consent forms (Child Medical Eval) EB - EOBs – for 275 attachments should only be used for non-covered or exhausted benefit letter CT - Certification of the Decision to Terminate Pregnancy AM - Ambulance Trip Notes/ Run Sheet
81	R	B3 qualifier and billing provider's taxonomy code (no spaces or dashes)

Common billing errors

- **Paper claims must be submitted on original pink and white CMS 1500 forms. Handwriting 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: 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.

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.

The review of the requirements are as follows:

- For paper CMS 1500 claims submission, qualifier and taxonomy should be listed in box 33b (billing information) and 24j (rendering provider). In addition, if using box 19 for the rendering provider, both qualifier and taxonomy should be listed. The qualifier for CMS 1500 paper submission is ZZ (Mutually Defined). For UB04 paper submission, the qualifier is B3 and should be listed in form locator 81 along with the appropriate taxonomy.
- For electronically submitted claims the taxonomy and qualifier should be PXC (health care provider taxonomy code):

– **837P:**

» Billing provider — Loop 2000A PRV Segment

» Rendering provider — Loop 2310B PRV Segment

– **837I:**

» Billing provider — Loop 2000A PRV Segment

All electronic claims submissions must comply with HIPAA 5010 implementation Guide Standards. The standards and guidance are available at the Washington Publishing Company via **www.wpc-edi.com**.

Claim Payment Disagreements

Please review EOBs closely to ensure you are paid correctly. It is the provider's responsibility to monitor payment that is received. In the event of a discrepancy, contact your Account Executive immediately.

PerformCare strongly suggests that providers bill their usual and customary charges rather than the rate indicated on the rate notice. In the event of a system or data entry error, this practice will help you avoid the need to resubmit corrected claims when the issue is resolved.

All claims payments will include an EOB. The EOB provides a detailed explanation of the amount of each claim paid and the reason for any amount of the claim that was denied. If you have questions about a denial or disagree with a claim payment for any reason, contact PerformCare's Claims Provider Services at **1-888-700-7370**. A Customer Service Representative can help facilitate a review of the claims in question.

Please be prepared to provide the provider/facility name, provider/facility NPI, member name and ID number, CPT/Rev code, and DOS. Providers also have the option of submitting a claim inquiry via NaviNet. The new **Claim Inquiry** feature lets you request an adjustment and track responses on claims that were previously finalized. For each submitted transaction, you will receive an electronic response to the claim inquiry. The response will indicate if the claim was adjusted or explain in detail why the claim was not considered for an adjustment. PerformCare encourages you to use the **Claim Inquiry** function. However, if you do not have NaviNet access, you can still contact Provider Services.

If the claim is denied as a result of a provider error that can be corrected, the Customer Service Representative will assist you in understanding the required corrections so you can resubmit the invoice. If after reviewing the denial with the Customer Service Representative, you continue to believe that a claim was denied in error, you have the right to request a formal review in writing using the administrative denial appeal process as discussed in this manual. Your assigned Account Executive can assist should you have questions about the process. PerformCare will complete the review within 30 business days. You will receive a written response to your request outlining the findings of the formal review. You must include all necessary information with your request because the decision of the reviewing committee is final.

Claim Resubmission

Resubmission of corrected claims

A corrected claim is defined as a claim that PerformCare paid incorrectly, either because the provider billed the wrong rate or number of units or PerformCare paid incorrectly. In cases where the resubmission serves to correct a claim that has already been paid, the claim must be clearly identified as a corrected claim and received within 365 days from date of service. Corrected claims may be submitted electronically through Change HealthCare or NaviNet or on paper submission to our London, Kentucky, claims address.

If there is an identified overpayment beyond 365 days from date of service, please send a refund check with documentation directly to the PerformCare Finance department at 8040 Carlson Road, Harrisburg, PA 17112.

Any claim that is resubmitted must be billed as a corrected or replacement claim and must include the original PerformCare claim number.

It is important to understand the difference between denied claims and rejected claims. Rejected claims are those returned without being processed or adjudicated. Rejected paper claims have a letter attached with a document control number (DCN). A DCN is not a PerformCare claim number. **Billing of a rejected claim should be done as an original claim.** If the claim was rejected, it is as if it never existed.

A corrected claim cannot be billed to change or correct the tax ID or the member name from what was originally billed. The claim would need to be submitted as an original claim under the correct tax ID. If the original claim was paid, a void claim should be submitted. **Note: A corrected claim cannot be submitted if the original claim denied for timely filing. Please follow the administrative appeal policy.** You can find the PerformCare claim number from the 835 ERA, the paper Remittance Advice or from the claim status search in NaviNet. If you do not have the PerformCare claim number, then you may need to wait for the original claim to be processed or conduct further research on NaviNet to get the PerformCare claim number.

Corrected/replacement and voided claims may be sent electronically or on paper. If sent electronically, the claim frequency code (found in the 2300 Claim Loop in the field CLM05-3 of the HIPAA Implementation Guide for 837 Claim Files) may only contain the values “7” for the replacement (correction) of a prior claim and

"8" for the void of a prior claim. The value "6" should no longer be sent. In addition, the submitter must also provide the original PerformCare claim number in Payer Claim Control Number (found in the 2300 Claim Loop in the REF*F8 segment of the HIPAA Implementation Guide for 837 Claim Files). This is not a special requirement of PerformCare but rather a requirement of the mandated HIPAA Version 5010 Implementation Guide.

If the corrected claim is being submitted on paper, the claim needs to have the following to be processed as such: On a Professional CMS 1500 Claim, the resubmission code of "7" or "8" along with the PerformCare original claim number is required in Field 22. On an Institutional UB04 Claim, bill type should end in "7" or "8" Form Locator 4 and the PerformCare original claim number is required in Form Locator 64A Document Control Number. This field should only contain the PerformCare original claim number. If anything else is entered in this field the claim will reject.

Unless you have an original PerformCare claim number, you may not resubmit a claim. Billing of a rejected claim is not considered a resubmission. Duplicate billing is not acceptable.

Paper claims must be submitted on original pink and white CMS 1500 forms. Handwriting the form is strongly discouraged for better, more accurate processing. Submit corrected paper claims to:

PerformCare
PA HealthChoices
P.O. Box 7308 London, KY 40742
PerformCare recommends that providers mail claims certified mail. Note that since the mailing address is a PO Box, FedEx and UPS deliveries are not accepted.

TPL and Claims Submission

All Medicaid plans, including PerformCare, have a contractual obligation to ensure that a member's primary insurance is used first where applicable. All claims for members with Medicare or commercial insurance as the primary insurance must be billed with the EOB from that primary carrier attached (one EOB for one claim). If no EOB is attached, the claim will be denied as "missing EOB."

We understand there are services not covered by Medicare or commercial insurances. The following services are generally not covered by Medicare or Medicare Advantage plans or are known to not be available for members under the primary insurers' networks but are state Medicaid plan services in HealthChoices and covered by PerformCare. These services are exempt from the requirements to bill the primary Medicare insurer.

- IBHS (except when ACT 62 or ABA coverage applies)
- Residential treatment services for children and adolescents
- Targeted case management, FBMHS, crisis intervention services, and assertive community treatment teams
- Clozapine/Clozaril support services
- Non-hospital-based partial hospitalization programs (drug and alcohol and mental health)

- Substance use non-hospital services (withdrawal management, residential treatment, and halfway house)
- Drug and alcohol outpatient services
- Peer support services
- Mobile mental health treatment

Except in accordance with Act 62, which provides coverage for certain services to children with a diagnosis on the autism spectrum and ABA (discussed below), the following services are generally not covered by primary commercial insurances. Except for members who have a primary insurance and a diagnosis on the autism spectrum, these services are exempt from EOB requirements from the primary commercial insurer.

- IBHS (non-ABA)
- Residential treatment services for children and adolescents
- Targeted case management, FBMHS, crisis intervention services, and community treatment teams
- Clozapine/Clozaril support services
- Methadone maintenance
- Substance use non-hospital services (halfway house only)
- Peer support services
- Mobile mental health treatment

Note: Substance use non-hospital withdrawal management and residential treatment services still require EOBs from the primary commercial insurer.

Please be aware that providers must be Medicare-enrolled or enrolled in the commercial insurance plans to bill PerformCare for non-exempt services provided to members with Medicare or commercial insurance as a primary payer. Do not accept members with Medicare or commercial insurance as primary coverage until you have qualified Medicare- or commercial insurance-enrolled clinicians available to provide treatment.

We strongly encourage providers to become enrolled in the Medicare program or commercial insurance. Information about the enrollment process for Medicare is attached for your convenience. Enrollment information is also available online at **www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp**.

Providers are expected to make all reasonable efforts as required per MA enrollment to secure payment from the primary source (§1101.64 MA Manual), including assignment of clinicians that meet the primary insurer's credentialing requirements. PerformCare will not override TPL requirements for services provided that would have been paid by the primary payer had it been provided by a clinician who met criteria of the primary payer, when the provider has available such certified clinicians on staff, because the provider is not in network or because the provider did not follow proper authorization requirements for the primary insurance. This expectation applies to all services rendered at either the primary clinic site, satellite sites, or any location that is recognized as a place of service by the provider.

Special consideration is given when Medicare is the primary payer and there is documented evidence that there is not a provider of the required service within HealthChoices access standards. Commercial insurance is subject to the same access standards under Pennsylvania Department of Health regulations as PerformCare; thus, the commercial insurer is expected to fulfill its obligation to make payment for services

included in their plan. If there is clinical support to bypass the TPL process, providers will be instructed to submit all claims on paper with an attached document. Further instruction will be provided as needed.

When submitting claims to PerformCare as a secondary payer, the EOB from the primary insurer must be attached to the claim when billing paper. Whether billing paper or electronically, **claims must be received within 60 days of your notification of payment or denial by the primary insurance company**.

Some claims will require an adjustment due to overpayment or underpayment of a prior claim. If an adjustment is required, the EOB will give a detailed explanation and include a description of the process for the adjustment. In most cases, PerformCare will make the adjustment to a future payment.

Act 62 and Third-Party Liability

Background: Coverage for autism services has changed since PA implemented Act 62 in July of 2008. Previous Act 62 TPL rules for PerformCare included exemptions for certain federal and out-of-state plans as well as self-funded plans. However, those TPL exemptions are no longer applicable in all cases. The conversion to IBHS and the use of ABA codes for members with or without a diagnosis of autism requires coordination of benefits and billing primary insurance plans because many commercial insurance plans cover ABA services. Medicaid remains the payer of last resort for these services and requires coordination of benefits. PerformCare is in the process of clarifying TPL non-covered service documentation requirements and updating our ACT 62 materials on our website, including our Provider Manual, but providers should use these TPL EOB requirements effective immediately.

P) ACT 62 and ABA Denial Letters and Explanation of Benefits: Providers must submit one denial or non- covered letter per CPT code billed per calendar year. The claim with EOB can be submitted via paper submission and mailed to:

PerformCare of Pennsylvania
HealthChoices
P.O. Box 7308
London, KY 40742

PerformCare recommends that providers mail claims certified mail. Note that since the mailing address is a PO Box, FedEx and UPS deliveries are not accepted.

Claims can also be submitted electronically with the appropriate denial explanation code. After the denial is submitted and on file, providers can submit directly to PerformCare as primary for the remainder of the calendar year.

2) Tricare covers autism services, so exemptions for ACT 62 are not applicable to Tricare. Providers should attempt to become credentialed by Tricare if serving members with Tricare as primary insurance. **https://tricare.mil/CoveredServices/IsItCovered/AutismSpectrumDisorder**

3) Insurance plans in all 50 states offer coverage for autism services. While there are variations and limitations to that coverage, a blanket exemption for out-of-state plans for members with a diagnosis of autism as originally permitted under ACT 62 implementation is no longer applicable, and TPL coordination of benefits with primary payers must be explored even for out-of-state plans. **www.disabilityscoop.com/2019/10/01/autism-insurance-coverage-now-required-50-states/27223/**

www.ncsl.org/research/health/autism-and-insurance-coverage-state-laws.aspx

4) Self-funded insurance plans in Pennsylvania continue to be exempt from ACT 62, but may pay for ABA services https://www.autismspeaks.org/health-insurance-coverage-autism Forty-five percent of companies with more than 500 employees include coverage for ABA or other intensive behavioral therapies, according to the Mercer National Survey of Employer-Sponsored Health Plans. Most companies of this size provide self- funded plans.

5) Providers billing any IBHS codes for a member with a diagnosis of autism that may be subject to ACT 62 requirements and/or providers billing any ABA codes regardless of diagnosis must coordinate benefits with the member's primary insurance plan, including attempting to come in-network with the insurance plan. As services have transitioned from BHRS to IBHS, providers should be working to ensure that they are credentialed with each member's primary insurance plan and working with families to develop a transition plan for any situations where they are unable to become credentialed. However, PerformCare expects that there will be no sudden interruptions in service and should notify the Clinical Care Manager in cases where a plan needs to be developed for a family to transition to a new provider covered by the primary plan.

6) Members with private insurance being newly referred to a provider for ABA services should be directed to an in-plan provider with that private insurance for the service if ABA is a covered service.

Please reference Provider Notice IBHS 21 103: IBHS TPL/EOB Clarifications IBHS 21 103 Notice and

and IBHS 23 105 IBHS TPL/EOB Clarifications Update IBHS 23 105 Notice

Because of the unique requirements of Act 62, autism service providers must follow procedures for both MA and private insurers. For example, providers should request prior authorization from both PerformCare and the private insurance company (if prior authorization is required from the private insurer.) DHS did not create special rules for autism services. Therefore, for those members and services that are applicable, providers should follow the existing TPL regulation (Title 55 §1101.64 concerning third-party medical resources). The procedure codes covered as Act 62 services are subject to cost avoidance. This means that the MA program through PerformCare should not pay a provider for services unless the private insurer denies the service. More specifically, certain denial reasons are not acceptable for PerformCare to pay per the existing TPL regulations.

Common reasons for non-payment by PerformCare include but are not necessarily limited to the following:

- Failure to follow the proper authorization procedures of the primary insurer
- Failure to follow the proper billing procedures of the primary insurer
- Accepting a member and providing service when the provider is out-of-network and no out-of-network benefits are available through the primary carrier. If a provider refuses to join the private insurance network of the MA recipient, PerformCare is not required to pay the provider for the service. The MA recipient cannot refuse to use available private insurance to avoid a copayment, deductible, or coinsurance.
- Families should not intentionally disenroll from private insurance. By law, MA is a government program and is the designated payer of last resort. As a condition of MA eligibility, the enrollees are agreeing to use other available insurance resources first. Families that intentionally drop private insurance coverage are at risk of losing continued MA coverage.

Expectations for PerformCare's Response to Claims Submission

PerformCare's turnaround time for claims is averaging approximately 18 days. PerformCare pays all "clean" claims (claims that are accurate and complete) within 45 days. Our goal is to provide payment as quickly as possible and to pay most claims within 30 days of receipt of a clean claim.

If you have not heard from PerformCare within 30 days after you sent the claim in, please contact the Claims Help Desk at 1-888-700-7370 to inquire on the status of the claim or check the claim status through NaviNet, as this will indicate whether or not the claim was received. It is imperative that providers closely monitor their claims submissions to identify potential issues quickly. Every call received at the Claims Help Desk is logged for future reference.

Checking on the Status of a Claim

You may check the status of a claim at any time by calling 1-888-700-7370. To make an inquiry, you will need to provide the provider/facility name, NPI, contact name, call back number, member's name and identification number, the procedure codes, and the dates of service and claim number if available for which you are billing. **Again, if you have not heard from PerformCare on a claim within 30 days of the date you believe it was submitted, contact PerformCare immediately as this may indicate that the claim was not received. Providers may also use NaviNet to check the status of claims at any time.**

Claims Appeals

Claims appeals are subject to the administrative appeal process (review of administrative denial) described in Chapter V: Provider Relations Services. No claim that is 365 days old or older will be considered for payment regardless of the circumstances. Providers must have an internal auditing system to ensure that claims are submitted timely.

Appendix A: Frequently Asked Questions

Provider Enrollment and Related Questions

How can I become a network provider?

All providers go through the credentialing process, which begins by completing an in-plan expansion application. Providers may obtain an application package by contacting Provider Relations at **1-888-700-7370**. All providers must be licensed and enrolled and in good standing within the Pennsylvania MA program.

How do I enroll with the Pennsylvania MA program?

All PerformCare HealthChoices providers must be enrolled in the Pennsylvania MA program. Providers can visit DHS' website at **www.dhs.pa.gov** or call the OMAP Enrollment Toll-Free Inquiry line at **1-800-537-8862**, **option 1** for more information on fee-for-service enrollments. To check the status of your application to be a MA provider, call **1-800-537-8862, option 1** but allow at least 45 days from the date the application was submitted. Please note that OMAP does not handle all types of enrollments. OMHSAS enrolls ICM, RC, BCM, FBMH, and crisis intervention services. For those enrollments, contact the behavioral health services line at **1-800-433-4459**. PerformCare's Provider Relations department assists with supplemental service enrollment when appropriate.

What if I cannot accept any new referrals or other changes occur that affect my ability to

see members?

It is important that you tell your Account Executive any new information that affects referrals so providers and members will not be inconvenienced. Please be sure to notify us of phone number and address changes as well. PerformCare will need the information in written form via fax **1-717-671-6522** or mail. A Provider Data Update Form may be used and is available on the PerformCare website. Temporary inability to accept referrals will not jeopardize network status.

Who do I notify when a site moves or a practitioner leaves/starts employment?

This information should be reported to your Account Executive in writing using the Provider Data Update Form. Up-to-date information prevents inconvenience for members as well as providers.

If you are structured as a group practice, each new practitioner must complete an individual credentialing application for enrollment. Please contact the Account Executive to request an application. If you are a provider with a license from OMHSAS to provide behavioral health services or with a license from DDAP to provide drug and alcohol services, you are probably categorized as a facility provider. If you are an individual clinician who works exclusively for a facility, it is not necessary to complete the individual application for enrollment. Please be certain to notify PerformCare if you have a new prescribing practitioner. Failure to enroll new ordering, referring, and prescribing providers in Medicaid may lead to problems when members get prescriptions filled. Except in the case of a supplemental service, anytime there is a change, DHS must also be notified.

Clinical Operations and Authorization Questions

How do I request authorization?

All services except crisis intervention, targeted case management and outpatient (psychiatric evaluation, psychological evaluation, medication management, family, individual, and group therapy) and substance use hospital and non-hospital withdrawal management require approval from a Clinical Care Manager before they are provided. Hospital withdrawal management does not require prior approval; however, it is important to contact the Clinical Care Manager prior to discharge so that an authorization can be generated for billing these services. Current authorization request forms as well as instructions for completing forms can be found on the PerformCare website under **Forms**. Inpatient psychiatric hospitalization and acute partial hospitalization require a phone call to PerformCare. You will have access to a live person 24 hours per day, seven days per week if you have questions or need to discuss a case.

When will I get the authorization?

Hard copies of authorizations will be mailed to you. You should receive a copy in approximately five business days, depending on mail service. If you have questions about the status of your authorization request, you may contact PerformCare at **1-888-700-7370** or check authorization status through NaviNet. If you do not receive the hard copy authorization, please call. In any circumstance, never hold your claims because you have not received hard copies of authorizations.

Should we stop services until we get an authorization even though we sent in the authorization request late?

Professional standards would indicate that services should not be discontinued based on late authorizations. The provider should work directly with the Clinical Care Manager to decide how to proceed. Providers should ensure that all authorization requests are submitted per PerformCare requirements so that there is minimal impact to the member's treatment.

How should we continue to provide services in the home and community when the member goes into inpatient or partial hospitalization?

The lead clinician should contact the member's assigned Clinical Care Manager to discuss treatment concerns when members are in partial hospitalization or inpatient. Continuation of services should be part of that discussion.

How do I know who is the assigned Clinical Care Manager?

Member Services Specialist staff can provide this information via phone inquiries.

What do I do if a member wants to go to a different provider?

As a provider, you are responsible for providing the member with other provider options and/or referring the member to PerformCare if they require additional information or experience any problems with transferring providers.

What if I do not agree with an administrative denial for authorization or claims payment?

If your authorization request or claim was denied due to administrative or procedural errors, you may request that PerformCare reconsider the decision. Reversal of administrative denials should be regarded as an exception and will not be routinely approved without compelling evidence that the provider did not follow protocol due to valid special circumstances as determined by PerformCare. An example of a valid special circumstance would be a conflict with EVS regarding an individual's eligibility, which can be proven by the provider in the form of EVS documentation.

Failure to follow guidelines outlined in the revised Mental Health Outpatient Authorization Request form instructions and detailed in this Provider Manual will result in administrative denial.

All requests for review of administrative denial must be submitted in writing within 30 days of the authorization request denial or date of service denial.

How will I know about changes in authorization processes and other procedures at PerformCare?

PerformCare will share this information with providers through provider notices. Provider notices should be regarded as supplements and clarifications to the PerformCare Provider Manual and are considered incorporated by reference into the Provider Manual when they are issued. All such communications can be found on the website in the Providers section and are available for download.

What do I do if a member needs emergency services?

PerformCare expects the provider to take immediate action to ensure the safety of the member and others. PerformCare should be contacted for service authorization at **1-888-700-7370** after the situation is stabilized.

Emergencies should be considered as incidents/behaviors when member is a direct threat to self and/or others and is in need of a higher level of care due to safety. Emergency care is defined as: A medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy

- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

The lead clinician should be consulted first for an acute exacerbation of target behaviors that do not result in risk to self and/or others but still require immediate interventions for stabilization. The lead clinician should contact the member's assigned Clinical Care Manager within one business day to discuss the case. A team meeting may need to be convened to discuss any changes to current treatment interventions.

Claims and Eligibility Questions

When do I submit a claim for payment?

Claims must be received within 60 days from the date of service.

When will I get paid?

A minimum of 90% of all clean claims are paid within 30 days. All clean claims are paid within 45 days. A clean claim includes all of the information necessary to process your claim. Necessary information is listed in Chapter XII: Claims and Claims Disputes of this manual. If you have not heard from PerformCare within 30 days of the date you believe you submitted the claims, call the Help Desk immediately at **1-888-700-7370**, as this may be an indicator that PerformCare has not received your claim.

What if I have a question about my claim?

PerformCare has a Claims Help Desk that is staffed from 8 a.m. to 4:30 p.m. each weekday. The phone number is **1-888-700-7370**.

How do I check member eligibility?

PerformCare is responsible for behavioral health services for HealthChoices members residing in Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, and Perry counties.

Due to volatility of continuous membership, we strongly recommend providers check eligibility frequently. We recommend that eligibility checks occur at a minimum every two weeks but ideally before each appointment. PerformCare has no involvement with determining eligibility. Member files are downloaded to PerformCare on a daily basis from DHS. Further, authorization is not a guarantee of payment. The provider must verify the member continues to be eligible prior to rendering the service.

Providers should check the member's eligibility by using EVS at **1-800-766-5387** at no cost to you. When calling EVS, be prepared to supply your provider MA ID and the member's identification number and date of birth. You can check eligibility 24 hours per day, seven days per week using this phone number.

If you are interested in obtaining PROMISe ready eligibility verification devices, two vendors are available, Insurance Benefit Spot Check at **1-800-233-7768** and TES at **1-800-843-5237**, **ext. 5604**. PROMISe ready Provider Electronic Solutions Software is also available at the DHS website or by calling the Provider Assistance Center at **1-800-248-2152**.