

# **BILLING MANUAL for COMMUNITY CARE PROVIDERS SERVING HEALTHCHOICES MEMBERS**

Original Claims Mailing Address:

Community Care Behavioral Health Organization  
P.O. Box 2972  
Pittsburgh, PA 15230

Corrected Claims Mailing Address:

Community Care Behavioral Health Organization  
One Chatham Center, Suite 700  
112 Washington Place  
Pittsburgh, Pennsylvania 15219

[Website: www.ccbh.com](http://www.ccbh.com)

Provider Line: 1-888-251-CCBH

## Billing Manual Introduction

Community Care has designed a claims payment process that ensures prompt and accurate payment for services. In this handbook you will find requirements and explanations for each of the components of the billing process.

Prompt and accurate claims payment is one of the most important tasks of any managed care company and Community Care is committed to excelling in that area. Community Care's ability to pay claims is directly related to the manner in which the Provider bills for services. If claim forms are incomplete or incorrect, claims for services that should be reimbursed may be denied. Providers should pay careful attention to the processes used for capturing services and billing since a healthy cash flow is critical to any organization's ability to provide service.

This billing manual is prepared as a guide to policies and procedures for individual practitioners, group practices, programs, facilities, and hospitals to reference when billing Community Care for HealthChoices Members.

Community Care endeavors to make billing and claims payment as straightforward a process for Providers as possible. Community Care's Provider Reimbursement Department is available for questions by calling 1-888-251-2224 and following the prompts to Provider Reimbursement. The Provider Reimbursement line is staffed from 8:30 a.m.-12 p.m., and from 1- 5:00 p.m., Monday-Friday. If you call between 12 and 1 p.m., you will receive a message advising you that the Provider Reimbursement line is closed. You can check the status of your claim on *Provider Online* or call the Provider Reimbursement line back during the hours of operation. Questions related to claims MUST be directed to the Community Care Provider Reimbursement Department.

The essentials of completing claim forms are related to ensuring that all the blocks on the specific claim form are populated based on the instructions provided in this manual. It is important to note that for the HealthChoices program, these instructions are based on Medical Assistance requirements rather than on the usual standards for billing commercial and other insurance payors. The UB-04 and the CMS-1500 Community Care field requirements are listed in the pages below.

## Before Providing Care

### Checking Eligibility

Community Care manages the behavioral health care benefits for HealthChoices Members in your area. Members must be Medicaid eligible to enroll with HealthChoices. Members are instructed to carry their Medicaid Access Card for eligibility verification.

As a Provider, it is important to ensure that a client is a current HealthChoices Member before providing services. **No matter what authorization you receive, if the Member**

**to whom you provide services is not eligible for Medical Assistance on the date services are rendered, we will not be able to pay you.**

You can verify eligibility in a number of ways. You must use your 13-digit PROMISE Provider Identification Number.

- You can check eligibility directly by calling 1-800-766-5387.
- Swipe the member's access card.

Listed below is the website related to obtaining the EVS software.

- EVS software – approved commercial vendors of EVS software appear on the OMAP website at <http://www.dpw.state.pa.us/omap/provinf/billing/270vendors.asp>.

### **Obtaining Authorizations**

**An authorization is an agreement that the care you want to provide to a specific Member meets medical necessity for that level of care. It is not a promise to pay a claim.**

While most services require an authorization or registration notification for claims payment, not all services require pre-approval or pre-certification. (Refer to Provider Manual for guidelines to obtain authorizations and for outpatient registration.)

The Care Management clinical staff is available 24 hours a day, seven days per week to provide pre-certification or pre-approval for urgent services. For non-urgent services, Care Managers are available Monday through Friday during the hours of 8:30 a.m. to 5:00 p.m. The Care Management Department is available at any time by calling 1-888-251-COMMUNITY CARE and selecting the appropriate options from the options menu. Community Care's after-hours coverage assures Providers will always have access to clinical personnel for clinically urgent situations.

While an authorization number is generated at the time of approval, this number is not required to appear on the billing form for consideration of payment. Our information system can match your bill to the appropriate authorization when you follow the procedures outlined in the section of this manual entitled "Completing & Submitting Claim Forms".

An authorization is NOT a guarantee of payment. All of the billing aspects of the service must be correct for the claim to be paid.

Even though an authorization may be issued to provide services, we cannot pay claims for a member who is not eligible for coverage by Medical Assistance at the time services were rendered. Since eligibility or enrollment status may change at any time, we strongly recommend that the member's eligibility status be confirmed or verified at the time of each visit. Failure to verify eligibility may result in claims denial.

## Billing

Provider claims should be submitted on one of the two standard claim forms that are accepted by Community Care – the UB-04 (Inpatient Services) or the CMS 1500 (Outpatient Services). In addition, Community Care accepts claims that are submitted electronically via claims clearinghouses and through Community Care’s web-based application, *Provider Online*. As part of the Health Information Privacy and Accountability Act (HIPAA), Providers are required to use the standards set by the Act, 837I (Inpatient Services) and 837P (Outpatient Services). Providers are strongly encouraged to submit claims to Community Care electronically. Providers are required to submit original red-lined claim forms; copied claim forms are not acceptable when billing original claims.

## Claims Filing

- Claims are to be submitted as soon as possible, once the *applicable authorizations have been obtained* and services have been rendered.
- If you are having difficulties obtaining the authorization, submit your claim to ensure that you are within the timely file deadline. It is easier and much faster to submit a claim correction on the denial for “no authorization” than it is to file for an “exception to timely file.” Submitting without your authorization should be an exception and NOT a routine occurrence.

## Timely Filing Guidelines by Contract

**Both *Initial* billing and *days to complete corrected claims* are based on *days from Date of Service*. *The initial claim must be filed timely before ‘days to complete claim process’ are applicable*. Submit initial claims ASAP!**

***Allegheny*** – 90 days, 180 days to complete claim process

***Berks*** – 60 days, 120 days to complete claim process

***Carbon/Monroe/Pike*** – 90 days, 180 days to complete claim process

***Chester*** – 60 days, 180 days to complete claim process

***North Central*** – 90 days, 180 days to complete claim process (North Central includes Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne counties)

**Northeast** – 90 days, 180 days to complete claim process (Northeast includes Lackawanna, Luzerne, Susquehanna, and Wyoming counties)

**York/Adams** – 90 days, 180 days to complete claim process

### **Timely File Submission Requirements**

Requests for an exception to the timely file guidelines must include documentation explaining why the exception is warranted.

The following items must be included with your appeal request:

- Providers must forward a letter outlining the details related to the reason or reasons a timely file appeal is being requested.
- A copy of the original billed claim (CMS1500 or UB04).
- The claim submitted must be CORRECT, meaning all required fields are populated correctly, the authorization must be in place as indicated, and the member must be eligible for the date(s) of service billed.
- A copy of the Community Care remittance.
- A copy of the electronic confirmation report, if the claim was billed electronically.
- If the claim being appealed is a secondary claim, include documentation demonstrating timely file to the primary carrier, follow-up with the primary carrier, and a copy of the final EOB from the primary carrier. The exception request should be sent to Community Care within 30 days from receipt of the primary EOB.
- Failure to do timely follow-up is *not* an acceptable reason for requesting a timely file exception. Reasonable follow-up is considered to be at approximately 45-day intervals.
- Claims **must** be on file prior to requesting an appeal.

Requests for exceptions to the timely file rule are sent to:

**Community Care Behavioral Health Organization  
Claims Department – Timely File  
112 Washington Place  
One Chatham Center, Suite 700  
Pittsburgh, PA 15219**

Community Care will present the exception requests to the applicable oversight group for approval. No timely file exceptions can be made without oversight approval. Claims must be on file in order to be appealed.

## Completing and Submitting Primary Claim Forms

Depending on the type of service you are providing, you must bill Community Care through Electronic Data Interchange (EDI), via a claims clearinghouse, through Community Care's web-based application, *Provider Online*, or on paper utilizing the applicable claim form (UB-04 or CMS-1500).

- Providers of inpatient services and accredited RTFs will use a UB-04 claim form or the EDI Institutional Claim screen for billing services provided to all HealthChoices Members.
- Individual practitioners or other Providers providing outpatient services (ambulatory, non-hospital residential, and non-accredited RTF) will use a CMS 1500 claim form or the EDI Professional claim screen for billing services provided to all HealthChoices Members.

HealthChoices Providers should mail original paper claims to:

**Community Care Organization**  
**P.O. Box 2972**  
**Pittsburgh, PA 15230**

## EDI Claims Processing Information

### Claims Clearinghouse

Payer Name – Community Care BHO  
Payer ID - # 23282

Providers have two options to submit claims electronically. The first of which is for claims to be submitted via a claims clearinghouse. Providers using this method must execute a contract with one of the clearinghouses listed below. The clearinghouses listed below are those with which we currently have working relationships. Beyond these three clearinghouses, we are certainly willing to work with any other clearinghouse that may express interest in doing so.

- Relay Health (McKesson)
- EMDEON (WebMD)
- Xactimed/MedAssets

## EDI (Claims Clearinghouse) Requirements

The EDI process for submitting claims to Community Care is the same as when submitting claims to other insurance carriers via EDI. The EDI specific fields will vary depending on the EDI software your billing system operates. However, the required fields for EDI claims submissions to Community Care through a claims clearinghouse are:

- Community Care's Payer Identification Number "**23282**"
- NPI Number
- Member's Medicaid Identification Number
- Payer's Name "Community Care Organization"

- Patient Demographics
- Provider Demographics
- Claim Detail

### **Community Care's Web based application, *Provider Online***

The second method for claims to be submitted electronically is the utilization of Community Care's Web based application, *Provider Online*. Providers are required to complete a non-disclosure agreement prior to receiving any access to Community Care's *Provider Online* website.

For further instructions visit: <http://www.ccbh.com/Providers/SecureSites/Claims.php>

*Provider Online* enables Providers to complete the following:

- Check the status of a claim online.
- Provide an alternative to the use of a claims clearinghouse in the submission of an 837 claim file electronically.
- Provide a vehicle for Providers to key claims directly into the system via an *Online* batch.
- Review Authorizations.
- Submit Claim Corrections.

Internet access is required to access *Provider Online*. Providers can query the claims system in real time and/or review authorizations, increasing the speed at which vital information can be obtained. A Provider can utilize *Provider Online* to query claims status and not choose to submit claims through the application.

### **The status of any claims submitted to Community Care can be queried via *Provider Online*, regardless of the manner in which it was submitted.**

Providers considering utilizing *Provider Online* for direct submission of their 837 files must submit two 837-test files; both files must pass the testing phase before the Provider will be given access to submit their 837 files via *Provider Online* into our production environment. Upon requesting a non-disclosure form for this access, Community Care will provide documentation on our 837 requirements and complete directions on our testing process.

Electronic files can be submitted any time of day or night 24/7 to your clearinghouse or via *Provider Online*. They can be received by Community Care at any time.

The daily process runs five days a week Monday through Friday, 7 a.m. – midnight. Monitors will not process any claims from midnight until 7 a.m., Monday through Friday. The monitors will process on Saturdays between 7 and 11:30 a.m. and on Sundays from 9 a.m. to 6:30 p.m. All output will be available prior to the respective cutoff times or after 7 a.m., Monday through Friday.

- Payer Name – Community Care BHO
- Payer ID – Available at the time of enrollment to the application – this is different than the format submitted via a claims clearinghouse.

### **General Claims Submission Rules**

All claim forms must contain:

- Member ID Number (10 digit MA Recipient ID.)
- NPI Number.
- ICD-9 diagnosis codes:
  1. Behavioral Health Diagnosis Range 290-319 (billed to the 5<sup>th</sup> digit; *do not add zeros*).
  2. In addition to the above span, Dx codes 995.5 and 648.33 can be billed.
  3. Diagnosis code 799.9 is not an appropriate or acceptable diagnosis *unless* the diagnosis code is billed with an acceptable procedure code.
- Procedure codes from the Community Care fee schedule.
- “Billing Units” as defined on the Community Care fee schedule.
- Data *must* be within the lines of the applicable claim form box.
- Font should be Arial and the size should be between 10 and 12.

Paper claims must be completed as instructed by Community Care or they cannot be scanned into the claims processing system. Claims that are not completed correctly may be denied. The Explanation of Payment (EOP) for the claim in question will include a denial code that indicates why the claim could not be paid.

### **Required Claim Fields**

In the following pages of detailed instructions:

- The “block number” refers to the space on the relevant claim form.
- The “required/optional/not required” column indicates the blocks that must be completed (marked with an R for required), can be completed but are not required (marked with an N for not-required), or should be included but are not required (marked as optional).

Note: Any claim field marked “REQUIRED” must be populated on the claim form or payment will be denied.

## CMS 1500

Listed below are instructions for completing the specific fields on the **CMS 1500 (HCFA 1500) claim** for Community Care.

<u>BLOCK #</u>	<u>Field Name</u>	<u>REQUIRED or NOT REQUIRED</u>
1	Payor Identifier	Not required
1a	<b>Member Number = 10 Digit Medicaid Recipient ID</b>	<b>Required</b>
2	<b>Member's Name</b> <i>(last name, first name, middle initial)</i>	<b>Required</b>
3	<b>Members' Birth Data (MM/DD/YY)</b>	<b>Required</b>
3	Sex	Not Required
4	Insured's Name <i>(last name, first name, middle initial)</i>	Required for COB
5	<b>Member's Address</b>	<b>Required</b>
6	<b>Member's Relationship to Insured</b> <i>(Always check box for self)</i>	<b>Required</b>
7	Member's Address <i>(number, apartment number, street, city, zip code, telephone number with area code)</i>	Required for COB
8	Member's Status <i>(check boxes for single, married, other, employed, full-time student, part-time student)</i>	Required for COB
9	Other Insured's Name <i>(last name, first name, middle initial)</i>	Required for COB
9a	Other Insured's Policy or Group	Required for COB
9b	Other Insured's Date of Birth (MMDDYY) and Sex	Required for COB
9c	Employer's Name or School Name	Required for COB
9d	Insurance Plan Name or Program Name	Required for COB
10a-c	Members' Condition Related to Employment, auto accident, and other accident	Not required
11	Insured policy, Group or FECA Number (if applicable)	Not required
11a	Insured's Date of Birth and Sex	Not required
11b	Employer's Name or School	Not required
11c	Insurance Plan Name or Program Name (if applicable)	Not required
11d	<b>Is there another health benefit plan?</b> <b>(Check block Yes or No)</b>	<b>Required</b> <b>If Yes, return to and complete item 9a-d</b>
12	<b>Member's or Authorized Person's Signature</b> <b>All invoices must have either the Recipient's signature or the words "Signature Exceptions" or "Signatures on File" and the date</b>	<b>Required</b>

13	Insured or Authorized Person's Signature	Not required
14	Date of Current Illness	Not required
15	Date of Same or Similar Illness	Not required
16	Date Client Unable to Work in Current Occupation	Not required
17	Name of Referring Physician or Other Source (if applicable)	Not required
17a	Name of Referring Physician or Other Source	Not required
17b	Referring Physician's ID	Not required
<b>18</b>	<b>Hospitalization Dates Related to Current Services FROM</b>	<b>Required</b>
<b>18</b>	<b>Hospitalization Dates Related to Current Services TO</b>	<b>Required</b>
19	Reserved for Local Use	Not required
20	Outside Lab	Not required
	Outside Lab Charges	Not required
<b>21</b>	<b>Diagnosis Code 1 (ICD-9-CM Diagnosis Code 290 – 319, 995.5 or 648.33)</b>	<b>Required</b>
21	Diagnosis Code 2	Not required
21	Diagnosis Code 3	Not required
21	Diagnosis Code 4	Not required
22	Medicaid Resubmission Code/Original Referral Number	Not required
23	Prior Authorization Number	Not required
<b>24A</b>	<b>Date of Service FROM</b>	<b>Required</b>
<b>24A</b>	<b>Date of Service TO</b>	<b>Required</b>
<b>24B</b>	<b>Place of Service (See Community Care's Fee Schedule)</b>	<b>Required</b>
24C	EMG	Not required
<b>24D</b>	<b>Procedure Code</b> <i>Enter the applicable procedure codes &amp; modifiers from Community Care's Fee Schedule</i>	<b>Required</b>
<b>24D</b>	<b>Modifier</b>	<b>Required</b>
<b>24E</b>	<b>Diagnosis Code Pointer</b> <i>Enter the diagnosis reference number as shown in block 21 to correlate the diagnosis code to the procedure or service performed</i>	<b>Required</b>
<b>24F</b>	<b>Total Charges being billed for the line</b>	<b>Required</b>
<b>24G</b>	<b>Total Days or Units being billed for the line (two digit maximum per line, 99)</b>	<b>Required</b>
24H	EPSDT Family Plan (if applicable)	Not required

24I	ID Qual	Not required
24J	Rendering Prov NPI#	Required
25	Federal Tax ID Number (Used for income tax purposes). It <b>MUST</b> be associated with the vendor information on your contract with Community Care.	Required
26	Provider's Patient Account Number	Required
27	Accept Assignment	
28	<b>Total Charges</b> <i>Enter the total sum of 24 F lines 1-6 in dollars and cents</i>	Required
29	Amount Paid by Other Insurance (if applicable) <i>Enter total sum of 24 K lines 1-6 in dollars and cents</i>	Required for COB
30	Balance Due from Community Care	Not required
31	<b>Name of physician, clinician, or facility named on the authorization for the service and the date</b>	Required
32	Name and Address of Facility where services were rendered	Not required
33	<b>Provider's Vendor Name, Address, Zip Code, and Telephone Number</b> <i>Enter the name that should appear on your checks and the address where the checks should be mailed. This information should match the vendor information on your Community Care contract.</i>	Required
33a	<b>NPI#</b>	Required
33b	Unlabeled	Not required

#### UB-04

Listed below are instructions for completing the specific fields on the **UB-04** claims form for Community Care.

<u>BLOCK #</u>	<u>Field Name</u>	<u>REQUIRED:</u> <u>OPTIONAL: or</u> <u>NOT REQUIRED</u>
1	<b>Name of Provider</b>	Required
2	Pay to Data	Not required
3a	<b>Patient Control Number</b>	Required
3b	Medical Record Number	Not required
4	<b>Type of Bill</b>	Required
5	<b>Federal Tax ID Number (Is used for income tax purposes.) It MUST be associated with the vendor information on your contract with</b>	Required

	<b>Community Care.</b>	
<b>6</b>	<b>From</b>	<b>Required</b>
<b>6</b>	<b>Through</b>	<b>Required</b>
7	Unlabeled	Not required
<b>8a</b>	<b>Patient Name ID</b>	<b>Required</b>
<b>8b</b>	<b>First Name</b>	<b>Required</b>
<b>8b</b>	<b>Last Name</b>	<b>Required</b>
<b>8b</b>	<b>Patient Name</b>	<b>Required</b>
<b>9a</b>	<b>Patient Address</b>	<b>Required</b>
<b>9b</b>	<b>City</b>	<b>Required</b>
<b>9c</b>	<b>State</b>	<b>Required</b>
<b>9d</b>	<b>Zip Code</b>	<b>Required</b>
<b>9e</b>	<b>Country Code</b>	<b>Required</b>
<b>10</b>	<b>Birthdate</b>	<b>Required</b>
11	Sex	Not required
<b>12</b>	<b>Admission</b>	<b>Required for INPATIENT claims ONLY</b>
<b>13</b>	<b>Admission Hour</b>	<b>Required for INPATIENT claims ONLY</b>
<b>14</b>	<b>Admission Type</b>	<b>Required for INPATIENT claims ONLY</b>
<b>15</b>	<b>Source of Admission</b>	<b>Required for INPATIENT claims ONLY</b>
<b>16</b>	<b>Discharge Hour</b>	<b>Required for INPATIENT claims ONLY</b>
<b>17</b>	<b>Discharge Status</b>	<b>Required for INPATIENT claims ONLY</b>
18	Cond. Code 1	Not required
19	Cond. Code 2	Not required
20	Cond. Code 3	Not required
21	Cond. Code 4	Not required
22	Cond. Code 5	Not required
23	Cond. Code 6	Not required
24	Cond. Code 7	Not required
25	Cond. Code 8	Not required
26	Cond. Code 9	Not required
27	Cond. Code 10	Not required
28	Cond. Code 11	Not required
29	Accident State	Not required

30	Unlabeled	Not required
31a	Occur. Code 1	Not required
31a.	Occur. Date 1	Not required
31b	Occur. Code 5	Not required
31b	Occur. Date 5	Not required
32a	Occur. Code 2	Not required
32a	Occur. Date 2	Not required
33b	Occur. Code 6	Not required
33b	Occur. Date 6	Not required
33a	Occur. Code 3	Not required
33a	Occur. Date 3	Not required
33b	Occur. Code 7	Not required
33b	Occur. Date 7	Not required
34a	Occur. Code 4	Not required
34a	Occur. Date 4	Not required
34b	Occur. Code 8	Not required
34b	Occur. Date 8	Not required
35	Occur. Span	Not required
36	Occur. Span	Not required
37a	Unlabeled	Not required
37b	Unlabeled	Not required
38	Responsible Party	Not required
39	Value Amount	Not required
39	Value Code	Not required
40a	Value Amount	Not required
40a	Value Code	Not required
41a	Value Amount	Not required
41a	Value Code	Not required
<b>42</b>	<b>Rev. Code</b>	<b>Required – If Authorized</b>
43	Description	Not required
<b>44</b>	<b>HCPCS &amp; Modifier / Rates/HIPPS</b>	<b>Required – If Authorized</b>
<b>45</b>	<b>Service Date</b>	<b>Required NOTE – Not required if confinement claim (determined by referencing Type of Bill info)</b>
<b>46</b>	<b>Service Units</b>	<b>Required</b>
<b>47</b>	<b>Total Charges</b>	<b>Required</b>
48	Non-Covered Charges	Not required
49	Unlabeled	Not required
<b>50A</b>	<b>Payer Name – Primary</b>	<b>Required</b>
<b>50B</b>	<b>Payer Name – Secondary</b>	<b>Required</b>

<b>50C</b>	<b>Payer Name – Tertiary</b>	<b>Required</b>
<b>51A</b>	<b>Plan ID – Primary</b>	<b>Required</b>
<b>51B</b>	<b>Plan ID - Secondary</b>	<b>Required</b>
<b>51C</b>	<b>Plan ID - Tertiary</b>	<b>Required</b>
52	Release Information	Not required
53	Assignment of Benefits	Not required
54	Prior Payments	Not required
55	Est. Amt. Due	Not required
<b>56</b>	<b>NPI #</b>	<b>Required</b>
57	Other Provider ID	Not required
<b>58a</b>	<b>Insured’s First Name</b>	<b>Required</b>
<b>58a</b>	<b>Insured’s Last Name</b>	<b>Required</b>
<b>58a</b>	<b>Insured’s Name</b>	<b>Required</b>
58b	Insured’s First Name	Not required
58b	Insured’s Last Name	Not required
58b	Insured’s Name	Not required
59a	P. Rel.	Not required
<b>60a</b>	<b>Member’s Unique ID (13-Digit Medicaid Recipient ID for primary HealthChoices Claims)</b>	<b>Required</b>
60b	Cert. SSN HIC ID No.	Not required
61	Group Name	Not required
62	Ins Group No.	Not required
63	Treatment Authorization Code	Not required
64	Doc Control Number	Not required
65	Employer Name	Not required
66	Dx Version Qualifier	Not required
<b>67</b>	<b>Principal Diagnosis Code (ICD-9-CM Dx Code 290 – 319, 799.9, 995.5 or 648.33)</b>	<b>Required</b>
<b>67a-q</b>	<b>Diag. Code</b>	<b>Required</b>
68	Unlabeled	Not required
<b>69</b>	<b>Adm. Diagnosis Code</b>	<b>Required</b>
<b>70</b>	<b>Patient Reason Diagnosis Code</b>	<b>Required</b>
71	PPS Code	Not required
72	Ext Cause of Injury	Not required
73	Unlabeled	Not required
74	Prin. Procedure Code	Not required
74	Prin. Procedure Date	Not required
74a	Other Procedure Code	Not required
74a	Other Procedure Date	Not required
74b	Other Procedure Code	Not required
74b	Other Procedure Date	Not required
74c	Other Procedure Code	Not required
74c	Other Procedure Date	Not required
74d	Other Procedure Code	Not required
74d	Other Procedure Date	Not required

74e	Other Procedure Code	Not required
74e	Other Procedure Date	Not required
75	NPI #	Not required
76	Attending Phys. ID/Phys. Name	Not required
76	Qual.	Not required
77	Operating	Not required
78	Other	Not required
79	Other	Not required
80	Remarks	Not required
81	Code Code	Not required

### Third Party Liability (TPL) -Coordination of Benefits (COB)

Often a Community Care Member will have other insurance coverage in addition to their coverage with Medical Assistance. In these situations, Medical Assistance, including HealthChoices, is always the payer of last resort. This means that you should always bill the other payer before billing Community Care. If you fail to bill the other insurance company or third party payer first, your claim will be denied by Community Care.

When you receive the Explanation of Payment (EOP) for claims that are denied because Community Care's records indicate the Member in question is covered by another payer, the EOP will indicate if the other payer is commercial or if it is Medicare. You may call the Community Care Provider Reimbursement Line, 1-888-251-2224, prior to submitting a claim to confirm a Member's other insurance coverage. Community Care will provide you with details associated with the Member's other coverage.

- **HealthChoices is the PAYER OF LAST RESORT** – All other applicable insurance MUST be exhausted before Medical Assistance funds can be used to pay a claim.
- Neither Provider nor Member can elect to avoid the requirements of the primary carrier.
- **Providers who are not part of the primary carrier's network should redirect the Member in-network or seek an out-of-network arrangement with the primary carrier.**
- If the Primary denied for medical necessity, the Provider MUST follow the denial procedures of the primary carrier and exhaust all Act 68 grievance levels to obtain payment. If the denial is upheld, Community Care will conduct a retrospective clinical review prior to making an authorization determination.
- When paying secondary claims, Community Care considers the "Patient Liability" indicated on the primary's EOB and will pay up to the fee schedule amount.
- Providers who are billing ACT62 claims **must** bill the Member's primary insurance, prior to billing Community Care unless:
  - The policy is self-funded.
  - There are fewer than **50** employees covered by the employer's health plan.
  - The insurance plan is **not** issued in the Commonwealth of PA.
  - Tri-Care/Champus is exempt from Act 62.

- Providers who are interested in billing COB claims electronically must contact the Provider Reimbursement Department to review the COB electronic billing requirements, as well as to schedule the COB test process.
- If there are any questions regarding TPL/COB/ACT62, call the Provider Reimbursement line at 1-888-251-2224 and follow the prompts to Provider Reimbursement.

Basic facts to make proper COB billing easier:

- Obtain insurance information from the Member, for every applicable policy:
  - Carrier Name.
  - Insured's Name.
  - Policy Number.
  - Telephone Number.
- Contact insurance carrier to verify benefits:
  - Confirm policy effective date.
  - Confirm benefits.
  - Confirm billing information.
- Follow the guidelines of the primary carrier:
  - Verify the Provider, group and/or facility is contracted, in the primary network.
  - Obtain necessary authorizations.
  - Render service.
  - Bill service to primary carrier.
- Community Care is always the payer of last resort:
  - You cannot elect to ignore the existence of another carrier.
  - Bill all other carriers before submitting to Community Care.
  - Primary denial must reflect an acceptable non-covered reason and not failure to follow the primary carrier's guidelines.
- Payment received from Primary Carrier:
  - Explanation of Benefits (EOB) indicates a Patient Liability.
  - Bill any other third party carrier *that may precede* Community Care.
  - If Community Care is the next payer:
    - Applicable authorization **MUST** be obtained.
    - Submit claim to Community Care with a copy of the Primary EOB.
    - Community Care will pay the *Patient Responsibility* up to the Community Care fee schedule amount.
- Denials received from Primary Carrier which are NOT acceptable:
  - Primary Denial indicates insurance guidelines were NOT followed to obtain primary coverage.
    - **NOT BILLABLE TO COMMUNITY CARE.**
  - Primary Denial indicates service not medically necessary.
    - **NOT BILLABLE TO COMMUNITY CARE.**
  - Providers are required to complete the following steps, if the Primary EOB indicates the service is denied, due to medical necessity.
    - Exhaust all appeal levels with the carrier.
    - If an appeal is granted by the carrier, submit the claim to Community Care with the following information:

- Copy of Original EOB.
- Copy of 2<sup>nd</sup> Level Appeal Decision.
- Claim form, CMS 1500 or UB-04.

**Acceptable denials received from Primary Carrier:**

- Diagnosis not covered by plan.
- Service not covered by plan.
- Yearly benefit is exhausted.
- Lifetime benefit is exhausted.
- Applied to deductible.
- Applied to out-of-pocket.
- Pre-existing condition, service not covered.
- Coverage terminated.

**If you receive any one of the above acceptable denial reasons** submit secondary claim to Community Care with a copy of the primary EOB.

**Acceptable documentation of primary denial:**

- EOB stating non-covered reason.
- Letter from carrier advising non-covered reason.
- Screen print from primary carrier’s system showing non-covered status.

**Understanding Claim Corrections**

Community Care will pay ***the lesser of our fee schedule amount or the amount billed by the Provider*** on the claim form (if the fee schedule is \$27.50 and you bill us \$25.00, we will pay you \$25.00). If you receive a payment that you believe is an underpayment or an overpayment you will need to initiate a claim correction. Claim corrections are also necessary to reprocess a denied claim. Clarification on denials can be obtained by calling the Provider Reimbursement line, 1-888-251-2224, and following the prompts. To change a key component of a claim, Community Care requires written documentation from the Provider regarding the request. Community Care will accept the documentation in the form of a claim form with “Corrected Claim” written on the top or notes on a copied claim form. Community Care cannot process a claim correction based on any Provider’s accounts receivable listings, remits issued by Community Care, or a screen print from the *Provider Online* system. Indicate which components need to be corrected and make sure that the corrected information is clearly identified.

***All claim corrections are subject to “timely file.”***

- Many of the services covered by Community Care can be rendered multiple times on the same date of service. When the same service has been rendered multiple times (same procedure code and modifier), the total number of units rendered should be combined on one line on the claim form. However, if a claim is submitted for a service and then subsequent units are discovered, the subsequent units **MUST** be submitted as a claim correction to the original submission ( 3 units originally billed,

an additional 4 units sent to Provider's billing office – a "corrected claim" for 7 units should be submitted to Community Care).

- Anytime you receive a denial for a "duplicate claim," verify that the service is a true duplicate and not a claim submission for subsequent units on the same day of service.
- If there is an issue with your claim related to the modifier, a "corrected claim," reflecting the correct procedure code and modifier needs to be submitted to update the original claim.
- To correct any inadvertent error in billing, submit a "corrected claim" to update the original claim.
- To reverse a denied claim, a "corrected claim" MUST be submitted with the additional information to update the original claim.
- Providers are required to stamp or write the words "Corrected Claim" on all corrected claims, regardless of the claim form type. This should NOT be done in black ink within the body of the claim. Black ink interferes with the scanning process, red ink does not.

Consistent and timely claims follow-up by the Provider is required to ensure payment for services. Non-payment for rendered services will likely result for claims that are not finalized within the number of days allowed for timely filing by each county. For original claims that have been submitted timely, the number of additional days allowed for settlement is listed at the beginning of this manual.

*Note: The original claim MUST have been received within the timely file guideline for the above to be applicable.*

### **Submitting Claim Corrections**

Community Care can accept claim corrections via three methods:

1. EDI – Preferred method
2. Provider Online
3. Paper Claim Corrections

### ***Provider Online – Claim Corrections***

Community Care strongly encourages Providers to make claim corrections via *Provider Online*. Submitting claims corrections electronically directly to Community Care in this manner expedites the processing of and ensures the accuracy of claim corrections. Community Care has updated its *Provider Online* website to accept all types of claim corrections (changes to diagnosis, procedure code, units, etc.). In order to complete a claim correction online, you must hand key in your claim. For instructions on how to complete electronic claim corrections, please review the *Provider Online* User guide. The *Provider Online* User Guide is located under the Reference Library. You are required to obtain access to *Provider Online* in order to complete claim corrections via *Provider Online*.

Your corrected claim must always mirror the original claim submission. For example, if your original claim was billed with three claim lines and the corrected claim lists two claim lines, the payment related to the missing line will be retracted.

The **Provider Online** website is accessible using the link: [https://online.CommunityCare.com/Community\\_Careproduction](https://online.CommunityCare.com/Community_Careproduction)

### **Paper Claim CMS-1500 – Claim Corrections**

- A copy of the original claim (with “*Corrected Claim*” written at the top of the form) **is a must.**
- Draw a line through the incorrect information and write the correct information directly on the claim form.
- Include the eight digit form number of the claim you are trying to correct.

### **UB-04 - Claim Corrections Type of Bill (Form Locator 4)**

- A copy of the original claim (with “***Corrected Claim***” written at the top of the form) **is a must.**
- Type of Bill (Form Locator 4) must be changed to the appropriate 3-digit code, 117.
- Draw a line through the incorrect information and write the correct information directly on the claim form.
- Include the eight digit form number of the claim you are trying to correct.

### **UB-04 - Claim Corrections - Type of Bill (Form Locator 4)**

#### **Applicable to Provider Online, Claims Clearinghouses & Paper Claims**

This three digit code gives three specific pieces of information.

- First Digit – identifies the type of facility
- Second Digit – classifies the type of care
- Third Digit – indicates the sequence of this bill in this particular episode of care

#### **First Digit**

- **1** - Type of Facility – Hospital

#### **Second Digit**

- **1** - Bill Classification – Inpatient

#### **Third Digit**

- **1** - Admit through Discharge Claim
- **2** - Interim – First Claim
- **3** - Subsequent Interim Claims
- **4** - Last Interim Claim
- **7** - Replacement of a Prior Claim
- **8** – Claim Voids

## Mail Paper Claim Corrections To:

Community Care Behavioral Health Organization  
Attn: Claims Corrections  
112 Washington Place  
One Chatham Center, Suite 700  
Pittsburgh, PA 15219

***Before a change to any critical claim component can be made, Community Care requires written documentation or a claim correction initiated electronically from the Provider.***

## Claims Not On File

If you are submitting your claims electronically, your claims should appear on an EOB within three weeks. Be sure you have obtained a report stating your batch/file was received by Community Care. If your claims were submitted via a clearinghouse, you will receive two reports: one from your clearinghouse and a second report from Community Care advising you of the batch and file number associated with your file submission.

If you are submitting paper claims, you should see your claims on an EOB within four weeks. If you have not seen a submitted claim appear within thirty (30) days, and you have confirmed that the claim is not on file via *Provider Online*, please resubmit the claim to Community Care as soon as possible.

## EDI

To your Clearinghouse  
Payer Name – Community Care BHO  
Payer ID - # 23282

- Receipt of claims submitted via a claims clearinghouse can be verified via *Provider Online* three to five days after the claim was submitted.
- Calls can also be made to the Provider Reimbursement phone line at the same time interval listed above. ***Do NOT call the Provider Reimbursement Phone Lines until the claim has finalized with both a check number and a check date.***
- Community Care strongly recommends the utilization of *Provider Online* for the verification and follow-up of claims.

## Paper Claims

Community Care Behavioral Health Organization  
P.O. Box 2972  
Pittsburgh, PA 15230

- Receipt of paper claim submissions can be verified 14 days after submission.
- Calls can also be made to the Provider Reimbursement Phone Lines at the same time interval listed above. **Do NOT call the Provider Reimbursement Phone Lines until the claim has finalized with both a check number and a check date.**
- Community Care strongly recommends the utilization of 'Provider Online' for the verification and follow-up of claims.

**Community Care strongly recommends Providers utilize the web-based application, Provider Online.**

*Do not contact the Community Care Claims phone line with questions concerning claim status until the claim has finalized. The Provider Online system will list both a check number and a check date. The claim has finalized when both details are available.*

**Claims Buzz Words and Phrases**

Act 62: Autism Insurance Law, PA Act 62 of 2008

Adjudicate: When a claim is processed and the result is 'posted/paid', the claim has adjudicated. It is the final step for that particular claim. If a corrected claim is presented, the corrected claim will have a new 'posted/paid' date.

Authorization Rules: The definition and parameters of the service as listed on the Community Care Fee Schedule. (If the authorization rules have not been followed, the claim will deny.)

COB: Coordination of Benefits

Community Care HealthChoices Member: A person receiving Medical Assistance through a County serviced by Community Care. The person who received treatment and was named on the claim submitted to Community Care.

Community Care Member Number: The member's 10-digit Recipient Number issued by Medical Assistance.

Community Care Provider: This is you, as a contracted private practitioner, agency, facility, or hospital.

Consecutive Billing Days: A continuous run of days in which the same procedure code was rendered to the same member by the same Community Care Provider. (Does not have to be by the same clinician within your agency).

Date of Service (DOS): The date the service was rendered.

EDI: Electronic Data Interchange; the computer software system used to encode and transmit claims data electronically.

EFT: Electronic Fund Transfer

EVS: Eligibility Verification System - Used by Providers to verify member's HealthChoices or Medicaid eligibility.

Federal Tax ID Number: The number used to identify your agency on your Federal Income Tax returns.

MA Provider ID Number: The 13-digit number assigned by the Commonwealth.

Member Eligibility: Member is covered for behavioral health by Community Care on the date of service. Eligibility can be verified through EVS by using a card swipe machine or calling 1-800-766-5387. *If the member is ineligible, your claim will deny, even if services were authorized.*

NPI Number: National Provider Identification Number (Mandatory as of May 23, 2008).

Paid/Posted Claim Status: Claims processed by Community Care post with a payment. The payment may result in a check being issued or, in the case of a denied claim, it will post a zero payment.

Community Care Procedure Code: The code assigned to a service and defined on the Community Care Service Code Fee Schedule.

Community Care Modifier: A two character code attached to a procedure code to identify a different service, to allow a unique rate, or to facilitate reporting.

OPR: Outpatient Registration – Community Care's method for notification by Providers of members receiving 'outpatient' services.

Provider Online: Community Care's web-based application for submitting claims directly and for checking the status of claims.

Provider's Vendor: This is the name and address that will appear on Provider checks. The Vendor is associated with a Federal Tax ID defined by the Provider. The Vendor information on the claim form *must* match the information on the Provider's contract or the claims will deny.

TPL: Third Party Liability

Unit of Service: The 'billing unit' defined on the Community Care Fee Schedule.  
NOTE: Your 'charge collection units' may need to be converted to 'billing units'.

Usual Charge: The amount charged by your agency, to all payers, for the service being rendered.

## Appendix B

### Glossary of Terms and Abbreviations

The following terms and abbreviations are defined as they are used in the Community Care Organization Provider Manual for HealthChoices Members.

**Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Also, recipient (i.e., Community Care Member) practices that result in unnecessary cost to the Medicaid program.

**ALOS:** Average Length of Stay

**ASAM:** American Society for Addiction Medicine

**Authorization:** An agreement that the services planned for a specific Member meet “Medical Necessity Criteria”/level of care criteria. A Provider must receive authorization to provide the services for a claim to be honored, but receiving authorization is not a promise that the claim will be paid (other criteria must be met).

**BDAP:** Bureau of Drug and Alcohol Programs

**BHMCO:** Behavioral Health Managed Care Organization (e.g., Community Care)

**BHRSCA:** Behavioral Health Rehabilitation Services for Children and Adolescents (formerly referred to as EPSDT or “wraparound”)

**BPI:** Bureau of Program Integrity (Commonwealth of Pennsylvania)

**CARF:** Committee on Accreditation of Rehabilitation Facilities

**CASSP:** Child and Adolescent Service System Programs

**CBCL:** Child Behavior Check List

**CMS:** Center for Medicare and Medicaid Services (previously HCFA/Health Care Financing Administration)

**COA:** Council on Accreditation

**Complaint:** An oral or written expression of dissatisfaction from a Member or Provider that initiates a formal investigation process.

**CSP:** Community Support Program

**C/FST:** Consumer/Family Satisfaction Team

**DOH:** Department of Health; the state agency responsible for licensing and inspecting healthcare facilities and services and setting quality standards for providing care to HealthChoices (Medicaid, Medical Assistance) Members.

**DOS:** Date(s) of Service (most often used on claim forms and similar documents)

**DPW:** Department of Public Welfare; the state agency that administers HealthChoices and other Medicaid/Medical Assistance programs.

**EDI:** Electronic Data Interchange; the computer software system used to encode and transmit claims data electronically.

**Emergency:** The sudden onset of a behavioral health 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 that the absence of immediate medical or clinical attention could result in seriously jeopardizing or endangering the mental health or physical well-being of the enrollee or seriously jeopardizing or endangering the physical well-being of a third party.

**EOB:** Explanation of Benefits; statement to a Provider showing the status of that Provider's outstanding claims with the insurer issuing the EOB (aka EOP – Explanation of Payment).

**EVS:** Eligibility Verification System

**Expedited Member Grievance:** A medical necessity determination grievance regarding an inpatient, acute partial, acute residential, 23-hour bed admission, or other urgent or emergent service, as determined by the Member or Provider.

**Fraud:** An unintentional or unintended deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

**GAF:** Global Assessment of Functioning (GAF score); a measure of mental health disability.

**Grievance:** Formal mechanism for a Member to disagree with Community Care's denial based on medical necessity of authorization for the level of care that the Member and Provider deem is indicated. Filing a standard or expedited grievance starts a formal review process. Community Care remains obligated to continue care for the Member until the grievance is resolved—up to a ruling from the state Department of Health.

**ICM:** Intensive Case Management; a Community Care HealthChoices (Medicaid, Medical Assistance) Covered Service that includes coordination of multiple levels and types of services for a Member with complex or rapidly changing care needs.

**LOC:** Level of Care; inpatient versus partial hospitalization versus outpatient.

**LOF:** Level of Functioning; a general term that includes specific measures such as GAF (Global Assessment of Functioning) scores.

**LOS:** Length of Stay; continuous service days for an admission to a facility or program.

**MA:** Medical Assistance (Medicaid)

**MATP:** Medical Assistance Transportation Program; provides transportation (for example, to mental health appointments) for HealthChoices (Medicaid, Medical Assistance) Members.

**MCO:** Managed Care Organization (see BHMCO and PHMCO)

**MIS:** Management Information Systems

**MOE:** Multicultural Outreach Education

**NAMI:** National Alliance on Mental Illness

**NCQA:** National Committee for Quality Assurance

**NEIC:** National Electronic Insurance Corporation; licensor of Envoy software used to batch process Community Care claims submitted electronically.

**OMHSAS:** Office of Mental Health and Substance Abuse Services; a component of the Department of Public Welfare that administers policies regarding mental health and substance abuse issues.

**PCP:** Primary Care Physician

**PCPC:** Pennsylvania Client Placement Criteria (for chemical dependency)

**PHMCO:** Physical Health Managed Care Organization

**POSNET:** Point of Service Network; a data transmission system with an electronic card reader that a Community Care Provider can use with HealthChoices Member's Medicaid/Medical Assistance identification card to verify that the individual is eligible to receive HealthChoices (Medicaid, Medical Assistance) Covered Services.

**PROMISe:** Provider Reimbursement and Operations Management Information System; Office of Medical Assistance Program's information management system that produces Provider Medical Assistance enrollment numbers. The Office of Mental Health and Substance Abuse Services and Community Care require Provider enrollment through the Office of Medical Assistance prior to rendering behavioral health services.

**PsychConsult™:** The computer software database program Community Care uses to record and report data to each Provider and Member.

**RC:** Resource Coordination; a Case Management service to meet a Member's need for multiple services and supporters.

**Routine:** Routine outpatient services, other than psychological evaluations, are identified related to Member need when a behavioral health condition requires assessment and/or treatment but there is no apparent imminent or impending risk to the Member or others and no evidence that the Member has significant function impairment.

**RTF:** Residential Treatment Facility

**SF-12:** Short Form Health Survey (a level of function measure)

**SBPH:** School-Based Partial Hospitalization

**Supplemental Services:** These services may be paid for by Community Care but are not HealthChoices in-plan services.

**Urgent:** The onset of a mental and/or nervous or substance abuse condition manifesting itself by serious symptoms such that the mental health or physical well-being of the enrollee will deteriorate unless the enrollee is treated by the Provider within 24 hours, or in a case in which the enrollee believes that urgent assessment is required.