



## Provider Billing Handbook

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For Community Care Behavioral Providers Serving the  
HealthChoices Members in all Counties

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Original Claims Mailing Address  
Community Care Behavioral Health  
P.O. Box 2972  
Pittsburgh, PA 15230

Corrected Claims Mailing Address  
112 Washington Place  
One Chatham Center  
Suite 700  
Pittsburgh, PA 15219

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# 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.

To providers, 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 providers bill for services. If claim forms are incomplete or incorrect, claims for services that should be reimbursed, may deny. 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 its service.

This billing handbook 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 members of HealthChoices.

Community Care wants to make billing and claims payment as straightforward a process for providers as possible. Community Care's Claims Department is available for questions by calling 1-888-251-2224 and following the prompts to Claims.

The basics of completing claim forms is related to ensuring that all the blocks on the specific form are completed based on the instructions. It is important to note that for the HealthChoices program, the instructions are based on MA requirements rather than on the usual standards for commercial and other insurance.

In this handbook, we describe the processes that are related to provider interaction with Community Care.

## **Credentialing Program**

The purpose of the credentialing program of Community Care Behavioral Health Organization is to establish guidelines and qualifications necessary for consistent credentialing and re-credentialing processes within Community Care and any of its subsidiaries.

Credentialing is the first step in the quality management process and ensures a quality, responsive, and culturally competent provider network necessary to deliver care to the diverse member population that we serve.

A provider is an all-encompassing term that includes both behavioral health practitioners and facilities/organizations.

The term "practitioner" includes psychiatrists, doctoral and masters level psychologists, certified registered nurse practitioners, clinical nurse specialists and masters prepared social workers who are licensed or otherwise authorized by the State of Pennsylvania to

provide health care services. “Practitioner” can also apply to other physicians as approved on an exception basis by the Community Care Medical Director.

The term “organization” includes hospitals, residential treatment centers, community mental health centers, clinics and partial hospitalization programs, and any other organizations that provide behavioral health care services in community settings.

A practitioner is fully credentialed on the date approved by the Credentialing Committee. An Organization is fully credentialed when the Director of Credentialing and Medical Director complete the assessment process. The credentialing process must be completed within 180 days from the date of the signed application up to and including Committee approval. The credentialing appointment for the individual practitioner expires two years from the date of the approval; the appointment for facilities expires in three years. Credentialed providers are offered contracts to join the network at the discretion of Community Care. Network decisions are based on the network’s capacity to meet access standards, as outlined in the Request for Proposal that was accepted by the State.

Providers must maintain credentialing status in order to continue as a contracted provider in the network(s). Providers are notified by Community Care approximately 6 months before their credentialing cycle expires. Recredentialing must be completed every two years for practitioners and every three years for organizations. Failure to do so will result in termination of a provider contract and members must be transitioned to a network provider. Payment for services delivered by a non-credentialed/recredentialing provider will not occur.

## Before Providing Care

### Checking Eligibility

Community Care manages the behavioral health care benefits for HealthChoices members of 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, you will not get paid.**

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

- You can check directly by calling 1-800-766-5387.
- 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>.
- You can also call Community Care at 1-888-251-CCBH (2224) 24 hours per day.

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 is confirmed/verified at the time of each visit. Failure to verify eligibility may result in claims denial.

## Obtaining Authorizations

**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.)

Care Management Clinical Staff are 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-CCBH 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.

## Billing

Provider claims should be submitted on one of the two standard claims forms that are accepted by Community Care. These are: UB-04 (Inpatient Services), formerly the UB-92 and CMS 1500 (Outpatient Services), formerly the 'HCFA 1500'. In addition, Community Care accepts claims that are submitted electronically via clearing houses and through our Provider-On-Line application. As part of the Health Information Privacy and Accountability Act (HIPAA), providers will be required to use the standards set by the Act, 837I (Inpatient Services) and 837P (Outpatient Services). Providers are encouraged to submit claims to Community Care electronically.

## Claims Filing

- Claims are to be submitted as soon as possible, once the *applicable authorizations have been obtained* and services have been rendered.

### Timely Filing By Contract

**Both *Initial billing and days to settlement* guidelines are based on days from *Date of Service***

***Berks*** - 60 Days, 120 Settlement days

***Chester*** – 60 Days, 180 Settlement days

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***Allegheny*** – 90 Days, 180 Settlement Days

***York/Adams*** - 90 Days, 180 Settlement Days

***North East*** - 90 Days, 180 Settlement Days

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***North Central*** – 120 Days, 240 Settlement days

***Carbon/Monroe/Pike*** – 120 Days, 240 Settlement Days

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**North Central** includes the following counties: Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntingdon, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren and Wayne

**North East** includes the following counties: Lackawanna, Luzerne, Susquehanna and Wyoming

Exception to Timely File requests must include documentation as to why the exception is needed.

- A copy of the original billed claim (CMS1500 or UB04)
- A copy of the Community Care remittance
- A copy of the electronic confirmation report, for those providers who bill electronically
- If it is a secondary claim, include documentation of timely file to the primary, follow-up with the primary, and a copy of the final EOB from the primary. The exception request should be sent to Community Care within 30 days from receipt of the primary EOB.

- If you have an issue within your office that causes a delay in billing, you must fully explain the situation in a statement on your company letterhead requesting the timely file exception.
- 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.

Requests for exceptions to the timely file rule are sent to

**Community Care Behavioral Health  
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.

## **Completing & Submitting Primary Claim Forms**

Depending on the type of service you are providing, you must bill Community Care with either one of two claim forms or through Electronic Data Interchange (EDI).

- Providers of inpatient services and JACHO RTF 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-JCACHO 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:

CCBHO  
P.O. Box 2972  
Pittsburgh, PA 15230

## **EDI Claims Processing Information**

Payer Name – Community Care BHO  
Payer ID - # 23282 (NOTE: This is NOT the same payer ID utilized to bill Community Care for any of our other contracts.)

North Central and Carbon, Monroe, Pike EDI files can be transmitted to Community Care by two methods. The first method is via a clearinghouse. Providers using this method would contract respectively with one of the following clearinghouses.

Cirius  
Emdeon/WebMD  
Gateway EDI  
GHOnline  
HBR  
Per-se (HDS/NDC)  
Zirned

## General Claims Submission Rules

All claim forms must contain:

- Member ID Number (10 digit MA Recipient ID)
- Thirteen Digit MA Provider PROMISe Provider Identification Number
- ICD-9 diagnosis codes on claims forms
- 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
- Behavioral Health Diagnosis Range 290-319 – billed to the 5<sup>th</sup> digit
- In addition to the above span, Dx codes 995.5, 799.9, and 648.33 can be billed

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).

Only the data in the “required” and “optional” boxes is read for claims processing.

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) will contain a code that tells the provider why the claim was unable to be paid.

The second method is to utilize Community Care’s Web based application *Provider Online*. Providers are required to complete a non-disclosure document prior to receiving any access to Community Care’s *Provider Online* website. *Provider Online* will enable providers to complete the following:

1. Check the status of a claim online;
2. Provide an alternative way to submit an 837 claim file electronically instead of using a claims clearinghouse; and
3. Provide a vehicle for providers to key claims directly into the system via an *Online* batch.
4. Review Authorizations

Providers require Internet access to utilize *Provider Online*. Providers can query the claims system in real time and/or review authorizations, increasing the speed at which they can obtain vital information. A provider can utilize *Provider Online* to inquire on the status of their claims and not choose to submit claims through the application.

Providers requesting access to hand key in claims into our Provider Online website first must take an online tutorial at our E-learning website: [<http://online.ccbh.com/elearning/>](http://online.ccbh.com/elearning/)

Upon receiving a passing grade and contacting Community Care access will be granted accordingly.

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 provided 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 of 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 any time.

The daily process runs five days a week Monday through Friday 7:00 a.m. – 12:00 midnight. Monitors will not process any claims from 12:00 midnight until 7 a.m. Monday through Friday. Saturday the monitors will process between 7am and 1130am, Sunday 9 a.m. to 6:30p.m. All output will be available respectively prior to the cutoff times or after 7:00 a.m. Monday through Friday.

### ***CMS 1500 (this form was previously known as HCFA 1500)***

**In July 2001, the Health Care Financing Administration (HCFA) became the Centers for Medicare & Medicaid Services (CMS). Because of this name change, the prefix of form numbers that had been 'HCFA' is being changed to 'CMS.' Visit [www.cms.hhs.gov/forms](http://www.cms.hhs.gov/forms) for more information.**

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

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

BLOCK #	Field Name	REQUIRED or NOT REQUIRED
	<i>date.</i>	
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, 799.9, 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>

BLOCK #	Field Name	REQUIRED or NOT REQUIRED
<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</b> <i>(two digit maximum per line, 99)</i>	<b>REQUIRED</b>
24H	EPSDT Family Plan (If Applicable)	Not Required
24I	ID Qual	Not Required
<b>24J</b>	<b>Rendering Prov NPI #</b>	<b>REQUIRED</b>
<b>25</b>	<b>Federal Tax ID Number (Used for income tax purposes.) It <i>MUST</i> be associated with the vendor information on your contract with Community Care.</b>	<b>REQUIRED</b>
<b>26</b>	<b>Provider's Patient Account Number</b>	<b>REQUIRED</b>
27	Accept Assignment	
<b>28</b>	<b>Total Charges</b> <i>Enter the total sum of 24 F lines 1-6 in dollars and cents.</i>	<b>REQUIRED</b>
29	<i>Amount Paid by Other Insurance (If Applicable)</i> <i>Enter the total sum of 24 K lines 1-6 in dollars and cents.</i>	<i>Required for COB</i>
<b>30</b>	Balance Due from Community Care	Not Required
<b>31</b>	<b>Name of physician, clinician or facility named on the authorization for the service and the date.</b>	<b>REQUIRED</b>
<b>32</b>	Name and Address of Facility where services were rendered	Not Required
<b>33</b>	<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>	<b>REQUIRED</b>
<b>33a</b>	<b>NPI #</b>	<b>REQUIRED</b>
33b	Unlabeled	Not Required

**UB-04**

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

<b>BLOCK #</b>	<b>FIELD NAME</b>	<b>REQUIRED ; OPTIONAL; NOT REQUIRED</b>
1	<b>Name of Provider</b>	<b>REQUIRED</b>
2	Pay to Data	Not Required
<b>3a</b>	<b>Patient Control Number</b>	<b>REQUIRED</b>
<b>3b</b>	Medical Record Number	Not Required
<b>4</b>	<b>Type of Bill</b>	<b>REQUIRED</b>
<b>5</b>	<b>Fed. Tax No. (Is used for income tax purposes.) It MUST be associated with her vendor information on your contract with Community Care</b>	<b>REQUIRED</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

<u>BLOCK #</u>	<u>FIELD NAME</u>	<u>REQUIRED ; OPTIONAL; NOT REQUIRED</u>
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
32b	Occur. Code 6	Not Required
32b	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>

<u>BLOCK #</u>	<u>FIELD NAME</u>	<u>REQUIRED ; OPTIONAL; NOT REQUIRED</u>
<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 Health Choices 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>

<u>BLOCK #</u>	<u>FIELD NAME</u>	<u>REQUIRED ; OPTIONAL; NOT REQUIRED</u>
<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

## EDI Requirements

The EDI process for submitting claims to Community Care will be the same as when submitting claims to other providers via EDI. The EDI specific fields will vary depending on the EDI software your billing system operates. However, listed below are required fields for EDI claims submissions to Community Care through WEBMD.

- Community Care’s Payer Identification Number “**23282**”  
(new Payer ID for the North Central)
- Medical Assistance Payer Identification
- Member’s Medicaid Identification Number
- Payer’s Name “Community Care Behavioral Health Organization”
- Patient Demographics

- Provider Demographics

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

Often a member of Community Care will have another insurance besides Medical Assistance. In these situations, Medical Assistance, including HealthChoices participants, 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 first, your claim will be denied by Community Care for traditional behavioral services.

There are support and non-traditional services for which Community Care is primary – as indicated on the Community Care fee schedule.

When you receive the Explanation of Payment (EOP) for claims that are denied because there is a primary insurance other than Pennsylvania Medical Assistance, the EOP will indicate if the other insurance company is Commercial or Medicare. You may call the Community Care Claims Line, 1-888-251-2224 and follow the prompts, before you submit a bill to us if you believe that a member may have additional insurance coverage. We will give you the insurance information Community Care has on file for the member.

Community Care currently contracts for certain services that are currently Third Party Liability exempt. For these services, Community Care can be billed as a primary payer regardless of the presence of another insurance. These services are as follows: Family Based, Intensive Case Management, Resource Coordination, Methadone Maintenance, Clozaril, BHRSCA (wraparound) services, Residential Treatment, Rehabilitation and Ambulatory Individual Therapy at the end of an inpatient admission. However, as the insurance industry changes, so does the coverage of these previously non-covered services. The TPL Unit of the Commonwealth of PA has made it clear to the Managed Care Organizations that HealthChoices is the payer of last resort. If coverage for a previously non-covered service is being offered by a third party payer, that carrier must be billed.

- **HealthChoices is the PAYOR 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 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.

## 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 Phone Line, 1-888-251-2224, and following the prompts..

Consistent and timely claims follow-up by the provider is required to ensure payment for services. Non-payment for services will likely result for claims that are not finalized within the number of days specified by the County. When claims are submitted timely, the days allowed for *settlement* by County are listed on page 5 of this document.

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

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 copy. Community Care cannot process a claim correction based on Provider’s Accounts Receivable listings. Indicate which components need to be corrected and make sure that you clearly identify the correct information.

All claim corrections subject to “timely file” should be mailed to the following address.

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

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## Claims Not On File

If you are submitting your claims via a clearinghouse, you should see your claims appear on an EOB within three weeks. Be sure you have obtained both the **first report** stating your batch was received by the clearinghouse and the **second report**, which advises the batch, was received into the claims processing system by Community Care.

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, call the claims phone line and inquire as to the status. If you are advised the claim is not on file, please resubmit the claim as follows:

### Paper Claim:

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

### EDI

To your Clearing house  
Payer Name – Community Care BHO  
Payer ID - # 23282 (New Payer ID for the North Central contract)

Web-based *Provider Online* application  
Payer Name – Community Care BHO  
Payer ID - # 23282.

A follow-up call should be made to the Claims Phone Line on these resubmitted claims in seven (7) working days. If the claim is still not on file, a paper copy should be sent to Community Care for ‘special handling’.

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

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## Claims Buzz Words and Phrases

<u>Adjudicate:</u>	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 ‘post/paid’ date.
<u>Authorization Rules:</u>	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.)
<u>Community Care by HealthChoices</u>	A person receiving Medical Assistance through a County serviced Community Care. The person who received treatment and was Named on the claim submitted to Community Care
<u>Community Care Member Number:</u>	The member’s 10-digit Recipient Number issued by Medical Assistance.
<u>Community Care Provider</u>	This is you, as a contracted private practitioner, agency, facility, or hospital.
<u>Consecutive Billing Days:</u>	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.)
<u>Date of Service (DOS):</u>	The date the service was rendered.
<u>Federal Tax ID Number:</u>	The number you use to identify your agency on your Federal Income Tax returns.
<u>MA Provider PROMISE Number:</u>	The 13-digit number assigned by the Commonwealth. The first 9-digits identify the provider and the last 4-digits the location the service was rendered. EXAMPLE 7789261552336
<u>Member Eligibility:</u>	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. <i>If the member is ineligible, your claim will deny, even if services were authorized.</i>

<u>Paid/Posted Claim Status:</u>	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.
<u>Community Care Procedure Code</u>	The code assigned to a service and defined on the Community Care Service Code Fee Schedule.
<u>Community Care Modifier</u>	A two character code attached to a procedure code to identify a different service, to allow a unique rate, or to facilitate reporting.
<u>Provider's Vendor:</u>	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 <i>must</i> match the information on the Provider's contract or the claims will deny.
<u>Unit of Service:</u>	The 'billing unit' defined on the Community Care Fee Schedule. NOTE: Your 'charge collection units' may need to be converted to 'billing units'.
<u>Usual Charge:</u>	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 Behavioral Health 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 (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 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

**CST**

Consumer 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 Function (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 process of review of the disagreement. 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 Care 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 Function) scores

**LOS**

Length of Stay; continuous days of service for an admission to a facility or program

**MA**

Medical Assistance (Medicaid)

**MA Member Identification Number**

Member's Medicaid/Medical Assistance identification number; the number has 10 digits

**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 for the Mentally Ill

**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 the required 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.

**PROMISe Provider Identification Number**

Number assigned to the Provider by the Office of Medical Assistance; providers that are enrolled through the Office of Medical Assistance Program are issued a unique 9-digit MPI provider number. Providers are also assigned a 4-digit service location code for each service at each site where treatment is being provided. The combination of the 9-digit number and 4-digit service location code, comprising a 13-digit provider identification number, must be submitted on all claims submissions. This information is used to verify the enrollment of provider services and report provider-specific claims payment information to OMHSAS. Information submitted on claim forms must be in an YYYYYYYYZZZZ format where Y is the Provider's unique 9-digit MPI number, and Z is the service location code for the particular Provider site, e.g., 1121122220010 (112112222- MPI Number assigned to the Provider; 0010-Address Code).

**PsychConsult**

The computer software database program Community Care uses to record and report data to each Provider and Member

**RC**

Resource Coordination; a Care 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 the Community Care but are not HealthChoices in-plan services

### **Urgent**

Urgent behavioral health condition means 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