CLAIMS & BILLING SUBMISSION GUIDELINES

Version 14.1

11/16/2022

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General Claims Submission Guidelines

Paper Claims Submission

Partners Health Plan
Claims Department
PO Box 16309
Lubbock, TX 79490

837 Electronic Claim Submissions

PHP Providers can submit electronic institutional and professional claims via various Clearinghouses using Partners Health Plan's EDI ***Payer ID# 14966***.

HealthSmart Clearinghouse:

To submit claims via the HealthSmart Clearinghouse contact HealthSmart EDI Support at 1-888-744-6638.

Complete an EDI Enrollment Form, as well as, a User License Agreement to begin the submission process. The EDI Enrollment Packet can be found at:

EDI Enrollment Packet

Change Healthcare Clearinghouse (formerly Emdeon):

To submit claim via the Change Healthcare Clearinghouse call 1-877-363-3666.

Availity EDI Clearinghouse

HealthSmart has moved into an exclusive Clearinghouse/EDI Gateway relationship with Availity for 837 (claims) and began receiving 837 transactions for PHP as of June 1, 2022.

Availity has a relationship with Change HealthCare so If you are submitting 837 claims for Partners Health Plan Payer ID 14966 via Change Healthcare you can continue to do so.

If you retrieve 835s from Change HealthCare you can continue to do so. The only difference is that you will need to enroll with ECHO to retrieve the 835s by selecting Change HealthCare-Emdeon as the clearinghouse for ERA delivery when enrolling with ECHO.

For more information regarding Availity go to https://www.availity.com/ediclearinghouse).

CLAIM PAYMENT OPTIONS

New Payment Vendor Effective 4/1/2022

Partners Health Plan, through the administration of **HealthSmart Benefit Solutions**, has a new payment vendor, ECHO Health, Inc., effective April 1, 2022. Please note that our previous vendor, Zelis Payments, will continue to issue payments on behalf of Partners Health Plan during a run-out period through May 31, 2022.

ECHO is one of the leading payment processors in healthcare connecting over one million providers to insurance companies, health plans, and TPA's across the country. Providers will have access to numerous services including historical payments and remittance details, the electronic delivery of 1099's, and notification when new payments are available by accessing https://providerpayments.com. This new service will be available to all PHP Providers regardless of the payment method selected.

To sign-up to receive EFT for **HealthSmart**, please visit the following website: https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart

If you already have an ECHO Provider portal account or an existing ECHO Draft Number/Amount, you can use that information to enroll. However, if you do not already have an existing relationship with ECHO, you will need the unique enrollment/verification code that was sent to your organization to enroll. No Fees apply.

If you do not currently have a relationship with ECHO Health, Inc and do not have the information necessary to proactively enroll in an electronic form of payment, a paper check will be initially generated. You will then be able to utilize the draft number and amount associated with that payment to enroll in an electronic form of payment.

Once enrolled and after this transition occurs, your EFT payments from HealthSmart will appear on your bank statement from Huntington National Bank and ECHO Health Inc., as "HNB – ECHO".

If you have any difficulty with the website or have additional questions, please contact ECHO directly at 800-937-0896.

835 Remittance Transactions

The HealthSmart Clearinghouse will no longer accept new enrollment requests for 835 electronic remittances.

Providers can enroll to receive 835 electronic remittances with our new Payment Vendor, ECHO Health Inc.

ECHO Health has an extensive listing of trading partners including Availity and Change Healthcare.

The PHP Member Id is sent in the 835 transaction.

Timely Filing

All claims must be submitted to Partners Health Plan within the timeframes specified by your provider contract. Claims submitted beyond the contractual timeframe will be denied for timely filing.

Non-participating providers must submit claims within 365 days/1 year from the date of service in accordance with New York State regulations.

Calendar Year

Multiple calendar years cannot be billed on a single claim form (i.e. Date of Service 12/26/16 and 1/4/17). Claims submitted spanning calendar years will be denied as follows:

EOB Code = BY	***The claim spans two calendar years. Please resubmit one claim per calendar year.***

Prompt Payment

In accordance with New York State Law:

- All clean claims submitted electronically will be processed for payment within 30 days.
- All clean paper or facsimile claims will be processed for payment within 45 days.
- All claims requesting additional information or being denied will be processed within 30 days.

Provider Billing Address

The billing address submitted on your claim does not drive updates or changes to provider records used in the processing of claims. Any payment address changes must be received by Provider Relations in writing. Please send payment address changes to phpproviders@healthsmart.com .

Delegated providers should provide address changes in the delegated file provided each month.

Balance Billing

Partners Health Plan's reimbursement for covered services provided to eligible participants is considered payment in full. Providers **MAY NOT** balance bill PHP's participants for the difference between the claim reimbursement and their charges.

Place of Service Values

For the specific place of service values to be utilized on a CMS-1500 claim form in Box 24B refer to https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

ICD10

All claims must be submitted with a valid ICD10 diagnosis. Please be sure to include all relevant diagnosis codes on your claim submission. Claims submitted with an invalid diagnosis will be denied as follows:

EOB Code = ZD	***Missing/incomplete/invalid diagnosis or condition. Please resubmit with a valid diagnosis code for further consideration of this claim.***

Units

Only whole units should be billed on your claim submission. Partial units are not accepted for processing (i.e., 0.5).

Admit Type

All Institutional claims must be submitted with a valid Admit Type (FL14). Please refer to the following of valid Admit Types:

1=Emergency	*4=Newborn*
2=Urgent	*5=Trauma*
3=Elective	*9=Information not available*

Admit Source

All Institutional claims must be submitted with a valid Admit Source (FL15). Please refer to the following of valid Admit Types:

1=Non-Health Facility Point of Origin	*8=Court/Law Enforcement*
2=Clinic	*9=Information not available*
4=Transfer from a Hospital	*A=Transfer from a Rural Primary Care Hospital*
5=Transfer from a SNF or ICF	*D=Transfer from one unit to another within same hospital requiring a separate claim to payer*
6=Transfer from another Health Care Facility	*E=Transfer from Ambulatory Surgery Center*
7=Emergency Room	

Bill Type

All Institutional claims must be submitted with a valid Bill Type (FL4). Claims submitted with an invalid Bill Type will be denied as follows:

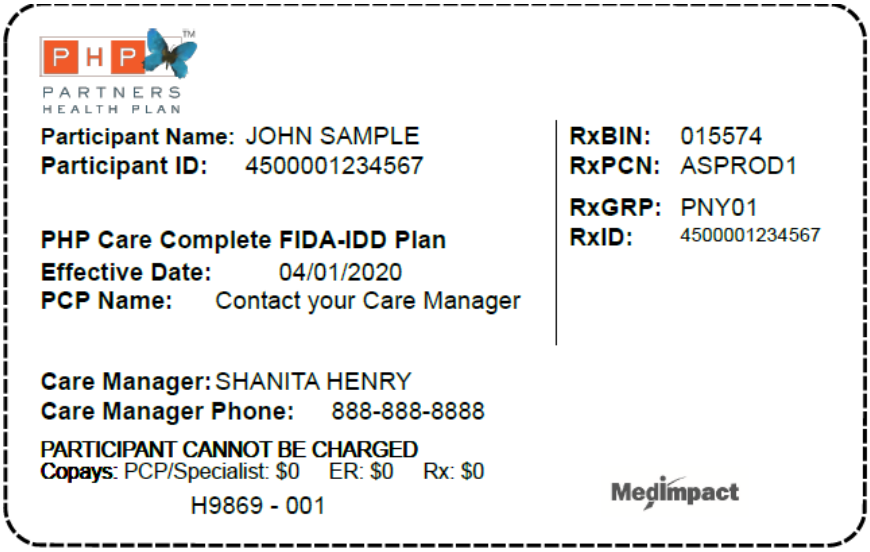
EOB Code = LI	***Claim/Service lacks information or has submission/billing error(s) which is needed for adjudication***

**Please refer to the Partners Health Plan website www.phpcares.org for additional Claims Processing and Encounter Reporting Guidelines referenced in Section 23 of the Provider Manual.*

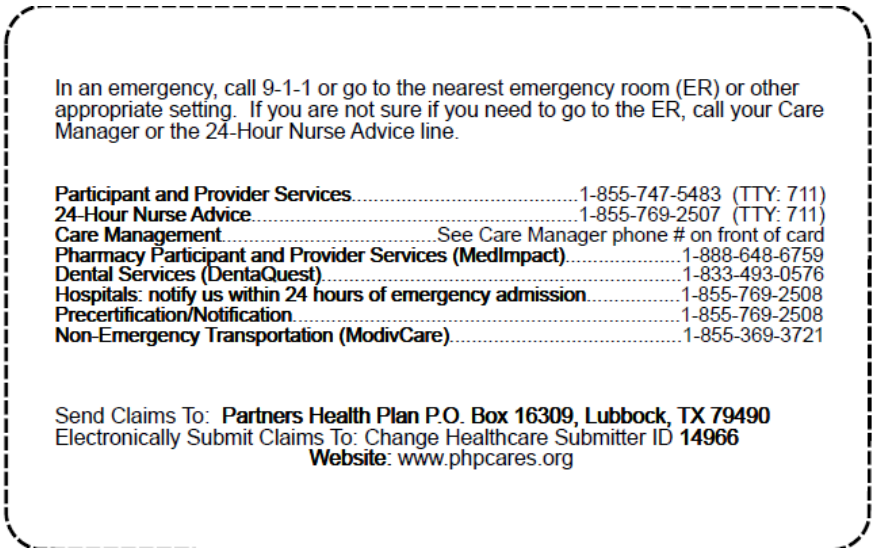
Member ID Card

The particpant's ID is a 13-digit value begining with 450000xxxxxx

Front



Back



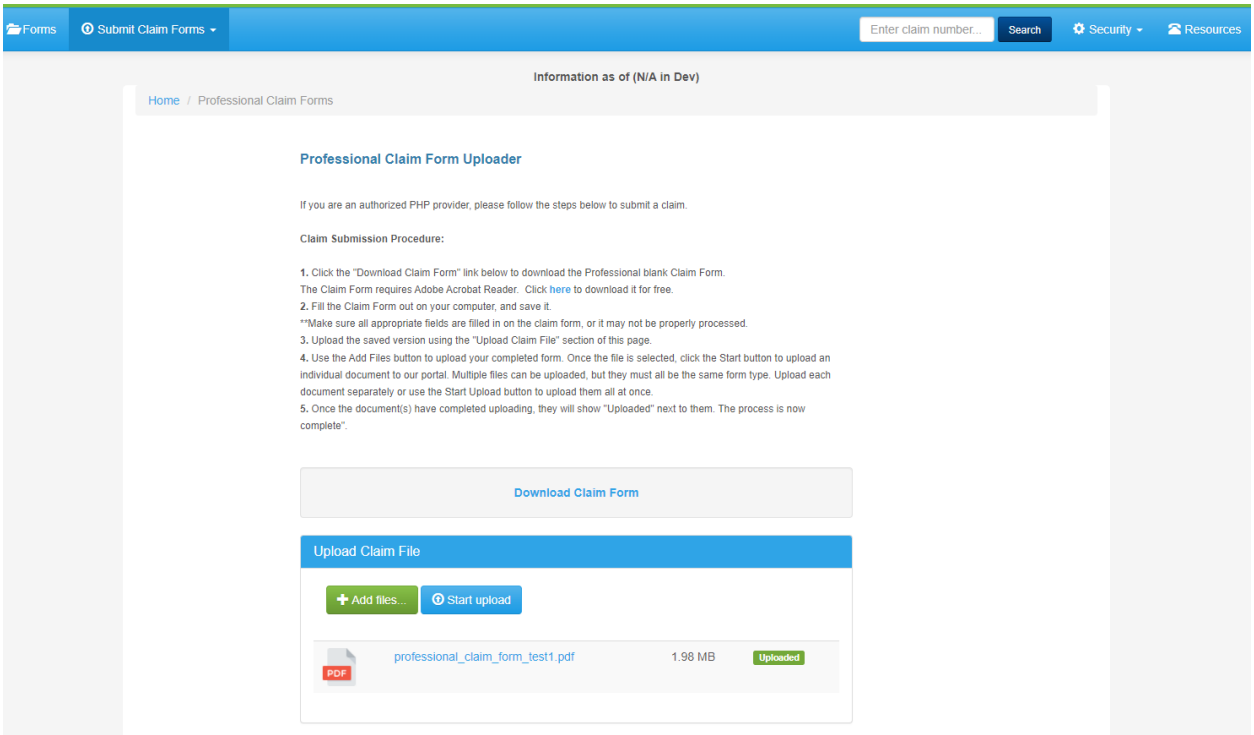
HealthSmart PHP myTPA Provider Portal Claim Form Submission

The HealthSmart PHP myTPA Provider Portal contains a new feature that allows providers with an existing PHP myTPA Portal account to download, fill-out, and submit Professional and Institutional PDF claim forms. Any claim form submitted will be reviewed and verified for required data elements and submitted to the claim workflow process.

Web-based claims are considered paper claims and will follow all existing claim submission protocols. Claims are retrieved from the portal on the day of submission but in some cases it takes 2-3 days before they are in our core processing system because they go through a series of validation checks prior to loading to our system.

The image below depicts the process for a Professional claim form, but the process is identical for an Institutional claim form. In the image, the process has been completed as described in the instructional text and the completed PDF form has been uploaded to the portal.

To gain access to this process, login to an existing provider account or register for a new account at https://php.healthsmart.com, and use the top menu option labeled “Submit Claim Forms” as shown in the image below.



General Billing Guidelines

Claims are processed on business days and are scheduled to be paid in accordance with New York State Insurance Law §3224-a. A "Clean Claim" is a claim that contains all of the data elements required by Partners Health Plan to process and adjudicate the claim including, but not limited to, all the data elements contained on a CMS-1500 form and UB-04 form. A clean claim can be processed without obtaining any additional information from the provider who rendered the service.

The following data elements are required for a claim to be considered a clean claim:

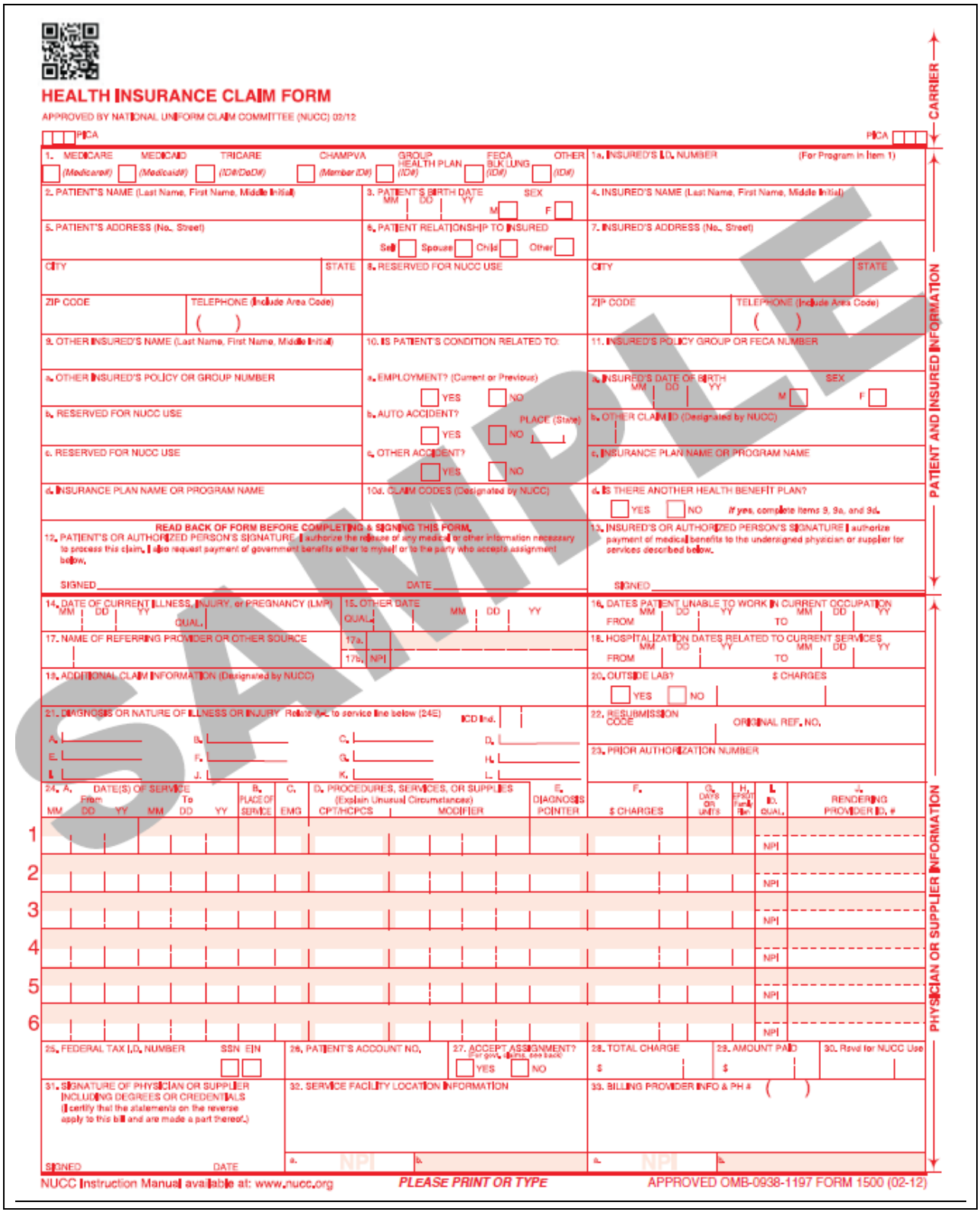
*Please note that additional fields/data may be required in addition to the below dependent upon the type of service being billed.

X = Required S = Situational

Data Element	CMS-1500	Field Locator	UB-04	Field Locator
Patient Name	X	FL2	X	FL8b
Patient Date of Birth	X	FL3	X	FL10
Patient Sex	X	FL3	X	FL11
Member Name/Address	X	FL5	X	FL9
PHP Member ID Number	X	FL1a	X	FL8a, FL60
COB/Other Insured's Information (if applicable)	X	FL9	X	FL50
Date(s) of Service	X	FL24A	X	FL45
ICD-10 Diagnosis Code(s), valid and coded to the appropriate digit	X	FL21	X	FL66
ICD-10 Procedure Code(s), if applicable			X	FL74, FL74a-e
CPT-4 Procedure Code(s)	X	FL24D	S	FL44
HCPCS Code(s)	X	FL24D	S	FL44
Place of Service	X	FL24B		
Service Units	X	FL24G	X	FL46
Charges per Service	X	FL24F	X	
Total Charges	X	FL28	X	FL47
Billing Provider Name	X	FL33		
Billing Provider Address/Phone Number	X	FL33		
Service Facility Location Information	X	FL32		
National Provider Identifier (NPI)	X	FL33a	X	FL56
Tax ID Number	X	FL25	X	FL5
Hospital/Facility Name and Address			X	FL1
Pay to Address (if different than in FL1)			S	FL2

Type of Bill			X	FL4
Statement From/Through Date			X	FL6
Admission Date and Type			X	FL12, FL14
Patient Discharge Status Code			X	FL17
Condition Code(s), if applicable			X	FL18-28
Occurrence Codes and Dates, if applicable			X	FL31-34
Value Code(s) and Value Amount(s), if applicable			X	FL39-41
Revenue Code(s) & corresponding CPT/HCPCS Codes (outpatient services)			X	FL42, FL44
Principal Diagnosis, if applicable			X	FL67
Admitting Diagnosis, if applicable			X	FL68
Other ICD-10 Diagnosis Codes			X	FL67a
Attending Physician Name and NPI			X	FL76

Sample CMS 1500 Professional Claim Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

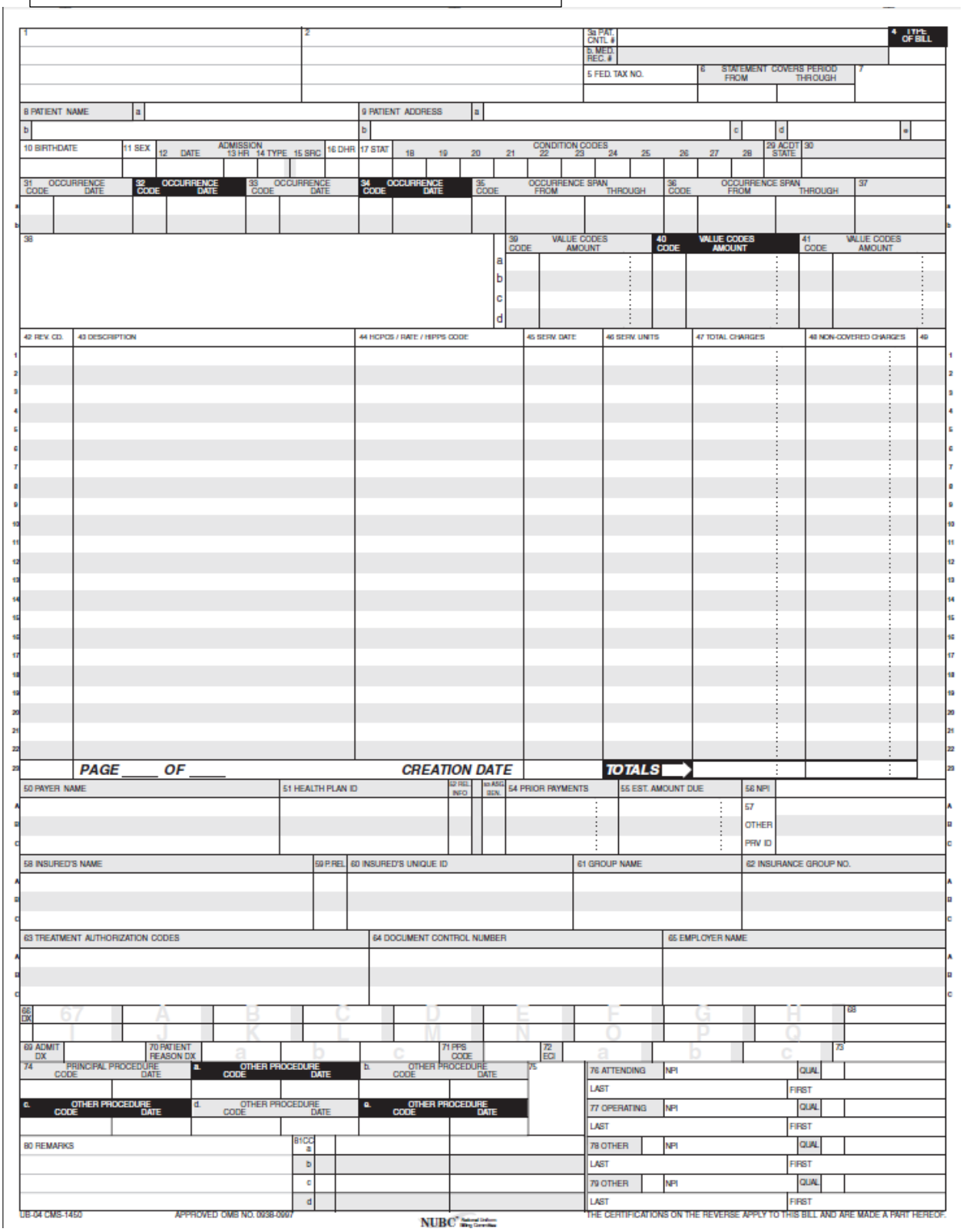
SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample UB-04 Institutional Claim Form (CMS 1450)



CMS-1500 Claim Form Crosswalk to 837P EDI Layout

CMS-1500 Item #	Description	ANSI 837 v5010 Loop, Segment, Element
1a	Medicare Number	Loop 2010BA, NM1/IL, 09
2	Patient Last Name	2010BA, NM1/IL, 03
	Patient First Name	2010BA, NM1/IL, 04
3	Patient Birth Date	2010BA, DMG, 02
	Patient Sex	2010BA, DMG, 03
4	Insured Last Name	2330A, NM1/IL, 03
	Insured First Name	2330A, NM1/IL, 04
5	Patient Street Address	2010BA, N3, 01
	Patient City and State	2010BA, N4, 01 (City) 2010BA, N4, 02 (State)
	Patient ZIP Code and Phone Number	2010BA, N4, 03 (Zip Code) Phone Number not available in format
6	Patient Relationship to Insured	2000B, SBR, 02
7	Insured's Address and Phone Number	Not Used – Use only if Insured is Different than Patient
8	Patient Status	Not Used
	Patient Student Status	Not Used
	Patient Employment Status	Not Used
9	Other Insured Last Name	2330A, NM1/IL, 03
	Other Insured First Name	2330A, NM1/IL, 04
	Other Insured Middle Initial	2330A, NM1/IL, 05
9a	Other Insurance Policy or Group #	2330A, NM1/IL, 09
9b	Other Insurance Date of Birth	Not available in format
9c	Employer Name or School Name	2330B, NM1/PR, 03
9d	Insurance Plan Name or Program	2330B, NM1/PR, 09
10a,b,c	Is Patient's Condition Related To: Employment, Auto Accident, Other Accident	2300, CLM, 11
11 MSP Claims	Insured Group or Policy Number (This item must be completed for paper claims.)	Note: There is no direct match for Blocks 11 - 11D of the CMS-1500 Claim Form to the ANSI 837 v5010 format.
	Claim Filing Indicator	See note in 11
	Insurance Type Code	See note in 11
11a	Insured Date of Birth	See note in 11
11b	Employer Name or School Name	See note in 11

11c	Other Insured Group Name	See note in 11
11d	Is there another Health Benefit Plan? (Leave blank. Not required by Medicare.)	See note in 11
12	Patient Signature	2300, CLM, 10 (Patient Signature Source Code)
	Release of Information Indicator	2300, CLM, 09
14	Accident Date	2300, DTP/439, 03
	Initial Treatment Date	2300 or 2400, DTP/454, 03
15	Same/Similar Symptom Indicator	Not used
	Onset of Similar Symptoms or Illness	Not used
16	Dates patient was unable to work in current occupation	2300, DTP/360/361/or 314, 03
17	Onset of current illness or injury	2300 or 2400, DTP/431, 03
	Referring Provider Last Name	2310A or 2420F, NM1/DN, 03
	Referring Provider First Name	2310A or 2420F, NM1/DN, 04
	Ordering Provider Last Name	2420E, NM1/DK, 03
	Ordering Provider First Name	2420E, NM1/DK, 04
17a	Ordering Provider Secondary Identifier, no longer reported	Not Used
	Referring Provider Secondary Identifier, no longer reported	Not Used
17b	Ordering Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2420E, NM1/DK, 09
	Referring Provider National Provider Identifier (NPI) (17B MUST be reported when a service was ordered or referred by a physician.)	2310A or 2420F, NM1/DN, 09
19	Ordering Provider Primary Identifier (SSN or EIN)	Not Available in Format
	Referring Provider Primary Identifier (SSN or EIN)	Not Available in Format
	Referring Provider Secondary Identifier (NPI)	Not Used
	Narrative	2300, or 2400, NTE, 02
	Date Last Seen and X-ray	2300 or 2400, DTP/304, 03
	Supervising NPI	2310D or 2420D, NMI/DQ, 09
	Anesthesia Minutes	2400, SV1, 04 (03=MJ)
	Homebound Indicator	2300, CRC/75, 03
	Hospice Employed Provider Indicator	2400, CRC/70, 02
	Assumed & Relinquished Care Dates	2300, DTP/90 or 91, 03
20	Purchased Service Charges	2400, PS1, 02
21	Diagnosis 1	2300, HI, 01-2
	Diagnosis 2	2300, HI, 02-2
	Diagnosis 3	2300, HI, 03-2
	Diagnosis 4	2300, HI, 04-2

	Diagnosis 5	2300, HI, 05-2
	Diagnosis 6	2300, HI, 06-2
	Diagnosis 7	2300, HI, 07-2
	Diagnosis 8	2300, HI, 08-2
	Diagnosis 9	2300, HI, 09-2
	Diagnosis 10	2300, HI, 10-2
	Diagnosis 11	2300, HI, 11-2
	Diagnosis 12	2300, HI, 12-2
23	CLIA Number	2300 or 2400, REF/X4, 02
	Prior Authorization Number	2300 or 2400, REF/G1, 02
	Care Plan Oversight Services: HHA or Hospice NPI (Enter the NPI of the home health agency (HHA) or hospice when HCPCS code G0181 (HH) or G0182 (Hospice) is submitted.)	2300/REF/1J/02
24a	Dates of Service (From Dates)	2400, DTP/472, 03
	Dates of Service (To Dates)	2400, DTP/472, 03
24b	Place of Service	2300, CLM, 05 or 2400, SV1, 05
24d	Procedure Code	2400, SV1, 01-2
24e	Diagnosis Pointer	2400, SV1, 07-1
24f	Charges	2400, SV1, 02
24g	Days or Units of Service	2400, SV1, 04 (03=UN)
	Anesthesia Minutes	2400, SV1, 04 (03=MJ)
24h	Leave blank. Not required by Medicare.	Leave blank. Not required by Medicare.
24i	Legacy Qualifier Rendering Provider: (No longer reported.)	Not used
24j	Rendering Provider Legacy Number (shaded area) (No longer reported.)	Not used
	NPI of rendering provider (unshaded area)	2310B or 2420A, NM1/82, 09 (08=XX)
25	Provider SSN# or EIN#	2010AA , REF, 02 (REF01=EI or SY)
26	Patient's Account Number	2300, CLM, 01
27	Accept Assignment	2300, CLM, 07
28	Total Charges	2300, CLM, 02
29	Amount Paid	2300, AMT/F5, 02
30	Balance Due	Not Used
31	Provider Signature Indicator	2300, CLM, 06
32	Facility Lab Name	2310C, NM1/77, 03
	Facility Lab NPI	2310C, NMI/77, 09
	Place of Service Address	2310C, N3, 01

	Place of Service City	2310C, N4, 01
	Place of Service State	2310C, N4, 02
	Place of Service Zip Code	2310C, N4, 03
	Lab ID (Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.)	2400, PS1, 01
	Mammography Certification Number	2300 or 2400, REF/EW, 02
32a	Facility NPI Number	2310C, NM1/77, 09
32b	Facility Qualifier and Legacy	Not used
33	Organization Name	2010AA, NM1/85, 03
	Provider’s Last Name	2010AA, NM1/85, 03
	Provider’s First Name	2010AA, NM1/85, 04
	Address	2010AA, N3, 01
	City	2010AA, N4, 01
	State	2010AA, N4, 02
	Zip Code	2010AA, N4, 03
33a	Billing Provider NPI	2010AA/NM1/85/09 (08 = XX)

UB-04 Claim Form Crosswalk to 837I EDI Layout

Form Locator #	Description	ASC 837I v5010A2 Loop, Segment
1	Billing Provider, Name, Address and Telephone Number	Loop 2010AA, NM1/85/03, N3 segment, N4 segment
2	Pay-to-Name and Address (required when different from form locator 01)	Loop 2010AB, NM1/77/03, N3 segment, N4 segment
03a	Patient Control Number*	Loop 2300, CLM01
03b	Medical Record Number	Loop 2300, REF/EA/02
4	Type of Bill	Loop 2300, CLM05-1, CLM05-3
5	Federal Tax ID Pay-to-provider = to the Billing Provider Pay-to-provider not = to the Billing PROV	Loop 2010AA, NM109, REF/EI/02 Loop 2010AB, NM109, REF/EI/02
6	Statement Covers Period (MMDDYY)	Loop 2300, DTP/434/03
7	Reserved for future use	
08a	Patient Name When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, NM1/IL/03, 04, 05, 07 Loop 2010CA, NM1/QC/03, 04, 05, 07
08b	Patient Identifier When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, NM1/IL/09 Loop 2010CA, NM1/QC/09
09a-e	Patient Address When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, N301, N401,02,03,04 Loop 2010CA, N301, N401,02,03,04
10	Patient Birth Date When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, DMG02 Loop 2010CA, DMG02
11	Patient's sex When patient = Subscriber When patient is not = Subscriber	Loop 2010BA, DMG02 Loop 2010CA, DMG02
12	Admission/Start of Care Date	Loop 2300, DTP/435/03
13	Admission Hour	Loop 2300, DTP/435/03
14	Priority (Type) of Visit	Loop 2300, CL101
15	Source of Admission	Loop 2300, CL102
16	Discharge Hour	Loop 2300, DTP/096/03
17	Institutional Claim Code	Loop 2300, CL103

18-28	Condition Codes	Loop 2300, HI01-2 (HI01-1=BG) Loop 2300, HI02-2 (HI02-1=BG) Loop 2300, HI03-2 (HI03-1=BG) Loop 2300, HI04-2 (HI04-1=BG) Loop 2300, HI05-2 (HI05-1=BG) Loop 2300, HI06-2 (HI06-1=BG) Loop 2300, HI07-2 (HI07-1=BG)
29	Auto State	Loop 2300, CLM11-4
30	Reserved for future use	
31-34	Occurrence Code/Date	Loop 2300, HI01-2 (HI01-1= BH) HI01-4 Loop 2300, HI02-2 (HI02-1= BH) HI02-4 Loop 2300, HI03-2 (HI03-1= BH) HI03-4 Loop 2300, HI04-2 (HI04-1= BH) HI04-4 Loop 2300, HI05-2 (HI05-1= BH) HI05-4 Loop 2300, HI06-2 (HI06-2= BH) HI06-4 Loop 2300, HI07-2 (HI07-1= BH) HI07-4 Loop 2300, HI08-2 (HI08-1= BH) HI08-4
35-36	Occurrence Span Code/Date	Loop 2300, HI01-2 (HI01-1=BI) HI01-4 Loop 2300, HI02-2 (HI02-1= BI) HI02-4 Loop 2300, HI03-2 (HI03-1= BI) HI03-4 Loop 2300, HI04-2 (HI04-1= BI) HI04-4
37	Reserved for future use	
38	Responsible Party	Not required by Medicare
39-41	Value Code/Amount	Loop 2300, HI01-2 (HI01-1= BE) HI01-5 Loop 2300, HI02-2 (HI02-1= BE) HI02-5 Loop 2300, HI03-2 (HI03-1= BE) HI03-5 Loop 2300, HI04-2 (HI04-1= BE) HI04-5 Loop 2300, HI05-2 (HI05-1= BE) HI05-5 Loop 2300, HI06-2 (HI06-1= BE) HI06-5 Loop 2300, HI07-2 (HI07-1= BE) HI07-5 Loop 2300, HI08-2 (HI08-1= BE) HI08-5 Loop 2300, HI09-2 (HI09-1= BE) HI09-5 Loop 2300, HI10-2 (HI10-1= BE) HI10-5 Loop 2300, HI11-2 (HI11-1= BE) HI11-5 Loop 2300, HI12-2 (HI12-1= BE) HI12-5
42	Revenue Code	Loop 2400, SV201
43	Revenue Description	Not Required by Medicare
44	HCPCS/Rate/HIPPS Code	Loop 2400, SV202-2 (SV202-1=HC/HP)
45	Service Date	Loop 2400, DTP/472/03
46	Service/Units	Loop 2400, SV205
47	Total Charges	Loop 2400, SV203
48	Nov-Covered Charges	Loop 2400, SV207
49	Save for Future Use	Not required by Medicare
50a-c	Name Last or Organization Name Other Payer Last or Organization Name	Not Required for 5010 Loop 2330B, NM1/PR/03

51	Identification Code Other Payer Primary Identifier	Not Required for 5010 Loop 2330B, NM1/PR/09
52	Release of Information	Loop 2300, CLM07
53	Assignment of Benefits Certification	Loop 2300, CLM08
54	Prior Payment Amounts	Loop 2320, AMT/D/02
55a-c	Estimated Amount Due	Loop 2300, AMT/EAF/02
56	National Provider Identifier (NPI)	Loop 2010AA, NM1/85/09
57a-c	Billing Provider Tax ID	Loop 2010AA, REF/EI/02
58a-c	Insured's Name Other Insured's Name	Loop 2010BA, NM1/IL/03, 04, 05 Loop 2330A, NM1/IL/03, 04, 05
59a-c	Patient Relationship	Loop 2000B, SBR02
60a-c	Subscriber Identification Code	Loop 2010BA, NM1/IL/09, REF/SY/02
61	Group Name	Loop 2000B,SBR04
62	Insurance Group No.	Loop 2000B,SBR03
63	Treatment Authorization Codes	Loop 2300,REF/G1/02
64	Document Control Number	Loop 2300,REF/F8/02
65	Employer Name	Loop 2320
66	Dx & Procedure Code Qualifier	Not Required by Medicare
67a-q	Diagnosis	Loop 2300, HI01-2 (HI01-1=BK)
68	Reserved for future use	
69	Admitting Dx	Loop 2300, HI02-2 (HI02-1=BJ)
70a-c	Patient Reason for Visit	Loop 2300, HI02-2 (HI02-1=PR)
71	Diagnosis Related Group (DRG) Code	Loop 2300, HI01-2 (HI01-1=DR)
72a-c	External Cause of Injury Code	Loop 2300, HI03-2 (HI03-1= BN)
73	Reserved for future use	
74	Principal Procedure Code Principal Procedure Date	Loop 2300, HI01-2 (HI01-1= BR) Loop 2300, HI01-4 (HI01-1=BR)
74a-e	Other Procedure Information	Loop 2300, HI01-2 (HI01-1=BQ) Loop 2300, HI01-4 (HI01-1=BQ) Loop 2300, HI02-2 (HI02-1=BQ) Loop 2300, HI02-4 (HI02-1=BQ) Loop 2300, HI03-2 (HI03-1=BQ) Loop 2300, HI03-4 (HI03-1=BQ) Loop 2300, HI04-2 (HI04-1=BQ) Loop 2300, HI04-4 (HI04-1=BQ) Loop 2300, HI05-2 (HI05-1=BQ) Loop 2300, HI05-4 (HI05-1=BQ)
75	Reserved for future use	

76	Attending Provider Name	Loop 2310A, NM1/71/09
	Attending Provider Secondary ID	Loop 2310A, REF02 (REF01= 0B/1G/G2/or LU
	Attending Provider Last Name	Loop 2310A, NM1/71/03
	Attending Provider First Name	Loop 2310A, NM1/71/04
77	Operating Physician Name	Loop 2310B, NM1/72/09
	Operating Physician Secondary ID	Loop 2310B, REF02 (REF01= 0B/1G/G2/or LU
	Operating Physician Last Name	Loop 2310B, NM1/72/03
	Operating Physician First Name	Loop 2310B, NM1/72/04
78	Other Operating Physician Name	Loop 2310C, NM1/ZZ/09
	Other Operating Physician Secondary ID	Loop 2310C, REF02 (REF01= 0B/1G/G2/or LU
	Other Operating Physician Last Name	Loop 2310C, NM1/ZZ/03
	Other Operating Physician First Name	Loop 2310C, NM1/ZZ/04
79	Not Crosswalked	
80	Claim Note Claim Note Text	Loop 2300, NTE/ADD/01 Loop 2300, NTE02 (NTE01=ADD)

*Note: Only the 1st 15 characters of the Patient Control # will be utilized within the claim processing system and reflected on the Explanation of Benefits in the Patient # field.

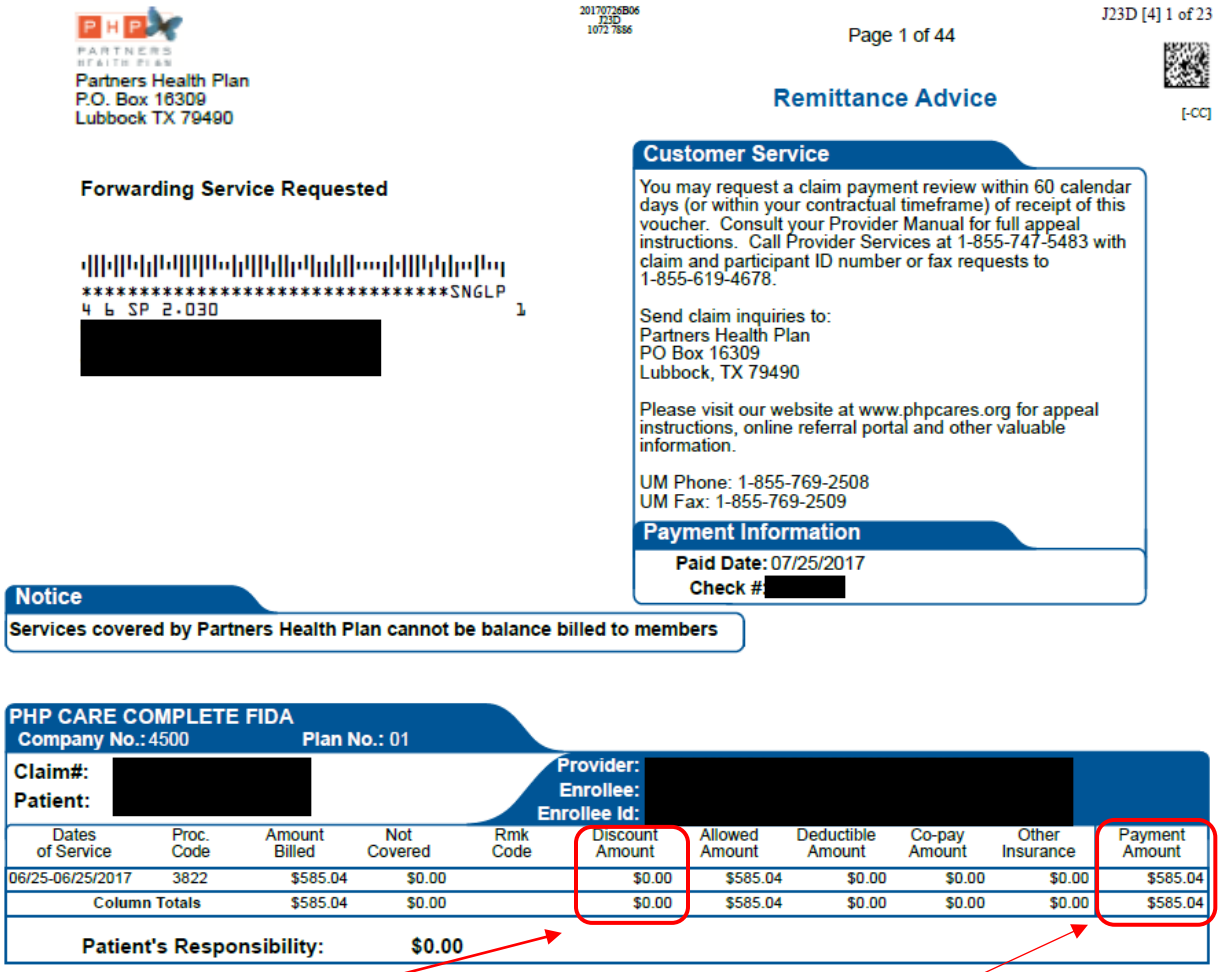
Patient Control Number

The Patient Control Number in FL3A is an internal identifier utilized by many providers. If you submit an internal reference number in this field it will be referenced on the Explanation of Benefits you receive with your claim payment.

Units

Claims must be billed in whole units.

Explanation of Benefits Example



Partners Health Plan
P.O. Box 16309
Lubbock TX 79490

20170726B06 J23D 1072 7886

Page 1 of 44

J23D [4] 1 of 23

[-CC]

Remittance Advice

Forwarding Service Requested

**********SNGLP
4 6 SP 2.030 1
[redacted]

Customer Service

You may request a claim payment review within 60 calendar days (or within your contractual timeframe) of receipt of this voucher. Consult your Provider Manual for full appeal instructions. Call Provider Services at 1-855-747-5483 with claim and participant ID number or fax requests to 1-855-619-4678.

Send claim inquiries to:
Partners Health Plan
PO Box 16309
Lubbock, TX 79490

Please visit our website at www.phpcares.org for appeal instructions, online referral portal and other valuable information.

UM Phone: 1-855-769-2508
UM Fax: 1-855-769-2509

Payment Information

Paid Date: 07/25/2017
Check # [redacted]

Notice

Services covered by Partners Health Plan cannot be balance billed to members

PHP CARE COMPLETE FIDA
Company No.: 4500 **Plan No.:** 01

Claim#: [redacted]
Patient:

Provider: [redacted]
Enrollee:
Enrollee Id:

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Other Insurance	Payment Amount
06/25-06/25/2017	3822	$585.04	$0.00		$0.00	$585.04	$0.00	$0.00	$0.00	$585.04
Column Totals		$585.04	$0.00		$0.00	$585.04	$0.00	$0.00	$0.00	$585.04

Patient's Responsibility: $0.00

*The ***Discount Amount*** reflects the difference between the ***Amount Billed*** and the ***Payment Amount***.

If you are a PHP in-network provider, the ***Payment Amount* will be based on your contract. If you are an out-of-network provider, your payment amount will be based on the Medicare or Medicaid fee-for-service equivalent based on the type of service provided unless negotiated otherwise.

Claim Appeal Guidelines

A claim payment review may be requested within 60 calendar days (or within your contractual timeframe) of receipt of the Explanation of Payment (EOP).

Full appeal instructions are available for review in the Provider Manual or visit our website at www.phpcares.org .

To request a claim payment review or for a general claim inquiry please submit inquiry to:

Partners Health Plan
PO Box 16309
Lubbock, TX 79490

For additional questions or assistance contact Provider Services at 1-855-747-5483 with claim and participant ID number.

Office for People with Developmental Disabilities (OPWDD) Services

Claim Form

All claims for OPWDD Services should be submitted on the UB-04 claim form or in the 837I EDI format.

*If claims for OPWDD Services are submitted on a CMS-1500 professional form they will be denied with the EOB message ***CLA*** – *INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.* (RARC = N34)

Rate Codes

Refer to the following link for the listing of OPWDD Rate Codes:
https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/info/docs/2018-02-01_rate_code_list.pdf ****subject to change if the NYSDOH*** revises (as of 2/1/18)

The Rate Code is to be entered in the Value Amount field with a Value Code of 24 (FL39-FL41).

Revenue Code

Revenue Code 0240 (All Inclusive Ancillary) should be utilized. It should be entered in FL42 on the UB-04.

Diagnosis Code

ICD-10 Diagnosis Code R69 (illness, unspecified) may be utilized as a default in the absence of a more specific diagnosis.

Bill Type

Bill Type 891 may be utilized for the submission of OPWDD Services with exception of claims submitted with Rate Codes 1537, 1546, and 1549. The 3rd digit of the bill type is the claim frequency code and should be submitted as applicable to the claims submission (1 = Original, 3 = Interim, 7 = Correction, 8 = Void).

Admit Date

The Admit Date in FL12 should be the start date of the episode of care being billed on the claim form. It should be equal to the first date of service on the claim being billed.

Statement From and Through Dates

All dates must be entered in the format MMDDYYYY.

Statement From and Through Dates are to be entered in FL6 using the following guidelines:

1) *Monthly: If billing for monthly rates (i.e., rate code 4709), only one date of service can be billed per claim form. Enter the last day of the month being billed (i.e., billing for month of June then enter 06302016) as the date of service on the line level. The Statement From and Statement Through date should represent the range of dates in the month (i.e., billing for month of June then enter as 06012016 – 06302016).

2) **Daily: If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016….06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

3) ***Hourly: If the rate code allows multiple units of service (hours, hour fractions, etc.) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Locator Codes

Claims for members that have been approved as highly complex/specialized will require manual pricing to be paid to the enhanced rates.

The claim should be submitted with the appropriate locator code and value code 61 in FL39-41.

Retroactive Rate Updates *****PARTICIPATING PROVIDERS ONLY***

Please complete the following form and email to rateupdates@phpcares.org

FACILITY NAME:
TAX ID:
AS OF:

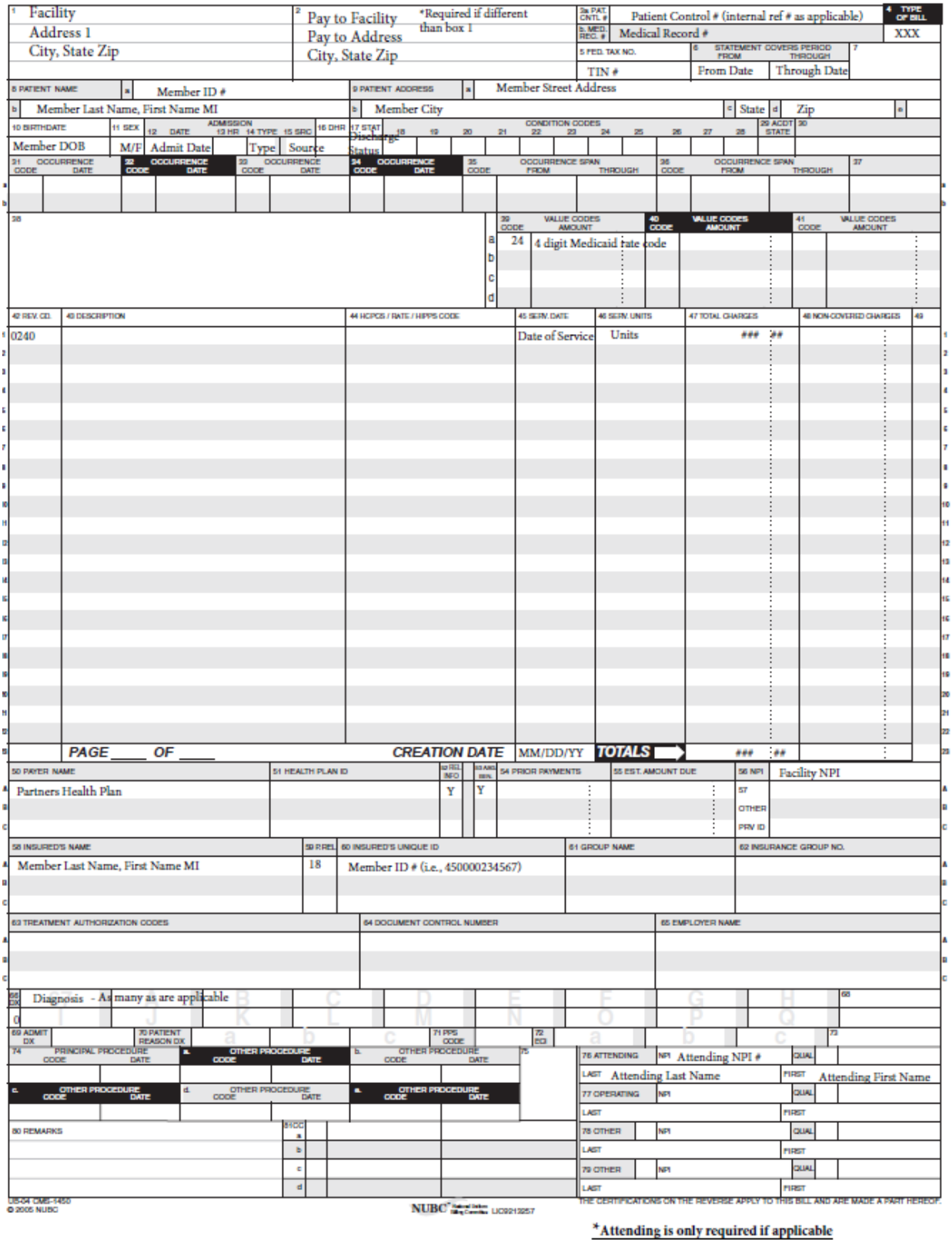
	Current Effective Rate 4/1/2017-6/30/2017	Medicaid Rate Code	Locator code
ICF		3822	003
Group DH Full Day Highly Complex FEE ICF		4104	029
Day Hab Services (ICF) Full Day		4104	027
Group DH Half Day Highly Complex FEE ICF		4105	029
Day Hab Services (ICF) Half Day		4105	027
In House Day Services Full ICF		4108	065
SUPV IRA		4437,4438,4439	005
SUPV IRA Specialized (Template) FEE		4437,4438,4439	006
SUPV IRA Highly Complex FEE		4437,4438,4439	007
SUPV IRA SNF Transfer (or Auspice Change) FEE		4437,4438,4439	008
Group DH Full Day Specialized (Template) FEE		4453	019
Group DH Full Day Highly Complex FEE IRA		4453	021
Group DH Half Day		4454	003
Group DH Half Day Specialized (Template) FEE		4454	019
Group DH Half Day Highly Complex FEE IRA		4454	021
Supp DH Full Day (Saturday)		4455	005
Supp DH Half Day (Saturday)		4456	005
Pre Voc Full		4464	004
Pre Voc Half		4465	004
SUPT IRA (Monthly)		4709	003
SUPT IRA (1st half Monthly)		4710	003
SUPT IRA (2nd half Monthly)		4711	003
Community Habilitation FEE (Qtr Hr) individual		4722	009
Community Habilitation FEE (Qtr Hr) group 2		4723	009
Community Habilitation FEE (Qtr Hr) goup 3		4724	009
SEMP Phase 1- INDIVIDUAL (Qtr Hr)		4759	037
SEMP Phase 1- GROUP (Qtr Hr)		4760	037
SEMP via FI Phase 2 - GROUP (Qtr Hr)		4772	
Respite (Qtr Hr)		4774	072
Prevoc Community GROUP of 3+ (Qtr Hr)		4783	67
SEMP Intensive- INDIVIDUAL (Qrtr Hr)		4790	058
SEMP Intensive- GROUP (Qtr Hr)		4791	058
SEMP Phase 2- INDIVIDUAL (Qtr Hr)		4792	058
Community Habilitation FEE (Qtr Hr) group 2		4793	063
SEMP Phase 2- GROUP (Qrtr Hr)		4793	058
Community Habilitation / IRA FEE (Qtr Hr)		4796	063

****Non-Participating Providers are NOT to utilize this form.**

Rate changes/updates are loaded to our system within 30 days of being publicly posted.

PHP does not retroactively adjust rates for Non-Participating Providers.

OPWDD Service Claim Layout Example



*Attending is only required if applicable

Day Habilitation Services

Rate Codes:

The following rate codes should be utilized when submitting a claim for Day Habilitation Services:

Rate Code	***Description***
4453	Group DH Full Day
4454	Group DH Half Day
4455	Supplemental Group DH Full Day
4456	Supplemental Group DH Half Day

*Only one Rate code may be submitted per claim

Claim Form:

Day Habilitation Services should be billed on a UB-04 claim form or in the 837I format.

Dates of Services:

Report the span of dates of service being reported in the Statement From/Through Dates.

Each individual date of service is to be submitted on an individual claim line.

Locator Codes:

Claims for members that have been approved as highly complex/specialized will require manual pricing to be paid to the enhanced rates.

The claim should be submitted with the appropriate locator code and value code 61 in FL39-41.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Day Habilitation Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP	2 FACILITY PAY TO ADDRESS CITY, STATE ZIP	3a PAT. CNTL # PATIENT CONTROL # b. MED. REC. # MEDICAL RECORD #		4 TYPE OF BILL 891
		5 FED. TAX NO. 123456789	6 STATEMENT COVERS PERIOD FROM 012317	THROUGH 012317

8 PATIENT NAME a 4500000999999	9 PATIENT ADDRESS a 123 MAIN STREET
b SMITH, MARY	b ANYWHERE c NY d 11999 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
010147	F	012317		3	9		30			

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	24	4453 00	61	3 00		
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			012317	1.0	250 00		
	PAGE ___ OF ___	CREATION DATE		TOTALS	250 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
PARTNERS HEALTH PLAN		Y	Y			1234567890

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX R69 | 67 | 68

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI 1234567890	QUAL		
LAST ATTENDING LAST	FIRST FIRST			
77 OPERATING	NPI	QUAL		
LAST	FIRST			
78 OTHER	NPI	QUAL		
LAST	FIRST			
79 OTHER	NPI	QUAL		
LAST	FIRST			

80 REMARKS | 81CC a b c d

Supervised IRA

Rate Codes:

The following rate codes should be utilized when submitting a claim for Supervised IRA Services:

Rate Code	***Description***
4437	IRA Supvd; Per Diem
4438	IRA Supvd; Med Leave; Per Diem
4439	IRA Supvd; Non-Med Leave; Per Diem

*Only one Rate code may be submitted per claim

Claim Form:

Supervised IRA Services should be billed on a UB-04 claim form or in the 837I format.

Dates of Services:

Report the span of dates of service being reported in the Statement From/Through Dates.

Each individual date of service is to be submitted on an individual claim line.

Bed Hold:

Medical Leave Prior to 7/1/19:

If a participant leaves the facility for a medical leave and the facility holds the bed, submit rate code 4438. There is a 14-day limitation which is referred to as retainer days. The 14-day limitation is applied per person per rate year.

The claim for medical leave should be submitted using charges for the days for which you are expecting reimbursement. If submitting 4438 for reporting purposes only, outside of the 14-day limitation, bill zero charges.

Medical Leave 7/1/19 and forward:

Retainer day payments are based on the certified capacity operated by each individual agency. Though there is still a limit on payment for retainer days, providers will no longer be limited to 14 allowable retainer days per individual per rate year but the limit will be based upon the certified capacity. The update to the retainer day methodology does not change any claim submission process. All retainer days should continue to be submitted for processing.

Non-Medical Leave:

If a participant leaves the facility for a therapeutic leave (non-medical) and the facility holds the bed, submit rate code 4439. There is no limitation on therapeutic leave but It must be justified in the life plan (requires Partners Health Plan approval).

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Supervised IRA Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP	2 FACILITY PAY TO ADDRESS CITY, STATE ZIP	3a PAT. CNTL # PATIENT CONTROL # b. MED. REC. # MEDICAL RECORD #	4 TYPE OF BILL 891
		5 FED. TAX NO. 123456789	6 STATEMENT COVERS PERIOD FROM 020417 THROUGH 020417 · 7

8 PATIENT NAME a 4500000999999	b SMITH, MARY	9 PATIENT ADDRESS a 123 MAIN STREET	b ANYWHERE	c NY	d 11999 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
010147	F	020417		3	9		30			

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	24	4439.00	61	5.00		
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			020417	1.0	250.00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
PARTNERS HEALTH PLAN		Y	Y			57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX R69 | 67 A B C D E F G H I J K L M N O P Q | 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI 1234567890	QUAL	
LAST ATTENDING LAST		FIRST FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Self-Directed Services

Direct Services:

Direct Services are agency supported self-direction in which the participant chooses the provider (agency). The provider submits their claims directly to Partners Health Plan's TPA for processing.

Indirect Services:

Indirect Services are known as self-direction via the Fiscal Intermediary (FI). The FI chooses the provider (agency) rather than the member and the FI arranges for care. The provider then bills the FI for the services and is paid by the FI. The FI then bills Partners Health Plan for both their monthly FI fee and for the reimbursement of the amount that they paid to the self-directed services provider (agency).

Rate Codes:

The following rate codes should be utilized when submitting a claim for Self-Directed Services:

Rate Code	***Description***	***Locator Code***
4787	Fiscal Intermediary; Vol; Level 1	56
4789	Fiscal Intermediary; Vol; Level 3 (PRA Amount under 60K)	56
4789	Fiscal Intermediary; Vol; Level 3 (PRA Amount over 60K)	57
4778	Support Broker; Via FI; Vol; ¼ Hr	

*Rate code 4788 (Fiscal Intermediary; Vol; Level 2) is not covered by Partners Health Plan

Claim Form:

Self-Directed Services should be submitted on a UB-04 claim form.

Rate Codes:

The Rate Code is to be entered in the Value Amount field with a Value Code of 24 (FL39-FL41).

Only one rate code may be submitted per claim.

Statement From and Through Dates:

All dates must be entered in the format MMDDYYYY.

Statement From and Statement Through date should represent the range of dates in the month (i.e., billing for month of June then enter as 06012016 – 06302016).

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Claim Submission:

Self-Directed claims may be submitted electronically or to the designated PO Box. Please refer to the section on page 2 of this document ***General Claims Submission Guidelines*** for details.

Self-Direction Inquiries:

All Self-Direction inquiries related to start up budgets, broker agreements, budget amendments, and budget approvals should be directed to the designated Self-Direction inbox at selfdirection@phpcares.org .

Self-Directed Service Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP	2 FACILITY PAY TO ADDRESS CITY, STATE ZIP	3a PAT. CNTL # PATIENT CONTROL # b. MED. REC. # MEDICAL RECORD # 5 FED. TAX NO. 123456789 6 STATEMENT COVERS PERIOD FROM 010117 THROUGH 013117 7	4 TYPE OF BILL 891

8 PATIENT NAME a 4500000999999 b SMITH, MARY	9 PATIENT ADDRESS a 123 MAIN STREET b ANYWHERE c NY d 11999 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
010147	F	020117		3	9		30			

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	24	4787.00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			013117	1.0	250.00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
PARTNERS HEALTH PLAN		Y	Y			57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX 67 R69 A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

80 REMARKS	81 CC a b c d

76 ATTENDING	NPI 1234567890	QUAL
LAST ATTENDING LAST	FIRST FIRST	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Pathways to Employment Services

Rate Code/Units:

Rate Code	Definition	Units
4444	Path to Employment; Vol; Indiv; ¼ hr	1 unit = 15 minutes
4445	Path to Employment; Vol; Group; ¼ hr	1 unit = 15 minutes

Dates of Service:

Hourly: If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Pathways to Employment Service Claim Layout Example:

Field	Value
1	FACILITY ADDRESS CITY, STATE ZIP
2	FACILITY PAY TO ADDRESS CITY, STATE ZIP
3a PAT. CNTL #	PATIENT CONTROL #
b. MED. REC. #	MEDICAL RECORD #
4 TYPE OF BILL	891
5 FED. TAX NO.	123456789
6 STATEMENT COVERS PERIOD FROM	010917
6 STATEMENT COVERS PERIOD THROUGH	010917
7	
8 PATIENT NAME a	4500000999999
8 PATIENT NAME b	SMITH, MARY
9 PATIENT ADDRESS a	123 MAIN STREET
9 PATIENT ADDRESS b	ANYWHERE
9 c	NY
9 d	11999
9 e	
10 BIRTHDATE	010147
11 SEX	F
12 ADMISSION DATE	010917
13 HR	
14 TYPE	3
15 SRC	9
16 DHR	
17 STAT	30
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE / AMOUNT a	24 / 4445.00
40 VALUE CODES CODE / AMOUNT	
41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			010917	26.0	250.00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
PARTNERS HEALTH PLAN		Y	Y			1234567890

57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

Field	Value
66 DX	R69
67, A–Q	
68	
69 ADMIT DX	
70 PATIENT REASON DX a, b, c	
71 PPS CODE	
72 ECI a, b, c	
73	
74 PRINCIPAL PROCEDURE CODE / DATE	
a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI	1234567890
76 QUAL	
76 LAST	ATTENDING LAST
76 FIRST	FIRST
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

ICF Services

Rate Code/Units:

Rate Code	Definition	Units
3822	ICF	1 unit = single date of service

Dates of Service:

Daily: If the rate code allows for only one unit of service per day (i.e., rate code 3822), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016….06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

ICF Claim Layout Example:

1 FACILITY ADDRESS CITY, STATE ZIP	2 FACILITY PAY TO ADDRESS CITY, STATE ZIP	3a PAT. CNTL # PATIENT CONTROL # b. MED. REC. # MEDICAL RECORD #	4 TYPE OF BILL 891
		5 FED. TAX NO. 123456789	6 STATEMENT COVERS PERIOD FROM 010317 THROUGH 010317

8 PATIENT NAME	a 4500000999999	9 PATIENT ADDRESS	a 123 MAIN STREET
	b SMITH, MARY		b ANYWHERE c NY d 11999

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
010147	F	010317		3	9		30			

31–34 OCCURRENCE CODE / DATE; 35–36 OCCURRENCE SPAN CODE / FROM / THROUGH; 37

38	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	24	3822 00				
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			010317	1.0	250. 00		
	PAGE ____ OF ____	***CREATION DATE***		***TOTALS***	250. 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
PARTNERS HEALTH PLAN		Y	Y			57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX R69 67 A B C D E F G H I J K L M N O P Q 68

69 ADMIT DX | 70 PATIENT REASON DX a b c | 71 PPS CODE | 72 ECI a b c | 73

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING	NPI 1234567890	QUAL
LAST ATTENDING LAST	FIRST FIRST	
77 OPERATING	NPI	QUAL
LAST	FIRST	
78 OTHER	NPI	QUAL
LAST	FIRST	
79 OTHER	NPI	QUAL
LAST	FIRST	

80 REMARKS | 81CC a b c d

ICF Day Services

Rate Code/Units:

Rate Code	Definition	Units
4104	ICF; Vol; Day Service; Full Unit	1 unit = single date of service
4105	ICF; Vol: Day Service: Half Unit	1 unit = single date of service

Dates of Service:

Daily: If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016….06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

ICF Day Service Claim Layout Example:

Field	Value
1	FACILITY ADDRESS CITY, STATE ZIP
2	FACILITY PAY TO ADDRESS CITY, STATE ZIP
3a PAT. CNTL #	PATIENT CONTROL #
b. MED. REC. #	MEDICAL RECORD #
4 TYPE OF BILL	891
5 FED. TAX NO.	123456789
6 STATEMENT COVERS PERIOD FROM	010317
6 STATEMENT COVERS PERIOD THROUGH	010317
7	
8 PATIENT NAME a	4500000999999
8 b	SMITH, MARY
9 PATIENT ADDRESS a	123 MAIN STREET
9 b	ANYWHERE
9 c	NY
9 d	11999
9 e	
10 BIRTHDATE	010147
11 SEX	F
ADMISSION 12 DATE	010317
13 HR	
14 TYPE	3
15 SRC	9
16 DHR	
17 STAT	30
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	

	39 VALUE CODES CODE	39 AMOUNT	40 VALUE CODES CODE	40 AMOUNT	41 VALUE CODES CODE	41 AMOUNT
a	24	4104.00	61	27.00		
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			010317	1.0	250. 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250. 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
PARTNERS HEALTH PLAN		Y	Y			1234567890

57 OTHER PRV ID

58 INSURED'S NAME	59 P.REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

Field	Value
66 DX	
67	R69
68	
69 ADMIT DX	
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE; a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI	1234567890
76 QUAL	
76 LAST	ATTENDING LAST
76 FIRST	FIRST
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81 CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Supportive IRA Services

Rate Code/Units:

Rate Code	Definition	Units	Statement From/Through Dates
4709	Res Hab; Vol; IRA/Cr-Suprt Monthly	1 unit = month	1st of the month through last day of month (i.e., 06012016-06302016)
4710	Res Hab; Vol; IRA/CR-Suprt Semi-Monthly 1st Half	1 unit = half of month	1st through the 15th of the month (i.e., 06012016-06152016
4711	Res Hab; Vol; IRA/CR-Suprt Semi-Monthly 2nd Half	1 unit = half of month	16th through the last day of the month (i.e., 06162016-06302016)

Dates of Service:

Monthly: If billing for monthly rates (i.e., rate code 4709), only one date of service can be billed per claim form. Enter the last day of the month being billed (i.e., billing for month of June then enter 06302016) as the date of service on the line level. The Statement From and Statement Through date should represent the range of dates in the month (i.e., billing for month of June then enter as 06012016 – 06302016).

When billing with a Semi-Monthly rate code (i.e., 4710), the date of service on the line level should be last date of the period being billed (i.e., billing for the 1st half of June then enter 061516). The Statement From and Statement Through date should represent the range of dates for the billing period for the rate code (i.e., billing for June 1-15 then enter as 06012016-06152016)

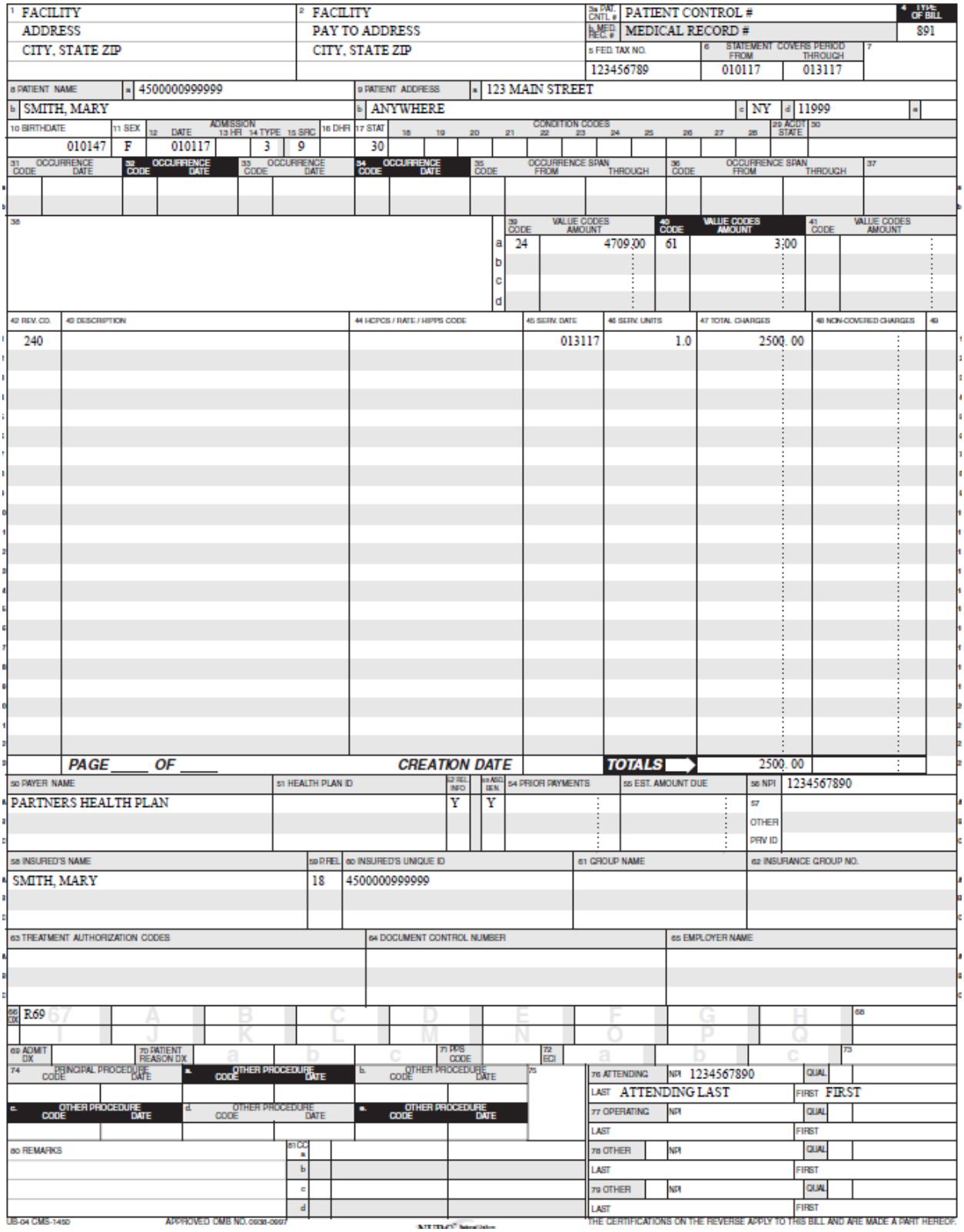
Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Supportive IRA Service Claim Layout Example (Full Month):



1 FACILITY	2 FACILITY	3a PAT. CNTL. # PATIENT CONTROL #	4 TYPE OF BILL 891
ADDRESS	PAY TO ADDRESS	b MED. REC. # MEDICAL RECORD #	
CITY, STATE ZIP	CITY, STATE ZIP	5 FED. TAX NO. 123456789	6 STATEMENT COVERS PERIOD FROM 010117 THROUGH 013117

8 PATIENT NAME a 4500000999999	9 PATIENT ADDRESS a 123 MAIN STREET		
b SMITH, MARY	b ANYWHERE	c NY	d 11999

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18-28 CONDITION CODES	29 ACDT STATE	30
010147	F	010117		3	9		30			

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
	a 24 4709.00	61 3.00	
	b		
	c		
	d		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			013117	1.0	2500.00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	2500.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 1234567890
a PARTNERS HEALTH PLAN		Y	Y			57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
a SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	67	A	B	C	D	E	F	G	H	68
	R69	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI 1234567890	QUAL	
LAST ATTENDING LAST	FIRST FIRST		
77 OPERATING	NPI	QUAL	
LAST	FIRST		
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS	81 CC	
	a	
	b	
	c	
	d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Supportive IRA Service Claim Layout Example (1/2 Month):

Field	Value
1	FACILITY ADDRESS CITY, STATE ZIP
2	FACILITY PAY TO ADDRESS CITY, STATE ZIP
3a PAT. CNTL #	PATIENT CONTROL #
b. MED. REC. #	MEDICAL RECORD #
4 TYPE OF BILL	891
5 FED. TAX NO.	123456789
6 STATEMENT COVERS PERIOD FROM / THROUGH	010117 / 011517
7	
8 PATIENT NAME a	4500000999999
b	SMITH, MARY
9 PATIENT ADDRESS a	123 MAIN STREET
b	ANYWHERE
c	NY
d	11999
e	
10 BIRTHDATE	010147
11 SEX	F
ADMISSION 12 DATE	010117
13 HR	
14 TYPE	3
15 SRC	9
16 DHR	
17 STAT	30
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE / AMOUNT	a: 24 / 4710.00
40 VALUE CODES CODE / AMOUNT	a: 61 / 3.00
41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			011517	1.0	800.00		
	PAGE ____ OF ____		CREATION DATE	TOTALS	800.00		

Field	Value
50 PAYER NAME	PARTNERS HEALTH PLAN
51 HEALTH PLAN ID	
52 REL. INFO	Y
53 ASG. BEN.	Y
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	
56 NPI	1234567890
57 OTHER PRV ID	
58 INSURED'S NAME	SMITH, MARY
59 P. REL	18
60 INSURED'S UNIQUE ID	4500000999999
61 GROUP NAME	
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	R69
67 A–Q	
68	
69 ADMIT DX	
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE	
a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI	1234567890
QUAL	
LAST	ATTENDING LAST
FIRST	FIRST
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81 CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Respite Services

Rate Code/Units:

Rate Code	Definition	Units
7421	In-Home Respite	1 unit = 15 minutes
7422	Site-Based Respite	1 unit = 15 minutes
7423	Recreational Respite	1 unit = 15 minutes
7424	Camp	1 unit = 15 minutes
7425	Intensive	1 unit = 15 minutes
7426	In-Home Agency Supported Self Direction	1 unit = 15 minutes
7427	Intensive In-Home Agency Self Direction	1 unit = 15 minutes
7428	In-Home Per Diem	1 unit = single date of service
7429	Site-Based Per Diem	1 unit = single date of service

Dates of Service:

Hourly: If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Daily: If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016….06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Respite Service Claim Layout Example:

Field	Entry
1	FACILITY ADDRESS CITY, STATE ZIP
2	FACILITY PAY TO ADDRESS CITY, STATE ZIP
3a PAT. CNTL #	PATIENT CONTROL #
3b MED. REC. #	
4 TYPE OF BILL	891
5 FED. TAX NO.	123456789
6 STATEMENT COVERS PERIOD FROM / THROUGH	010118 / 010118
7	
8 PATIENT NAME a	4500000999999
8 b	SMITH, MARY
9 PATIENT ADDRESS a	123 MAIN STREET
9 b / c / d / e	ANYWHERE / NY / 11999 /
10 BIRTHDATE	010147
11 SEX	F
ADMISSION 12 DATE	010118
13 HR	
14 TYPE	3
15 SRC	9
16 DHR	
17 STAT	30
CONDITION CODES 18–28	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE / AMOUNT a	24 / 7421 00
40 VALUE CODES CODE / AMOUNT	
41 VALUE CODES CODE / AMOUNT	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			010118	27	250 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250 00		

Field	Entry
50 PAYER NAME	PARTNERS HEALTH PLAN
51 HEALTH PLAN ID	
52 REL. INFO	Y
53 ASG. BEN.	Y
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	
56 NPI	1234567890
57 OTHER PRV ID	
58 INSURED'S NAME	SMITH, MARY
59 P. REL	18
60 INSURED'S UNIQUE ID	4500000999999
61 GROUP NAME	
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	R69
67 A–Q	
68	
69 ADMIT DX	
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE	
a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI	1234567890
QUAL	
LAST / FIRST	ATTENDING LAST / FIRST
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81 CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Prevocational Services

Rate Code	Definition	Units
4464	Prevoc; Voluntary; Full Unit/OPWDD	1 unit = single date of service
4465	Prevoc; Voluntary; Half Unit/OPWDD	1 unit = single date of service

Dates of Service:

Daily: If the rate code allows for only one unit of service per day (i.e., rate code 4453), multiple dates of service can be billed on the same claim form. Each date of service should be reported on a distinct claim line (i.e., 06012016, 06022016….06072016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Prevocational Service Claim Layout Example:

Field	Value
1	FACILITY ADDRESS CITY, STATE ZIP
2	FACILITY PAY TO ADDRESS CITY, STATE ZIP
3a PAT. CNTL #	PATIENT CONTROL #
b. MED. REC. #	MEDICAL RECORD #
4 TYPE OF BILL	891
5 FED. TAX NO.	123456789
6 STATEMENT COVERS PERIOD FROM	012317
6 STATEMENT COVERS PERIOD THROUGH	012317
7	
8 PATIENT NAME a	4500000999999
8 PATIENT NAME b	SMITH, MARY
9 PATIENT ADDRESS a	123 MAIN STREET
9 PATIENT ADDRESS b	ANYWHERE
9 c	NY
9 d	11999
10 BIRTHDATE	010147
11 SEX	F
12 ADMISSION DATE	012317
13 HR	
14 TYPE	3
15 SRC	9
16 DHR	
17 STAT	30
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES a	CODE 24, AMOUNT 4464.00
40 VALUE CODES a	CODE 61, AMOUNT 4.00
41 VALUE CODES	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			012317	1.0	250. 00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250. 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A PARTNERS HEALTH PLAN		Y	Y			1234567890

57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A SMITH, MARY	18	4500000999999		

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

Field	Value
66 DX	R.69
67 A–Q	
68	
69 ADMIT DX	
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE; a.–e. OTHER PROCEDURE CODE / DATE	
75	
76 ATTENDING NPI	1234567890
76 ATTENDING LAST	ATTENDING LAST
76 ATTENDING FIRST	FIRST
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81 CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Community Habilitation Services

Rate Code/Units:

Rate Code	Definition	Units
4722	Comm/Res Hab; Vol; Indiv; ¼ hr	1 unit = 15 minutes
4723	Comm/Res Hab; Vol; Group – 2 individuals; ¼ hr	1 unit = 15 minutes
4724	Comm/Res Hab; Vol; Group – 3 individuals; ¼ hr	1 unit = 15 minutes
4725	Comm/Res Hab; Vol; Group – 4 individuals; ¼ hr	1 unit = 15 minutes

Dates of Service:

Hourly: If the rate code allows multiple units of service (quarter-hour increments) then multiple dates of service can be billed on the same claim form. When billing for one date of service, enter the date as the Statement From date and as the Statement Through date (i.e., 06142016 – 06142016). When billing for multiple service dates, enter the first service date of the billing period as the Statement From date and the last service date as the Statement Through date (i.e., 06012016 – 06072016).

Claim Form:

Services should be billed on a UB-04 claim form or in the 837I format.

Units:

Claims must be billed in whole units. If partial units are submitted, they will be rounded down to the nearest whole number for reimbursement purposes. Units will not be rounded up.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Community Habilitation Service Claim Layout Example:

Field	Value
1	FACILITY ADDRESS CITY, STATE ZIP
2	FACILITY PAY TO ADDRESS CITY, STATE ZIP
3a PAT. CNTL #	PATIENT CONTROL #
b. MED. REC. #	MEDICAL RECORD #
4 TYPE OF BILL	891
5 FED. TAX NO.	123456789
6 STATEMENT COVERS PERIOD FROM	012317
6 STATEMENT COVERS PERIOD THROUGH	012317
7	
8 PATIENT NAME a	4500000999999
8 PATIENT NAME b	SMITH, MARY
9 PATIENT ADDRESS a	123 MAIN STREET
9 PATIENT ADDRESS b	ANYWHERE
c	NY
d	11999
e	
10 BIRTHDATE	010147
11 SEX	F
ADMISSION 12 DATE	012317
13 HR	
14 TYPE	3
15 SRC	9
16 DHR	
17 STAT	30
18–28 CONDITION CODES	
29 ACDT STATE	
30	
31–34 OCCURRENCE CODE / DATE	
35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	
37	
38	
39 VALUE CODES CODE a	24
39 VALUE CODES AMOUNT a	4722.00
40–41 VALUE CODES	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
240			012317	32.0	250.00		
	PAGE ____ OF ____	CREATION DATE		TOTALS	250.00		

Field	Value
50 PAYER NAME	PARTNERS HEALTH PLAN
51 HEALTH PLAN ID	
52 REL. INFO	Y
53 ASG. BEN.	Y
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	
56 NPI	1234567890
57 OTHER PRV ID	
58 INSURED'S NAME	SMITH, MARY
59 P.REL	18
60 INSURED'S UNIQUE ID	4500000999999
61 GROUP NAME	
62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES	
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX / 67	R69
68	
69 ADMIT DX	
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
73	
74 PRINCIPAL PROCEDURE CODE / DATE; OTHER PROCEDURE a–e	
75	
76 ATTENDING NPI	1234567890
76 ATTENDING QUAL	
LAST	ATTENDING LAST
FIRST	FIRST
77 OPERATING NPI / QUAL / LAST / FIRST	
78 OTHER NPI / QUAL / LAST / FIRST	
79 OTHER NPI / QUAL / LAST / FIRST	
80 REMARKS	
81 CC a–d	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Home Health Care Billing

Coding Requirements:

Partners Health Plan requires that all providers contracted to Medicare Reimbursement submit a HIPPS (Health Insurance Prospective Payment System) Code (using revenue code 0023), CBSA Code (using value code 61) and Bill Type 32X or 34X on a UB-04 claim form or in the 837I format.

All other applicable home care coding for services, i.e. HCPCS codes and units on the line level, are also required.

If a provider contract stipulates Medicare Reimbursement, all claims should be submitted utilizing CMS Medicare Coding. If a service is determined to not be covered by Medicare it will then be reimbursed at a Medicaid rate (if available). Partners Health Plan will process and pay the claim to New York State Medicaid Reimbursement Methodology and indicate this using an appropriate EOB message.

EOB Code = MC ***Payment based on an alternate fee schedule (Medicaid)***

If a provider contract stipulates Medicare Reimbursement but you feel that it should be reimbursed as Medicaid or another contracted rate, please contact Provider Services at 1-855-747-5483.

Denial Messages:

If contracted to Medicare Reimbursement and the claim lacks the required HIPPS Code along with additional coding requirements necessary to group and price the claim accordingly, a claim will be denied with the following message:

EOB Code = HIP ***Missing/Incomplete/Invalid HIPPS Rate Code***

CARC Value = 16 ***Claim/service lacks information or has submission/billing error(s) which is needed for adjudication***

RARC Value = N471 ***Missing/Incomplete/Invalid HIPPS Rate Code***

The most current listing of HIPPS Codes can be found at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/HomeHealthPPS/coding_billing.html

The following claim denial message indicates that a review of coding is required by the provider and a resubmission of the claim is necessary:

EOB Code = LI ***Claim/Service Lacks Information or has Submission/Billing Error(s) Which is Needed for Adjudication***

CARC Value = 16 ***Claim/service lacks information or has submission/billing error(s) which is needed for adjudication***

Based upon the home care coding submitted on the claim possible reasons for this denial are as follows:

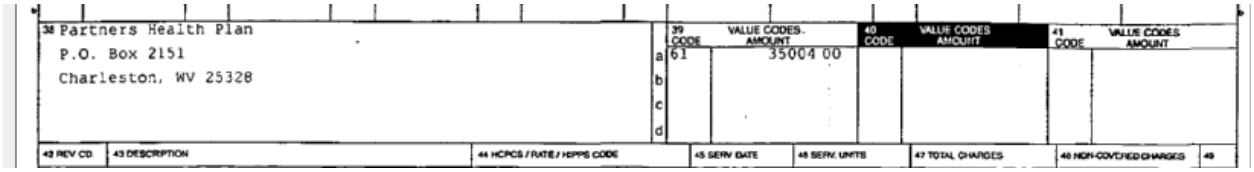
1) Medicare Billing: Ensure that all required data elements noted above are present as well as the Patient Status Code and correct Statement From/Through Date.
2) Medicaid Billing: Ensure that all correct revenue codes, HCPCS, Units, and Bill Type are on the claim.

If further clarification on the specific reason for this denial message on a claim, contact the Partners Health Plan Provider Services Department at 1-855-747-5483.

Value Code 61:

Value Code 61 is required on all Medicare coded claims to indicate the CBSA (Core-Based Statistical Area) of where the service took place.

- 61 is defined as: Location where service is furnished
- Report on the UB-04 claim form in FL39 with the CBSA Number as the Value Amount. The CBSA Number should be reported as a dollar amount with two zeroes in the cents field.



- The most current listing of CBSA by CCN can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html

Procedure Codes:

The appropriate procedure codes must be submitted based upon a provider's contractual arrangement for reimbursement.

If contracted to receive a Medicare rate, then the Medicare accepted HCPCS codes must be submitted on the claim (i.e., G0156 Home Health Aide).

If contracted to receive a Medicaid rate, then the Medicaid accepted codes must be submitted on the claim (i.e., S9122 Home Health Aid – CNA Care).

Units:

Claims must be billed in whole units. If partial units are submitted, they will be rounded to the nearest whole number for reimbursement purposes.

Personal Care Services – Dates of Service 1/1/2018 & Greater

Procedure Codes:

Procedure Code	***Level of Care***
S5130	PCS Level I
T1019	PCS Level II
T1020	PCS Level II – Live In

Modifiers:

**At this time PHP is only authorizing services with modifier U1.*

Level I

Modifier	***Level of Care***
U1	PCS Level I – 15 minutes

Level II

Modifier	***Level of Care***
U1	PCS Level II – 15 minutes

*No modifier is required for PCS Level II – Live In (single client)

Units:

Requirements for units are dependent upon the procedure code being used when reporting personal care services.

- If billing with S5130 or T1019 (15 minute increments) each unit should represent 15 minutes. Partners Health Plan will not reimburse more than 13 hours per day when billing S5130 or T1019 unless the member has specifically obtained authorization for split shifts.
- If billing T1020 (live in care) each unit should represent one date of service as this code represents per diem care. If billed with greater than 1 unit of service per date it will be denied with the following EOB Code:

EOB Code = PC1 ***Per Diem Services billed as greater than one unit per service date not payable. Please resubmit with correct unit(s).***

Claims must be billed in whole units.

Claim Form:

Personal Care Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 580 should be used when submitting on a UB-04 claim form.

Statement From and Through Dates:

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

*If a claim is submitted with a modifier that differs from what was authorized the claim will be denied with the following EOB Code:

EOB Code = A4 ***Not Authorized for Billed Level of Service***

Personal Care Services – Dates of Service Prior to 1/1/2018

Modifiers:

All Personal Care claims require a modifier be submitted to identify the level of care.

Modifier	***Level of Care***
U1	PCA Level 1 Care
U2	PCA Level 2 Care

In the absence of a modifier a claim will be denied to resubmit with the appropriate modifier with the following EOB Code:

EOB Code = MOD ***The procedure code is inconsistent with the modifier used or a required modifier is missing***

Units:

Requirements for units are dependent upon the procedure code being used when reporting personal care services.

- If billing with T1019 (15 minute increments) each unit should represent 15 minutes. Partners Health Plan will not reimburse more than 13 hours per day when billing T1019 unless the member has specifically obtained authorization for split shifts.
- If billing T1020 (live in care) each unit should represent one date of service as this code represents per diem care. If billed with greater than 1 unit of service per date it will be denied with the following EOB Code:

EOB Code = PC1 ***Per Diem Services billed as greater than one unit per service date not payable. Please resubmit with correct unit(s).***

Claims must be billed in whole units.

Claim Form:

Personal Care Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 580 should be used when submitting on a UB-04 claim form.

Statement From and Through Dates:

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

CDPAS/CDPAP Services – Dates of Service 1/1/2018 & Greater

Procedure Codes:

Procedure Code	***Level of Care***
T1019	CDPA
T1020	CDPA Live In

Modifiers:

**At this time PHP is only authorizing services with modifier U6.*

All CDPAS/CDPAP claims require a modifier be submitted to identify the level of care.

Modifier	***Level of Care***
U6	CDPA - Basic

Units:

Claims submitted with T1019 and the appropriate modifier will be reimbursed in quarter hour increments (15 minutes per unit).

CDPAS/CDPAP rates are available per hour and Partners Health Plan will divide the rate by 4 to determine ¼ increment.

Claim Form:

CDPAS/CDPAP Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 580 should be used when submitting on a UB-04 claim form.

Statement From and Through Dates:

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

*If a claim is submitted with a modifier that differs from what was authorized the claim will be denied with the following EOB Code:

EOB Code = A4 ***Not Authorized for Billed Level of Service***

CDPAS/CDPAP Services – Dates of Service Prior to 1/1/2018

Modifiers:

All CDPAS/CDPAP claims require a modifier be submitted to identify the level of care.

Modifier	***Level of Care***
U6	Level 1 Care
U7	Level 2 Care
U8	Per Diem Care

In the absence of a modifier a claim will be denied to resubmit with the appropriate modifier with following EOB code:

EOB Code = MOD ***The procedure code is inconsistent with the modifier used or a required modifier is missing***

Units:

Claims submitted with T1019 and the appropriate modifier will be reimbursed in quarter hour increments (15 minutes per unit).

CDPAS/CDPAP rates are available per hour and Partners Health Plan will divide the rate by 4 to determine ¼ increment.

Claim Form:

CDPAS/CDPAP services are to be submitted on a UB-04 claim form or in the 837I format with the necessary data elements.

When submitting on a UB-04, there are specific rate codes required to support the CDPAS/CDPAP services.

2401 - CONSUMER DIRECT PERS ASSIST 1 CLIENT HOURLY

2402 - CONS DIRECT PERS ASSIST 2 OR > CLNTS HRLY PER CLNT

2403 - CONS DIR PERS ASSIST 1 CLNT HRLY ENHANCED RATE

2404 - CONS DIR PERS ASSIST 2 OR > CLNTS HRLY PER CLNT EN

2405 - CONSUMER DIRECT PERSONAL ASSIST 1 CLNT LIVE-IN

2406 - CONS DIR PERS ASSIST 2 OR > CLNTS PER CLNT LIVE-IN

2422 - CDPAP 1 CLIENT, QUARTER HOUR

2423 - CDPAP 2 CLIENTS, PER CLIENT, QUARTER HOUR

2424 - CDPAP 1 CLIENT, ENHANCED RATE, QUARTER HOUR

2425 - CDPAP 2 CLIENTS, PER CLIENT, ENHANCED RATE, QTR HR

Revenue Code 0580 should be submitted in FL42 with the number of units in FL46 when submitting on a UB-04.

Statement From and Through Dates:

All dates must be entered in the format MMDDYYYY.

When billing for one date of service, enter the date as the FROM date and as the THROUGH date.

When billing for multiple service dates, enter the first service of the billing period as the FROM date and the last service date as the THROUGH date. The FROM/THROUGH dates should be in the same calendar month.

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Adult Day Health Care Services – Dates of Service 1/1/2018 & Greater

Adult Day Health Care (ADHC) services include care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. ADHC includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

Procedure Codes:

Code	***Definition***	***Units***
S5102	Day Care Service; Adult; per day	1 unit = one day

Modifiers:

Modifier	***Level of Care***
U1	Basic Level
U2	Standard Level
U3	Intensive Level

Claim Form:

ADHC Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 3103 should be used when submitting on a UB-04 claim form.

Reimbursement:

ADHC services are reimbursed based on contracted rates. If the reimbursement indicates a percentage of NYS Medicaid it will be paid according to the most current published rate available from NYSDOH. If no rate is obtained or published the claim will be denied with the following EOB code:

EOB code = NA ***No allowable amount***

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

*If a claim is submitted with a modifier that differs from what was authorized the claim will be denied with the following EOB Code:

EOB Code = A4 ***Not Authorized for Billed Level of Service***

Transportation for ADHC Services:

Non – emergent transportation services billed in combination with an ADHC claim are reimbursable if authorized regardless if it is individually specified in the provider contract. This service is generally billed through using the below procedure code:

Code	***Definition***	***Units***
T2003	Non-emergent transport; encounter/trip	1 unit = one way trip

NOTE: Transportation units are 1 unit per one-way trip. They are NOT based on mileage.

Reimbursement:

Transportation services are reimbursed based on contracted rates. If the contract does not include a specific rate for Transportation the services will be paid according to the most current published rate available from the NYSDOH Transportation fee schedule.

ADHC Claim Lines Example:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
3103	ADULT DAY CARE MED/SOC D	S5102	020217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020217	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020817	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020817	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021417	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021417	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	022117	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	022117	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	022217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	022217	1.0	42.42	

Adult Day Health Care Services – Dates of Service Prior to 1/1/2018

Adult Day Health Care (ADHC) services include care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. ADHC includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.

Code/Units:

Code	***Definition***	***Units***
S5101	Day Care Services; Adult; per half day	1 unit = one half day
S5102	Day Care Service; Adult; per day	1 unit = one day

Claim Form:

ADHC Services may be submitted on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format with the necessary data elements.

Revenue code 3103 should be used when submitting on a UB-04 claim form.

Reimbursement:

ADHC services are reimbursed based on contracted rates. If the reimbursement indicates a percentage of NYS Medicaid it will be paid according to the most current published rate available from NYSDOH. If no rate is obtained or published the claim will be denied with the following EOB code:

EOB code = NA ***No allowable amount***

Prior Authorization:

Please contact the member's care manager as indicated on the participant's ID card accordingly to obtain the necessary authorization for services.

Transportation for ADHC Services:

Non – emergent transportation services billed in combination with an ADHC claim are reimbursable if authorized regardless if it is individually specified in the provider contract. This service is generally billed through using the below procedure code:

Code	***Definition***	***Units***
T2003	Non-emergent transport; encounter/trip	1 unit = one way trip

NOTE: Transportation units are 1 unit per one-way trip. They are NOT based on mileage.

Reimbursement:

Transportation services are reimbursed based on contracted rates. If the contract does not include a specific rate for Transportation the services will be paid according to the most current published rate available from the NYSDOH Transportation fee schedule.

ADHC Claim Lines Example:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
3103	ADULT DAY CARE MED/SOC D	S5102	020217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020217	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	020817	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	020817	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021317	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021317	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021417	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021417	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021617	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021617	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	021717	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	021717	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	022117	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	022117	1.0	42.42	
3103	ADULT DAY CARE MED/SOC D	S5102	022217	1.0	109.64	
3103	ADULT DAY CARE MED/SOC D	T2003	022217	1.0	42.42	

SNF (Skilled Nursing Facility) Billing

CODING REQUIREMENTS:

- UB04 Claim form (basic required fields)
- Occurrence Span Code 70 (dates of qualifying hospital stay)
- Type of Bill 21X
- Revenue Code 0022 (indicates claim being paid to SNF PPS-used to report HIPPS Rate Code data)
- HIPPS Code
    - 5 digit code reported in the HCPCS/Rate/HIPPS field (FL44)
    - First 3 positions contain the RUG group, last 2 contain the assessment indicator code
    - HIPPS codes should be billed in order of which member received that level of care
    - Number of covered days for each HIPPS code in FL46
    - Total charges should equal $0 for HIPPS line
- Room & Board Rev Code. PHP utilizes Code Set #2 from the NYS Medicaid SNF Billing Codes. Claims submitted with a Revenue Code other than Code Set #2 will be denied with EOB code **IC - INCORRECT REVENUE CODE. PLEASE RESUBMIT WITH VALID ROOM & BOARD REV CODE FROM CODE SET 2 OF THE NYS MEDICAID SNF GUIDELINES**
    - Custodial Care – 120
    - AIDS Specialty Unit – 160
    - Ventilator Specialty Unit – 101
    - Neurobehavioral Specialty Unit – 124
    - TBI Specialty Unit – 199
    - Pediatric Specialty Unit – 123
    - Bed Hold (Hospitalization) – 185
    - Bed Hold (Other Leave of Absence) – 183
    - Bed Hold (Therapeutic) – 189
    - Respite Care (Short Term) – 663
- CBSA Code (Core-Based Statistical Area)
- Treatment Authorization Code (max of 18 digits)

RESPITE CARE IN THE SNF SETTING:

- Long Term Respite Services
    - Authorized as Rev Code 663
    - Rev Code Billed – 663
    - Covered as a Medicaid Waiver service
    - Reimbursed to current Medicaid Benchmark rate for facility
    - Not a covered benefit under Medicare
- Short Term Respite Services
    - Not part of Medicaid Waiver service
    - If approved is reimbursed to Medicaid Facility specific Rate (not published)
    - Medicare only covers under Hospice benefit plan of care (max of 5 days covered)

MEDICAID RATES:

- Located here: health.ny.gov/facilities/long_term_care/reimbursement/nhr/
- Use most current rates effective set file
- Under appropriate tab (Medicare Elig/Non-Medicare Elig/Specialty Non-Medicare/Specialty Medicare)

HIPPS VALUES:

- Defined as Health Insurance Prospective Payment System code set
- Listing can be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes
- Effective 10/1/19, new classification model called Patient Driven Payment Model (PDPM). Guidelines and coding information can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM
- Claims for date of service 1/1/20 and forward must have a valid PDPM HIPPS code.
- Claims submitted with an old HIPPS code after date of service 1/1/20 will be denied with EOB code **PDG - HIPPS CODE INVALID EFFECTIVE 1/1/2020. PLEASE SUBMIT A VALID PDGM HIPPS CODE**

RUGS VALUES:

- Defined as Resource Utilization Groups (version IV)
    - Rehabilitation plus Extensive Services
    - Ultra-High Rehabilitation
    - Very High Rehab
    - High Rehab
    - Medium Rehab
    - Low Rehab
    - Extensive Services
    - Special Care High
    - Special Care Low
    - Clinically Complex

LEVEL OF CARE:

- When/if there is a change in the level of care authorized during an episode of care (billable month) the claim must be billed appropriately. Example below:
  Approved 1/1/20 – 1/31/20 (Skilled level 1/1-1/15 and Custodial level 1/16-1/31)
    - Claim submitted with valid SNF Inpatient coding for DOS 1/1/20 – 1/15/20 at Skilled level of care.
    - Claim submitted with valid SNF Custodial coding for DOS 1/16/20 – 1/31/20 with proper Room & Board Revenue Code.
- If claim is submitted with both levels of care on one claim it will be denied with EOB code **LOC - LEVEL OF CARE BILLED DOES NOT MATCH LEVEL OF CARE AUTHORIZED. PLEASE RESUBM IT WITH APPROPRIATE CODING**

NDC Code Submission

Coding Requirements:

The New York State Department of Health (NYSDOH) mandates that all Managed Care Plans must report National Drug Codes (NDCs) for all physician administered drugs.

All physician administered drugs, by all provider types, require a valid 11-digit NDC number and the applicable quantity and measurement. This includes all J-codes and all other applicable drug codes (i.e., chemotherapeutics, therapeutics, etc.)

Claim Form:

The NDC information may be reported on either a CMS-1500 or in the 837P format or a UB-04 claim form or in the 837I format, as applicable.

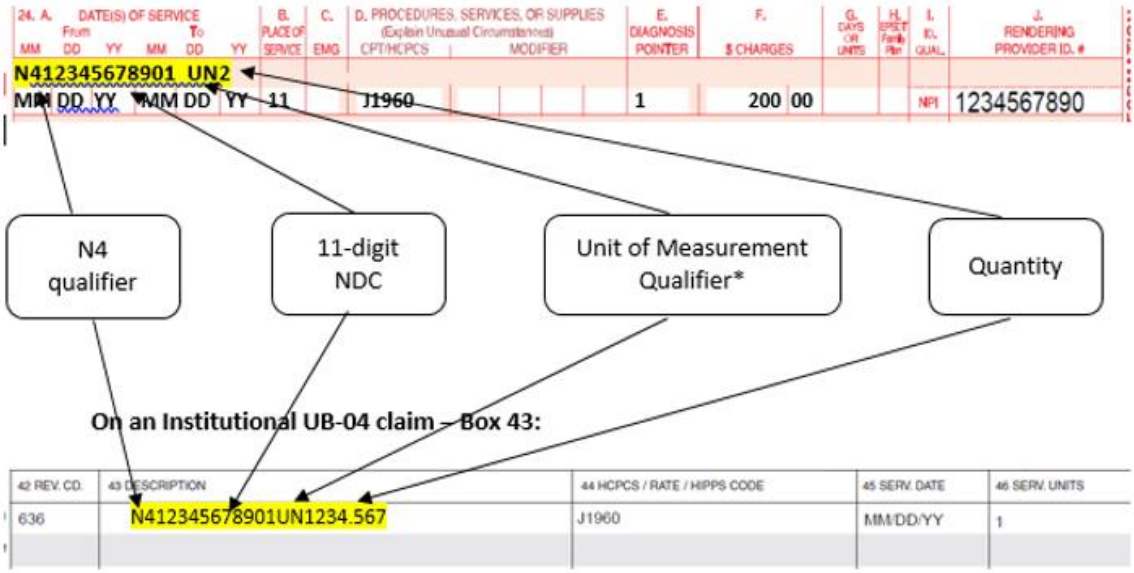
Electronic Submission:

In either the 837I or 837P format providers must report the 11-digit NDC and its corresponding information, in addition to the procedure code, in the LIN segment of Loop ID 2410 to specify the physician-administered drug that is part of the service described in SV1 for the 837 format. Providers must also report the quantity and unit of measure of the NDC as outlined in the table below:

LIN Segment – Drug Identification i.e., LINN4*01234567891**		
LIN02	**N4**	**N4 Qualifier identifies NDC being billed**
LIN03	**Actual NDC i.e., 01234 5678 91**	**Report NDC in the 11-digit format – do not use hyphens or spaces**
CTP Segment – Drug Segment i.e., CTP*2.50*2*UN**		
CTP03	**Unit Price**	**i.e., 2.50**
CTP04	**Dispensing Quantity**	**i.e., 2**
CTP05	**Unit of Measure Value**	**F2 = International Unit GR = Gram ML = Milliliter UN = Unit ME = Milligram**

Paper Claim Submission:

On a Professional CMS-1500 claim – Box 24A (shaded area):



On an Institutional UB-04 claim – Box 43:

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS
636	N412345678901UN1234.567	J1960	MM/DD/YY	1

The following are the only acceptable values for submission as a Unit of Measurement Qualifier:

F2 = International Unit
GR = Gram
ML = Milliliter
UN = Unit
ME = Milligram

Denial Messages:

EOB Code ***PA*** identifies that you have submitted a procedure code which requires the NDC Code, Qualifier, and Units for which you did not submit any or all these data elements on your claim submission.

EOB Code = PA	***NDC Code, qualifier and unit required***
CARC = 204	***This service/equipment/drug is not covered under the patient's current benefit plan***
RARC = M119	***Missing/incompleted/invalid/deactivated/withdrawn National Drug Code (NDC)***

You may resubmit your claim for payment as follows:

- On an Institutional UB-04 claim you should submit as a corrected claim, which is identified by utilizing the applicable Bill Type ending in ‘7’ to designate as corrected (i.e., XX7, 137, 737, etc.)

- On a Professional CMS-1500 claim you should mark the claim as corrected and include the original claim number in Box 22 ‘Original Reference No.’.

All resubmissions/corrected claims should include all original claim lines.

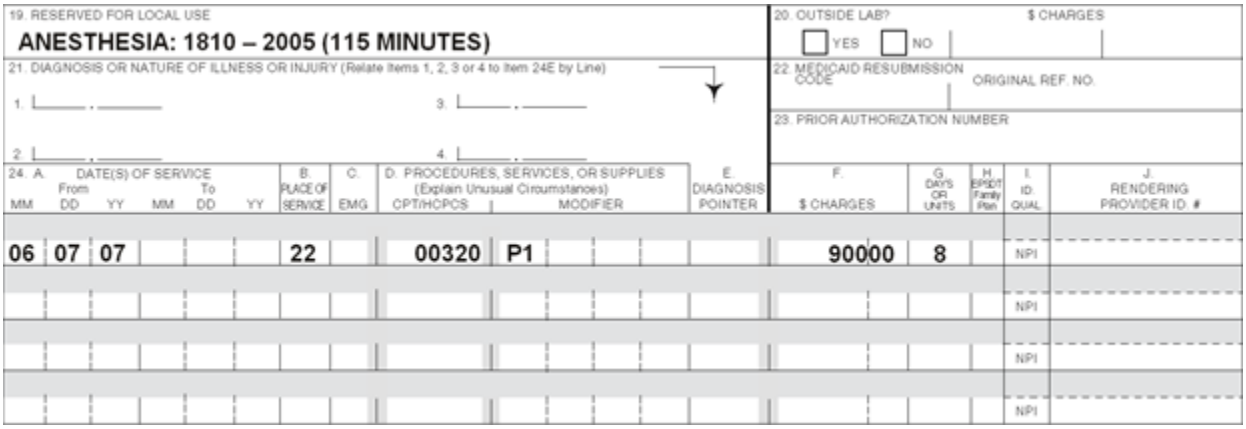
Anesthesia Billing

Coding Requirements:

Anesthesia services should be billed with the number of actual minutes in the units field (Item 24G) of the CMS-1500 form. The minutes will be divided by 15 minute increments and rounded to the nearest tenth to obtain the total anesthesia units. If the claim is submitted without the minutes in field 24G, the claim will be denied.

Services should be reported in the following format:

Paper claims should have the Start and End time of the anesthesia service in Box 19 of a CMS-1500 (see below example).



19. RESERVED FOR LOCAL USE
ANESTHESIA: 1810 – 2005 (115 MINUTES)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. ____ 3. ____
2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
06	07	07				22		00320	P1		90000	8		NPI	
														NPI	
														NPI	
														NPI	

Electronic claims should include the correct qualifier for the Units indicator.
Qualifier MJ = total minutes

Denial Messages:

If a claim is missing the above information it will be denied with the following message:

EOB code = MT	***Missing/Incomplete/Invalid Anesthesia Time/Units***
CARC code = 16	***Claim/Service lacks information or has submission/billing error(s) which is needed for adjudication***
RARC code = N203	***Missing/Incomplete/Invalid Anesthesia Units***

Procedure Codes:

When billing anesthesia please utilize CPT codes 00100-01999.
CPT codes 99100 (special anesthesia services) and 99140 (emergency anesthesia) are not separately reimbursed.

Do **NOT** bill general anesthesia using surgical CPT codes with anesthesia modifiers.

Modifiers:

- AA - Anesthesia Services performed personally by the anesthesiologist;
- AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures;
- G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;
- G9 - Monitored anesthesia care for patient who has a history of severe cardiopulmonary condition;
- QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;
- QS - Monitored anesthesia care service;
- QX - CRNA service; with medical direction by a physician;
- QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist;
- QZ - CRNA service: without medical direction by a physician; and
- GC - these services have been performed by a resident under the direction of a teaching physician.

The following modifiers are **NOT** covered by Medicare:

- P1 - A normal healthy patient
- P2 - A patient with mild systemic disease
- P3 - A patient with severe systemic disease
- P4 - A patient with severe systemic disease that is a constant threat to life
- P5 - A moribund patient who is not expected to survive without the operation
- P6 - A declared brain-dead patient whose organs are being removed for donor purposes
- 47 – Anesthesia by surgeon – Used to report regional or general anesthesia provided by the surgeon (Not covered by Medicare)

Anesthesia formula for payment calculations:

Base Units + Time Units x Conversion Factor = Anesthesia Fee Amount

Example:
CPT code 00810 (box 24D)
Minutes 45 (box 24G) *Minutes will be converted to units for payment calculations; 15 minutes = 1 unit
Anesthesia time: 1500 – 1545 45 minutes (box 19)

Base units (per 2014 CMS Base Units)		**5**
	+	
Time Units (45/15=3)		**3**
	x	
Conversion Factor (2017 CMS CF File based on NYC/LI locality)		**25.12**
Payment		**$200.96**

The CMS conversion factors are update annually and can be found at:

https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html

Please note that the base units have remained unchanged since 2014.

Provider:

Claims are processed under the provider group record when applicable; NOT the individual anesthesiologist.

APG Reimbursement

Claim Form:

All claims for APG Reimbursement as per your contractual arrangements are to be submitted on a UB-04 claim form or in the 837I format.

APG Guidelines:

Refer to https://www.health.**ny**.gov/health_care/medicaid/rates/**apg**/ for APG specific claim submission requirements.

Rate Code:

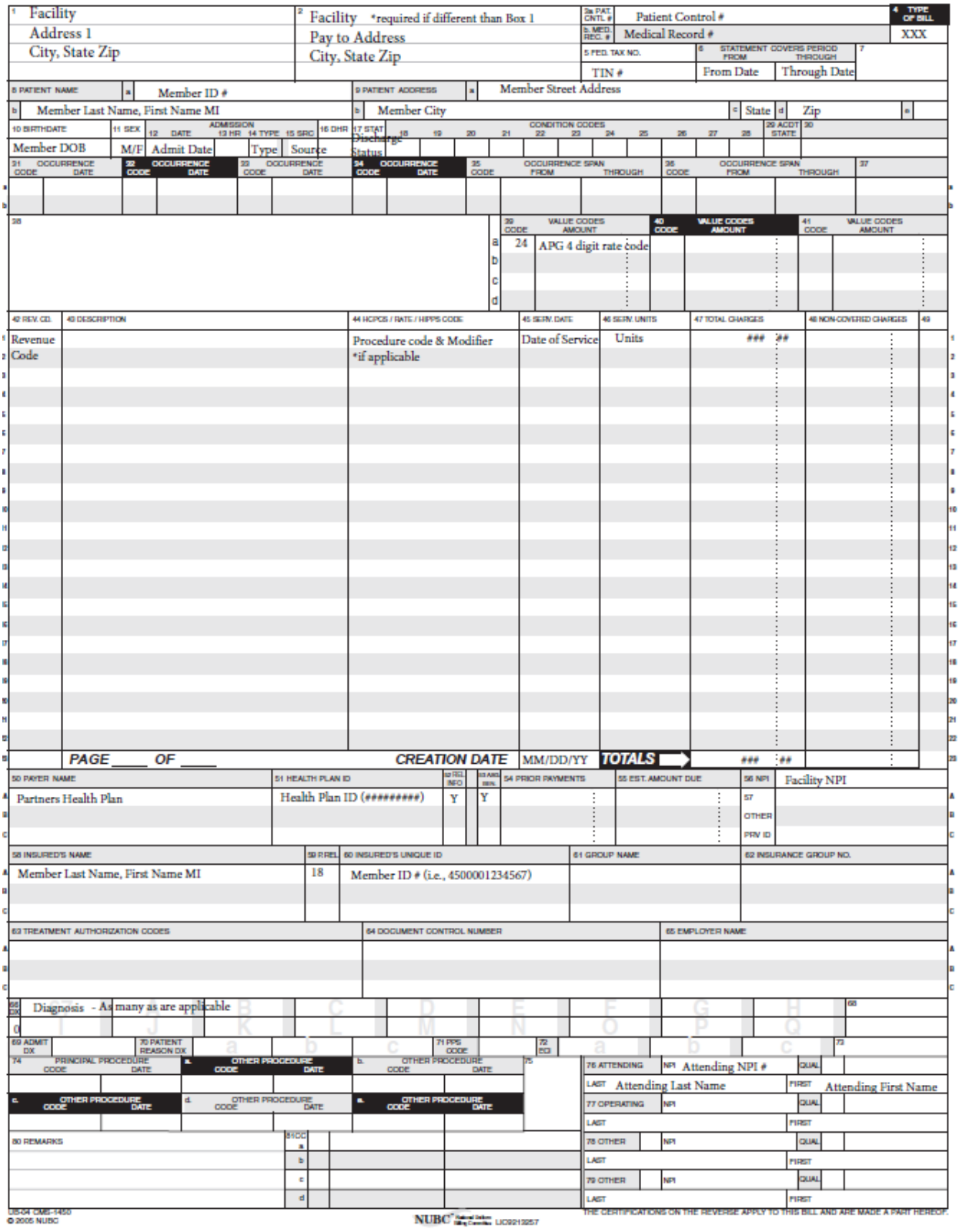
The Rate Code is to be entered in the Value Amount field with a Value Code of 24 (FL39-FL41).

Utilize the appropriate rate code for the setting of the service rendered and based upon the rate codes approved by New York State Medicaid for your entity.

Facility NPI:

The facility NPI must be entered in FL56 in order to allow processing to APG reimbursement.

APG Claim Layout Example:



FQHC Claims

FQHC claims processed to Medicare reimbursement may require a valid payment code on the encounter service line for each billed service date. This does not apply to claims processed to Medicaid reimbursement (i.e., rate code 4013).

FQHC Visit Codes:

G0466	FQHC visit, new patient - A medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
G0467	FQHC visit, established patient - A medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
G0468	FQHC visit, IPPE or AWV - A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
G0469	FQHC visit, mental health, new patient - A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
G0470	FQHC visit, mental health, established patient - A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare covered services that would be furnished per diem to a patient receiving a mental health visit.

Qualifying Visits:

The qualifying visits that correspond to the specific payment codes, as per revised CMS guidance dated 12-06-17 are as follows:

G0466:	
	92002
	92004
	97802
	99201
	99202

	99203 99204 99205 99304 99305 99306 99324 99325 99326 99327 99328 99341 99342 99343 99344 99345 99406 99407 99497 G0101 G0102 G0108 G0117 G0118 G0296 G0442 G0443 G0444 G0445 G0446 G0447 G0490 Q0091
G0467:	92012 92014 97802 97803 99212 99213 99214 99215 99304 99035 99306 99307 99308 99309 9910

	99315 99316 99318 99334 99335 99336 99337 99347 99348 99349 99350 99406 99407 99495 99496 99497 G0101 G0102 G0108 G0117 G0118 G0270 G0296 G0442 G0443 G0444 G0445 G0446 G0447 G0490 Q0091
G0468:	G0402 G0438 G0439
G0469:	90791 90792 90832 90834 90837 90839 90845
G0470:	90791 90792 90832 90834 90837 90839 90845

*Effective 1/1/18: When reporting HCPCS code G0511 or G0512 as a stand-alone visit a FQHC payment code is not required.

Refer to the following link for additional guidance on the use of FQHC Payment Codes:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

Claim Form:

All claims are to be submitted on a UB-04 claim form or in the 837I format.

Bill Type:

Bill type 77X (i.e., 771) should be utilized for FQHC encounters.

Revenue Code:

The appropriate Revenue Code should be submitted as follows:

- Rev Code 052X (for payment codes G0466, G0467 or G0468)
- Rev Code 0519 or 0900 (for payment codes G0469 or G0470)

Net Available Monthly Income (NAMI)

NAMI is determined by the member's local county Department of Social Services. This member will be required to pay this amount directly to the Skilled Nursing Facility (SNF) or Independent Care Facility (ICF).

Value Code:

Value Code 23 should be used to indicate that the member's NAMI amount is entered as the Value Amount (FL39-41).

NAMI Submission:

If billing occurs more than once a month, the full NAMI amount should be submitted on the first claim for the month. For example, when submitting an ICF claim with Rate Code 3822 daily. The claim dated as the 1st of the month should include the member's NAMI amount.

Reimbursement:

The reimbursement of the claim will be reduced by the NAMI amount.

Claim Message:

EOB Code = NAM	**Payment Reduced By Monthly NAMI Amount**
CARC Code = 142	***Monthly Medicaid Patient Liability Amount***

Corrected Claims

If a claim was submitted to and accepted by Partners Health Plan but was later found to have incorrect information, certain data elements on the claim can be corrected and/or added and the claim can be resubmitted. The resubmitted claim is a corrected claim. Examples of data elements that may be corrected and/or added are:

- Diagnosis Code
- Number of Units
- Date(s) of Service
- Procedure Code(s) and/or modifiers
- Place of Service (POS)
- Revenue Code
- Total Charges
- Rate Code (full day vs. half day)

Corrected Claims should include all claim lines from original claim unless removal of a line is due to the service not being rendered**. Failure to include all original claim lines may result in claim denial or takeback.**

Corrected claims (XX7) are assigned a new claim number upon receipt. The original claim will be reversed and a full takeback of the claim payment will occur. The corrected claim will be processed and paid accordingly.

UB-04 Institutional Claim Form:

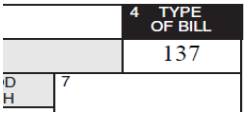
Corrected claims can be submitted either electronically via EDI transaction or manually via paper claim form.

EDI corrected claims submitted on an 837I transaction must be in the following data file format:

- The claim type (segment CLM05-03) must be a '7'.

Manual UB-04 claim forms should:

- List the number '7' in the third digit of the bill type in FL4.



CMS-1500 Professional Claim Form:

Corrected claims must be submitted manually via paper claim form. If submitted electronically it may result in your claim being denied as a duplicate.

CMS-1500 claim forms should be marked as “CORRECTED CLAIM” and in addition you may reference the original claim number, as shown in the three examples below.

Voided Claims:

If a claim processed by Partners Health Plan was later determined was a service that did not occur, you may submit a voided UB-04/837I transaction by submitting the following:

EDI voided claims submitted on an 837I transaction must be in the following data file format:

- The claim type (segment CLM05-03) must be a ‘8’.

Manual UB-04 claim forms should:

- List the number ‘8’ in the third digit of the bill type in FL4.

Upon receipt of a voided claim, a takeback will occur in a future check run cycle. A takeback will be applied to the original claim and the XX8 voided claim submission will be processed and denied with EOB code X8.

Late Charges:

PHP will not process the claims reporting late charges (bill type XX5). Claims are expected to be resubmitted as a corrected claim including all claim lines. Claims submitted with a bill type XX5 will be denied with EOB Code: X5.

Unidentified Claim Returns

If a paper claim submission is received but is unable to be processed into the claims processing system, it will be returned to the provider.

To ensure a claim can be loaded successfully for processing please include the following:

- Participant's Full Name
- Participant's Date of Birth
- Participant's Correct Address
- Participant's Member Identification Number (as presented on the Member's ID Card)

The most common reason for claims to be returned as "Unidentified" is due to a discrepancy in the date of birth submitted on the claim form.

UNIDENTIFIED CLAIM RETURN LETTER

The enclosed claim was received by our office for processing. Based on the information provided, we are unable to process this claim.

The claim(s) could not be processed because:

REASON

As a reminder, to ensure prompt service from **Partners Health Plan**, please provide the following information on all claims submitted:

- Participant's Full Name & Patient's Full Name (if different from Participant)
- Participant's Date of Birth
- Participant's Correct Address
- Social Security Number/ Identification Number provided by group plan ID card.
- Group Name & Group Number

This information is necessary for us to process your claim(s) both promptly and accurately.

Additionally, please note that for the most expedited processing, it is best to submit claims electronically per the instructions on the Participant's ID card.

We greatly appreciate your assistance.

Please correct the issue(s) referenced above and resubmit the claim to the appropriate address.

Thank you for your cooperation.

Mail Services Department

Zelis Editing

Partners Health Plan uses correct coding software provided by Zelis.

All PHP professional claims are currently audited by Zelis.

If the claim is edited and the procedure is denied based upon correct coding logic the claim line will be denied and an applicable EOB code/message will be applied to the claim line.

The following is a list of possible EOB codes for Zelis denials:

EOB Code	***EOB Code Description***
• Z01	PROCEDURE CODE IS OBSOLETE
• Z02	PROCEDURE IS WITHIN THE GLOBAL FEE PERIOD OF AN EXPERIMENTAL PROCEDURE
• Z03	PROCEDURE IS CONSIDERED EXPERIMENTAL
• Z04	PROCEDURE IS WITHIN THE GLOBAL FEE PERIOD OF A COSMETIC PROCEDURE
• Z05	PROCEDURE IS CONSIDERED COSMETIC OR DISCRETIONARY
• Z06	CO-SURGEON/TEAM SURGERY INAPPROPRIATE
• Z07	INAPPROPRIATE USE OF MODIFIER
• Z08	ALREADY PAID IN PART OR FOR THE GLOBAL AMOUNT ON ANOTHER CLAIM/PROVIDER
• Z09	ADD-ON CODE. PRIMARY PROCEDURE NOT FOUND
• Z10	NOT ALLOWED SEPARATE PAYMENT WITH PROCEDURE
• Z11	INCIDENTAL TO PROCEDURE/SERVICE AND IS BUNDLED. NO SEPARATE PAYMENT WARRANTED
• Z12	ASSISTANT SURGERY NOT APPROPRIATE
• Z13	IN GLOBAL FEE PERIOD OF PROCEDURE
• Z13	IN GLOBAL FEE PERIOD OF PROCEDURE
• Z14	TOO MANY NEW PATIENT CODES. REBILL AS ESTABLISHED PATIENT
• Z15	INAPPROPRIATELY BILLED INITIAL ADMISSION/DISCHARGE FACILITY VISIT CODES
• Z16	TOO MANY ICU VISITS ON SAME SERVICE DATE
• Z17	OTHER OFFICE VISIT ON SAME SERVICE DATE
• Z18	INAPPROPRIATE USE OF HCPCS CODE. CPT CODE EXISTS
• Z19	NOT ALLOWED PAYMENT WITH PROCEDURE
• Z20	NOT WITHIN MEDICAL PROTOCOL. DIAGNOSIS DOES NOT QUALIFY PROCEDURE OR FREQUENCY OF PROCEDURE
• Z21	EXCEEDS CLINICAL GUIDELINES
• Z22	AMBULANCE CHARGE DENIED DUE TO LACK OF MEDICAL NECESSITY

• Z23	LABORATORY CHARGE DENIED DUE TO LACK OF MEDICAL NECESSITY
• Z24	REBUNDLED WITH OTHER PROCEDURE(S)
• Z25	PAYMENT REDUCED AS SECONDARY PROCEDURE
• Z26	PAYMENT REDUCED BASED ON MODIFIER
• Z27	UNLISTED CPT CODE
• Z28	REBUNDLED WITH OTHER PROCEDURE(S)
• Z29	AS PER NCCI, SEPARATE PAYMENT NOT ALLOWED WITH COMPREHENSIVE PROCEDURE
• Z30	AS PER NCCI, MUTUALLY EXCLUSIVE
• Z31	NON-COVERED PROCEDURE/SERVICE
• Z32	TOO MANY PROCEDURES OF THIS TYPE BILLED
• Z33	DUPLICATE PROCEDURE
• Z34	PROCEDURE IS INCONSISTENT WITH THE PATIENT'S AGE
• Z35	PROCEDURE IS INCONSISTENT WITH THE PATIENT'S GENDER
• Z36	DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
• Z37	DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER
• Z38	PROCEDURE NOT COMPATIBLE WITH DIAGNOSIS
• Z39	AS PER NCCI PTP, SEPARATE PAYMENT NOT ALLOWED.
• Z40	INCOMPLETE DIAGNOSIS CODE

nThrive

nThrive is the software utilized to price claims to Medicare reimbursement methodology.

Some of the correct coding modules within the nThrive software are also utilized.

If the claim is edited and the procedure is denied based upon nThrive logic the claim line will be denied and an applicable EOB code/message will be applied to the claim line.

Information EOB codes/messages will also be applied based upon reimbursement methodology.

The following is a list of possible denial and information EOB codes for nThrive pricing and/or denials:

EOB Code	***EOB Code Description***
• MR	PRICED PER MEDICARE REIMBURSEMENT METHODOLOGY
• LCD	NON-COVERED CHARGES. THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD).
• NCD	NON-COVERED CHARGES. THIS DECISION WAS BASED ON A NATIONAL COVERAGE DETERMINATION (NCD).
• MIH	APC PRICING REQUIRES A HCPCS CODE TO PRICE
• 001	CODE IS BUNDLED
• 002	MODIFIER REQUIRED
• 004	ESRD MODIFIER ISSUE
• 005	REVENUE CODE NOT ALLOWED
• 006	CHARGES NOT ALLOWED
• 007	CPT CODE 90999 REQUIRES A G MODIFIER
• 008	NO APC FOUND
• 009	APC DELETED
• 010	CPT CODE NOT FOUND
• 011	CPT DELETED
• 012	NOT CPT AND REVENUE CODE 278 FOUND
• 013	NO CPT ON LINE
• 014	NOT PAID BY MEDICARE
• 016	NO CMG FOUND
• 017	CMG NOT ZERO
• 018	NO DRG FOUND
• 019	INVALID DRG
• 020	CONDITION CODE 20 OR 21 NOT PAID BY MEDICARE
• 021	MANDATORY CPT CODE
• 022	NOT PAID BY MEDICAID
• 023	THIS CPT CODE/MODIFIER WAS NOT FOUND IN THE PHYSICIAN FEE SCHEDULE
• 024	NO RVU DATA

• 025	NO ENDOSCOPY BASE RATE FOUND
• 026	CPT CODE MISSING
• 027	NO ANESTHESIA CODE FOUND
• 028	NO POST OP CARE ON 1500 OR BAD FORMAT
• 029	DIAGNOSIS NOT PAID
• 030	EXCEEDED MAXIMUM LINE COUNT
• 031	NO PHYSICIAN CODE WAS ON UB
• 032	NOT COVERED
• 072	CLAIM UNGROUPABLE BY MEDICARE REPRICER
• 035	NOT RECOGNIZED BY OPPS ON BILL TYPE 12X, 13X, OR 14X; AN ALTERNATE CPT/HCPCS CODE MAY BE AVAILABLE.
• 036	INPATIENT PROCEDURE, ONLY; ADMIT PATIENT, BILL AS INPATIENT
• 037	DELETED CODE; NOT PAID UNDER MEDICARE
• 038	DELETED/DISCOUNTED CODE; NO PAYMENT MADE
• 039	NOT-COVERED (OR UNUSED) CODE
• 041	CURRENT DRUG OR BIOLOGICAL PAID UNDER TRANSITIONAL PASS-THROUGH
• 044	BRACHYTHERAPY SOURCE PAID SEPARATELY WHEN PROVIDED INTEGRAL TO SURGICAL PROCEDURE ON ASC LIST; PAYMENT CONTRACTOR-PRICED
• 046	NOT VALID FOR MEDICARE PURPOSES, NOT SUBJECT TO 90 DAY GRACE PERIOD
• 047	NEW DRUG OR BIOLOGICAL PAID UNDER TRANSITIONAL PASS-THROUGH (FORMER)
• 048	OPPS PASS-THROUGH DEVICE PAID SEPARATELY WHEN PROVIDED INTEGRAL TO A SURGICAL PROCEDURE ON ASC LIST; PAYMENT CONTRACTOR-PRICED.
• 050	NON PASS-THROUGH DRUG/BIOLOGICAL
• 055	ITEMS AND SERVICES NOT BILLABLE TO THE FISCAL INTERMEDIARY
• 056	SERVICES OR PROCEDURES INCLUDED IN THE APC RATE, BUT NOT PAID SEPARATELY. (THIS IS A PACKAGED ITEM)
• 057	PACKAGED SERVICE/ITEM; NO SEPARATE PAYMENT MADE.
• 058	PAID ONLY IN PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS AND UNDER MENTAL HEALTH
• 065	CLINIC OR EMERGENCY DEPARTMENT VISIT; MAY INCLUDE ER PHYSICIAN OR PERSONAL PHYSICIANS
• 066	STATUTORY EXCLUSION, CODE REPRESENTS AN ITEM/SERVICE NOT IN THE STATUTORY DEFINITION OF PHYSICIAN SERVICES
• 067	NON-IMPLANTABLE DME; NOT PAID UNDER OPPS. MUST BE BILLED TO DMERC.

- 065 | CLINIC OR EMERGENCY DEPARTMENT VISIT; MAY INCLUDE ER PHYSICIAN OR PERSONAL PHYSICIANS

For more information regarding an NCD or LCD denial, you may utilize the following link as a resource: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

CareVu

CareVu Clearinghouse FAQ's:

1. **Do I need to have billing software to submit my claims using the CareVu Clearinghouse?**

   Yes, the CareVu Clearinghouse is not a software vendor or billing agency.

2. **Where do I go to retrieve my electronic 835 remittance advice (ERA)?**

The HealthSmart Clearinghouse is no longer providing this service as of April 1, 2022. Provider received the last ERA's from the HealthSmart Clearinghouse Portal on 4/7/2022. Providers have access to the last 90 days. The 835 transaction type will be removed and you will no longer have access to historical remits via our Clearinghouse Portal.

To enroll to receive electronic remittances (835) please contact our payment vendor, ECHO Health Inc.

ECHO Provider Payment Portal

www.providerpayments.com

3. **What does it mean when I receive a message that an Invalid file uploaded into the CareVu Clearinghouse?**

   You loaded a file other than an 837I or 837P file.

4. **What are the PHP ID numbers that I must submit in the header record of the 837 transaction?**

Segment	Element Identifier	Description or Value
ISA	ISA01	Must be 00
ISA	ISA03	Must be 00
ISA	ISA05	Must be ZZ (mutually defined)
ISA	ISA06	Sender ID **(PHPHHA)**
ISA	ISA07	Must be ZZ (mutually defined)
ISA	ISA08 (receiver)	Preferably 'HEALTHSMART', but can be anything.
GS	GS02 (Sender)	Must be the same as ISA06 **(PHPHHA)**
GS	GS03 (receiver)	Preferably 'HEALTHSMART', but can be anything.

5. **Is there a portal user guide?**

   Yes. You can request it from support.his@healthsmart.com, and/or we can give it to PHP to distribute if they are contacted.

6. **How do I resolve an invalid payer ID message?**

   Check the value you are sending as PHP's payer ID. This value should be 14966.

7. **Why am I receiving an invalid charge amount message?**

   Check to be sure you are sending a zero (0) and not the alpha character O.

8. **How do I resolve an invalid diagnosis message?**

   Check the ICD-10 diagnosis code you are submitting. It most likely requires an additional digit or cannot be used for the date of service billed.

9. **How do I resolve an invalid procedure code message?**

   Check the CPT/HCPCS code that you are submitting. It is possible the code is not valid for the date of service billed. There are new codes and codes that are terminated each calendar year.

10. **When should I use the support.his@healthsmart.com email box to submit an inquiry?**

    Please do not submit emails pertaining to member eligibility or claim status to this email box. Please contact the PHP Provider Services department at 1-855-747-5483 for assistance.

11. **Do you have billing guidelines that I can refer to?**

    Yes, the Claims and Billing Submission guide is posted to the PHP website (www.phpcares.org) under Provider Materials

12. **Who should I contact to be able to generate claims from my system to PHP?**

    You should converse with your software vendor to inquire about how they can support generating claims either on paper or electronically via an 837I/P transaction to PHP.

13. **I am having difficulty reconciling the ERA and am unsure as to the root cause.**

    Possible issues include:

    - Check to be sure you are evaluating all 8-digits of the check number including the leading zeroes

14. **What should I expect to occur once I initiate the EDI Enrollment Process?**

    You will receive an email including the following information:

    a. The direct clearinghouse link, your username and password,
    b. Portal document, and

c. Companion guide

15. Who should I contact if I submitted a claim but have not been paid for the services provided?

Please contact the PHP Provider Services department at 1-855-747-5483 to inquire about claim status.

We will need to know the following information to assist you:

- Your Tax Identification Number
- PHP member ID and name
- Date of service
- Type of submission
    - UB or CMS1500
    - Paper or electronic
        - If electronic, what clearinghouse
- Date of submission

Provider Quick Reference Guide

Provider Relations	**Please Open a Ticket** CLICK HERE: Provider Relations Ticket Submission Form
Provider Services • Member Eligibility • Claims Status • Benefit Coverage	**Phone:** 1-855-747-5483 CLICK HERE: PHP Website
Credentialing • Inquiries • Demographic Updates	**Email:** phpproviders@healthsmart.com
Utilization Management • Prior Authorizations	**Phone:** 1-855-769-2508 **Fax:** 1-855-769-2509 **Mail:** P.O. Box 16309 Lubbock, Tx 79490 CLICK HERE: Authorization Requirements
Prescription Drugs • Coverage Determinations • Inquiries	**Phone:** 1-888-648-6759 **Fax:** 1-858-790-7100 **Mail:** 10181 Scripps Gateway Court San Diego, CA 92131 CLICK HERE: Formulary (List of Covered Drugs)
Provider Portal • Member Eligibility • Claims Status	CLICK HERE: Provider Portal Access
Claims Submission • Paper	Partners Health Plan Claims Department P.O. Box 16309 Lubbock, Tx 79490
Claims Submission • Electronic/EDI	Change HealthCare Submitter ID: 14966 Change HealthCare Phone Number: 888-363-3361 **Alternative:** Call HealthSmart Clearinghouse 888-744-6638 to set up electronic claim submission (free of charge)
Claims Submission • Web-based	Upload a CMS-1500 or UB-04 PDF claim form to https://php.healthsmart.com

CLIA (Clinical Laboratory Improvement Act) Billing

The CLIA mandates that virtually all laboratories, including physician office laboratories (POLs), meet applicable Federal requirements and have a CLIA certificate in order to receive reimbursement from Federal programs. CLIA also lists requirements for laboratories performing only certain tests to be eligible for a certificate of waiver or a certificate for Physician Performed Microscopy Procedures (PPMP). The CLIA number must be included on each claim billed on the ASC X12 837 professional format or Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA.

All laboratory testing sites must have either a CLIA certificate of waiver, certificate for provider performed microscopy procedures, certificate of registration, certificate of compliance, or certificate of accreditation to legally perform clinical laboratory testing on specimens from individuals in the United States. The Food and Drug Administration approves CLIA waived tests on a flow basis. The CMS identifies CLIA waived tests by providing an updated list of waived tests to the A/B MACs (A) and (B) on a quarterly basis via a Recurring Update Notification. To be recognized as a waived test, some CLIA waived tests have unique HCPCS procedure codes and some must have a QW modifier included with the HCPCS code. For a list of specific HCPCS codes subject to CLIA see
https://www.cms.gov/files/document/r10564cp.pdf

The HCPCS codes that are considered a laboratory test under CLIA change each year. The CMS identifies the new HCPCS (non-waived, non-provider performed procedure) codes, including any modifiers that are subject to CLIA edits by providing an updated listing of these tests to the A/B MACs (A) and (B) on an annual basis via a Recurring Update Notification. A facility that submits a claim for any test mentioned in the HCPCS codes that are subject to CLIA edits list must have either a valid, current CLIA certificate of registration (certificate type 9), a CLIA certificate of compliance (certificate type 1), or a CLIA certificate of accreditation (certificate type 3). For a list of the specific HCPCS codes subject to CLIA edits refer to the following Internet site: https://www.cms.gov/files/document/r10564cp.pdf In addition, this document lists HCPCS codes in the 80000 series that are excluded from CLIA edits by providing an updated listing of these tests to the A/B MACs (A) and (B) on an annual basis via a Recurring Update Notification. No CLIA certificate is required for a claim submitted for any test mentioned in the HCPCS codes in the 80000 series that are excluded from CLIA edits list.

100 - CPT Codes Subject to and Not Subject to the Clinical Laboratory Fee Schedule (Rev. 1, 10-01-03) HO-437, A3-3628, B3-5114.1 For fee schedule purposes, clinical laboratory services include most laboratory tests listed in codes 80048-89399 of CPT-1996. The CMS issues an update to the laboratory fee schedule each year, with information about whether prices have been determined by CMS or whether the individual A/B MAC (B) must determine the allowable charge. Codes not included are not paid under the laboratory fee schedule but may be paid under the MPFS if covered for Medicare.

Q&A

1. Do all labs done on site require a CLIA number even if they are not below? Yes.

2. Do you require the QW modifier and the CLIA number for these CPT codes CPT CODE(S) (cms.gov)? All waived tests require modifier QA.

3. The below tests are the ones that require a CLIA waiver (CLIA certificate). Should these be billed with a CLIA number on claim? Yes.

☐ Adenovirus	☐ Drugs of Abuse	☐ Nicotine
☐ Aerobic/Anaerobic Organisms-Vaginal	☐ Erythrocyte Sedimentation Rate *(ESR)*	☐ Occult Blood
☐ Alanine Aminotransferase *(ALT)*	☐ Ethanol	☐ Ovulation Tests
☐ Albumin	☐ Follicle Stimulating Hormone (*FSH*)	☐ pH
☐ Alkaline Phoshatase *(ALP)*	☐ Gamma Glutamyl Transferace *(GGT)*	☐ Phosphorous
☐ Amylase	☐ Glucose	☐ Platelet Aggregation
☐ Aspartate Aminotransferase *(AST)*	☐ Glycosylated Hemoglobin	☐ Potassium
☐ B-Type Natriuretic Peptide *(BNP)*	☐ HDL Cholesterol	☐ Pregnancy Test (*Urine*)
☐ Bacterial Vaginosis, Rapid	☐ Helicobacter Pylori	☐ Protime
☐ Bladder Tumor Associated Antigen	☐ Hematocrit	☐ RSV *(Respiratory Syncytial Virus)*
☐ Blood Urea Nitrogen *(BUN)*	☐ Hemoglobin	☐ Saliva Alcohol
☐ Breath Alcohol *(FDA OTC Devices Only)*	☐ HCV, Rapid	☐ Sodium
☐ Calcium	☐ HIV, Rapid	☐ Strep A Test (*Rapid*)
☐ Calcium, Ionized	☐ Influenza	☐ Thyroid-Stimulating Hormone *(TSH)*
☐ Carbon Dioxide	☐ Ketones	☐ Total Bilirubin
☐ Catalase *(Urine)*	☐ Lactic Acid *(Lactate)*	☐ Total Protein
☐ Chloride	☐ LDL Cholesterol	☐ Trichomonas, Rapid
☐ Cholesterol	☐ Lead	☐ Triglycerides
☐ Creatine Kinase *(CK)*	☐ Microalbumin	☐ Urinalysis
☐ Creatinine	☐ Mononucleosis	☐ Other: _____

Source:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c16.pdf

https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA

Document Updates

DATE	UPDATE	DESCRIPTION	SECTION
1/6/2017	New	Version 1.0	
3/30/2017	Update	Version 2.0	Cover Page
3/30/2017	New Section	Adult Day Health Care Services	Adult Day Health Care Services
3/30/2017	Update	ICD-10 Diagnosis R69 for OPWDD Services	Office for People with Developmental Disabilities (OPWDD) Services
3/30/2017	Update	Semi Monthly Date Range	Supportive IRA Services
3/30/2017	New Section	Community Habilitation Services	Community Habilitation Services
3/30/2017	Update	Personal Care – Use of procedure codes and units	Personal Care Services
3/30/2017	Update	Data Requirement Corrected Claims	Corrected Claims
3/30/2017	Update	Calendar Year Spanning Benefit Years	General Submission Guidelines
3/30/2017	New Section	UFO Claim Returns/DOB Discrepancies	Unidentified Claim Returns
3/30/2017	Update	Claim form examples added to all OPWDD Services	
3/30/2017	Update	Additional FQHC guidance	FQHC Claims
6/9/2017	Update	Version 2.1	Cover Page
6/9/2017	Update	Paper Claims – Mailing Address	General Claims Submission Guidelines
7/31/2017	Update	Version 3.0	Cover Page
7/31/2017	New Section	Day Habilitation Services	Day Habilitation Services
7/31/2017	New Section	ICF	ICF
7/31/2017	Update	Self-Directed Services – Rate Code at header level	Self-Directed Services
7/31/2017	Update	Revised mailing address on Member ID Card	General Claims Submission Guidelines
7/31/2017	Update	Revised mailing address on EOB example	General Billing Guidelines
7/31/2017	Update	Valid Admit Types, Admit Sources, Bill Types	General Claims Submission Guidelines
7/31/2017	Update	Clearinghouse, EFT, 835 Information	General Claims Submission Guidelines
7/31/2017	New Section	Claim Check Editing	Claim Check Editing
7/31/2017	New Section	MedAssets	MedAssets
7/31/2017	Update	Pay to Name qualifier - 77	UB-04 Claim Form Crosswalk to 837I EDI Layout

1/1/2018	Update	Version 4.0	Cover Page
1/1/2018	Update	Revised Change Healthcare telephone number	General Claims Submission Guidelines
1/1/2018	New Section	Provider Quick Reference Guide	Provider Quick Reference Guide
1/1/2018	Change	• Effective Dates • Statement From & Through Dates	Personal Care Services
1/1/2018	New	• New Billing Codes 1/1/18 • Statement From & Through Dates	Personal Care Services
1/1/2018	Change	• Effective Dates • Statement From & Through Dates	CDPAS/CDPAP Services
1/1/2018	New	• New Billing Codes 1/1/18 • Statement From & Through Dates	CDPAS/CDPAP Services
1/1/2018	Change	• Effective Dates	ADHC Services
1/1/2018	New	• New Billing Codes 1/1/18	ADHC Services
1/1/2018	Update	Rate Codes, Submission Guidelines and Inquiries	Self-Directed Services
5/1/2018	Update	ID Card – New Logo	General Claim Submission Guidelines
5/1/18	Update	Explanation of Benefits Example – New Logo	General Billing Guidelines
5/1/18	Update	Updated Billing Codes	Respite Services
10/18/18	Change	Claim Form Example	Respite Services
10/18/18	Change	Transportation Units Note	ADHC Services
10/18/18	Change	Remove reference to denial EOB Code BG	Personal Care Services
10/18/18	Change	Remove reference to denial EOB Code BG	CDPAS/CDPAP Services
10/18/18	Change	Remove reference to denial EOB Code BG	ADHC Services
10/18/18	Update	Units	Home Health Care Billing
10/18/18	Update	Units	Community Habilitation Services
10/18/18	Update	Units	General Billing Guidelines
10/18/18	Update	FQHC Coding	FQHC Claims
10/18/18	Change	Voided Claims	Corrected Claims
2/28/19	Update	Updated Electronic Funds Transfer (EFT) enrollment and contact information	General Claims Submission Guidelines
3/19/19	Change	Add credit card payment information	General Claims Submission Guidelines
5/21/19	Update	Added CareVu EDI FAQ's	General Claims Submission Guidelines
5/21/19	Update	Added Zelis ePayment steps	General Claims Submission Guidelines
12/18/19	Update	Updated EOB Code – Changed to Zelis	Zelis Editing
12/18/19	Update	Change from MedAssets to nThrive	nThrive

12/31/19	Update	Removal of Lower of Reimbursement	General Claims Submission Guidelines
12/31/19	Update	Link to EDI Enrollment Packet	General Claims Submission Guidelines
1/2/2020	Update	Link to OPWDD Rate Codes	Office for People with Developmental Disabilities (OPWDD) Services
01/03/2020	Update	Member ID Card Example	General Claims Submission Guidelines
3/27/2020	New Section	CFCO Benefits Effective 1/1/2020	CFCO Benefits
3/27/2020	Update	Retroactive Rate Updates	Office for People with Developmental Disabilities (OPWDD) Services
3/30/2020	New	CMS link - NCD/LCD Denials	nThrive
3/30/2020	New	Claim Appeal Guidelines	Claim Appeal Guidelines
3/31/2020	New Section	SNF Billing Guidelines	SNF (Skilled Nursing Facility) Billing
12/22/2020	Delete	Remove section on CFCO Benefits due to delay in implementation until 2022	CFCO Benefits
12/22/2020	Update	Member ID Card Example – Revision effective 1/1/2021	General Claims Submission Guidelines
12/22/2020	Update	Provider Billing Address Updates– Delegated Providers	General Claims Submission Guidelines
12/22/2020	Update	Remove Provider Relations phone number	Provider Quick Reference Guide
12/23/2020	Update	Corrected and voided claims processing	Corrected Claims
12/23/2020	Update	Supervised IRA Medical Leave	Supervised IRA
9/1/2021	New Section	Office Labs and CLIA	Office Laboratory
9/1/2021	Updated	FQHC Claims	FQHC Claims
1/1/2022	Updated	Member ID Card Example – Revision effective 1/1/2022	General Claim Submission Guidelines
3/31/2022	New Section	Provider Portal Claim Form Submission	HealthSmart PHP myTPA Provider Portal Claim Submission
3/31/2022	Update	Availity EDI Clearinghouse	General Claim Submission Guidelines
3/31/2022	Update	ECHO Health	General Claim Submission Guidelines
3/31/2022	Delete	Zelis Epayment Enrollment Process	General Claim Submission Guidelines
3/31/2022	Update	Electronic Funds Transfer (EFT) and/or Credit Card Payments	General Claim Submission Guidelines
6/13/2022	Update	Responses to ERA questions	CareVu

6/13/2022	Update	837 Electronic Claim Submissions	General Claim Submission Guidelines
6/21/2022	Update	Link to EDI Enrollment Packet	General Claims Submission Guidelines
10/26/2022	Update	Provider Quick Reference Guide	Provider Quick Reference Guide
11/16/2022	Update	Links	Provider Quick Reference Guide
11/16/2022	Update	EDI Enrollment Packet – Link	General Claim Submission Guidelines