Supervising CHW/P/R Providers Claims

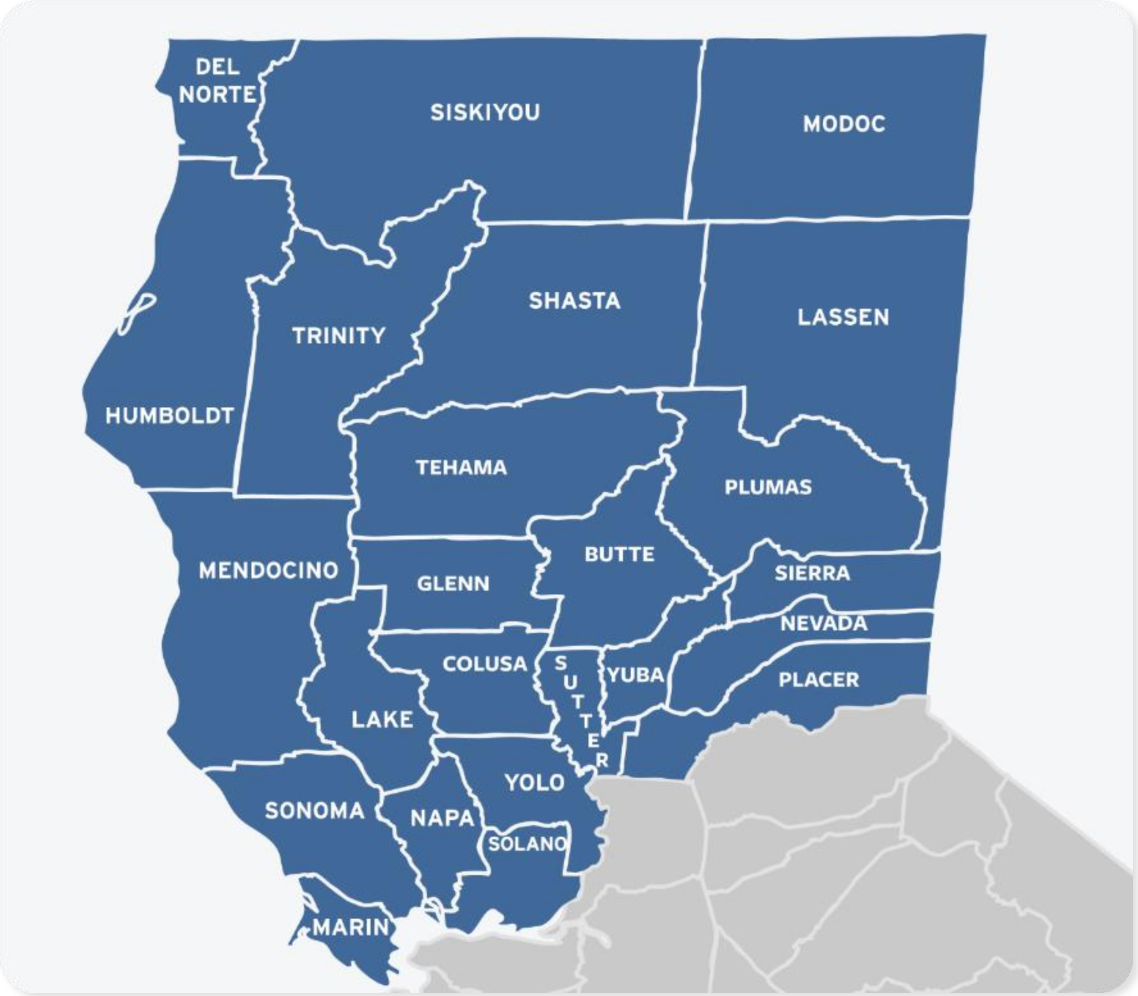
Claims Resolution Team

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

ACCREDITED NCQA HEALTH PLAN ACCREDITED

About Us



Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Overview

- What is a Claim/Clean Claim?
- Clean Claim Billing Tips
- Methods of claim submission
- Benefits of Electronic Billing
- CMS 1500 Form
- Billing Requirements
- Claims Example
- Claim Corrections
- Best Practices
- Contact Us

What is a Claim?

- A claim is a “bill” that healthcare providers submit to a member’s insurance provider
- The bill contains unique medical codes detailing the care or services administered during a member visit
- The codes describe any service that a provider uses to render care
- A provider submits a claim that includes all relevant codes and charges for that visit, including procedure codes, diagnosis codes, and modifier.

What is a Clean Claim?

- A “**clean claim**” is a claim that can be processed without obtaining additional information from the provider of a service or a third party.
- Partnership has 45 business days from the received date to process claims.
- Currently, we are processing most clean claims within 20 days of receipt.

Clean Claim Billing Tips

Providers have 365 days from the date of service to submit claims to Partnership for payment consideration. Claims received on the 366th day from the date of service will be denied.

Verify the member's Client ID/CIN is valid and complete on the invoice. Do **NOT** use the member's Social Security number.

Make sure you are using the current version of the claim form dated 02/12 printed in red "drop-out" ink.

All CMS1500 forms require a "**wet**" signature. This means an actual signature; not initials, a stamp, and/or typed. This includes copies for crossover claims. The signature does not have to be the actual physician, it can be the biller or any designated representative of the practice. Use black ink only.

Claim Submission

Electronic Claims

Electronic Data Interchange (EDI)

- ✓ Submission of HIPAA-compliant 5010 version 837P File
- ✓ Preferred submission method for faster reimbursement
- ✓ Contact EDI Enrollment and Testing at:
  Phone: (707) 863-4527 or EDI-Enrollment-Testing@partnershiphp.org

Paper Claims

- ✓ Submission of CMS-1500 format only
- ✓ Send to: Partnership HealthPlan of California (Medi-Cal)
  P.O. Box 1368
  Suisun City, CA
  94585-1368

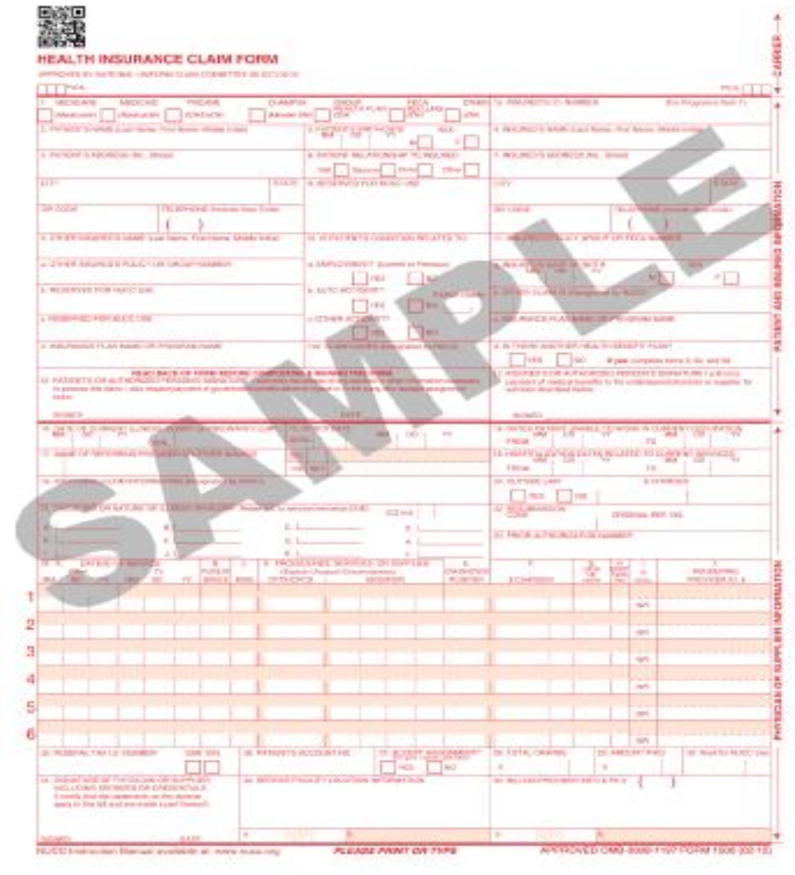
Benefits of Electronic Billing

Why bill electronically?

- Improve data quality
  - Eliminating illegible handwriting errors
  - Keying and re-keying error
- Real-time visibility into transaction status
  - Error reports from Clearing House enables corrections of errors
- Reduced administration expenses
  - No more purchasing claims forms
  - No printing necessary
  - Postage and handling cost eliminated
- Expedited claims adjudication & payment
  - Exchange transaction in minutes instead of days for postal service
  - Quicker processing and turnaround for reimbursement

CMS 1500 Form

Professional Claim Type	
Provider Information	Supervising Provider's NPI
	Supervising Provider's Taxonomy
	Spervising Provider Address
Member Information	Member Name
	Date of birth
	PHC Member ID or CIN
	Address
	Gender
	Signature on file or member signature
Service Visit Information	Date of service
	Place of service code
Service delivered	Appropriate Diagnosis + ICD 10 Indicator 0
	Proc code + modifier
	Number of units to bill
	Charges (in $)



Note: All services for Community Health Workers MUST be billed on a CMS-1500 form or the electronic equivalent (837P v.5010 transaction).

Billing Requirements

CPT Code	Description	Time	Number of Patients	Frequency Limit
98960	Self-management education and training, Face-to Face	30 minutes	1	12 units up to 6 hours total
98961	Self-management education and training, Face-to Face	30 minutes	2 - 4	
98962	Self-management education and training, Face-to Face	30 minutes	5 - 8	
Modifiers	**Description**		**Location Code**	
U2	Used to denote services rendered by Community Health workers		ANY	

Please note: If billing for telehealth services location code 02 is required

CMS 1500 Form

HEALTH INSURANCE CLAIM FORM

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

PARTNERSHIP HEALTHPLAN OF CALIF

PO BOX 1368
SUISUN CITY, CA 94585

CARRIER

PICA | PICA

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) X | 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): 99999999K1

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

3. PATIENT'S BIRTH DATE MM DD YY: 06 23 1963 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME AS PATIENT

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

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 4665 BUSINESS CENTER DRIVE

CITY: FAIRFIELD STATE: CA

8. RESERVED FOR NUCC USE

CITY: FAIRFIELD STATE: CA

ZIP CODE: 94534 TELEPHONE (Include Area Code): (707) 555-5555

ZIP CODE: 94534 TELEPHONE (Include Area Code): (707) 555-5555

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 X 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 SIGNATURE ON FILE DATE 01/02/2022

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 SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

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 FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

CMS 1500 Form-CHW

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. Z556 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER PK2404270001

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. #
08	22	23	08	22	23	99		98960	U2	A	106 64	4		NPI	
														NPI	
														NPI	
														NPI	

25. FEDERAL TAX I.D. NUMBER 941235687 SSN EIN ☐ ☑

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 106 64

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.)

Bonnie Fries 08/24/2023

SIGNE DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING ROVIDER INFO & PH # ( )

PHC BILLING DEPT.

a. 168669999 NPI b.

Claim Corrections:
Provider Dispute Resolution

Providers have the right to submit a payment dispute if they disagree with a claim decision regarding the denial or compensation of a claim. Providers may submit disputes via Provider Online Services or by mail.

The Provider Claims Dispute Resolution process is a used by contracted and non-contracted providers for disputes regarding invoices, billing determinations or other contractual or non-contractual issues.

PROVIDER CLAIMS DISPUTE RESOLUTION REQUEST (Attachment A)

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: **Partnership HealthPlan of California**
  Attn: Claims PDR
  P.O. Box 1368
  Suisun City, CA 94585-3172

Note: DO NOT USE THIS FORM FOR UM/MEDICAL NECESSITY/TAR OR PHARMACY APPEALS
FAX UM/TAR APPEALS TO: **(707)863-4118** FAX PHARMACY APPEALS TO: **(707) 863-7330**

***PROVIDER NPI:**	***PROVIDER TAX ID:**
***PROVIDER NAME:**	
PROVIDER ADDRESS:	

PROVIDER TYPE: ☐ MD/PCP ☐ Specialist ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab
☐ Home Health ☐ Ambulance/Transportation ☐ MH ☐ Other ____________ (please specify)

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet)

***Member Name:**		***Date of Birth:**
***CIN/Mem ID Number:**	**Patient Account Number:**	***Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
***Service "From and To" Date:**	***Original Claim Amount Billed:**	**Original Claim Amount Paid:**

***DISPUTE TYPE**

☐ Corrected claim/Additional documentation attached
☐ Underpayment
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Retroactive Authorization now on file
☐ Other:

***DESCRIPTION OF DISPUTE:**

***EXPECTED OUTCOME:**

Claim Corrections:
Provider Dispute Resolution

- ✓ Disputes can be submitted within 365 days (one year) from the original paid/denied date on the Partnership RA. Disputes received after one year are subject to automatic denial.
- ✓ Partnership will acknowledge receipt of the dispute immediately and will respond electronically indicating the outcome of the dispute review within 45 working days.
- ✓ Provider Dispute form can be downloaded from the Partnership website.

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***DESCRIPTION OF DISPUTE:**

***EXPECTED OUTCOME:**

Best Practices

- Submit claims regularly – this allows for time if you need to submit for an authorization.
- Review your claim for any necessary attachments, remarks, modifiers, and other claim requirements.
- Review your EOB/RA immediately for any billing errors and generate an e-CIF to make corrections. e-CIFs are the easiest and quickest method of claims corrections.
- Verify billing requirements on the Medi-Cal website or Partnership website before submitting your e-CIF.
- Any questions about claim payments and/or denials, please call Claims Customer Service for clarification prior to submitting an e-CIF.
- It is important to follow the e-CIFs levels. Skipping straight to an appeal will result in a final outcome and no additional options to make corrections.

TAR Information

- CHW/P/R services only require a TAR if billing for more than 12 units (six hours) and must be recommended by a licensed provider.
- TARS for CHW/P/R services will require the following attachments:
  - Referral from licensed provider per APL 24-006
  - Plan of Care
- CHW/P/R TARs will be approved for 180 days (six months).
- Providers may not bill CHW/P/R services for a member, during the same time period as enrolled in Enhanced Care Management. Those claims will be denied.

Contact Us

Partnership – Provider Online Services

- https://provider.partnershiphp.org

Claims Resolution Unit

- 1 (855) 798-8761

Claims Customer Service

- 1 (855) 798-875

Support Emails

- claimshelpdesksr@partnershiphp.org
- esystemssupport@partnershiphp.org

Questions