Value Behavioral Health of Pennsylvania, Inc.

Billing Guide

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VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
A BEACON HEALTH OPTIONS COMPANY

Table of Contents

Introduction 1

Eligibility 2

Prior to Service Delivery 2

Authorization 3

Authorization Letters 3

Authorization Questions 3

Timely Filing Requirements 4

Claims Processing Turnaround Time 4

Timely Filing Waiver Requests 5

Methods of Claims Submission 6

Electronic Claims Submissions 6

Direct Claims Submitters 6

Claims Clearinghouses 7

Paper Claims Submissions 8

Claims Submissions Guidelines 8

Inpatient and JCAHO Residential Treatment Facilities (RTF) 9

Claims Data Submitted to DHS 9

Non-JCAHO and Other Providers 11

Member Demographic Information 12

Date Span Billing 13

Duplicate Billing 13

Reportable Diagnosis Codes 13

ICD-10 Codes Update 14

Third Party Liability (TPL) 15

Coordination of Benefits 16

HRA/HSA/HIA Accounts 16

TPL Updates 17

Act 62 18

Important Reminders 18

FAQs 19

Claims Corrections 22

Tips to Resolve Claim Denials 23

ProviderConnect® 25

Notes 26

Introduction

Since 1999, Value Behavioral Health of Pennsylvania, Inc. (VBH-PA) has managed behavioral health services as part of the HealthChoices program. VBH-PA manages behavioral health services for Medical Assistance (MA) recipients in 12 Western Pennsylvania counties: Armstrong, Beaver, Butler, Crawford, Fayette, Greene, Indiana, Lawrence, Mercer, Venango, Washington, and Westmoreland.

The VBH-PA dedicated Claims Department processes all claims for its HealthChoices contracts. The staff is highly trained and well-versed in the payment rules for HealthChoices. VBH-PA utilizes its tested and proven Connections Administrative System (CAS) for claims processing. VBH-PA accepts electronic and paper claims.

All claims are received and processed at VBH-PA in Cranberry Township, Pennsylvania. The claims payment department at VBH-PA is responsible ***only*** for those claims submitted by providers serving Pennsylvania HealthChoices members.

VBH-PA's claims processing success results from the highly-skilled and efficient claims personnel in Cranberry Township along with the Beacon Health Options CAS claims processing module. The integrated eligibility/enrollment, provider, electronic claims submission, inquiry tracking, data warehouse, and interactive voice response components augment the claims system.

CAS integrates claims data, authorization, utilization management processes and results, and provider data. This integration allows Claims Analysts and Member and Provider Service Representatives (MPSRs) to have real-time access to all case and claims data. The system performs automatic claim suspension routines for such situations as duplicate claim submission, Third Party Liability (TPL) notification, eligibility discrepancies, and authorization edits.

VBH-PA encourages all of our providers to contact the Customer Service Department at 1-877-615-8503. The Customer Service Department staff is available Monday through Friday from 8:00 a.m. to 5:00 p.m. to answer questions or direct providers to the appropriate department.

Eligibility

Prior to Service Delivery

Before providing services, Verification of Eligibility is the first step to confirm if the member is eligible for services under Pennsylvania Medicaid and/or HealthChoices.

Eligibility verification can be completed in a variety of ways:

- Eligibility verification information is provided by OMAP and EDS free of charge for download from the OMAP Website.
    - **Web Interactive** - A Web eligibility window is available to approved providers and other agencies. The Web address for this is http://promise.dpw.state.pa.us/
    - **Eligibility Verification System (EVS)** – The Medical Assistance HIPAA compliant PROMISe™ ready software referred to as Provider Electronic Solutions Software can be downloaded at: https://promise.dpw.state.pa.us/ePROM/_ProviderSoftware/softwareDownloadForm.asp?m=1
    - **Telephone** - Requires your 13-digit PROMISe™ Provider Identification Number. Providers utilizing the telephone access method should dial 1-800-766-5387 to check recipient eligibility via phone.

- ProviderConnect® (Beacon Health Options' Provider Services Web portal) should be used to obtain online access to check member eligibility, request inpatient/outpatient authorization, view and submit claims, and to view payment vouchers. ProviderConnect is easy to use, secure, and available 24/7.
    https://www.valueoptions.com/pc/eProvider/providerLogin.do

Medical Assistance Eligibility is determined by the County Assistance Office and is highly variable and dependent upon the recipient's personal circumstances. VBH-PA strongly encourages providers to verify eligibility at the time of each visit to confirm eligibility.

Authorization

An authorization is a determination made to approve or deny a provider's request to provide a service or course of treatment of a specific duration and scope to a member.

Authorizations can be obtained in a variety of ways based on the level of care being provided to the member. Those ways are:

- **Via telephone** – VBH-PA's service management staff is available 24 hours a day, seven days a week. The toll-free Provider Services Line is 1-877-615-8503.
- **Via ProviderConnect**
- **Via Facsimile** – fax the precertification forms

All in-network providers should refer to the **Authorization Requirements** document to determine the appropriate method to request authorization. This document is updated frequently. The most recent version can be found in our Provider Manual, under Section III: Utilization Management, Authorization Requirements.

Out-of-network providers must call the Provider Services Line at 1-877-615-8503 to request Single Case Agreement.

Authorization Letters

Upon approval, authorization letters for in-network providers are generated within 24 hours and can be viewed and printed via ProviderConnect.

Authorization Questions

Be sure to confirm authorization (if required) for services prior to submitting your claim. ProviderConnect is available to all providers to confirm authorization. Additionally, if you have any questions regarding your authorization, please call the Customer Service Department at 1-877-615-8503.

Customer Service staff are available to assess your concern and initiate an authorization investigation to resolve outstanding issues.

Remember, payment for all authorized services is contingent upon the eligibility of the member.

Timely Filing Requirements

Claims for services provided to eligible members should be submitted promptly once all required authorizations are in place. VBH-PA strongly encourages providers to bill within 30 days of rendering service.

The Timely Filing Requirement to submit initial claims to VBH-PA for HealthChoices members is within 90 days of:

- The date of service (DOS),
- The date of discharge (DOD), or
- The date of the primary carrier Explanation of Benefits (EOB) for secondary claims submissions.

Please review the Provider Covered Services Grid to determine if the service must be submitted within 90 days of the date of service or date of discharge. Here is the link to the Provider Covered Services Grid: http://www.vbh-pa.com/providers/provider-manual/3-provider-covered-services-grid-hipaa-compliant/

Claims Processing Turnaround Time

VBH-PA's standard for claims processing is to adjudicate 90% of all clean claims within 30 days, 100% of clean claims within 45 days, and 100% of all claims within 90 days.

Clean Claim (def.) – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the primary contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for Medical Necessity, or a claim that is from a provider who is under investigation by a governmental agency or the primary contractor or BH-MCO for fraud or abuse. However, if under investigation by the primary contractor or BH-MCO, the Department must have prior notification of the investigation.

Timely Filing Waiver Requests

Requests for an exception to the 90-day timely filing requirement can be submitted for review. Before a timely filing waiver request can be considered, authorization must be in place (if required), and the member must be eligible on the dates of service outstanding.

The documentation required must include:

- Letter from provider (on letterhead) explaining why the waiver is being requested, including any remedies put in place to prevent the issue from reoccurring
- A listing of the outstanding amounts (contracted rate) by member that includes
    - Medical Assistance Recipient Number
    - Service code/modifier
    - Date of service
    - VBH-PA claim number if previously billed
    - Outstanding amount
    - County of member
- A claim form (CMS-1500 or UB-04) for claims not on file with VBH-PA with all required fields populated

The Timely Filing Waiver Request may be mailed to:

Value Behavioral Health of Pennsylvania
Attention: Timely Filing Committee
P O Box 1840
Cranberry Township, PA 16066-1840

VBH-PA staff will present the timely filing waiver request to the applicable oversight group for approval/denial.

Methods of Claims Submission

VBH-PA only accepts claims through

- Electronic Data Interchange (EDI)
- Direct Claims Submission (ProviderConnect Web-based application)
- Claims Clearinghouses
- Industry Standard Claim Forms (UB-04 or CMS-1500)

Electronic Claims Submission (EDI)

Providers can submit claims electronically to our system via a direct, secure Website. Batch claims submission can be sent via EDI. This is best for large volume submitters. For my information, see the Beacon Health Options EDI Resource Document at the link below:

https://www.beaconhealthoptions.com/wp-content/uploads/2016/11/Appendix-2C-2-EDI-Resource-Document-E-Support-Services-for-ProviderConnect-and-Electronic-Claims.pdf

You may use either **EDI Claims Link for Windows** (Beacon Health Options' proprietary software), or any third party software that creates a HIPAA compliant 837 file.

EDI Claims Link for Windows software and instruction manual can be found under **ECLW Resources** on this page:

https://www.beaconhealthoptions.com/providers/beacon/providerconnect/

Direct Claims Submitters

ProviderConnect allows for submission of a single claim online. You may use only Direct Claims Submission for outpatient claims. **Inpatient claims <u>may not</u> be entered through Direct Claims Submission at this time.** Once provider and member information is entered and validated, the user will be prompted to provide the remainder of the information required to complete the claim. The results page will contain real-time adjudication information.

- Read Beacon Health Options' *Guide to Direct Claim Submission for Professional Claims* under **Guides** on this page: https://www.beaconhealthoptions.com/wp-content/uploads/2016/11/Direct-Claim-Submission-Guide.pdf
- Log onto ProviderConnect to submit claims

Claims Clearinghouses

Your clearinghouse should be able to convert this to a 5-digit number: **Payor Name – FHC & Affiliates**.

If you have any additional questions regarding this information, please contact the Beacon Health Options' EDI Helpdesk at 1-888-247-9311.

Paper Claims Submission

VBH-PA only accepts industry standard claim forms:

- **CMS-1500 Claim Form**
  - Beginning June 1, 2014, Beacon Health Options will only accept claims submitted on the revised CMS-1500 paper claim form (version 02/12). Copies will not be accepted.
- **UB-04 Claim Form**
  - The provider must submit the actual form. Copies will not be accepted.

As of October 1, 2017, the *NEW* Paper Claims Mailing Address is:

Beacon Health Options
Pennsylvania Claims
P O Box 1853
Hicksville, NY 11802-1853

E-Commerce Reminder

According to results from our annual Provider Satisfaction Survey, providers who use electronic solutions are overall more satisfied with the level of services they receive from Beacon Health Options (Beacon), formerly known as ValueOptions. Therefore, in an effort to increase cash flow for our providers, decrease their administrative costs, and ensure all providers are satisfied with the level of services they receive from Beacon, we have launched an initiative aimed at helping transition providers from paper-based to electronic processes for all routine transactions.

Providers in Beacon's network are expected to conduct all routine transactions electronically, including:

- **Submission of claims**
- **Submission of authorization requests**
- **Verification of eligibility inquiries**
- **Submission of re-credentialing applications**
- **Updating of provider information**
- **Electronic fund transfer**
- **Provider claims and authorization status checks.**

Please refer to the Beacon Health Options' E-Commerce Initiative for helpful resources.

Claims Submissions Guidelines

Inpatient and JCAHO Residential Treatment Facilities (RTF)

Inpatient and JCAHO residential treatment facilities' (RTF) claims submission methods:

- EDI – 837 Institutional Format
- Paper UB-04

Inpatient and JCAHO residential treatment facilities' (RTF) claims require additional data elements when submitted by hospitals, skilled nursing facilities and other providers. The data elements are determined by the National Uniform Billing Committee (NUBC) and the state uniform billing committees (SUBC).

Please refer to the Provider Covered Services Grid "Form Type" column which designates if the 837I/UB form should be used when submitting your claim.

Claim Data Submitted to Department of Human Services

VBH-PA is required to submit a file to the Pennsylvania Department of Human Services that contains detailed claim data on processed claims. Multiple edits can take place, where if the claim is not completed correctly VBH-PA receives an "error." With the implementation of 5010, additional edits have been added and more information is needed from the provider than was previously required.

In an effort to help us reduce the number of errors VBH-PA receives, VBH-PA is adding several edits to our adjudication program. If missing data elements are missing or invalid, VBH-PA will begin to deny claims. An example of the data elements that are required are statement covers period, bill type, admit date, discharge hour, patient status, value codes/amount and covered/non-covered days. The purpose of the additional edits is to ensure acceptance when extracts are sent to DHS.

Below is a list of the fields VBH-PA is required to submit:

- The service address must be a street address – Post Office Boxes are not valid service addresses
- If the payment address is different than the service address, a Post Office Box is allowed in this field
- Federal Tax ID
- Statement Covers Period
    - From and Through dates (of service). Note – if there are itemized dates in the detailed portion of the claim they must fall within the From and Through dates
- Patient Name

- Patient Address
  - Street
  - City
  - State
  - Zip code
- Birth Date
- Bill type – One issue VBH-PA has seen with this field is that the patient status indicates the patient is "still a patient," but the bill type ends in a '1' or a '4' indicating the patient has been discharged. The notes below hold true for all UB claims, Inpatient, Residential Treatment, TC, and Outpatient:
  - If the bill type ends in a '1' this indicates an admission through discharge claim
    - The patient status cannot be '30'
    - There must be a discharge hour billed
  - If the bill type ends in a '2' this indicates the member has been admitted to care and is still in care
    - The patient status must be '30'
    - There cannot be a discharge hour billed
  - If the bill type ends in a '3' this indicates the member is still in care
    - The patient status must be '30'
    - There cannot be a discharge hour billed
  - If the bill type ends in a '4' this indicates the member was discharged from care on the end date of service
    - The patient status cannot be '30'
    - There must be a discharge hour billed
- Admission Date
- Admission Hour
- Admission Type
- Admission Source
- Discharge Hour
- Patient Status
- Value Codes (only submit both if you are submitting covered and non-covered days on your bill)
  - 80 – Covered Days
  - 81 – Non-covered Days
- Value Amount
  - Number of covered days
  - Number of uncovered days
- Revenue Code
- Description
- HCPCS Code, if applicable; otherwise Rate is optional
- Service Date – only if a HCPCS code is billed
- Service Units
- Total Charge by Revenue Code
- Total Billed Charge for claim
- National Provider Identifier (NPI)
- Payer Name (including any primary insurance carriers)

- Health Plan ID
- Release of Information indicator
- Assignment of Benefits indicator
- Primary Insurance Carrier payments
- Insured's Name
- Relationship
- Insured's ID Number
- Diagnosis Code (all that apply)
- Present on Admission (POA) Indicator
- Admitting Diagnosis
- Attending Physician's NPI
- Attending Physician's Name
    - Last name
    - First name
- Ordering, Referring, or Prescribing Provider's NPI
- Ordering, Referring, or Prescribing Provider's Name
    - Last Name
    - First Name

If your organization has not been submitting this information to VBH-PA, it is possible that your claim will be rejected with a request to submit the missing information.

Non-JCAHO and Other Providers

Claims submission methods for individual practitioners, clinics, and other outpatient services providers, including non-hospital residential and non-JCAHO residential treatment facilities (RTFs):

- EDI – 837 Professional Format
- ProviderConnect Direct Claims
- Paper CMS-1500

Please be sure to review your contract to confirm your service code(s) and modifiers (if applicable) required for reimbursement for services provided. Combining modifiers that are not specifically listed on the Provider Covered Service grid for the type of service will delay payment.

All HealthChoices claims billed via 837 Professional Format or CMS-1500 require a valid Place of Service (POS) Code for adjudication. All valid POS codes are listed with the service code/modifier combination reimbursable by VBH-PA. This information is available on the Provider Covered Services Grid.

Place of Service Codes (POS)

POS	Place of Service Description	POS	Place of Service Description
03	School	49	Independent Clinic
11	Office	50	Federally Qualified Health Center
12	Home	52	Psychiatric Facility - PH
15	Mobile Unit	54	ICF/MR
21	Inpatient Hospital	56	Psychiatric RTF
22	Outpatient Hospital	57	Non-Residential Substance Abuse Treatment Facility
23	Emergency Room - Hospital	65	End-Stage Renal Disease Treatment Facility
24	Ambulatory Surgical Center	72	Rural Health Clinic
31	Skilled Nursing Facility	81	Independent Laboratory
32	Nursing Facility	99	Other POS

Member Demographic Information

Review member demographic information before submitting claims. Due to HIPAA confidentiality guidelines, accuracy has become more important than ever. Pay special attention to the member's date of birth and spelling of first and last names. If VBH-PA receives member information that does not match Department of Human Services (DHS) files, your claim payment will be delayed or possibly denied under PAUNKNOWN.

To alert you to discrepancies, you will notice informational explanation of payment (EOP) codes on your voucher when these claims are processed. Those EOP codes will identify members that are being billed with either date of birth or name spelling discrepancies. The informational EOP codes are as follows:

X10 – Check member date of birth on future submissions
X11 – Check spelling of name on future submissions

Helpful Hint: Submit the member's name exactly as it appears on your authorization letters and/or the member's access or Physical Health Plan Identification Card. This will ensure that your submission matches the eligibility data VBH-PA receives from DHS. Pay special attention to nicknames and initials!

If you are unsure of the correct date of birth or spelling, or if you have an update to the demographics of a member, please call the Provider Services Line at 1-877-615-8503 and speak to a Provider Services Representative.

Date Span Billing

To reduce the number of claims denied for needing itemized statements, providers' billing services codes/modifiers that are not valued at one (1) unit per day should refrain from date span billing.

Services that could be billed and reimbursed with more than one (1) unit per day, should be submitted with each date of service on a separate claim line showing the appropriate number of units provided for that date.

Duplicate Billing

In a recent article published by HGSA, Medicare expects duplicate submissions to be less than one percent of all claims processed. The article emphasizes that "patterns of filing duplicate claims are considered a form of program abuse." According to the Centers of Medicare and Medicaid Services, abuse is defined as, **"Intentionally or unintentionally filing duplicate claims, even if it does not result in duplicate payment."**

Below are some helpful hints that may prevent duplicate claim denials:

- Do not resubmit claims until you have received confirmation from ProviderConnect or a Provider Services Representative that the initial claim is not on file.
- If your software automatically generates a resubmission, please keep in mind that VBH-PA has thirty (30) days to process a claim. Program your software to allow sufficient time for receipt of payment and posting to patients' accounts.
- Claims received with the identical date of service, place of service code and service code/modifier of an existing claim will be denied as a duplicate. If you need to increase/decrease units for services already submitted and paid, please use the Change/Reprocess feature in Direct Claims Submission to update your claim.

Reportable Diagnosis Codes

The implementation of ICD-10 will:

- Accommodate new procedures and diagnoses unaccounted for in the ICD-9 code set;
- Allow for greater specificity of diagnosis-related groups and preventive services; and
- Allow for improved accuracy in reimbursement, fraud detection, historical claims and diagnoses analysis for the health care system.

Pay special attention to the age of the member in relation to the diagnosis code description. For example, when billing diagnosis code F93.0 - Separation Anxiety D/O of Childhood. This diagnosis code can be applied to recipients aged 0-20 years old. If you bill a claim with this diagnosis code for a recipient aged 21 years old, your claim will be denied. The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.

New for 2017 - ICD-10 Compliance Updates

Effective October 2, 2017, VBH-PA will be fully compliant with the ICD-10 Code Changes. There are ICD-10 coding updates that are now in effect. The changes are below:

Codes identified by Clinical that affect our business:		
Action	**Code**	**Description**
Add:	F10.11	Alcohol abuse, in remission
Add:	F11.11	Opioid abuse, in remission
Add:	F12.11	Cannabis abuse, in remission
Add:	F13.11	Sedative, hypnotic or anxiolytic abuse, in remission
Add:	F14.11	Cocaine abuse, in remission
Add:	F15.11	Other stimulant abuse, in remission
Add:	F16.11	Hallucinogen abuse, in remission
Add:	F18.11	Inhalant abuse, in remission
Add:	F19.11	Other psychoactive substance abuse, in remission
Revise from:	F41.0	Panic disorder without agoraphobia
Revise to:	F41.0	Panic disorder [episodic paroxysmal anxiety]
Add:	F50.82	Avoidant/restrictive food intake disorder
Add:	T14.91XA	Suicide attempt, initial encounter
Add:	T14.91XD	Suicide attempt, subsequent encounter
Add:	T14.91XS	Suicide attempt, sequela

See the following resources for more information on these changes:

https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-CM-and-GEMs.html

Third Party Liability (TPL)

Value Behavioral Health of Pennsylvania is payor of last resort. It is important that the Third Party Liability information contained within ProviderConnect is reviewed at the time services are delivered to ensure that the primary carrier's procedures are followed. If you do not provide an Explanation of Benefits with your claim, the claim will be denied. Listed below is helpful information to reference when providing and billing services that are not TPL exempt.

Providers must always confirm the following information with the member prior to service delivery:

- ✓ Does the member have private insurance or Medicare Primary?
  - If yes, obtain a copy of the front and back of the private insurance or Medicare card.
- ✓ Determine if there is a ***carve-out*** responsible for managing behavioral health benefits
- ✓ Contact private insurance plan (***carve-out***) or Medicare to obtain authorization (if required)
- ✓ Submit claims to the private insurance or Medicare plan within their timely filing guidelines.

Secondary claims to VBH-PA must be received within 90 days of the date of the primary Explanation of Benefits. Secondary claims can be submitted via EDI, ProviderConnect Direct Claims, and paper claim forms.

EDI Secondary Claims must include the following:

- Identify Primary Insurance Carrier Name
- Identify Primary Insurance Group and Member Number
- Identify Primary Carrier Paid Date
- Identify Primary Carrier Total Patient Responsibility Amount (Deductible/Co-Pay/ Co-Insurance)
- Denial Reason/Remark Codes
- Date(s) of Service
- Service Codes/Modifiers

ProviderConnect Direct Claims must include the following:

- Upload a legible copy of the Explanation of Benefits (EOB) and always check **YES** to the question "Does a COB exist for the claim?" and always include the primary payer's denial legend/remark code reason.

- Coordination of Benefits (COB)/Other Payer Information must be completed when submitting your claim via ProviderConnect Direct Claims

Paper Claim Forms:

- Legible copy of paper EOB, including the primary payer's denial legend/ remark code reasons
- The date of the primary payer's EOB is required to establish timely filing guidelines
- One EOB should be behind **each** claim form
- **Do not staple claims forms and EOB together**
- Secondary paper claims must be mailed to the paper claims mailing address (see Methods of Claims Submission)

Coordination of Benefits

Value Behavioral Health of Pennsylvania is payor of last resort. All primary/secondary/tertiary insurances must be billed prior to submitting the claim to VBH-PA.

- Providers and members must follow the primary carrier's requirements.
- Providers who are not in-network/non-participating with the primary carrier's network should request an out-of-network arrangement with the primary carrier or redirect the member to the primary carrier for referrals to an in-network or participating provider.
- VBH-PA considers the Patient Responsibility/Member Liability/Patient Liability (coinsurance/co-pays/deductibles) on the EOB and will only pay up to the lesser of the VBH-PA contracted rate or the primary carrier's allowable.

Inappropriate Primary Carrier Denials

- Primary carrier requirements were not followed
- Primary carrier denial for no authorization or precertification
- Primary Carrier denial for not meeting timely filing requirements
- Primary Carrier denial for rendering provider not being contracted/credentialed

HRA/HSA/HIA Accounts

Health Reimbursement, Savings, and Incentive Accounts are considered by VBH-PA when coordinating benefits. VBH-PA is the payor of last resort. When funds from and HRA/HSA/HIA are included and applied to the primary carrier explanation of benefits, VBH-PA will further reduce our secondary payment.

Third Party Liability (TPL) Updates

VBH-PA is required to submit Third Party Liability (TPL) insurance updates to the Department of Human Services TPL Division. If the coverage listed in PROMISe™ and/or VBH-PA is no longer active, VBH-PA will need proof of the termination date before a claim can be processed for payment. This information can be faxed to TPL Update Team at (855) 842-1285

Please remind member and/or responsible party that they must provide the most accurate information regarding their primary insurance coverage to the County Assistance Office. Do not request that members/responsible parties call VBH-PA to provide TPL information. VBH-PA cannot make TPL updates or terminations based on information received verbally.

When there is active third party insurance listed for a member receiving behavioral health services, VBH-PA requires that the provider submit an Explanation of Benefits from the primary insurance plan (Medicare/Commercial) along with the claim. If there is no third party insurance listed in PROMISe™ or ProviderConnect, the provider is responsible for reporting Third Party Resource information to the VBH-PA TPL Update Team.

Documentation that is ***not*** sufficient for TPL updates:

- ✓ Navinet sheets with no effective and/or termination dates (Blue Exchange must be verified for out-of-state and out-of-area plans)
- ✓ Third Party Administrator (TPA) eligibility sheets can **only** be used to terminate the TPA eligibility information

Act 62

The Pennsylvania Autism Insurance Act (Act 62) requires private health insurance companies to cover the costs of services for the treatment of autism spectrum disorders for children under 21 up to $38,562.00 per year (for policies issued or renewed in calendar year 2016) that are determined to be medically necessary. The most recent Medical Assistance Bulletin – Payment of Claims for Services Provided to Children and Adolescents for the Diagnostic Assessment and Treatment of Autism Spectrum Disorders was issued on August 17, 2016.

http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_238192.pdf

Act 62 also requires the Pennsylvania Department of Human Services (DHS) cover the cost of services for individuals who have private insurance coverage and are enrolled in a Medical Assistance program when the costs exceed the yearly benefit maximum during the plan year.

If the member has coverage under a private insurance plan to cover services, VBH-PA will process claims as secondary and coordinate benefits to pay co-pays, deductibles and/or coinsurance until the maximum benefit under the private insurance plan is exhausted. Once the maximum benefit is exhausted, VBH-PA must be notified via an Explanation of Benefits (EOB) and will begin to pay for services deemed medically necessary at the VBH-PA contracted rate for the remainder of the plan year.

If no Autism benefits exist under the private insurance plan, VBH-PA must be notified immediately with an EOB. The documentation must include the Group Plan Renewal Date.

Autism coverage information must be faxed to VBH-PA at **1-855-842-1285**. Upon receipt, VBH-PA staff will validate and make the proper system updates.

Important Reminders

- Send one fax per member and clearly indicate the member's MA ID number
- Do not send requests for claims adjustments with your Autism coverage information
- Allow 10 business days for processing

Unacceptable denials from the private insurance:

- Denials for no authorization/precertification
- Provider not contracted to perform services
- Provider's licensure does not meet criteria for level of care

Please feel free to contact the VBH-PA Customer Service Department at 1-877-615-8503 for assistance if you have any questions.

The dedicated fax number for Autism eligibility information is 1-855-842-1285.

Act 62

Frequently Asked Questions for ACT 62

Knowing if ACT 62 Benefits may apply:

Q. What qualifies the client to be ACT 62 eligible?

A. The child must have an autism spectrum disorder and have third party coverage under a private insurance plan.

Q. How do we check to see if the client has a primary insurance?

A. The easiest way to check to see if a member has a primary insurance is to ask the family. This should be done regularly. Primary insurances can also be verified through the PROMISe™ system in addition to ProviderConnect.

Q. How do we find out the effective date and the renewal date of the primary insurance?

A. The most accurate way for providers to find out the effective date and the renewal dates on the policy is to either ask the family to contact the employer or contact the primary insurance carrier about each child.

Q. How often should providers verify benefits?

A. Providers should verify benefits every time a service is provided to ensure that no changes have occurred.

Q. If the primary insurance carrier is from another state, can the client be ACT 62 eligible?

A. It is possible. The provider should always verify the member's primary insurance benefits.

Navigating the VBH-PA system regarding clients with ACT 62 coverage:

Q. What information is needed by VBH-PA if the client has an Autism diagnosis, and has private insurance coverage?

A. VBH-PA must immediately know the **Group Plan Renewal Date**, as well as if ACT 62 is applicable in the specific situation.

Q. If there is no Autism coverage under the client's private insurance benefit plan, what do I need to do to ensure consistent reimbursement from VBH-PA?

A. If there is no Autism coverage, the provider must forward documentation of the reason from the primary insurance carrier to VBH-PA. The information can be submitted via fax to the Claims Liaison Team at 1-855-842-1285.

Q. If there is Autism coverage under the client's private insurance plan, what do I need to do to ensure consistent reimbursement from VBH-PA?

A. If there is Autism coverage, the provider must bill the private insurance plan. If there is a co-insurance, deductible, or co-pay due, these claims should then be submitted to VBH-PA as the secondary payor. VBH-PA is responsible for any co-insurance, deductible, or co-pay until the member reaches the benefit maximum.

Q. Can I submit the completed ACT 62 coversheet to the Claims Liaison Team for use as documentation?

A. No, the ACT 62 coversheet alone is not sufficient documentation. The ACT 62 coversheet can be submitted with an EOB clearly identifying the level of coverage for autism.

Q. Where can I find the ACT 62 coversheet?

A. The ACT 62 coversheet is located at http://www.vbh-pa.com/provider/prv_forms.htm under the BHRS Forms section.

Q. Will an authorization letter be sent out to providers when a child is ACT 62 eligible?

A. Providers will receive an acknowledgement letter from VBH-PA indicating that services requested are covered under ACT 62 and the services will be reviewed for Medical Necessity once the primary insurance benefit has been met. The service classes for children whose services are covered by a primary insurance are:

- YT5 – TSS in School
- YT6 – TSS in Home/Community
- MT2 – Mobile Therapy
- BS2 – Behavioral Specialist Consultant

Q. If a primary insurance has deductibles or co-pays will VBH-PA pay for these? Will the provider need an authorization for this?

A. Primary insurance, co-insurance, co-pays, and deductibles will be paid by VBH-PA. There is no requirement for a VBH-PA authorization for services covered under ACT 62 if the provider is only billing for deductibles/co-pays/co-insurance.

Q. What if the provider is not "in-network" with the member's primary insurance plan? Can the provider just bill VBH-PA?

A. No. The provider must arrange to be paid for services by the primary insurance. If that is not possible, the family may need to choose a provider that is "in-network" with the primary insurance carrier. VBH-PA is not permitted to pay for services if the provider is not participating with that member's primary insurance.

Q. If I get a claim denied by VBH-PA requiring a documented explanation of benefits (EOB), what should I do next?

A. If the client has an autism diagnosis and has private insurance, VBH-PA will deny the claim and request the primary insurance EOB. VBH-PA will assume that Autism coverage is available until informed by the provider that it does not. The provider must verify the private insurance information. If Autism benefits are available, you must work within the private insurance billing guidelines. If Autism benefits are not available, you need to provide VBH-PA with proof so that VBH-PA can continue to reimburse for services provided.

Q. What if I receive an EOB from the private insurance plan that denies the ACT 62 covered service?

A. If you receive a denial from the private insurance plan for services that should be covered under ACT 62, you must contact the private insurance plan and dispute the denial. If there are Autism benefits, the private insurance plan is mandated to pay for services.

Act 62 ICD-10-CM Diagnosis Codes	
Diagnosis Code	**Diagnosis Label**
F84.0	Childhood Autism
F84.5	Asperger's Syndrome
F84.9	Pervasive Developmental Disorder, unspecified

Claim Corrections

Any time that a change is being made to a claim, please be sure to submit your request for correction on an industry standard claim form. The only acceptable claim formats are the CMS-1500 or a UB-04. All other types of formats submitted as a corrected claim will be returned to the provider.

A corrected claim form consists of a change to any line of a prior claims submission. All corrected claim forms must have a notation as to what is changed from the original, as well as the VBH-PA claim number.

Corrections Do's:

- If the claim line paid zero dollars and is within the timely filing limitations, it can be submitted as new using EDI, Direct Claims via ProviderConnect, or mailing a paper claim to the **New Claims** address.
- All corrections to a claim should be made at one time to avoid further billing errors.
- All claim lines must reflect the actual service that took place for the date billed.
- Web inquiries via ProviderConnect are still an acceptable means for submitting reprocessing requests. If you are not currently using this method and would like to understand this better, please contact the VBH-PA Customer Service Department.
- Quality check adjustment requests before mailing to VBH-PA. A large volume of adjustment requests are returned because they are not compliant with VBH-PA reimbursement policies.
- Submit all requests for corrections within 90 days of the provider summary voucher date.
- Utilize ProviderConnect **Change/Reprocess of Professional Claims** for all corrections to CMS-1500 or 837 Professional Claims for exceptional turnaround time. The link to the step-by-step guide is below: http://valueoptions.com/providers/Compliance/Guide_to_Changing_or_Reprocessing_Professional_Claims_Online.pdf

Corrections Don'ts:

- Do not include dates of service that have never been processed on a corrected claim.
- Do not bill date spans for any service that is more than one (1) unit per day. If a claim denies for needing an itemized statement, this indicates that each date within the specified date range will need billed to reflect the services and units provided for those dates.
- Do not submit a claim form if corrections are not necessary. Copies of authorization letters, PROMISe™ eligibility printouts, or any other internal documents are not necessary unless they are specifically requested by the Customer Service Department for resolution of a specific issue.

Tips to Resolve Claim Denials

VBH-PA would like to point out some of the top reasons for denied claims. Please see our suggestions as to what action you can take to investigate and resolve the denial and prevent future reimbursement issues.

Reason for Claim Denial	Investigation to Resolve Denial
Claim denied for no authorization	▪ Review authorization using ProviderConnect to verify authorizations status, dates of authorization, units approved and paid-to-date
Claim denied due to an invalid procedure code and/or modifier	▪ Review your contract to verify the appropriate procedure/service codes and modifiers assigned to your facility
Claim denied due to invalid diagnosis code	▪ Review International Classification of Disease (ICD-9/ICD-10) to determine if the diagnosis code you billed is valid
Claim denied due to invalid date of service	▪ Review dates of service submitted on original claim submission to determine and correct error
Claim denied due to invalid place of service (POS) code	▪ Review the Provider Covered Services Grid to determine valid HCFA POS codes for the service code submitted
Claim denied due to an invalid service and/or billing address	▪ Review the billing/pay-to address submitted on the claim and use ProviderConnect to validate what VBH-PA has on file ▪ If internal changes have been made, submit a change of address form to VBH-PA, or contact your provider field coordinator to discuss the current set up
Claim denied due to the existence of Third Party Liability information in VBH-PA's system	▪ Review COB information within ProviderConnect to determine if submission to the private insurance is warranted before submission to VBH-PA ▪ VBH-PA is the payor of last resort
Claim is denied as a duplicate submission	▪ Review paid claims for the same date of service to validate previous submissions

	▪ Claims denied as a duplicate cannot be adjusted for payment unless the claim information is corrected. ▪ A subsequent claim will be denied as a duplicate if the date(s) of service, POS code, and service code/modifier match a paid claim.
Claim is denied for being filed past the timely filing limit	▪ Initial claims submissions must be received within 90 days of the date of service, date of discharge, or date of Explanation of Benefits from the private insurance plan ▪ Requests for adjustments must be received within 90 days of the VBH-PA Provider Summary Voucher
Claim is denied for Promise Id Issue	▪ Review the Promise ID assigned to your service location. Contact your Provider Field Coordinator to confirm Promise information.

VBH-PA encourages all of our providers to be proactive when resolving problems. The VBH-PA Customer Service Department is available Monday through Friday from 8:00 a.m. to 5:00 p.m. to answer questions or direct providers to the appropriate department. The toll-free number is 877-615-8503.

ProviderConnect®

ProviderConnect® is a secure, HIPAA-compliant website that enables participating Beacon Health Options network providers to conduct online claims and authorization transactions accurately and efficiently, while also providing them the opportunity to spend more time with who matters most — their patients.

Capabilities

- Verify member eligibility
- Submit claims, re-credentialing applications and provider updates
- View and submit authorization requests
- Print forms and authorization letters
- Communicate to VBH-PA via an online message center
- Access Provider Summary Vouchers

Benefits

- Reduce paper files, phone calls, labor and postage expenses, and potential errors
- Improve cash flow due to faster claims processing
- Submit claims files from any system outputting 5010 HIPAA formatted 837P or 837I files (and from EDI claims submission vendors)
- Complete multiple transactions in a single sitting

Please click on the link below to access the ProviderConnect® User's Guide:
http://valueoptions.com/providers/ProviderConnect/ProviderConnect_External_Users_Guide3.pdf

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