Provider Billing

Q1. What are the CHC-MCO billing requirements, timeframes, submission options, and IT requirements?

A. Each CHC-MCO will establish its provider billing requirements, filing timeframes, and submission options. These topics should be discussed with the CHC-MCOs. CHC-MCOs are required to have provider manuals that include their billing and other filing instructions.

Q2. How will CHC-MCOs adjudicate the coordination of benefits for dual eligible participants who receive services from a non-Medicare provider?

A. CHC-MCOs will be required to conduct provider training on coordination of benefits and dual eligibility for Medicare and Medicaid and coordination of services for participants who are dual eligible. This topic should be discussed with the CHC-MCOs to learn more about their provider training plan.

Q3. When is the claims testing period going to start?

A. As part of Readiness Review, the CHC-MCO be required to successfully test its claims processing system prior to implementation of CHC in a given zone. Test samples will include all types of payments and adjustments that are billed through the Department of Human Services’ PROMISE™ claims processing system. Providers should contact the CHC-MCOs to learn more about their testing plans.

Q4. If a nursing facility (NF) has its own bus or van, can transport services be reimbursed?

A. The CHC agreement specifies that CHC-MCOs must provide non-emergency medical transportation for NF residents and non-medical transportation to nursing facility clinically eligible participants. NFs should discuss reimbursement with the CHC-MCOs as part of their rate negotiation. NFs may not directly bill the CHC-MCO for transportation related reimbursement unless they are enrolled as a transportation provider in the Pennsylvania Medical Assistance program.

Q5. How will hospice services in a nursing facility be reimbursed under CHC? Will the nursing facility have to bill hospice for the Medical Assistance residents’ room and board or will hospice bill Medical Assistance?

A. After CHC is implemented in a zone, the hospice provider and nursing facility will bill the CHC-MCO for services rendered. The hospice provider will bill the CHC-MCO for any hospice services rendered and nursing facilities will bill the CHC-MCO for the Medical Assistance residents’ room and board. Please refer to Q32 for additional information.

Q6. Will a Medicare denial be required to be on file for an invoice to be approved and paid?

A. If the participant has a third-party resource (TPR), including Medicare, that covers a service, providers must bill the TPR first for payment of the covered service and obtain an Explanation of Benefits (EOB) from the TPR. Once the TPR has paid or denied the claim, providers may then bill CHC-MCOs.
Q7. If a provider is not Medicare certified, how will the CHC-MCO handle the services?

A. CHC-MCOs will be required to develop and implement Person-Centered Service Plans (PCSP) that address how the participant’s physical, cognitive and behavioral health needs will be managed, including how Medicare coverage (if the participant is dual eligible) will be coordinated and how the participant’s long-term services and supports will be coordinated. CHC-MCOs will be required to train providers on Medicare coordination for dual eligible services.

Q8. What will be the claim payment timeframes? Are there "Prudent payment" policies?

A. The Department of Human Services (DHS) has established claims payment timeliness requirements for the CHC-MCOs. Ninety percent (90.0%) of clean claims must be adjudicated within thirty (30) days of receipt. One hundred percent (100.0%) of clean claims must be adjudicated within forty-five (45) days of receipt. One hundred percent (100.0%) of all claims must be adjudicated within ninety (90) days of receipt. If DHS determines that a CHC-MCO has not complied with the claims processing timeliness standards, DHS may impose sanctions on the CHC-MCO. Providers should discuss claim submission and expected payment timeframes with the CHC-MCOs.

Q9. Will providers have to use three different CHC-MCO billing systems?

A. Each CHC-MCO will have its own billing system. The CHC-MCOs must demonstrate to the Department of Human Services that their systems work. CHC-MCOs will be testing their billing systems and will seek provider volunteers to participate in the testing.

Q10. Who do providers contact if they have problems with payment from CHC-MCOs?

A. Providers must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2018. Services prior to January 1, 2018 must be billed to the Department of Human Services via PROMISe™ for reimbursement. Each CHC-MCO will have its own claims system. CHC-MCOs are required to train providers on claims submission, any electronic visit verification system and other software systems such as their service coordination system. Providers should contact the CHC MCO if they are having problems receiving payment on their claims. CHC-MCOs must have a provider dispute resolution process to resolve provider disputes and appeals.

Q11. If a CHC participant has Medicare, or a supplemental insurance and Medicaid, how does this impact the participant?

A. CHC participants must exhaust their available Medicare or other third-party resource (TPR) coverage before CHC will cover a service or item. Except for drugs covered through Medicare Part D, CHC-MCOs will pay most coinsurance and deductibles related to the service or item.
Q12. If a CHC participant has Medicare, or a supplemental insurance and Medicaid, how does this impact the provider?

A. When a CHC participant has Medicare or supplemental insurance coverage for a service or item, providers must bill the Medicare program and/or the supplemental insurance first before billing the participant’s CHC-MCO. Some Medicare Advantage plans and Special Needs Plans may cover personal assistance services. The service coordinator and Personal Assistance Services (PAS) agency are responsible for verifying coverage of services with other payers. For more information, the PAS agency should check with the CHC-MCO to ensure that they are following the CHC-MCO’s billing procedures correctly.

Q13. How can a provider check whether a CHC participant has Medicare or other supplemental insurance coverage?

A. Providers are required to check the Eligibility Verification System (EVS) to ensure a participant is eligible for services prior to rendering services. EVS will identify the participant’s CHC-MCO and will identify any third-party resource (TPR) information, including Medicare. At the date of service, providers should always ask participants for all forms of insurance, not just their CHC MCO insurance card or ACCESS card. This is to ensure that benefits are properly coordinated and that the CHC MCO remains the payer of last resort.

Q14. Why can’t providers use PROMISe™ to bill the CHC-MCOs?

A. Providers must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2018. Each CHC-MCO will have a billing/claims system. CHC-MCOs are required to train providers on claims submission, electronic visit verification systems, and other software systems such as service coordination system, as well as many other aspects of CHC.

Q15. What is the billing procedure and how can providers test the claims process?

A. Each CHC-MCO will have its own billing/claims system. The CHC-MCOs are required to demonstrate to the Department of Human Services that their billing system works. CHC-MCOs will be testing their billing systems and will seek provider volunteers to participate in the testing. CHC-MCOs are required to train providers on claims submission, electronic visit verification systems, and other software systems such as service coordination system.

Providers must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2018.
Q16. How will nursing facilities be reimbursed for newly eligible CHC participants?

A. Newly eligible nursing facility residents will be enrolled in CHC with an effective date of the day after the eligibility determination date. The CHC-MCO will begin paying for nursing facility services provided on and after the residents’ CHC enrollment date.

Newly eligible nursing facility residents may also be eligible for retroactive MA coverage of their nursing facility services prior to their enrollment in CHC. Nursing facilities will be reimbursed for services provided to newly eligible participants during this retroactive period as they are today through the fee-for-service delivery system.

Current physical HealthChoices (HC-MCO) participants who apply and are approved for Long Term Care eligibility will remain in the HC-MCO after the initial 30 days of nursing facility coverage until the day after the eligibility determination date. In this case, the HC-MCO would also be responsible for the nursing facility charges from day 31 through the day of the eligibility determination.

Q17. Will the patient liability be paid by the claim or per the EVS system?

A. The CHC-MCO will receive the patient pay amount from the eligibility file. Nursing facilities (NFs) will continue to collect patient pay and continue to deduct costs for medical services and insurance premiums from the resident’s payment toward the cost of nursing facility services. NFs will continue to receive the Pennsylvania Medicaid Long Term Care Application or PA-600L. The CHC-MCOs will review the nursing facility patient pay calculation as submitted on the claim.

Q18. Will the CHC-MCOs still use Myers and Stauffer for nursing facility assessment submissions?

A. The Department of Human Services (Department) will continue to use the existing Pennsylvania nursing facility assessment system which allows nursing facilities to submit necessary patient days and the Department to obtain the assessment amount that is due.

Q19. What service location is OBRA in PROMISE™?

A. The OBRA program waiver code in PROMISE™ is WAV09. Providers need to review their provider profile in PROMISE™ to determine which service location is associated with the OBRA waiver.

Q20. What are the criteria for a clean claim?

A. A clean claim is a claim that can be processed without obtaining additional information from the provider or from a third party, including a claim with errors originating in the CHC-MCO’s claims system. Claims under investigation for fraud or abuse or under review to determine if they are medically necessary are not clean claims.

Q21. Define "adjudicated claim."

A. An adjudicated claim is a claim that has been processed for payment or denial.
Q22. Will EVS reflect the participant's current CHC-MCO selection?

A. The Eligibility Verification System (EVS) methods, inquiry and response formats will not change with CHC implementation. EVS will display the participant’s CHC-MCO plan code information and PCP if available. All other existing waiver benefit packages and HealthChoices managed care responses remain unchanged. Please reference Provider Quick Tip #11 for more information related to EVS. [http://www.dhs.pa.gov/publications/forproviders/QuickTips/](http://www.dhs.pa.gov/publications/forproviders/QuickTips/)

Q23. Will providers use PROMISe™ after CHC implementation?

A. Providers must submit claims for services prior to January 1, 2018 to the Department of Human Services via PROMISe™ for reimbursement. Providers must bill the appropriate CHC-MCO to receive reimbursement for services after January 1, 2018 except that: (1) providers will continue to use PROMISe™ for ACT 150 and OBRA waiver participants and (2) nursing facility providers will continue to bill PROMISe™ for nursing facility services provided during the retroactive eligibility period for nursing facility residents.

Q24. Will providers use HCSIS after CHC implementation?

A. After the CHC implementation, providers will only use HCSIS for ACT 150 and OBRA waiver participants. Please refer to Q30 for additional information.

Q25. If a nursing facility believes that a resident with Medicare is eligible for CHC, what should the facility do?

A. The nursing facility should contact the Independent Enrollment Broker (IEB) to initiate the Medical Assistance long-term services and supports application process.

Q26. How long will providers have to finish billing for services provided before 12/31/2017?

A. Providers must submit claims for services rendered to participants in CHC prior to 1/1/2018 following the current timely filing requirements.

Q27. Will changes be made to place of service codes, i.e. nursing facilities for the delivery of behavioral health services?

A. There are currently no plans to change place of service codes in PROMISe™.

Q28. Will individuals with third party behavioral health coverage need to be coordinated with the Behavioral Health MCOs (BH-MCO)?

A. CHC participants with another non-Medicaid insurance including Medicare, must exhaust behavioral health benefits available under that coverage before BH-MCOs cover services.

Q29. Are high cost medications such as HIV medications covered and how are they billed?

A. Coverage of prescription drugs will remain the same after CHC implementation. Coverage under Medicare, if available, must be exhausted before CHC-MCOs cover prescriptions.
**Questions Added on December 8, 2017**

**Q30. Can providers and CHC-MCOs continue to use HCSIS and SAMS after the CHC transition period?**

A. CHC-MCOs will have their own systems and will not be required to use HCSIS and SAMS. Providers should consult with CHC-MCOs regarding the systems and procedures that will be used to authorize services.

**Q31. How do nursing facilities bill for in-facility respite?**

A. Nursing facilities must bill the CHC-MCO for in-facility respite services and should contact the CHC-MCO for more information regarding the CHC-MCO’s billing process.

**Q32. How will hospice services in a nursing facility be provided and reimbursed under CHC?**

A. The CHC-MCO must provide Hospice and use Medical Assistance (MA) enrolled hospice providers to provide these services. To be an MA enrolled provider, the hospice must be a Medicare certified provider. The CHC-MCO must coordinate with hospice providers for dual eligible participants who are receiving hospice through their Medicare coverage. As with other Medicare-covered services, CHC participants will be required to exhaust their available Medicare hospice benefits. Medicare hospice provided to participants by Medicare-approved hospice providers is directly reimbursed by Medicare.

Under CHC, the hospice provider will bill the CHC-MCO for hospice services rendered to CHC participants which is not covered by the participant’s Medicare hospice benefit. The nursing facilities will bill the CHC-MCO for the resident’s room and board.