Wellness & Recovery FAQs: Claims

When will we receive our user names and passwords for logging in to Online Services?

If you haven't already completed registration for online services, please contact your provider education team by emailing esystemssupport@partnershiphp.org

If we have other people in our outpatient groups that we are not billing Partnership for, do we include or exclude them from the group formula?

All members who complete the session in full will be factored in your equation, even if some have other coverage that you will be billing, instead of PHC. The only time you will remove a member from the equation is if they leave the group early.

Do we do group formula for residential? Do we bill for the day and then separate for group?

Residential is billable each day in which a required service activity occurs (see MHSUDS IN 18-001.) Case management is billable as a separate activity unless the PHC/provider agreement states that the rate is all-inclusive.

Are we able to bill partial units? Example an 11-minute case management or crisis?

Yes you are able to bill partial units. As an example: rate is $14.66 ÷ 15 minutes = 0.98¢ per minute, billing 20 minutes = $19.60. Place in box in 24F.

For non-group client services, is there a minimum/maximum allowed minutes for each service?

Outpatient services have a maximum limit of up to nine hours of services per week (up six hours per week for youth.) Intensive outpatient have a minimum limit of nine hours of services per week (minimum of six hours per week for youth.)

If we draw labs onsite but analysis is done offsite, are we able to collect reimbursement for our component of the procedure?

The service activities described in the state/county contract (assessment, treatment planning, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination) are billable up to the minimum and maximum allowed minutes described in Question 4. Drawing labs is not one of the billable service activities.

Please give an example of lab work other than drug testing.

TB testing.

If a provider chooses to submit claims via CMS1500 are those uploaded similar to an 837P file?

Yes.

How are 837P files uploaded?

These are uploaded as they are received.

Can they be uploaded once a month?

Each office will determine the frequency of billing.

We were told recently that PHC is not ready to accept 837P files. If we have an EDI agreement on file, can we submit an electronic 837P file for claims?

There must be one payment made before signing up for electronic claims submissions which must include testing.

Do we have to enter a description above the procedure code in Box 24?

No description is necessary.

If 837P files are not allowed to be submitted and you are showing how to fill out a CMS 1500, can we submit paper HCFA 1500's and forgo the entry of claims manually into the portal?

Yes

If so, where do send the paper claims?

All claims will be submitted to Partnership HealthPlan of California, P.O. Box 1368, Suisun City, CA 94585

Outpatient Claims - Does a claim have to be sent in for each counseling session or can you put more than one than session on a claim?

Multiple dates of service can be entered on one claim, however, they must all be for the same month of service. We cannot accept claims with multiple months of service.

If we are currently sending 837's and receiving 835's do we need to retest for ODS?

Yes

Why would we use/not use the U6 modifier all the time, for instance when would we just use the H0005 with only U7 vs H0005 with a U6 and U7?

Modifiers are used to describe the level of service. The applicable modifier for the services rendered must be used on the claim.

What's the difference between 1st modifier and 2nd modifier?

They are used to describe all the care rendered. So, if you are rendering recovery services in residential 3.1, you would need both modifier to advise those services.

If a provider submits a claim electronically through a clearinghouse, how will the provider be notified it was denied?

All claims will be viewable on our Provider Portal.

Will it be both electronically and by U.S. mail?

Until you are signed up for electronic remittances they will be delivered via U.S. mail.

Will we receive specifics of why the claim was denied?

Each claim will be assigned an EX (explanation) code that will advise the status of your claim to include the reasons for denial.

How will counties receive payments so that they can post them to services in their own EHR?

Payments are made by paper checks unless a provider is enrolled in EFT through FIS 877 330 4950.

We will need to see how claims are entered that have a COB? Counties will have to bill private insurance and receive a remittance prior to billing Medi-Cal.

We can receive secondary claims either electronically or via paper submission. On electronic submissions, the primary carrier values will need to be entered on the submission, we cannot accept attachments via electronic. For paper submissions a copy of the primary EOB will be required for us to coordinate the claims correctly.

How do we submit an 837P file if you can receive files? This was not demonstrated on the claims training.

Providers must submit a completed 837 agreement. There must be a Trading Partner and Billing Provider plus signature for each. Providers must use a Trading Partner unless they are able to submit 837 file format claims on their own without assistance from Partnership. Once an agreement is received, we will email the contacts provided on the agreement to request a test file. All claims must be submitted on paper until a final approval for 837 has been sent after successful testing.

If we have an EDI agreement on file, will the remittance be on an 835P file or on paper?

Once we receive an 835 agreement and it’s approved ,the NPI that applied will receive 835 files to the Trading Partner they list on the agreement. Paper will not be turned off, until 835 has been turned on.