PerformCARE®
8040 Carlson Road
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PERFORMCARE CLAIMS FAQ 2022

CLAIMS

- Can secondary claims be sent electronically?
  - Yes
- Does the ZZ qualifier need to go in box Box 32B and Box 33B?
  - Yes, the ZZ qualifier must be used in box 32 and 33 with the taxonomy code.
- Do claims need to be on the pink and white forms?
  - Yes, they need to be completed on the pink and white form.
- When should telehealth POS 02 be used?
  - Please reference provider notice AD 21 110 Telehealth Audio Only Modifier 95
  - https://pa.performcare.org/assets/pdf/providers/resources-information/ad-21-110-telehealth-audio-only-modifier.pdf
- What information is needed in box 24J
  - The rendering taxonomy code if different from billing provider and not listed in field 19. The rendering NPI if rendering NPI is different from the billing NPI (Box 33a). *For MH-OP groups only.
- Should provider put EOB and the number of pages following the secondary claims?
  - No, not permitted.
- If the member has multiple diagnoses, should the provider list all diagnoses or just the primary?
  - Provider should list all but be aware that the primary diagnosis should line up with what type of service is being provided. (Example- MH diagnosis for a MH service or SA diagnosis for a SA service.)
  - If a member is dual diagnosed and the facility is a MH facility the primary diagnosed needs to be submitted as a MH diagnosis to pay.
- When should a TPL termination be submitted through Navinet?
  - Submission of a TPL termination through Navinet should be submitted after a claims denial is received.
- For TPL claim submission, do providers need to include an EOB and final denial letter?
  - The claims denial must be a final denial.
- How long does certified mail of claims take to process?
  - PerformCare processes claims within 30 days.
- If a provider is not a Medicare facility, does PerformCare override Medicare in this situation?
  - PerformCare is the payer of last resort. Member should find a provider that is in network with Medicare.
- For inpatient claims, is the 60 days from day of admission or discharge?
  - Timely filing goes by each date of service, not admission of discharge.

- Provider received a final denial letter from a 2nd level appeal with a primary payer for inpatient services, can we start billing PerformCare immediately after the final denial letter is received or bill the primary first and receive an EOB with denial code before billing PerformCare?
    - Provider will have to submit the final denial letter from the primary with each claims.
- Are there additional fees to use features within Navinet?
    - No additional fees.
- If a POS code is incorrect and the claims denies; does the provider have 60 days from DOS or 365 days from DOS to submit a correct claim?
    - 365 days
- Is the referring/ordering provider required on claims?
    - It depends on your provider type and specialty. See Provider Notice AD 17 104.
    - https://pa.performcare.org/assets/pdf/providers/resources-information/policies/admin/ad-17-104-ordering-providers.pdf
- Corrected claims are set up with a new claim number, why?
    - Each corrected claim is given a unique claim number for tracking purposes.

CHANGE HEALTHCARE

- Will every claim that is billed be loaded into ConnectCenter?
    - Paper claims will not be visible in ConnectCenter. Only claims submitted through ConnectCenter would be visible.
- How do you sign up for ConnectCenter? As an individual or facility?
    - Users should register for ConnectCenter as individuals.
- Are groups able to bill under the group NPI and tax id without the individual provider NPI when submitting claims through ConnectCenter or does the individual provider that rendered the service need to be included in the claim information?
    - The individual provider that rendered the service needs to be included in the claim information.
- Can you attach an original EOB to the 1500 in ConnectCenter?
    - ConnectCenter does not yet support electronic attachments but does allow for the entry of the primary carriers denial code if it is an acceptable denial reason. Examples of acceptable denials include but are not limited to- Non covered service, Benefits exhausted and Does not meet MNC (but service is approved or authorized by PerformCare).
    - For any services that a provider cannot get an acceptable denial reason via the EOB (ex. IBHS) the additional documentation must be sent with a paper claim and cannot be submitted electronically.
- Does ConnectCenter permit entry of z-codes?
    - Any valid code is allowed to be entered.
- Is there an 837i companion guide to set up EHR billing?
    - ConnectCenter has guides to specifics of ConnectCenter claims submission.

- Will the remittances pull for claims not sent via ConnectCenter?
    - Remittances will be available for PerformCare in ConnectCenter after you enroll in ConnectCenter and is not dependent on claims being submitted in ConnectCenter.
- Are there fees associated with using ConnectCenter to upload 837 files?
    - There are no fees associated.
- For 837 files with secondary claims, is the primary EOB still required for the specific claims needing it?
    - Yes
- Are administrative users required to have a NPI?
    - The NPI would be the NPI that belongs to the provider that you will be billing on behalf of.
- Do providers have to use ConnectCenter if they are in network with PerformCare?
    - If you are using another service other than ConnectCenter, it is a business decision of the provider to switch or continue using their current services. Providers are not required to use ConnectCenter. It is a tool made available, sponsored by PerformCare, to Providers who do not already have a tool for electronic Claim submission.
- Does a primary claim need to be submitted in ConnectCenter to bill secondary in ConnectCenter?
    - No.
- Who do I contact if I need support submitting claims in ConnectCenter?
    - ConnectCenter support: 800-527-8133 x2, indicate you are going to be using the Amerihealth Caritas sponsored account for submitting claims. Additionally, a claims training is available on PerformCare website.
- Do you need a copy of the EOB when entering secondary claims?
    - For secondary claims, EOB information is entered directly in ConnectCenter so sending an actual copy of the EOB is not necessary.
- Can an OON provider submit claims through ConnectCenter?
    - Yes, once the OON is approved and the provider has their single case agreement from PerformCare.