Claims Submission (837P) Questions

I. General & Data Related Questions

NPI Numbers

Q: *We have multiple NPI's how do we bill?*
Q If we have multiple NPI numbers what do we put in each loop on an 837P?
Q: Why does service location need to be submitted? Define service location – food pantry?
Q: Do we have to have a different NPI # for each site? Our Tax ID # is the same for all sites
Q: We currently have NPI's by site , do we have to have individual NPI#'s for licensed staff? What about unlicensed staff?
On the claims form - where you Identify where the service was rendered - if the service took place at multiple community locations bank, grocery store) do you still need to indicate the address of all places?

Response: The Agency determines how to request its NPI numbers. If you have multiple NPI numbers you must be sure they are on file with the Collaborative.

Always send Agency/Billing NPI in the Billing Provider Loop

If you have NPI by service location, send Service Location NPI in the Service Location Loop

It is not necessary, nor optimal to have an NPI number for each staff person. To do so will require that all are on file with the Collaborative, and that you notify them of all related personnel changes. NPIs may be submitted at the agency or site level depending upon how you have structured your NPIs..

If services are rendered at a location other than a place with a Medicaid site ID, use the service location from where the service originated. For example, if the service occurred in a grocery store, use the service location NPI for where the practitioner is based, and use place of service code 99 on the claim detail line.

Group IDs

Q: *How do we get the group ID?*
Q: What is a group ID for group services? Is this already assigned?

Response
The group ID is user (agency) defined. This is the identification number you assign to a group of practitioners who perform a group based service.

Session Start Time

Q Is the start time of sessions required for all billable services?
Q: Is start time in the Collaborative software military time?

Response: The start time and duration are required on all billed service lines.
Start time is in military time

VO Submitter ID

Q: We already have a VO submitter ID, from when we billed for the Texas Northstar program. Do we need a new submitter ID?

Response: A separate ID for the Il Collaborative is necessary.

Copay Submission

Q: If a copay is sent on the 837, how will the collaborative use it?

Response: The collaborative collects copay for informational purposes only.

COB – When Collaborative is Primary

Q *Within the same loop and segment, under SBR01, if there is no other insurance coverage, is the default automatically supposed to be P? The comment saying "If there is other insurance coverage (emphasis added), identify if the Illinois Mental Health Collaborative is the primary, secondary or tertiary payer." is somewhat confusing in the case where there is no other insurance coverage*

Response: The default is 'P'. If the Collaborative is primary the value should be 'P', if the Collaborative is secondary the value would be 'S' and if the Collaborative is tertiary the value would be 'T'.

Provider / VO Relationship for Consumers of 3rd Parties

Q: Will our agency be considered in-network with VO for 3rd party billing since we now have a provider number with VO.

Response: If your agency has been accepted as an in-network provider by the Collaborative you can send files via ProviderConnect. Once registered, you can also bill via third party billing. To obtain information pertaining to your network status for other contracts/clients, contact our National Provider Line at (800) 397-1630 from 8 am - 5 pm Eastern Standard Time.

Pre-7/1/08 dates of service

Q *When entering June services in the month of July, will we still be able to use ROCS or will all services entered after 7-1 have to be entered in the new system?*

Response: Dates of service before 7/1/08 will continue to be submitted through ROCS.

837P vs Claim

Q: What is the difference between 837P and a claim?
Response: An 837P is the HIPPA compliant electronic claims file; individual claims exist within the 837P file.

Electronic Data Interface (EDI)Training

Q: Will there be any hands-on training available in smaller groups or will consultants be available to agencies? It was difficult to capture the "nitty gritty" of claims preparation in the large audience format. Fran is concerned about accurate claim preparation
Q: What is the Helpdesk phone number for providers to call for help?
Q: *Have a meeting for 3rd party software. Users away from ROCS (CAS) users.*

Response: Individualized training available through appointment with the EDI Help Desk 888-247-9311
Training will also be provided on-site in Illinois as well as via webcasts.

Collaborative Web-site

Q: *What is the Web-site for down loading the free Illinois Collaborative software? Mercy has always used RoCS DHS software.*
Response: You can access Direct Claim Submission or down load eclaims link via http://www.illinoismentalhealthcollaborative.com . Log-on and chose either, Enter a Claim for Direct claim Submission, or chose Compliance (on the left hand side of the page) and download EDI claims link. Please note that the final versions will be posted shortly.

Sign-ons & Passwords

Q: *Users should not share sign-in/passwords, but if one person sends an email and then goes on vacation can the user have the answer sent to another email?*
Q: How many employees can have access to the Collaborative system?
Q What are reasons we should or shouldn't have additional log-ons? One for our agency or one for Each user?

Response: In order to track who submitted a file, or if you have multiple users in the system at the same time, you should have multiple sign-ons.
Submit an Account Request Form for each required ID.
We can change the email address on a submitter as needed, just let us know.

Q: *If multiple staff (billing, IT, Act,) have log-in IDs to access provider connect, will they also be able to update provider demogr? Can that be restricted to MNGT staff Only?*
Q Will the multiple ID's be able to update provider demographics?

Response: All user id's associated to an agency will have the ability to request demographic updates.

eClaims Link Software

Q*: Will Eclaims link save the clients demographic information and RIN number?*
Response: Once you have initially loaded the client demographic and provider information, eclaims link saves it and you are able to choose the information from a drop down.

Access to ProviderConnect

Q*: On the 'Intermediary Authorization Form' if the Agency has multiple NPI's should we list all numbers or jus the one number?*

Response: Agencies should submit the 'Account Request Form' to register for access to submit claims. On this form you should list all NPI numbers that are on file with the Collaborative.

Q: *Do we register in our Agency name, or with our psychiatrist name, or by direct service providers*

Response: If you will be billing as an Agency then you would register under your agency name. You would then use the appropriate licensure level modifier to reflect the level of staff rendering service.

Q: What do we fill out on the account request forms?

Response: Agency name/address/NPI #'s please call the help desk if you have questions

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II. 837P Technical Questions

837P Size

Q: Are there any size limits for the 837P? A max number of CLM segments

Response: There is an 8MB limit, not based on claims themselves, but the size of the whole file

Expected Value for Illinois MH Collaborative

Q*: In the companion guide there are a few different occurrences where the expected value is listed as the Illinois Mental Health Collaborative or as The Illinois Mental Health Collaborative. What is the exact value which should be placed there? With or without the "The"? And is it case sensitive*?

Response: The value should be 'The Illinois Mental Health Collaborative', this is not case sensitive

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Delivery Method

The delivery method (face to face, telephonic, or video) should be indicated on the 837P in LOOP 2400 – SERVICE LINE, NTE – line notes. The delivery method note does not impact rate

Placement of Modifiers

Q: Can you coordinate a conference call for discussion on the modifiers in loop 2400?
Response: The level of care modifier is always in the first modifier position.

The following are Level of Care Modifiers:

HQ – Group Modality
HR – Family Modality
HT – Multi-Disciplinary Team
HA – Child/adolescent
TF – Intermediate level of Care
TG – Complex Level of Care
HC - Elderly
HE- Mental Health program
HK- Path

The staff level modifier is always last modifier place in the series of modifiers.

Modifiers will be discussed in future conference calls and training sessions.

Testing of Claims Batch Submission

Q: For 3rd party software testing- What are the submission procedures? What is the turn around cycle time?

Response: Once you register for an ID/password you are set up in a 'test' mode. You may submit as many test files as you feel necessary, once you are satisfied with the test results, call the EDI helpdesk to be changed to 'production' mode. When you submit test or production files you will receive an email stating we have received your file and then another stating if your file passed or failed.

Claims Policies

Charge / Billed Amount

Q: *Why submit a charge?*

Response: It is a Medicaid requirement that charges reflect the actual cost of the provider's services.

Billing "Off-site" Rates

Q: *Some services are billed at different rates, when services are provided on-site vs. off-site, is there a way to indicate on-site vs. off site to receive the correct payment when submitting a claim?*

Response Rates are set according to service code, modifier, and place of service combinations. The place of service codes replace on-site vs off-site distinction. The collaborative's claims adjudication software will recognize the off-site location, and approve rates as contracted for the service location.

Services not contracted or not authorized

Q: Are claims specific to the provider authorized? Can a provider (s) provide service even though they are not registered, authorized?
Response: Only services for which an agency is contracted can be processed for payment. H0039 HQ, H0039 HT, H2015 HT, W00H1, & W00H2 require precertification/authorization. Authorizations are specific to an agency. If no precertification/authorization exists for the specified provider, date, consumer and service - the claim will be rejected accordingly

Pseudo RIN

Q: Urban Systems of Care – when working with Parents, do they bill Pseudo RIN? Only the kids have an actual RIN…not the parents.
Response: Always use a pseudo RIN for Urban Systems of Care

Service Precertification

Q: W00R2 shouldn't require precertification
Q: Crisis intervention doesn't require precertification

Response: The Service Matrix has been updated and posted on the Illinois Mental Health Collaborative Website. Please refer to this update.

Spend Down

Q: How will you handle spend down?
Response: No change – spend down will apply as it always has.

Coordination Of Benefits (COB)

Q: What if your agency computers do not calculate 3rd party billing contracted amount? Can you still bill the amount?
Response: The Collaborative has been directed to coordinate benefits in the manner it is today. Methodology: Collaborative calculates benefits as if there was no other coverage, and subtracts the OHI payment from the normal benefit. You must submit the amount of payment made by the primary carrier

Q: Medicare non-covered provider, how do we bill for COB?
Q Medicare- Should we expect claims to go smoothly for our Medicare/Medicaid covered clients? This was a problem early on with ROCS/HFS interface.
Q: In ROCS we could submit services for a Medicare eligible person …non Part B provider with denial from Medicare. How is this done in ..software?
Q: How does COB work with third party payers for services they do not cover - such as case management?

Response: Certain service codes have been identified by DMH as requiring primary payment information, if the service code is other than these, the Collaborative will not expect that primary carriers will cover it.

Primary Carrier is Commercial Insurance	Primary Carrier is Medicare
H0031 AH H0031 HO H0032 HO	90862 SA 90862 UA

90862 52 90862 SA 90862 UA H0004 HO H0004 HQ HN H0004 HR HO H0034 SA T1502 SA	

Note: If the primary carrier made payment on other service codes, send that payment information on the 837P as well.

If a consumer is Medicare eligible and the Collaborative receives a claim for 90862 (with any modifier combination) we will deny the claim. Only code 90862 requires evidence of Medicare payment. This does not include 90862 with modifier 52.