

1. Who is HealthSmart?

HealthSmart is PHP's Third Party Administrator (TPA). HealthSmart provides various management services for Partners Health Plan (PHP) including but not limited to claims processing.

2. What are my options for submitting claims to PHP:

- **Paper claim submission by mail:**

**Partners Health Plan
Claims Department
PO Box 16309
Lubbock, TX 79490**

- **EDI submission through Change HealthCare (formerly Emdeon) Clearinghouse**
- **EDI submission through HealthSmart Clearinghouse**

3. What is PHP's EDI submitter number? Is it the same for both clearinghouse options?

14966

Yes, it is the same submitter ID value regardless of submission to the Change HealthCare (formerly Emdeon) or HealthSmart Clearinghouse

4. Can I submit claims through the provider portal?

No, we do not offer the ability to submit claims through the web portal.

5. Is there a charge for submitting claims through the HealthSmart Clearinghouse?

No, there is no charge to PHP providers to submit claims via the HealthSmart Clearinghouse.

6. Who should I contact if I am interested in submitting EDI claims to the HealthSmart Clearinghouse?

Contact HealthSmart EDI Support at 1-888-744-6638.

You will have to complete an EDI enrollment form, as well as, a User License Agreement to begin the submission process.

The EDI enrollment packet can be found on our website: <http://phpcares.org/wp-content/uploads/2016/05/PHP-Provider-EDI-Enrollment-Packet.pdf>

7. Who should I contact if I am interested in submitting EDI claims through the Change Healthcare Clearinghouse?

Call 1-888-363-3361

8. When can I expect to receive my PHP claim payments each week? How often are PHP's check runs?

PHP generates two check runs per week. The check runs are typically released on Tuesday and Friday evenings. The vendor receives the information on the following day and generates payments to providers. How long it will take for you to receive your payment will depend on the payment method for which you are receiving PHP payments.

9. What forms of payments are offered?

- a. EFT/ACH
- b. VPay®
- c. Paper check

10. What is a VPay®?

VPay® is virtual card solution designed specifically for claim payments. The payment is delivered to the payee electronically either by fax or secure email. The payee processed the payment just like any other credit card transaction.

11. I received a virtual card payment and do not wish to receive payments in this form. How do I opt-out of this form of payment?

Contact our third party vendor, VPay® at 1-877-657-8560 to change your payment method.

12. I would like to obtain my PHP payment via Electronic Funds Transfer, how can I go about doing so? Will I have to complete any paperwork if I wish to receive my payments via Electronic Funds Transfer (EFT)?

Contact our VPay® Customer Care at 1-877-657-8560. You will need to complete an EFT Agreement form in order to provide your financial institution information including attaching a voided check and return to our third party vendor:

**StoneEagle Services, Inc.
111 West Spring Valley Road
Suite 100
Richardson, Texas 75081**

13. Who is StoneEagle?

StoneEagle is the parent company of VPay®.

14. Why would I receive a PHP payment via virtual card payment if I did not specifically request this method for receipt of PHP payments?

If you already have a relationship with a payer that currently uses VPay® for which you are receiving this form of payment, this payment method will also be used for PHP.

To change to a different payment method option, please contact VPay® Customer Care directly at 1-877-657-8560

15. I submit my claims via the HealthSmart Clearinghouse. What do I need to do to receive electronic remittances (835)?

Contact HealthSmart EDI Support at 1-888-744-6638

You will have to complete an EDI enrollment form, as well as, a User License Agreement to begin this process.

16. I submit my claims via the Change Healthcare Clearinghouse. What do I need to do to receive electronic remittances (835)?

Contact Change Healthcare at **1-888-363-3361**

17. Do I have to be receiving EFT/ACH payments from VPay® to be able to obtain an 835 remittance transaction?

No, you do not have to receive your payments electronically in order to be able to receive an electronic remittance.

18. How soon after a check run should I expect to retrieve my 835 electronic transmission via the HealthSmart Clearinghouse?

The 835s should be posted the day after the check run is released which would be Wednesdays and Mondays based on the current check run schedule.

If you do not receive your 835 within 5 business days of the check run date, please contact HealthSmart EDI support at 1-888-744-6638.

19. Who should I contact if I am having issues with receiving my 835 remittance transaction?

Contact HealthSmart EDI Support at 1-888-744-6638

20. Why is my claim denying with a Remark Code 'PA'?

This code identifies that you have submitted a procedure code which requires the NDC Code, Qualifier, and Units for which you did not submit any or all of these data elements on your claim submission.

21. Why did I receive a Claim Adjustment Reason Code 204 and Remittance Advice Remark Code M119 on my 835 Claim Payment/Advice?

This identifies that you have submitted a procedure code which requires the NDC Code, Qualifier, and Units for which you did not submit any or all of these data elements on your claim submission.

22. Why is an NDC code required?

New York State Department of Health (NYSDOH) mandated that all Managed Care Plans must report National Drug Codes (NDCs) for all physician administered drugs.

23. Which procedure codes require NDC information be reported?

All physician administered drugs, by all provider types, require a valid 11-digit NDC number and the applicable quantity and measurement. This includes all J-codes and all other applicable drug codes (i.e., chemotherapeutics, therapeutics, etc.).

24. How to I submit the required NDC information on an 837 electronic claim submission?

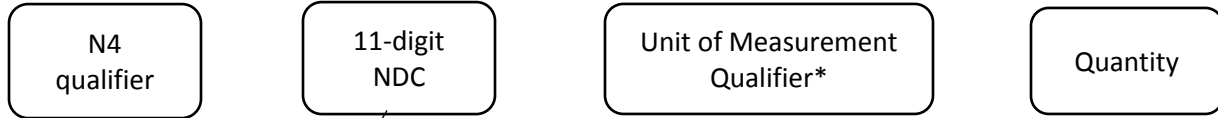
In either the 837I or 837P format providers must report the 11-digit NDC and its corresponding information, in addition to the procedure code, in the LIN segment of Loop ID 2410 to specify the physician-administered drug that is part of the service described in SV1 for the 837 format. Providers must also report the quantity and unit of measure of the NDC as outlined in the table below:

| LIN Segment – Drug Identification i.e., LIN**N4*01234567891 | | |
|--|-----------------------------------|--|
| LIN02 | N4 | N4 Qualifier identifies NDC being billed |
| LIN03 | Actual NDC i.e., 01234 5678 91 | Report NDC in the 11 digit format – do not use hyphens or spaces |
| CTP Segment – Drug Segment i.e., CTP***2.50*2*UN | | |
| CTP03 | Unit Price | i.e., 2.50 |
| CTP04 | Dispensing Quantity | i.e., 2 |
| CTP05 | Unit of Measure Value | F2 = International Unit GR = Gram ML = Milliliter UN = Unit |

25. Where do I enter the required NDC information if I am submitting a paper claim?

On a Professional CMS-1500 claim – Box 24A (shaded area):

| 24. A. DATE(S) OF SERVICE | | | | | | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | | E. DIAGNOSIS POINTER | F. \$ CHARGES | G. DAYS OR UNITS | H. EPSDT Partly Paid | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---------------------------|----|----|----|----|----|---------------------|-----------|---|--|---|----------------------|---------------|------------------|----------------------|--------------|-----------------------------|
| From | To | | | | | | CPT/HCPCS | MODIFIER | | | | | | | | |
| MM | DD | YY | MM | DD | YY | | | | | | | | | | | |
| N412345678901 UN2 | | | | | | 11 | J1960 | | | 1 | 200 00 | | | NPI | 1234567890 | |



On an Institutional UB-04 claim – Box 43:

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS |
|-------------|-------------------------|------------------------------|---------------|----------------|
| 636 | N412345678901UN1234.567 | J1960 | MM/DD/YY | 1 |

*The following are the only acceptable values for submission as a Unit of Measurement Qualifier:

- GR (gram)
- ML (milliliter)
- UN (unit)
- F2 (international unit)

26. How do I resubmit my claim if I received a denial for missing/invalid NDC information?

On an Institutional UB-04 claim you should submit as a corrected claim, which is identified by utilizing the applicable Bill Type ending in '7' to designate as corrected (i.e., XX7, 137, 737, etc.)

On a Professional CMS-1500 claim you should mark the claim as corrected and include the original claim number in Box 22 'Original Reference No.'

All resubmissions/corrected claims should include all original claim lines.