2 Health Partners Provider Manual
Frequently Asked Questions

Purpose: This chapter provides answers to frequently asked questions concerning member, provider and disease management issues.

Topics:

- Benefits & Eligibility FAQ
- Claims FAQ
- Referral Information FAQ
- Authorizations FAQ
- Behavioral Health FAQ
- Disease Management Services FAQ
- Provider Information FAQ

Module Contents

Overview

This chapter provides a series of frequently asked questions pertaining to the following broad categories:

- Benefits & Eligibility
- Claims
- Referrals
- Authorizations
- Behavioral Health
- Disease Management
- Provider Information

Benefits & Eligibility

- **Do I have to verify member eligibility?**

  Yes, you must verify eligibility whenever a Health Partners or KidzPartners member visits your office. We offer a direct phone number to member eligibility verification.

  For Health Partners members, simply call **1-800-225-2978** or **215-849-4791**, Monday through Friday, from 8:30 am to 5 pm, to go directly to eligibility verification. Of course, the general Provider Services Helpline is available 24 hours a day, seven days a week at **215-991-4350** or **888-991-9023**.

  For KidzPartners members, call **215-967-4540** or **888-888-1211**, for eligibility verification.

  To gain access to HP Connect you will need to first register online for a secured log-on ID and password. Please visit our website at www.healthpart.com. Click **Providers** and complete the online registration form. Make sure to designate a primary Super User. The requesting Super User is authorized to set up additional user profiles and reset passwords. Please allow three business days for processing your registration. We will contact you by e-mail or phone to confirm that you have access to HP Connect.

  Specialists, ancillaries, and hospitals also need to confirm eligibility. Because of the frequent changes in eligibility (especially for Medical Assistance members) and the member's right to change his/her Managed Care Organization (MCO) choice from month to month, all providers must verify member eligibility on the date of service (via the avenues described in the paragraph above) to ensure the patient's eligibility in the plan.

- **What insurance coverage is primary?**

  Employer group health, Worker's Compensation, automobile coverage and any other liability insurance or payment is always primary. Absent any of these liable parties, Medicare is primary. Medicaid is always the payer of last resort.

- **If a member has another insurance, what is Health Partners' payment liability?**

  Medicaid is always the payer of last resort. If a member has other coverage, such as Medicare or Blue Cross, the Medicaid liability is limited. Specifically, payment will be made only up to the contracted Medicaid rate. So if a primary insurer has paid more than Health Partners would have paid if its coverage were primary, no additional reimbursement will be made. The one exception to this rule

concerns payment of the Medicare inpatient copayments, which are normally payable as a secondary benefit.

- **If Health Partners is secondary, is it necessary to get authorization from HealthCare Management?**

  Health Partners requires an authorization from our HealthCare Management department regardless of whether Health Partners is the member's primary or secondary insurance. Please refer to Sections IV and V to determine which services require authorization.

- **Is there a copayment or deductible for doctor visits?**

  Copayments vary according to the member's benefit package under Medical Assistance/General Assistance for Health Partners members, and under CHIP for KidzPartners members. For more information, see Copays for Medicaid Members on page 4-20 and Copays for KidzPartners Members on page 5-10.

Claims

- **Does Health Partners accept electronic claims submissions?**

  Health Partners offers the speed, convenience and lower administrative costs through Electronic Data Interchange (EDI), also known as electronic claims processing. Health Partners has contracted with Emdeon as our claims transaction clearinghouse. Please use Payer ID number **80142** for Health Partners and KidzPartners claims.

  For more information, call the EDI Support Line (see Table 1: Service Department Contact Information on page 1-14).

  Health Partners Transaction Code Set Companion Guides are available through the HIPAA section of our website under **Providers**.

- **Where do I mail claims for Health Partners and KidzPartners?**

  Please note the following addresses:

  - Health Partners (Medical Assistance)

    P.O. Box 1220

    Philadelphia, PA 19105-1220

  - KidzPartners (CHIP)

    P.O. Box 1230

    Philadelphia, PA 19105-1220

  - Claims Reconsiderations

    Health Partners

    901 Market Street, Suite 500

    Philadelphia, PA 19107

For more information, see Claim Reconsiderations on page 9-24.

- **What is the normal payment cycle for releasing claim payments?**

  Health Partners records the date of receipt of each claim received at our claim processing center and tracks its status through processing and check generation. With few exceptions, claims are processed within 30 days of receipt. Checks are produced on a weekly basis and mailed within two days of generation.

- **What is Claim Check?**

  Claim Check is a software product that identifies potential unbundling of services. Certain claims are compared against expected norms. In some cases, a service will be denied as being part of another major procedure. Your remittance should indicate the code review message if that situation occurs.

- **What does the term "pre-paid" mean?**

  When you don't receive payment and your remittance shows an amount in a pre-paid column, it indicates that the service billed has already been reimbursed. This usually occurs when a capitated payment has been made and no additional fee for service reimbursement is available for the procedure code billed.

- **Why don't I get paid correctly for services that have been authorized?**

  There are a number of possible answers. In some cases, the services authorized are different than the services billed. This can occur because individual CPT or HCPCS codes differ between authorization entry and claim billing.

  Also, dates of service authorized may vary from the dates of service shown on the form. It is important to make sure that both the persons calling for prior authorization and the billing staff have a common understanding about exactly what services have been authorized.

- **When, if ever, am I allowed to bill the member for balances due?**

  The general rule to follow for the Health Partners Medicaid line of business is that the member cannot be balance billed. If you disagree with a claim payment decision, you should appeal the claim decision to Health Partners and not attempt to collect monies from the member. The member may be billed only if: 1) the member knows that the service he or she is requesting is not a covered benefit; and 2) the provider obtains written agreement in advance of the service from the member that he or she understands that and will pay for the service.

  This restriction regarding balance billing does not apply to members enrolled in the KidzPartners (CHIP) program.

- **When should I resubmit a claim in lieu of appealing a decision?**

  In very few instances does resubmission of a claim lead to monetary reimbursement. If a claim has been returned with a letter indicating the form is being sent back because of incorrect provider number, diagnosis or procedure code, you should resubmit a corrected copy of that claim.

  In all other cases, the claim decision should be appealed. Simply resubmitting a claim, on which you feel an underpayment was made, will generally lead to an automatic system denial for duplicate billing.

- **What are the timely filing limitations?**

  For claim submission, the timely filing limit is 180 days from the date of service. For secondary billings, the 60-day timeframe starts with the primary explanation of payment notification date.

  Claim appeals must be filed within 180 days of the claim notification date noted on the Health Partners Explanation of Payment notice.

- **What information do I need to submit my claims electronically to Health Partners?**

  Make sure to include the following items prior to sending claims electronically for Health Partners members:

  Payer ID Number for Health Partners: 80142

  Payer ID Number for KidzPartners: 80142

  Individual and billing NPI numbers are required. Failure to include this information will result in a rejection of the claim. Please refer to the Health Partners 837 Institutional and Professional Companion Guide for the required provider number field.

- **What is my Health Partners Provider ID number?**

  Health Partners providers must use their individual and billing NPI numbers when submitting claims electronically. A Health Partners legacy number may be billed on paper claims. Legacy provider numbers are specific to individual providers or facilities by their practice location/site. If you are unsure of your Health Partners Provider ID number, please contact the Health Partners Provider Helpline (see Table 1: Service Department Contact Information on page 1-14).

- **What if my billing company or EDI software vendor uses another clearinghouse such as NDC, Med-E America, ETS, or Equifax instead of Emdeon (WebMD/NEIC/Envoy)?**

  Emdeon is the leading clearinghouse in the country and almost all claims clearinghouses forward claims to them for processing. Check with your software vendor for details.

- **How can providers obtain copies of Health Partners' Companion Guide?**

  All Companion Guides are available on the Health Partners website: *http://www.healthpart.com/HIPAA.asp*, click **Providers** > **Eligibility & Claims** > **HIPAA Connect** > **EDI Claims**. Please check this site frequently for updates.

- **Who can we contact at Health Partners if we have Transaction and Code Set or EDI questions?**

  If you have questions regarding electronic billing or Transaction and Code Sets, please contact the Health Partners' EDI Support Line (see Table 1: Service Department Contact Information on page 1-14).

- **Can Health Partners accept HIPAA- and non-HIPAA-compliant formats?**

  No, Health Partners can only accept HIPAA-compliant transactions.

Referral Information

Primary care providers should refer Health Partners/KidzPartners members to a participating specialist or facility.

- **What is Health Partners' referral process?**

  In July 2009, Health Partners introduced an easier referral process: Participating providers are now able to order services using a script.

  A copy of the script should be kept in the member's medical chart, but it is not necessary to send a copy to Health Partners with your claim. Please keep in mind that prior authorization must be obtained for certain services. For more information, see Health Partners Benefit Summary and see KidzPartners Benefit Summary.

- **If the script says "consult only," but the specialist believes treatment is warranted for a Health Partners/KidzPartners member, what is the procedure?**

  The specialist should communicate the clinical situation to the member's PCP who may authorize additional services by forwarding or faxing a written referral or script to the specialist's office. As with all referrals, the specialist and the referring PCP must keep a copy of this new referral in the member's medical record.

- **Can the specialist give a verbal report to the PCP, or does it have to be written?**

  Verbal communication is acceptable initially, but it must be followed with a written report. A notation regarding communication between the PCP and specialist should be recorded in the patient's medical record.

- **Can members go outside of the Health Partners/KidzPartners provider network?**

  Health Partners realizes that PCPs might occasionally refer members to a non-participating provider for medical care not available through a participating provider. However, we require that you seek prior authorization before making a referral to a non-participating physician.

  If prior authorization is not obtained for out-of-network services, reimbursement will be denied. Please call the Inpatient and Outpatient Services department for prior authorization of both inpatient and outpatient services (see Table 1: Service Department Contact Information on page 1-14).

  Please see the Health Partners Primary Care, KidzPartners Primary Care, and/or Health Partners Specialist Directory for lists of participating plan providers, or consult PROVIDER Plus+, our online provider directory (http://*www.healthpart.com*) which is updated more frequently. You can also call the Provider Helpline for information about participating providers.

- **How long is a referral valid?**

  A referral is valid for 60 days from the date it is written as long as the member remains an active member in Health Partners/KidzPartners.

  A PCP is not restricted regarding the specialist referral criteria (i.e. the length of time the member sees the specialist or the number of visits that comprises). If the specialist does not participate with Health Partners/KidzPartners, prior authorization is required and these claims are adjudicated accordingly. PCPs are expected to keep a copy of all referrals on file in the patient's record. Members are given a copy of the referral to bring to the specialist office to confirm that the PCP made the referral. If the PCP does not indicate the number of visits on the referral, the specialist will assume only one visit is authorized and may refuse to see the member for follow-up care (without an additional referral).

- **What services require referrals?**

  Specialist services for Health Partners/KidzPartners members require a referral.

  A referral is not needed for emergency services (i.e., emergency room visits, emergency inpatient stays, emergency SPUs), family planning, routine dental, vision or ob/gyn services, or initial chiropractic evaluations. Please refer to the benefits grid in chapter IV for details about services requiring referral, script and/or prior authorization.

Authorizations

- **Who should contact HealthCare Management for authorization of an elective hospital admission – the PCP, the specialist or the hospital?**

  Any of the three. The ideal caller is the party who has the best understanding of the patient's medical condition and proposed treatment. Keep in mind, however, that unauthorized elective hospital admissions will be subject to denial.

  All hospital admissions, including patients admitted through the emergency room, as well as elective admissions, should be called in to Health Partners for notification and authorization within two business days (see Table 1: Service Department Contact Information on page 1-14). If your need for prior authorization occurs on a weekend or holiday, please make your request the next business day.

- **What should I do if a member requires home care or DME?**

  Call Health Partners' Outpatient Services Unit for DME, outpatient rehabilitation services, and home care (see Table 1: Service Department Contact Information on page 1-14). Rentals-regardless of reimbursement-and DME/Supplies over $500 per claim line require prior authorization. All home care, shift care, and outpatient rehabilitation services also require prior authorization.

  A prescription request and letter of medical necessity must be faxed to **215-849-4749**.

- **Is authorization needed for radiology services?**
  - Yes, Prior authorization is required for all PET scans, CT scans and MRI through Medsolutions, Inc (MSI).
- **Is authorization needed for short procedure unit (SPU) services?**
  - Health Partners: No authorization is needed, but a prescription from the PCP or specialist is required. For more information, see Table 1: Short Procedure Unit (SPU)/Ambulatory Procedures on page 6-8.
  - KidzPartners: Prior authorization is required for all SPU services.

Behavioral Health

- **How do Health Partners members access behavioral health treatment?**

  Behavioral health services do not require a referral. Providers who identify a Health Partners member in need of behavioral health services should contact the Medical Assistance behavioral health managed care organization (BHMCO) assigned to the county in which the member resides (these are listed below). Our Special Needs Unit is also available to help with coordination of care issues.

  Behavioral Health Managed Care Organizations in the five county Philadelphia area include:

  – Philadelphia County - Community Behavioral Health (CBH) [**215-413-3100** or **1-888-545-2600**]

  – Bucks County - Magellan [**1-877-769-9784**]

  – Chester County - Community Care Behavioral Health (Provider) [**1-888-251-2224**] (Member) **[1-866-622-4228]**

  – Delaware County - Magellan [**1-888-207-2911**]

  – Montgomery County - Magellan [**1-877-769-9782**]

- **How do KidzPartners members access behavioral health treatment?**

  Behavioral health services do not require a referral. To self-refer, members must call the KidzPartners' contracted behavioral health managed care organization, CompCare, at **877-710-8222**. Providers who identify a KidzPartners member in need of behavioral health services can contact CompCare at this same number. Our Special Needs Unit is also available to help with coordination of care issues.

Healthier You Disease Management Program

- **How should I enroll a member in the Healthier You Disease Management program provided by Health Partners?**

  To enroll a member in the Healthier You, Disease Management, contact the department by calling **215-967-4690** or **866-500-4571** and leaving all the pertinent member information on the confidential line. You may enroll adult and children in our asthma, diabetes and Fit Kids program. We also have a heart failure program for adults members too.

  For more information, see Table 1: Service Department Contact Information on page 1-14.

Perinatal/Baby Partners Program

- **What does the Baby Partners program offer members?**

  Our Baby Partners Case Managers are highly qualified nurses and social workers who will outreach and case manage members throughout their pregnancy and follow up after delivery in coordination with the member's health care provider. We will facilitate members who wish to quit smoking, provide breast feeding counseling, coordinate transportation to appointments and home care, screen for depression and follow up as needed, and ensure that the member understands the importance of all appointments.

  For more information, see Table 1: Service Department Contact Information on page 1-14.

Provider Information

- **How do I reorder PCP supplies, such as the Health Partners Authorization forms?**

  Simply log on to *http://www.healthpart.com* and click **Providers**. You can order your supplies via our online Supply Request Form. You can even have them shipped to a different location than your main office for easier storage.

  In addition, supplies can be ordered by calling the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-14).

- **Who should I contact when there is a change such as a new physician joining the practice, an office address change, or a change in practice ownership?**

  Call the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-14).

- **Who should I contact about problems, including claim appeals, provider disputes, denial of credentialing, or termination?**

  Call the Provider Services Helpline (see Table 1: Service Department Contact Information on page 1-14).