

# Finance FAQ's

## Enrollment/Consumer Record

### ❖ How does a provider enroll in the PBH network?

- A prospective Provider should contact Provider Network at 1-800-958-5596 to request an application for either an Agency or LIP.

### ❖ I have a consumer who had primary insurance that's now terminated OR I have a consumer who has new primary insurance. How do I let PBH know to update their records?

- Fill out the Health Insurance Information Referral form found on the provider website under Finance Forms quick link and send to your claims specialist.
- To Complete this information electronically in provider direct:
  - Log Into Provider Direct, go to Modules, Members, Client Gateway
  - Click on Select and Update Client
  - Click the Add button beside Create New Update Request
  - Search and Select the Consumer
  - Complete any missing information on the 1<sup>st</sup> page of the screen (Demographic information)
  - Click Save and fix any errors that appear on the top of the screen
  - Once saved, navigate to the Go To Details link at the top of the page
  - Click on the COB tab
  - Enter any COB information and click Accept/Add to list or click on old COB on the right of the screen to fill in an end date

Back to Gateway  
BACK

[Go to Header](#) [Go to Comments History](#)

Diagnosis **COB** Target Pop SA History LOC / CALOC

COB

Insurer: None

Plan:

Insurance No.:

Effective Dt.:

Exp. Dt.:

Insurer	Plan	Ins. No.	Eff. Dt.	End Dt.	ID#
BCBS of Kansas	123545	987-6543	01/01/2008		15

Select

Accept / Add to List

Existing COB's

- ❖ **How do I find out how many basic units a consumer has left?**
  - In Provider Direct: Go to Modules -> Members -> Enter clients' information and click on search for clients. The client will be selected - click on search for patients information. The number of remaining basic units will be displayed under the last name and birth date. This information is also included in the "current clientdump" report which is located out in your provider folder.
  
- ❖ **How do I find the unit frequencies associated with the authorization?**
  - Located in your provider folder in the "current authdump" report or on the auth letter.
  
- ❖ **Why was my authorization only set up for a certain number of units per day/week/month?**
  - Authorizations are set up according to the TAR (Treatment Authorization Request) and the treatment plan of the consumer or service limitations. For further clarification, contact UM (Utilization Management) @ 704-743-2100.

### Provider Direct/Claim Status

- ❖ **How do I get a login for Provider Direct?**
  - E-mail the helpdesk @ <mailto:providertesting@pamh.com> or call the helpdesk @ 704-784-8411 opt 1
  - Supervisors should request logins for their employees and email your name, the names for which you are requesting logins, their email addresses and phone numbers. Send to [providertesting@pamh.com](mailto:providertesting@pamh.com)
  - **Note:** Providers will need to contact provider testing when staff are terminated to disable their logins.
  
- ❖ **Why can't I enter claims through Provider Direct -> Modules -> Provider -> 1500 Search and UB04 Search?**
  - When claim forms were updated in May 2007, providers were instructed to use the new CMS 1500 and UB04 forms through

Provider Direct - > Modules - > Members - > Client Gateway - > Create New Claim. The old forms and links have been disabled.

❖ **How can I check claims status?**

- For Provider Direct claims: Go to Modules -> Members -> Client Gateway -> Search for a claim. Type in the client's full name and DOB or Social Security Number. Select "Status Link" from the right hand column of the search results box.
- For 837 billers: Go to Modules > Provider > File Download. The claim status dump can be accessed and is a cumulative file that is updated weekly and shows you claim status information.

❖ **How do I inquire about a claim I can't find in provider direct or the claim status dump?**

- Complete the claim inquiry form from the provider website and send to your claims specialist.

### Claims Submission/Payment

❖ **How do I submit a claim to PBH?**

- Claims for services must be submitted to PBH by one of the following methods:
  - Electronically using the 837 format.
  - Via Provider Direct.
    - The Provider Direct Billing Guide is on the Provider Website. You may sign up for training electronically by clicking on the following link:  
[http://www.pbhcare.org/Provider\\_training\\_form.asp](http://www.pbhcare.org/Provider_training_form.asp)
  - Via paper CMS1500 or UB04 form (only for the first sixty (60) days per your contractual agreement)

❖ **How often should I submit a claim?**

- Claims must be submitted within ninety (90) days from the date of service, with the exception of Hospital claims and claims involving

Coordination of Benefits, which must be submitted within one hundred-eighty (180) days from the date of service. Claim Resubmissions have an additional ninety (90) days when using the proper resubmission guidelines.

❖ **I'm a new provider and I need training on submitting claims. How do I get the information I need?**

- Refer to the Provider Direct Training Manual on the provider website. You can also access Provider Direct video training (coming soon) on the provider website or contact your claims specialist.

❖ **How does PBH pay a provider**

- By either electronic funds transfer or check.
- Payments are processed every Tuesday. Claims must be submitted by 5:00p.m. on Tuesday in order to receive payment the following Tuesday.
- Applications for Electronic Funds Transfer are on the Provider Website

❖ **How do I access my Remittance Advice (RA)?**

- You can access the RA by logging into provider direct. Go to Modules > Provider > File Download. The RA's are posted the next day following the check write.

### Denials

❖ **I made a mistake on a claim I submitted. How do I correct this error?**

- If this is an unpaid claim send a "claim inquiry/ correction form". If it is a paid claim use a "claim adjustment form". Both of these forms along with the instructions are on the Provider Website under the Finance Forms quick link. Send completed forms to your claims specialist.

❖ **Why did my claim deny for 1024 max basic units exhausted?**

- Allowed basic units for children are 12, for adults 8. These are counted by Fiscal Year (July 1-June 30) and apply to all providers of basic services.

- ❖ **What does “Service not in state contract” mean?**
  - Generally, providers are contracted to provide Medicaid funded services to Medicaid eligible consumers. If the consumer loses Medicaid and the provider is not contracted to provide State funded services the claim will deny. Only if providers are contracted to provide State funded services are they reimbursed for services provided to Non-Medicaid eligible consumers.
  
- ❖ **Why did my claim deny for no authorization when I have an auth?**
  - There are several reasons this could happen
    - The auth date has expired
    - Billing a service not on the auth
    - UM has end dated an auth (you will need to call UM @ 704-743-2100 for clarification)
  
- ❖ **Why did my claim deny for code 1018, claim received after billing period?**
  - You have ninety (90) days from the date of service for submission of most claims. Hospitals and claims involving Coordination of Benefits have one hundred-eighty (180) days from the date of service to submit. Resubmissions have one hundred-eighty (180) days from date of service as long as the original denial is within ninety (90) days billing terms and the proper resubmission guidelines (see Communication Bulletin FY-0809-FN-37) were followed.
  
- ❖ **Why did my resubmission deny for code 1018, claim received after billing period?**
  - To resubmit a previously denied claim, you must follow the resubmission guidelines (see Communication Bulletin FY-0809-FN-37) found on the website and bill within one hundred-eighty (180) days of the date of service.
  
- ❖ **Why did my claim deny for code 76, missing/incomplete/invalid diagnosis or condition?**
  - Diagnosis code must be consistent with services provided and diagnosis group (MH, DD, or SA) of the consumer. For further clarification, call the UM Department @ 704-743-2100.

- ❖ **Why did my hospital claim for a bill type 131 deny for non-covered services?**
  - PBH only approves and pays for services associated with room charges from an inpatient stay. We do not cover ancillary charges.
  
- ❖ **Why did my corrected claim deny as a duplicate claim?**
  - You submitted the correction before the claims specialist completed the adjustment request. Once a claim adjustment is submitted, you need to wait until the claims specialist notifies you the claim has been deleted before you submit corrections.
  
- ❖ **Why did my claim deny for code 1032, authorized units consumed when I have a valid authorization?**
  - Refer to your authorization letter to see the number of units approved. You have billed more than that amount for the service/dates of service indicated.
  
- ❖ **Why did my claim deny for code 77, missing/incomplete/invalid place of service. How do I find the correct place of service code?**
  - Please refer to the Place of Service Crosswalk on the provider website under Finance Forms quick link to ensure you have submitted a valid place of service code.
  
- ❖ **I have a denied claim for 1021, monthly frequency exceeded OR I have a denied claim for 1020, weekly frequency exceeded. It was the 1st claim I entered for the month/week. Why did it deny?**
  - Check your authorization start date. The auths are not counted by calendar weeks or months. The months begin counting on the 1st date of the auth for 31 days. Weeks begin counting on the day of the week the auth begins. For example, auth date range 8/6/08-10/6/08. The weeks begin counting on Wednesday 8/6/08. The 1st week is 8/6-8/12/08. The months begin counting on 8/6/08. The 1st month is 8/6-9/5/08.

## Contract/Rates

- ❖ **Where do I find my rates for services I provide?**
  - On the Provider Website > Under "Quick Links" click on PBH Rate Tables for providers.
  
- ❖ **Will the rate change for my contracted services; if so, when?**
  - Refer to the provider website regarding any rate changes. A communication bulletin will be posted with any rate changes and effective dates.
  
- ❖ **How would I be able to add state coverage to my contract?**
  - Contact your Provider Relations Manager.

## Overpayments/Refunds

- ❖ **I know I owe money back to PBH for billing errors. How do I start the recoupment process?**
  - Complete the claim adjustment forms found on the provider website and submit to your claims specialist. PBH will adjust claims indicated and the overpayment will be recouped from future checkwrites. You will see the recouped claims on your RA.
  
- ❖ **Can I send a refund check to PBH for an overpayment?**
  - Yes. Verify that you are sending the correct refund amount.
  - Please complete and attach the Provider Refund Detail form found under Finance Forms quick link on the provider website and submit to your claims specialist

**Alphabetical listing for providers is listed below:**

<b>A - D</b>	<b>Sheila Morton, Claims Specialist</b>	<b>704- 721- 7038</b>
<b>E - H</b>	<b>Deana Harkey, Claims Specialist</b>	<b>704- 721- 7081</b>
<b>I - Q</b>	<b>Beth Thompson, Claims Specialist</b>	<b>704- 721- 7077</b>
<b>R - Z</b>	<b>Annette James, Claims Specialist</b>	<b>704- 721- 7078</b>