

PURPOSE: *This resource is intended to provide pre-billing preparation information to Support Coordination Organizations (SCOs). Late calendar year 2015, it is anticipated that the HCSIS bimonthly submission of Supports Coordination (SC) and Targeted Services Management (TSM) service claims to PROMISE™ will be terminated. SCOs will be responsible for submitting their own SC and TSM service claims to PROMISE™.*

**WHAT IS
PROMISE™?**

PROMISE™ is an acronym that stands for “Provider Reimbursement and Operations Management Information System in electronic format”. PROMISE™ is Pennsylvania’s Medicaid Management Information System (MMIS). All states are required to operate a MMIS unless this requirement is waived by the Federal Government. A MMIS is an integrated enterprise information system that typically contains at least six defined functional areas which include:

- *Claims Processing:* Reviews all provider invoice claims and edits them against the other MMIS subsystems for proper reimbursement.
- *Management and Administrative Reporting:* Provides management with financial and statistical data from the claims information.
- *Provider Enrollment:* Processes and maintains files of qualified providers enrolled in the Medicaid program.
- *Recipient Eligibility:* Contains comprehensive profiles of each recipient/consumer for use in invoice processing.
- *Reference File:* Consists of nine reference files that are used by the Claims Processing subsystem to monitor and check provider claims for proper processing in accordance with state and federal requirements. The reference file includes pricing, procedure and diagnosis files.
- *Surveillances and Utilization Review:* Assists management in monitoring providers and recipients to help identify potential abuse of the Medicaid programs.

**Topical Areas
Covered in this
Resource**

- Selecting a billing method
- Description of billing methods
- Assess if your staffing is equipped to support billing
- Assessing your information technology needs
- Registering on the PROMISE™ Internet
- Understanding the prudent pay cycle
- Electronic Remittance Advice (Referred to as the 835, ERA or RA)
- PA PROMISE™ Provider Handbooks and Billing Guides
- PA PROMISE™ Edits/Audits

SELECT A BILLING METHOD

There are four (4) ways to submit claim transactions:

1. Submit a “real time” claim submission via the PROMISE™ Internet;
2. Submit a batch transaction using third party vendor software, a clearinghouse or using your organization’s existing information system;
3. Mail a paper claim (CMS 1500) and/or
4. Mail a compact disc (CD)



NOTE: The provider is **not** restricted as to which billing method to use. Providers can use all methods at any time. For example, if the user typically submits a batch transaction and noticed a claim was missing from the batch, they have the option to submit the omitted claim via the PROMISE™ Internet. If the batch processes and one of the claims from the batch was denied, the provider has the option to use the PROMISE™ Internet to submit a claim adjustment instead of waiting to submit it in the next batch. If the provider omitted a claim from their batch transaction and the claim is nearing the 180-day deadline for original claim submission, the PROMISE™ Internet is available as a submission method to ensure timely filing.

NOTE: A “service note extract” from HCSIS is currently being designed and will be available to SCOs once implementation occurs. The extract will gather data from service notes entered into HCSIS and could be used to support billing. The extract **should not** be the primary source used to determine billable service notes. The extract will be made available to assist with claim reconciliation activities.

DESCRIPTION OF BILLING METHODS

INTERNET

Billing via the internet is done “real time”. In other words, the claim is submitted via a web based portal and is processed immediately. The user will know immediately if their claim submission is paid, denied or suspended. The advantage to this method is that if the claim is denied, the user can review the errors (referred to as error status codes (ESCs)), fix the claim accordingly, resubmit the claim “real time” and obtain submission results immediately.

A PROMISE™ e-learning course is available to walk users through its functionality. Please note that ODP claims are “Professional” claims so when users view the e-learning course they may want to consider skipping the sections of the course related to other claim types (ie dental, institutional etc). This course requires the use of Flash player. [Click here to download Flash.](#)

Click on the following hyperlink to access the PROMISE™ e-learning course:
http://promise.dpw.state.pa.us/promisehelp/PortalDesign_WIP/PortalDesign_WIP.htm.

The PROMISE™ Internet User Manual is also available to assist providers with program specific billing rules. Click on the following hyperlink to view this manual:
http://www.dhs.state.pa.us/cs/groups/public/documents/manual/s_002302.pdf

DESCRIPTION OF BILLING METHODS (con't)**BATCH**

A batch refers to a file that is downloaded from a source system, sent to a temporary storage area by the submitter, referred to as the electronic batch bulletin board system (BBS), waits for its turn to be processed, is recognized by the host system and is then uploaded to PROMISE™. Batch files can be transmitted by submitters to the BBS 24 hours per day, 7 days per week, and will be processed when they are received. To be accepted by PROMISE™ the batch file must be in an 837 Professional, version 5010 format. This billing method is advantageous for providers with high claim volumes because the batch file can contain and submit thousands of individual claims all at once. When using a batch transaction method, claim data is typically entered into an ancillary system by the user then downloaded all at once into one file and submitted on demand by the user to the MMIS (PROMISE™) BBS. A batch may be submitted to PROMISE™ every day, many times a day or at regular intervals (ie weekly, biweekly etc). An example of a batch transaction billing software is Provider Electronic Solutions (PES) software. PES is available free from the Pennsylvania Department of Human Services (DHS). See the following hyperlink for more information:

<http://promise.dpw.state.pa.us/ePROM/ProviderSoftware/softwareDownloadMain.asp>

Third party billing vendors, referred to as clearinghouses or service bureaus, typically use batch transaction software to submit claims on behalf of the provider. Click on the following hyperlink for more information regarding software and service vendors:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/softwareandservicevendors/index.htm>

PAPER/CD

Paper Billing (CMS 1500) and CDs: These billing methods are rarely used. They tend to be prone to higher submitter errors than the other billing methods. It takes approximately 2-4 weeks from when the paper submission is billed before the MMIS processes these type of claim(s).

ASSESS IF YOUR STAFFING IS EQUIPPED TO SUPPORT BILLING

Provider organizations should assess whether they have skilled staff to perform the various functions associated with billing. Billing functions include, but are not limited to, the following:

- Understanding the required fields on a claim transaction;
- Populating claim transactions that adhere to Medical Assistance and waiver rules;
- Submitting claim transactions, adjustments and voids (outside of HCSIS);

Other important activities that support billing but should already be done by SCOs include:

- Error reconciliation;
- Financial reconciliation which includes reviewing and understanding remittance advices;
- Ensuring and validating that documentation exists to support claim transactions.

ASSESS YOUR INFORMATION TECHNOLOGY NEEDS

If your organization elects to submit your own claim transactions, you should ensure your information system supports billing either via the internet and/or is able to download a batch transaction in an 837 format. If it does not, providers may want to consider updating/modifying their current software, replacing it with third party vendor software that supports billing or using a clearinghouse to submit your claim transactions.

If you choose to purchase commercial billing software or modify your current software to accommodate billing, submitters (i.e individual providers, billing services, software vendors) must complete a certification process in order to submit transactions to PROMISe™ for production processing. PROMISe™ Provider/Payer Certification assures the compatibility between Providers and the Pennsylvania Medical Assistance Payer (PA Department of Human Services) when processing HIPAA transactions. This certification process confirms the ability of software products and users to submit readable, HIPAA compliant transactions. Certification cannot; however, ensure that claims will be paid. The certification process consists of the submission of test claims to verify that all transactions are HIPAA compliant and conform to PROMISe™. If you use commercial software, the vendor who supplies the software to you is responsible for certifying their software. If you modify existing solution software in house, it is the provider's responsibility to get their software certified. To initiate the certification process, see the certification registration process on the DHS web site at [PROMISe™ Certification](#) or contact the HP Enterprise Services Provider Assistance Center at 800-248-2152.

If a provider chooses to modify their existing software to perform billing, you should consult the Pennsylvania PROMISe™ Companion Guide, 837 Professional, version 5010 to understand the loops, segments and data elements associated with the 837P/5010 format and Pennsylvania specific information required in the transaction set. Currently this Companion Guide is not posted on the DHS website but is anticipated to be posted soon. In the meantime, SCO technical staff may review an older version of the handbook to get started: <http://www.lsmhmr.org/837Info/837CompanionGuide.pdf>. When the updated version of the PA 837 Profession Companion Guide is available it will be posted [here](#).

As was indicated earlier, providers have the option to contract with a third party billing entity to submit claims on their behalf (clearinghouses). Click on the following hyperlink for more information regarding software and service vendors: <http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/softwareandservicevendors/index.htm>

REGISTERING ON THE PROMISE™ INTERNET

Even if you elect not to use the PROMISE™ Internet to submit claims, it is strongly recommended you register on it anyway. The PROMISE™ internet has additional functionality other than billing including:

- Allows the user to check claim status (paid, denied or suspended) regardless of submission method
- The ability to access real time eligibility verification information
- Retrieving online versions of your remittance advices (RAs)
- Accessing web based training courses from your desktop
- Accessing DHS website to download and review user manuals and claim forms
- Accessing ePEAP, electronic provider enrollment automation project, to access and update your provider file

See the section of this document called “Internet Billing”, for resources associated with the PROMISE™ Internet.

Directions for registering and logging on to the PROMISE™ Portal begins on page 8 of the *PA PROMISE™ Provider Internet User Manual*. Click on the following hyperlink to access this manual:

<http://promise.dpw.state.pa.us/promisehelp/manuals/PROMISEProviderInternetUserManual.pdf>

UNDERSTANDING THE PRUDENT PAY CYCLE

Federal regulation 42 CFR § 447.45(d)(2) (relating to timely processing of claims) sets forth that the Department will pay 90 percent of clean claims within 30 days of the date of receipt. “Clean claims” refer to claims submitted and processed with no errors. The practice of paying clean claims within 30 days of receipt, but not sooner, by holding the claim in processing, is called “Prudent Payment” and is consistent with general business standards. In order to comply with payment standards set forth by the American Recovery and Reinvestment Act of 2009 (ARRA), the Department currently ‘holds’ clean claims of both practitioners and non-practitioners no less than 18 days from receipt before processing the claims through the weekly financial cycle. The remaining days leading up to the 30-day threshold are used to produce a Remittance Advice; to clear the claim for payment; and to have the issued payment mailed or paid via ACH (Automated Clearinghouse). ACH is analogous with the term Electronic Funds Transfer (EFT).

Although HCSIS currently submits claims on behalf of SCOs, payments for those claims are currently subject to prudent pay. When SCOs submit their own claims, payment for those claims will continue to be subject to the prudent payment of claims policy. Prudent pay impacts the length of time in which a claim is held before it is released to the financial cycle. Once a claim is released from “prudent pay”, it processes through the next financial cycle. If the claim is released from prudent pay on a Sunday through Friday, it will process through the financial cycle the Saturday that follows. After the claim processes through the financial cycle, beginning early Saturday morning and through the weekend, the Remittance Advice (RA) is generated and the release of funds is initiated. Only claims approved for payment are subject to the Prudent Pay provisions. Denied claims are exempt. See [Informational Packet 075-11](#) and [Bulletin 99-06-04](#) for more information regarding the prudent payment of claims policy.

ELECTRONIC REMITTANCE ADVICE (Referred to as the 835, ERA or RA)

WHAT IS AN ERA?

Electronic Remittance Advice (ERA) or 835 file is the electronic remittance describing the payer, payee, payment amount, and other identifying information about the payment. ERA is analogous with the term Remittance Advice or "RA". This document/file plays a critical role in a provider's financial reconciliation process. It also includes other information that resulted from the adjudication process, including denial information and adjustment reasons codes and amounts. The ERA is transmitted in a HIPAA compliant ANSI X12 5010 format.

If you do not currently receive an electronic remittance advice, 835, you may want to consider doing so. If your billing system/software supports file uploads and is programmed to translate the data contained in the 835, it may benefit your organization to receive the 835 from a claims and financial reconciliation perspective. For providers who elect to receive the 835, speak to your software provider and/or technical staff to ensure your system can support upload and translation of this file.

HOW DO I RECEIVE AN ERA/RA?

Electronic Enrollment: To obtain an ERA/RA, providers are required to enroll. Providers can access the electronic enrollment application found on the [PROMISe™ Provider Portal](#). This is a quick, secure, and easy way to enroll for ERA/RA. Make sure to have the following information available when completing the ERA/RA enrollment form.

- 9 Digit Submitter ID number assigned to provider or clearinghouse by PROMISe™
- Clearinghouse information (if applicable)
 - Clearinghouse name
 - Contact name
 - Telephone Number
 - Email Address
- On the Login page click the EFT/ERA Enrollment tab and complete the required fields.

ERAs/RAs are delivered on Mondays and the corresponding payment is issued two days later on Wednesdays (excluding holidays). The paper remittance advice is delivered on the PROMISe™ portal nine (9) days prior to payment issuance. Click on the following hyperlink to view Remittance Advice (RA) Mailing Dates/Electronic Remittance Advice (ERA) Delivery Dates:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/medicalassistance/mailingdatesforremittanceadvicesandchecks/index.htm>

More information regarding ERAs can be found on the following website:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation/index.htm>

WILL THE MIRROR BILL CONTINUE TO BE MADE AVAILABLE?

The mirror bill is generated and stored on eGov after HCSIS sends the SC/TSM claim batch file to PROMISe™ for claims processing. Since HCSIS will no longer be submitting this file after implementation, the mirror bill will not be generated. However, a "service note extract" is under development and will be available to be used by SCOs to support claim reconciliation activities.

PA PROMISe™ Provider Handbooks and Billing Guides

The PA PROMISe™ Provider Handbooks and Billing Guides were written to aid the various claim types that submit claims to PROMISe™. All program offices under the Department of Human Services utilize the Handbooks. ODP providers bill using the 837 Professional format, which is the electronic version of the CMS-1500 paper claim form. The Billing Guides detail the critical fields on the CMS-1500 paper claim form for each provider type. Please note, the data field rules are slightly different for paper vs electronic claim submissions. Click on the following hyperlink to view the Handbooks and Billing Guides associated with each provider type: [PA PROMISe™ Handbooks/Billing Guides](#)

NOTE: The information currently in the handbooks reflect how things are currently done. The handbook will be updated to reflect this particular initiative before SCOs/SCs are required to bill directly to PROMISe™. A future communication will announce when this action has been completed.

PA PROMISe™ Edits/Audits

When the Home and Community Services Information System (HCSIS) submits claims on behalf of Supports Coordinators (SCs), targeted services management (TSM) claims (T1017) and Supports Coordination (SC) Services (W7210), the claims are currently subject to edits and audits in the MMIS (PROMISe™). These edits will continue to be applied once providers become responsible for their own claim submissions. TSM and SC claim submissions will also be subject to additional edits that relate to claims submission and Individual Support Plan (ISP) validation. For example, if a claim is missing information in a critical field on a claim, the provider will need to interpret the ESC, troubleshoot what data is incorrect or missing, correct the issue and resubmit the claim appropriately. In addition, SCO claims will be subject to Individual Support Plan (ISP)/service note validation which occurs during claims processing. In other words, if the service being billed is not authorized on the plan or service note for the date of service specified on the claim, the claim will be denied. The provider should also be mindful of timely filing rules in regards to invoicing. Click on the hyperlink below to view the applicable regulation:

<http://www.pacode.com/secure/data/055/chapter1101/s1101.68.html>

ODP is in the process of developing training material that details the critical fields on an ODP professional claim, how to submit claim transactions, adjustments, voids, ODP-specific billing rules, timely filing rules and other valuable claim/billing related information. ODP's plan is to conduct face-to-face training prior to implementation. Once this training has been finalized, ODP will issue a communication to SCOs describing how to register.

Although SCOs will be trained on how to bill/submit claims, it is important to note, at this time, that a single claim can only contain claim detail lines for one 13-digit MPI (9-digit legal entity number plus a 4-digit service location code) and one Recipient Identification Number (RID)¹. If, for example, a SC renders services to 20 ODP consumers, the SCO will need to submit 20 separate claims, one claim for each consumer. If an SC renders services to one consumer for four (4) consecutive business days, for example, those services rendered to that consumer can be submitted on one claim.

Note: The ODP Claims Resolution Hotline is available to support provider inquiries and issues regarding claims. ***This hotline is to assist current providers submitting active claims and should not be utilized until after the transition.*** 1-866-386-8880, ra-odpclaimsres@pa.gov; Hours of operation: Monday - Thursday, 8:30 am -12 PM & 1 PM-3:30PM.

¹ The Recipient Identification Number (RID) is 10-digits and the MCI number is 9-digits. HCSIS refers to the MCI number as the "MA" number. The service note extract will be designed to include the RID number.