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 currently 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 PHP 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 https://www.phpcares.org/wp-content/uploads/2018/06/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 1-877-363-3666
8. How often are PHP’s check runs?

   PHP typically generates two check runs per week.

9. What forms of payments are offered?

   a. ePayments
      • EFT/ACH
      • Virtual credit card
   
   b. Paper check

10. I received a virtual card payment and no longer wish to receive payments in this form. How do I opt-out of this form of payment?

    Contact our third-party vendor, Zelis Payments at 1-877-828-8834 to change your payment method.

11. I would like to obtain my PHP payment via Electronic Funds Transfer, how can I go about doing so?

    Visit healthsmart.epayment.center/register, reach out via email to help@epayment.center or call 1-855-774-4392.

12. 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 Zelis Payments 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 Zelis Payments at 1-877-828-8834.

13. 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.

14. Do I have to be receiving EFT/ACH payments from Zelis Payments to be able to obtain an electronic 835 remittance transaction?

    No, you do not have to receive your payments electronically to be able to receive an electronic remittance.
15. How soon after check payments are generated should I expect to retrieve my 835 electronic transmission via the HealthSmart Clearinghouse?

The 835s should be posted the day after the check run payments are released.

If you do not receive your 835 within 5 business days of receiving payment notification please contact HealthSmart EDI support at 1-888-744-6638.

16. Who should I contact if I am having difficulty with receiving my 835 electronic remittances?

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

17. 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 these data elements on your claim submission.

18. Why did I receive a Claim Adjustment Reason Code 252 (an attachment/other documentation is required to adjudicate this claim/service) 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 these data elements on your claim submission.

19. Why is a National Drug Code (NDC) required?

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

20. 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.).

21. How do 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:

<table>
<thead>
<tr>
<th>LIN Segment – Drug Identification</th>
<th>i.e., LIN**N4*01234567891</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIN02</td>
<td>N4</td>
</tr>
<tr>
<td>LIN03</td>
<td>Actual NDC i.e., 01234 5678 91</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CTP Segment – Drug Segment</th>
<th>i.e., CTP**<em>2.50</em>2*UN</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTP03</td>
<td>Unit Price i.e., 2.50</td>
</tr>
<tr>
<td>CTP04</td>
<td>Dispensing Quantity i.e., 2</td>
</tr>
<tr>
<td>CTP05</td>
<td>Unit of Measure Value</td>
</tr>
</tbody>
</table>

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

CMS-1500 Box 24A example: NDC qualifier (N4) + NDC (11-digits) + unit of measurement qualifier (UN) + unit quantity (1)

UB04 FL 43 example: NDC qualifier (N4) + NDC (11-digits) + unit of measurement qualifier UN) + unit quantity (1)

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

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

23. 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, not just the correction to the physician-administered drug claim line.