Appendix

Corrected Claims Documents

Network Notification

Date: February 26, 2016

To: Kentucky Health Partners

From: Humana - CareSource

Subject: Requirements for Corrected Claims Submissions

In order to provider faster claims processing and payment times, Humana – CareSource requires the original claim number on all corrected claims.

Accepted standards for corrected claim submissions require that the original claim number is populated on both EDI 837 transactions and paper forms. Including the original claim number allows your corrected claim to auto adjudicate, resulting in the fastest payment.

Humana – CareSource rejects both EDI and paper form corrected claims that are received without the original claim number.

EDI Billing Instructions:

We strongly encourage use of electronic claim submission for all standard claim transactions, including corrected claims.

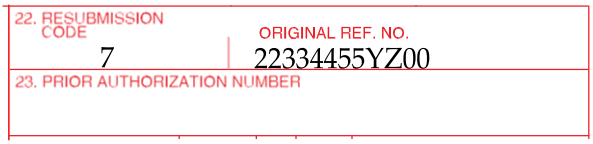
- Submit the corrected claim in the nationally-recognized Electronic Data Interchange (EDI) 837 file format.
- Use an EDI 837 Loop 2300 CLM 05-3 value of “7” (Replacement).
- Carry over the Original Reference No./Claim No. (12-character data) on the REF 02 data element with a Qualifier “F8” on Loop 2300.

Paper Form Billing Instructions

Professional Claims:

For Professional claims, the health partner must include the original Humana – CareSource claim number and a frequency code of “7” per industry standards. When submitting a Corrected claim, enter a ”7” in the left-hand side of Box 22 and the original claim number in the right-hand side of that box as shown below.

Example:

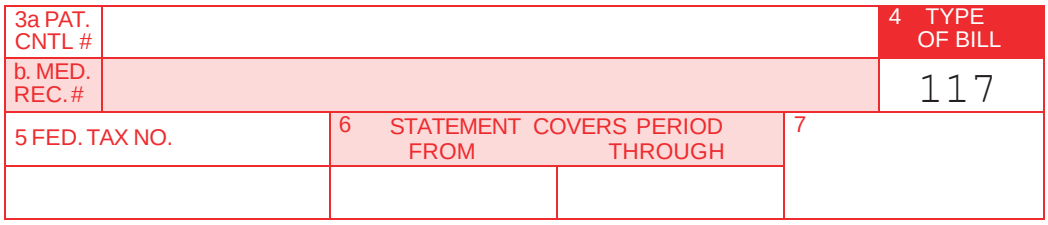


***Institutional Claims**:*

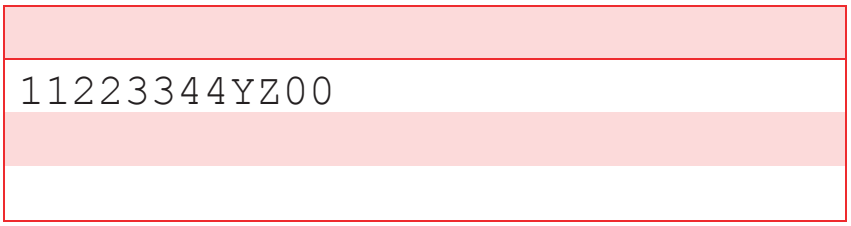
For Institutional claims, the health partner must include the original Humana – CareSource claim number in Box 64 and a valid bill frequency code in Box 4 per industry standards (shown below).

Example:

Box 4 – Type of Bill: the third character represents the "Frequency Code"



Box 64 – Place the Original Humana – CareSource claim number in Box 64



Please Note: If a corrected claim is submitted without this information, the claim will be processed as an original claim and rejected or denied as a duplicate. Additionally, this process

is for correcting denied claims only, not for resubmission of rejected claims (rejected claims are defined as EDI claims not accepted by Humana – CareSource).

If you have any questions regarding the information in this communication, please contact our please contact Provider Services at 1-855-852-7005. Hours of operation are Monday to Friday, 8 am – 6pm Eastern Standard Time (EST).

KY-P-416

Claim Reconsideration Requests Quick Reference Guide

A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly, including if your provider information and/or contract are set up incorrectly in our system, which could result in the original claim being denied or reduced.

This reference tool provides instruction regarding the submission of a Claim Reconsideration Request and details the supporting information required for claim reconsiderations or to correct claims, and explains those processes.

There are several ways to submit a Claim Reconsideration Request.

1. Electronic Claim Reconsideration Request **with attachments** on ***Optum Cloud***.
   For information on registering for access to the Optum Cloud Dashboard, see the Administrator Registration and Importing Users Quick Reference Guide.
   By using this method, you can:
   - Reduce the overall turnaround time for the request.
   - Receive immediate confirmation and a unique tracking number to show we received your request.
   - Check submission status throughout the process.

   To learn more about Optum Cloud, view the UnitedHealthcareOnline.com website

2. If you are a registered user on UnitedHealthcareOnline.com, use Electronic Claim Reconsideration for submissions **without attachments.**
   By using this method:
   - You will be notified that your request was received.

   To learn more about submitting claim reconsiderations "without attachments" view the step-by-step instructions Claim Reconsideration Quick Reference Guide

3. Mailing Paper Claim Reconsideration Request forms. This form can be downloaded from:
   - UnitedHealthcareonline.com Claim Reconsideration
   - UHCWest.com>Choose your state>Resource Center>Claim Reconsiderations

Where to send Claim Reconsideration Requests:

- **For UnitedHealthcare/UnitedHealthcare West**, if your request for a claim reconsideration is for a *Commercial* or *Medicare* member, send the paper Claim Reconsideration Requests to one of the following:
  - The address on the Explanation of Benefits (EOB) or the Provider Remittance Advice (PRA)
  - The claim address on the back of the member's ID card
- **For UnitedHealthcare Empire Plan**, send to:
  P.O. Box 1600
  Kingston, NY 12402-1600
- **For UnitedHealthcare Community Plan**, if your request for a claim reconsideration is for a *Medicaid/Chip* member, go to:
  Community Plan Claim Reconsideration Mailing Addresses

UnitedHealthcare

NOTE:

- **This reference guide should not accompany the paper Claim Reconsideration Request form you are submitting.**
- **No new claims should be submitted with the paper form.**
- **Do not use the paper form for formal claims appeals or disputes. When applicable, continue to follow your standard appeals process for formal appeals or disputes as found in your provider manual or agreement.**

Below are the explanations of reasons for requesting a paper claim reconsideration

1. **Previously denied as "Exceeds Timely Filing"**
   Timely filing is the time limit for filing claims, which is specified in the network contract, a state mandate or a benefit plan. For a non-network provider, the benefit plan would decide the timely filing limits. When timely filing denials are upheld, it is usually due to incomplete or invalid documentation submitted with Claim Reconsideration Requests**.**

   Submission requirements for electronic claims:
   - Submit an electronic data interchange (EDI) acceptance report. This must show that UnitedHealthcare or one of our affiliates received, accepted and/or acknowledged the claim submission.
   - A submission report alone is not considered proof of timely filing for electronic claims. It must be accompanied by an acceptance report.
     - The acceptance report must indicate the claim was either "accepted," "received" and/or "acknowledged" within the timely filing period.

   Submission requirements for paper claims:
   - Submit a screen shot from your accounting software that shows the date the claim was submitted. The screen shot must show the:
     - Correct member name
     - Correct date of service
     - Submission date of claim that is within the timely filing period

2. **Previously denied for "Additional Information"**
   Please attach a copy of all information requested and include the following information on the first page of the request:
   - Patient name
   - Patient's address
   - Patient member ID number
   - Provider name and address
   - Reference number

   Add the additional information requested. Examples include:
   - Medical notes
   - Anesthesia time units
   - Current Procedural Technology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes (missing, illegible, or deleted)
   - Date of service
   - Description of service
   - Diagnosis code where the primary code is missing, illegible or is the wrong number of digits
   - Physician name
   - Patient name
   - Place of service (POS) code

- Provider's Tax Identification Number (TIN)
- Semi-private room rate
- Accident information

3. **Previously denied for Coordination of Benefits information**

Commercial Coordination of Benefits claim requirements

- **Primary Payer Paid Amount** – Submit the primary paid amount for each service line on the 835 Electronic Remittance Advice (835) or EOB. Submit the paid amount on institutional claims at the claim level.
- **Adjustment Group Code** – Submit the other payer claim adjustment group code found on the 835 or the EOB. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Reason Code** – Submit the other payer claim adjustment reason code on the 835 or the EOB. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Amount** – Submit the other payer adjustment monetary amount.
- **Preference** – Submit professional claims at the line level as allowed by the primary payer. Submit institutional claims at the claims or line level. The service level and claim level should be balanced. UnitedHealthcare follows 837p Health Care Claim Encounter – Professional (837p) and 837i Health Care Claim Encounter - Institutional (837i) guidelines.

Medicare Primary Coordination of Benefits claim requirements

- **Adjustment Group Code** – Submit the other payer claim adjustment group code on the 835 or the EOB. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Reason Code** – Submit the other payer claim adjustment reason code on the 835 or the EOB. At the claim level, do not enter any amounts included at the line level. Common reasons for the other payer paying less than billed include: deductible, co-insurance, copayment, contractual obligations and/or non-covered services.
- **Adjustment Amount** – Submit the other payer adjustment amount.
- **Medicare Paid Amount** – Submit the other payer claim level and line level paid amounts when UnitedHealthcare is the secondary payer to Medicare.
- **Medicare Approved Amount** – Submit the other payer claim level and line level allowed amounts when UnitedHealthcare is the secondary payer to Medicare.
- **Patient Responsibility Amount** – Submit the monetary amount for which the patient is responsible from the 835 or the Medicare EOB.
- **Medicare Acceptance of Assignment** – Indicate whether the provider accepts the Medicare assignment.
- **Preference –** Submit professional claims at the line level if the primary payer provides the information, and submit institutional claims at either the line or claim level. The service level and claim level should be balanced. UnitedHealthcare follows 837p and 837i guidelines.

Medicaid Primary Coordination of Benefits Claims Requirements

Medicaid is the final payer in all coordination of benefits scenarios.

4. **Resubmission of a corrected claim**

   Consistent with Health Insurance Portability and Accountability Act (HIPAA) requirements, submit corrected claims in their entirety.

   If a claim needs correction, please follow these guidelines:

   - Make the necessary changes in your practice management system, so the corrections print on the amended claim.
   - Attach the corrected claim (even line items that were previously paid correctly). Any partially-corrected request will be denied. Enter the words, "Corrected Claim" in the comments field on the claim form. Your practice management system help desk or your software vendor can provide specific instructions on where to enter this information in your system. If you do not have this feature, stamp or write "Corrected Claim" on the CMS 1500 form. Changes must be made in your practice management system and then printed on the claim form. You may not write on the claim itself.
   - The resubmitted claim is compared to the original claim and all charges for that date of service. The provider and patient must be present on the claim, or we will send a letter advising that all charges for that day are required for reconsideration.
   - Complete the reconsideration form as instructed and mark the box on Line 4 for Corrected Claims. Continue to the comments section and list the specific changes made and rationale or other supporting information.

   UB04: UB Type of Bill should be used to identify the type of bill[1] submitted as follows:

   - XX5 Late Charges
   - XX7 Corrected Claim
   - XX8 Void/Cancel previous claim

5. **Previously processed but rate applied incorrectly resulting in over/underpayment**

   Network Providers - Please check your fee schedules prior to submitting a claim reconsideration request for this reason. Indicate the contract amount expected by code or case rate, compared to the amount received, as well as other factors related to the over- or under-payment. If you disagree with the fee schedule your claim was paid by, contact your Network Management Representative. Use http://www.uhc.com/contact_us.htm and select your state to find the appropriate network management contact for your area.

6. **Resubmission of "Prior Notification/Prior Authorization Information"**

   Submit a prior authorization number and other documents that support your request. If you spoke to a customer service representative and were told that notification was not required, please submit the date, time and reference number of that call and the name of the representative handling the call. Please also advise if the service was performed on an emergency basis and therefore notification was not possible.

7. **Resubmission of a claim with bundled services**

   Review your claim for appropriate code billing, including modifiers. If the claim needs to be corrected, please submit a corrected claim. If a bundled claim is not paid correctly, submit a detailed explanation including any pertinent information on why the bundling is incorrect.

8. **Other**

   Provide any additional information that supports your request.

To learn more about Claim Reconsiderations, go to UnitedHealthcareonline.com Claim Reconsideration.

[1] Please check your Administrative Guide and reimbursement policies to reconfirm types of bill allowable for reconsideration.

UnitedHealthcare®

UnitedHealthcare Single Paper Claim Reconsideration Request Form

This form is to be completed by physicians, hospitals or other health care professionals for paper Claim Reconsideration Requests for our members.

NOTE

- **Please submit a separate claim reconsideration request form for each request.**
- **No new claims should be submitted with this form.**
- **Do not use this form for formal appeals or disputes. Continue to use your standard appeals process for formal appeals or disputes.**

Please refer to the attached Claim Reconsideration Reference Guide, your provider administrative manual or our provider website for additional details including where to send Claim Reconsideration Requests. You may verify the member's address using the eligibility search function on the website listed on the member's health care ID card.

☐ Physician ☐ Hospital ☐ Other health care professional (Lab, Durable Medical Equipment (DME), etc.)

Member information **Date form completed:** _____

Member ID:	Control / Claim #:	Date of Service:	Billed Amount:
Member Last Name		First Name	MI
Street Address		State	Zip
Patient Name: Last		First	MI

Physician/Health care professional information

Tax Identification Number (TIN): _____ Phone Number (with area code): _____

Email Address: _____

Physician Name or other health care professional (as listed on Provider Remittance Advice (PRA)/Explanation of Benefits (EOB):

Last Name First MI

Street Address City State Zip

Facility/Group Name _____ Contact Person _____

Expected amount owed: _____ Contact Fax Number (with area code): _____

Reason for request: ***(More information on the definition reasons listed below and what documentation needs to be submitted can be found on the Claim Reconsideration Request definition sheet on UnitedHealthcareOnline.com)***

☐ 1. Previously denied / closed as "Exceeds Filing Time"
☐ 2. Previously denied / closed for "Additional Information"
☐ 3. Previously denied / closed for "Coordination of Benefits" information
☐ 4. Resubmission of a corrected claim
☐ 5. Previously processed but rate applied incorrectly resulting in over/underpayment (Network Providers - Check your fee schedules)
☐ 6. Resubmission of "Prior Notification Information"
☐ 7. Resubmission of a claim with "Bundled" services
☐ 8. Other *(explain below)*

Please include what you are expecting from UnitedHealthcare regarding this Claim Reconsideration Request to close this out in your practice management system, including dollar amount if possible.

Comments:

Required attachments:
• Copy of PRA or EOB• Claim Form is **ONLY** required for Corrected Claims Submissions
• Other required attachments as listed above

You may have additional rights under individual state laws. Please review the provider website, your provider administrative guide or your provider agreement/contract if you need more information.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates.

Doc#: UHC1060p_20140203

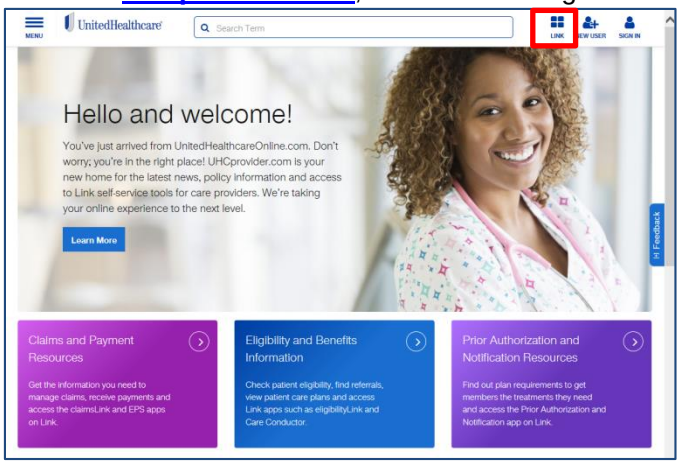
Link

Claims & Payments
claimsLink – Claim Reconsideration
QUICK REFERENCE

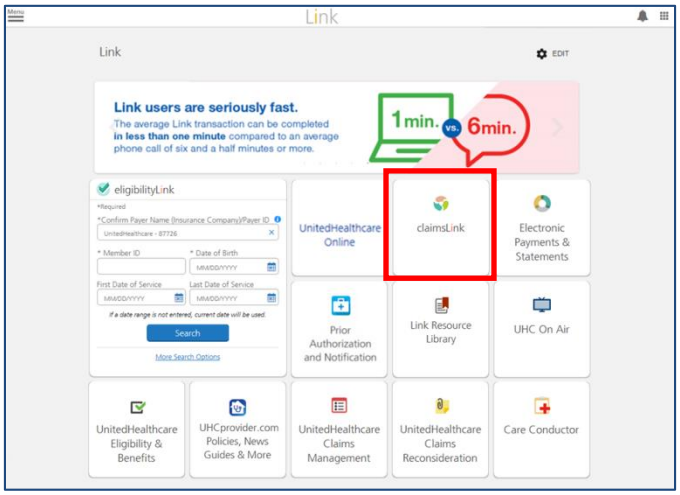
claimsLink is where you can look up claim status and payment information to understand how a claim was paid (claims processed within the last two years are available). You may also submit processed claims for reconsideration. This guide will review how to submit and check the status of a reconsideration request.

Get Started

1. From **UHCprovider.com**, click **Link** and sign in

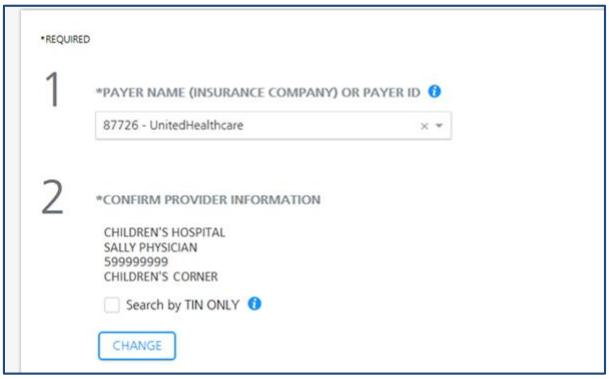


2. Select **claimsLink**

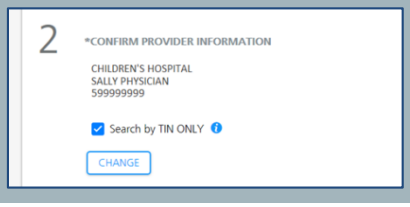


Confirm Information

1. Confirm the **Payer Name**
2. Confirm, or if needed, change **Provider Information**



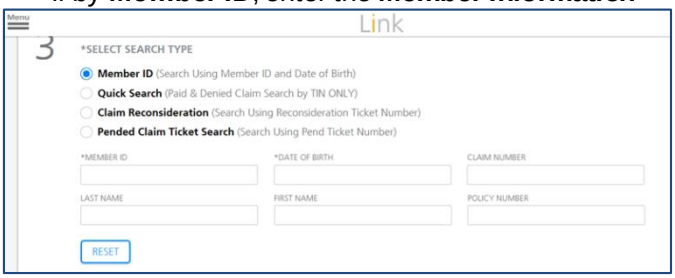
NOTE: The Provider Information defaults to **Search by TIN ONLY**, if available. (Contact your Password Owner or ID Administrator to ensure your Access Profile is set to **All Tax-IDs-Specialties)**.



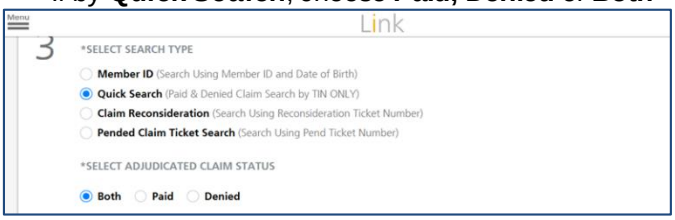
Claim Search

Select Search Type

- If by **Member ID**, enter the **Member Information**



- If by **Quick Search**, choose **Paid, Denied** or **Both**



NOTE: The **Quick Search** will return a maximum of 450 claims. If there is an error, choose **Paid** or **Denied** instead of **Both** and/or narrow the date range.
You must also be able to **Search by TIN Only** (see above) to have the **Quick Search** option.

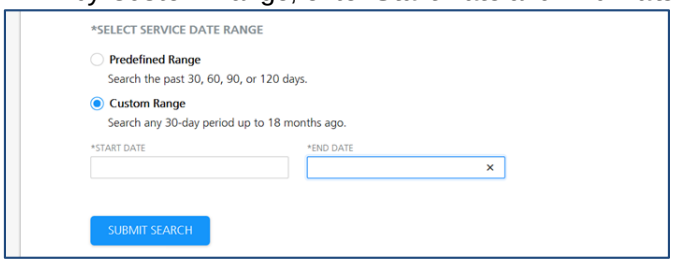
Service Date Range

- If by Predefined Range, click the appropriate radio button

v20171229

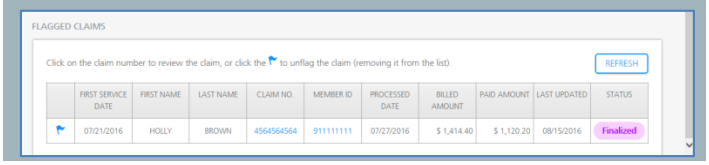
Claim Search (continued)

- If by Custom Range, enter **Start Date** and **End Date**



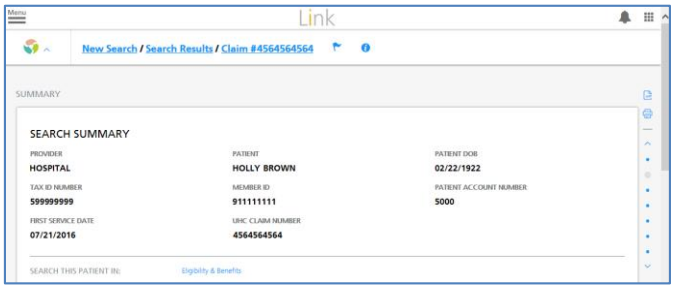
- Click **Submit Search**

NOTE: Previously **Flagged Claims** will appear below the Service Date Range.



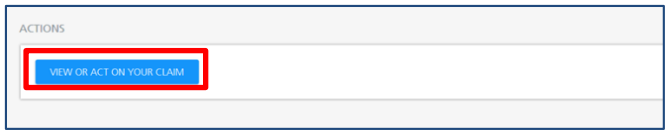
Review Claim Information

1. Review the claim



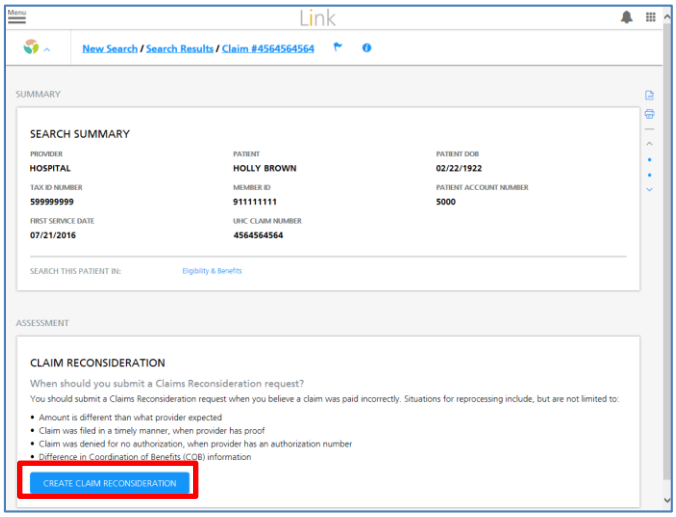
Submit a Reconsideration Request

1. To submit a reconsideration request, if not satisfied with the outcome, at the bottom of the screen, click **View or Act On Your Claim**



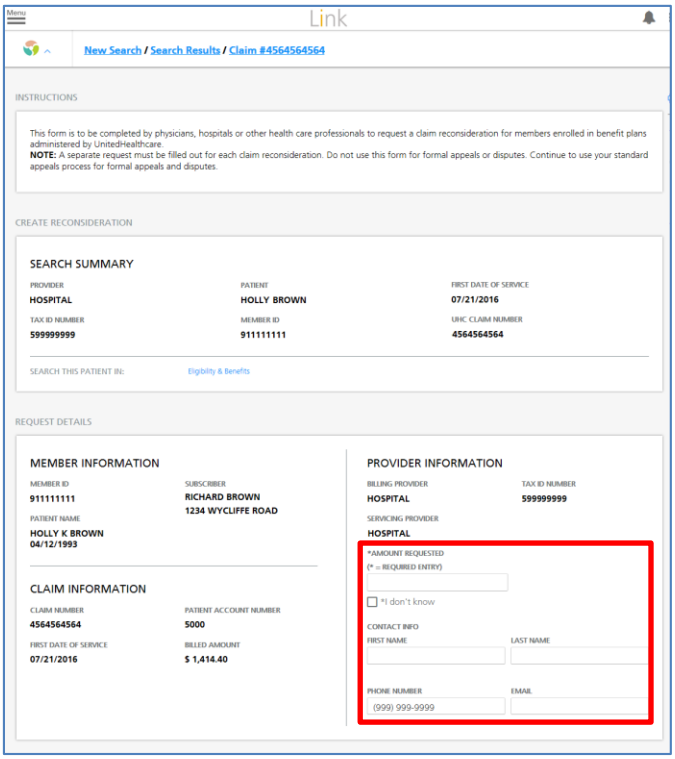
Note: If there is an open reconsideration request, this button will allow you to **View Claim Reconsideration**

2. Click **Create** a **Claim Reconsideration**

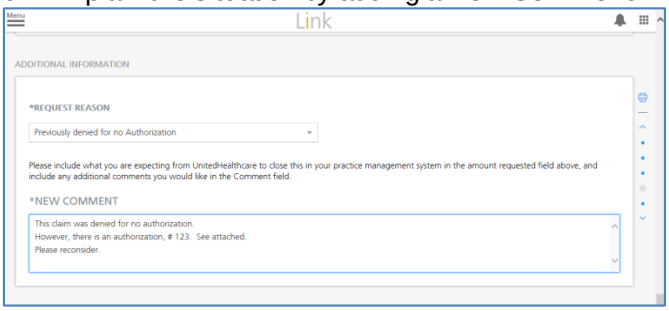


Submit a Reconsideration Request (continued)

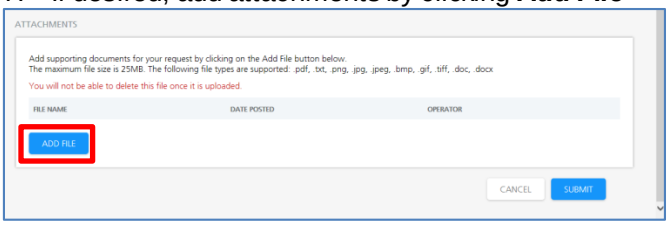
3. Review the **Request Details**
4. Complete the **Amount Requested** and **Contact Info**



5. Choose a **Request Reason** from the pull-down menu
6. Explain the situation by adding a **New Comment**

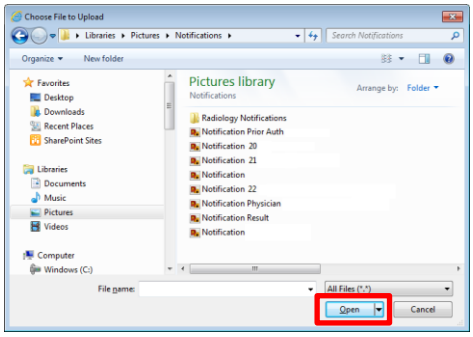


7. If desired, add attachments by clicking **Add File**



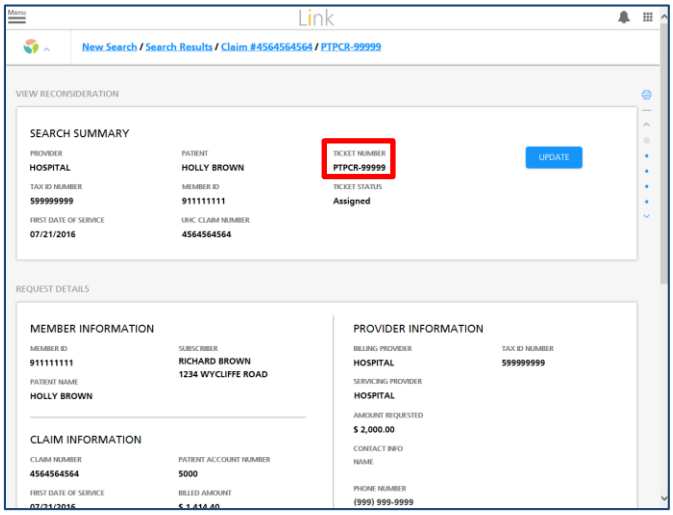
Submit a Reconsideration Request (continued)

8. Choose the desired file from your directory and click **Open**



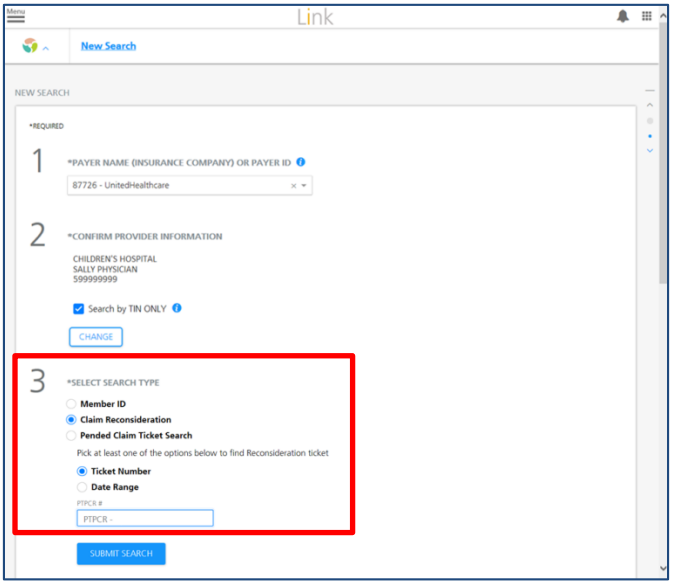
9. When complete, click **Submit**

10. You will receive a Confirmation screen with **Reference (Ticket) Number**

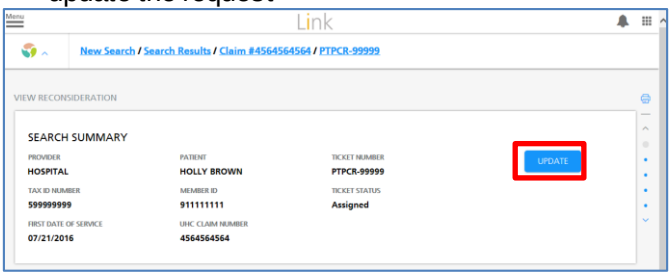


Check Reconsideration Status

1. At the beginning of the Claim Search, click the radio button for **Claim Reconsideration**
2. Choose a Search Type
3. Enter the **Reference (Ticket) Number** or **Date Range**
4. Click **Submit Ticket Search**

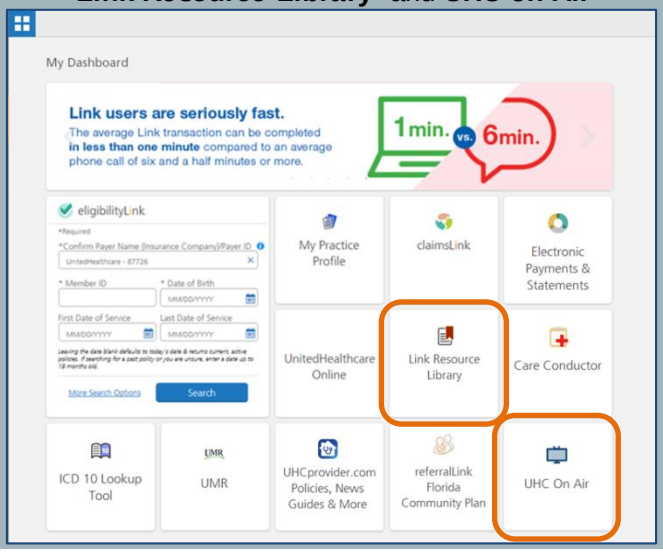


5. Review the Reconsideration Request
6. If desired and the status is not “processed”, you may update the request



Note: If the reconsideration request has been fully processed, it will show **Re-open** instead of Update.

Additional **Help Resources** are available at the **Link Resource Library** and **UHC on Air**



Submitting corrected claims electronically

Guidelines for professional and institutional ANSI-837 claims

Share with your vendor

Providers are encouraged to share the following guidelines with their electronic vendor to assist in the submission of corrected claims in the ANSI-837 professional and institutional electronic formats to Anthem Blue Cross and Blue Shield Medicaid.

ANSI-837P: professional claims

Both items listed below must be completed for an ANSI-837 professional claim to be considered a corrected claim:

1. In the **2300 Loop**: under the claim information (CLM) segment, **CLM05-3** (claim frequency type code) must indicate one of the following qualifier codes:
   - ☐ 7 – REPLACEMENT (replacement of prior claim)
   - ☐ 8 – VOID (void/cancel of prior claim)
2. In the **2300 Loop**: the original reference number (ICN/DCN) (**REF02**) segment must include the original claim number issued to the claim being corrected. The original claim number can be found on your remittance advice.

ANSI-837I: institutional claims

Both items listed below must be completed for an ANSI-837 institutional claim to be considered a corrected claim:

1. In the **2300 Loop**: under the claim information (CLM) segment, the **CLM05-3** (claim frequency type code) must indicate the third digit of the type of bill being sent. The third digit of the type of bill is the frequency and can indicate if the bill is an adjustment, replacement or voided claim as follows:
   - ☐ 7 – REPLACEMENT (replacement of prior claim)
   - ☐ 8 – VOID (void/cancel of prior claim)
2. In the **2300 Loop**: the original reference number (ICN/DCN) (**REF02**) segment must include the original claim number issued to the claim being corrected. The original claim number can be found on your remittance advice.

Questions?

For technical support assistance contact E-Solutions at **1-800-470-9630** Monday through Friday from 8 a.m. to 4:30 p.m. Eastern time, or via email at **e-solutions.support@anthem.com**.

AKYPEC-0733-15 November 2015

Submitting Corrected Claims Electronically

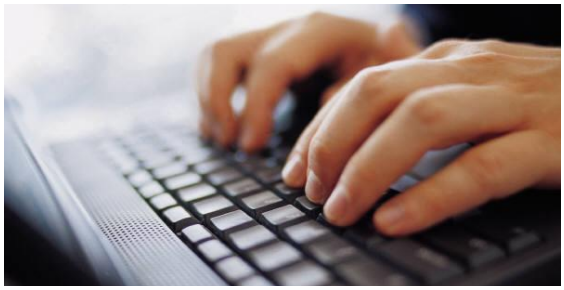
Guidelines for Professional and Institutional ANSI-837

Share With Your Vendor

Providers are encouraged to share the following guidelines with their electronic vendor to assist in the submission of Corrected Claims to BlueCross BlueShield of Tennessee in the ANSI-837 Professional and Institutional electronic formats.

ANSI-837P - (Professional)

Both items listed below must be completed for an ANSI-837 professional claim to be considered a corrected claim.



1. In the ***2300 Loop***, the CLM segment (Claim Information), **CLM05-3** (claim frequency type code) must indicate one of the following qualifier codes:
   - "**7**" – REPLACEMENT *(Replacement of Prior Claim)*
   - "**8**" – VOID *(Void/Cancel of Prior Claim)*
2. In the **2300 Loop**, the **REF02** segment (Original Reference Number (ICN/DCN)) **must include the Original Claim Number** issued to the claim being corrected. The original claim number can be found on your Remittance Advice.

ANSI-837I - (Institutional)

Both items listed below must be completed for an ANSI-837 institutional claim to be considered a corrected claim.

1. In the **2300 Loop**, the CLM segment (Claim Information), the **CLM05-3** (Claim Frequency Type Code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an Adjustment, a Replacement or a Voided claim as follows:
   - "**7**" – REPLACEMENT *(Replacement of Prior Claim)*
   - "**8**" – VOID *(Void/Cancel of Prior Claim)*
2. In the **2300 Loop**, the **REF02** segment (Original Reference Number (ICN/DCN)) **must include the Original Claim Number** issued to the claim being corrected. The original claim number can be found on your Remittance Advice.

These guidelines apply to Commercial BlueCross BlueShield, BlueCare® and TennCare*Select* claims and are outlined in the standard Implementation Guide for ANSI-837. The Implementation Guides are available at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

Questions?

For Technical Support assistance contact eBusiness Service at (423) 535-5717
Monday – Friday 8:00 a.m. to 5:15 p.m. (EST) or via email at eBusiness_Service@bcbst.com.

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Provider Manual
Section 15.0
Provider Billing Manual

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PASSPORT HEALTH PLAN

15.0 Provider Billing Manual

15.1 Claim Submission

15.1.1 Procedures for Claim Submission

Passport is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims.

When required data elements are missing or invalid, claims will be rejected by Passport for correction and resubmission.

The provider who performed the service to the Passport member must submit the claim for a billable service.

Claims filed with Passport are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms.
- Verification that all diagnosis and procedure codes are valid for the date of service.
- Verification of the referral for specialist or non-primary care physician claims.
- Verification of member eligibility for services under Passport during the time period in which services were provided.
- Verification that the services were provided by a participating provider or that the "out- of-network" provider has received authorization to provide services to the eligible member (excluding "self-referral" types of care).
- Verification of whether there is Medicare coverage or any other third party resources and, if so, verification that Passport is the "payer of last resort" on all claims submitted to Passport.
- Verification that an authorization has been given for services that require prior authorization by Passport.
- Verification that the provider is enrolled with Kentucky Medicaid during the claim date of service and that the claim includes the appropriate NPI code and taxonomy code on file with Kentucky Medicaid.

In addition, Passport uses claim edit applications following NCCI, AMA and CMS guidelines:

- Procedure unbundling (billing two or more CPT codes when one CPT code exists for same procedure)
- Incidental procedures (procedures performed at the same time as a more complex procedure but requires little to no additional physician resources or is clinically integral to the performance of the procedure)
- Mutually-exclusive procedures (two or more procedures that should not be performed or billed for the same member on the same date of service)
- Multiple surgical procedures (surgical procedures are ranked according to clinical intensity and are paid following percentage guidelines)
- Multiple Procedure Payment Reduction (MPPR) for selected therapies (applies to multiple procedures and multiple units)
- Duplicate procedures (procedures billed more than once on same date of service)

- Assistant surgeon utilization (reimbursement and coverage determination)
- Evaluation and management service billing (review the billing of services with procedures performed)
- ER evaluation and management services (review the billing for consistency with ACEP guidelines)

Claims for emergency room services will be subject to review for medical necessity and whether treatment was required for an Emergency Medical Condition as defined in paragraph 10.1.1 of this manual.

Any CPT/HCPCS level 1 or 2 codes that have been denied due to claims editing will be associated with appropriate disposition code on the remittance advice.

As part of the agreement between Passport and the provider, the provider agrees to cooperate with Passport in its efforts to comply with all applicable Federal and State laws, including specifically the provisions of Section 6032 of the Deficit Reduction Act of 2005, PL-019-171, False Claims Act, Federal Remedies for False Claims and Statements Act, and KRS 205.8451, et. Seq. (relating to fraud).

15.1.2 Rejected and Denied Claims

Rejected claims are defined as claims with invalid or missing data elements (such as the provider tax identification number) that are returned to the provider or EDI source without registration in the claims processing system. Since rejected claims are not registered in the claims processing system, the provider must re-submit corrected claims within 180 calendar days from the date of service. This requirement applies to claims submitted on paper or electronically. Denied claims are different than rejected claims and are registered in the claims processing system but do not meet requirements for payment under Passport guidelines. For more information on denied claims, see Section 15.3 and 15.4 in this Provider Manual.

15.1.3 Claim Mailing Instructions

Passport encourages all providers to submit claims electronically. For those interested in electronic claim filing, contact your EDI software vendor or the Change Healthcare (formerly Emdeon) Provider Support Line at (800) 845-6592 to arrange transmission.

Passport Electronic Payer ID: 61325 for dates of service on or after 10/1/17 or 61129 for dates of service prior to 10/1/17

If you choose to utilize paper claims, please submit to Passport at the following address:

Passport Health Plan
P. O. Box 7114
London, KY 40742

15.1.4 Claims Status Review

Providers may view claims status using any of the following methods:

- **Online** – check eligibility/claims status by logging into Passport's Provider Portal at https://phkyportal.valence.care/
- **Telephone** – you may also check eligibility and/or claims status by calling our interactive voice response (IVR) system at (800) 578-0775.
- **Real-Time** – depending on your clearinghouse or practice management system, real-time claims status information is available to participating providers. Contact your clearinghouse to access:
  - Change Healthcare Products for claims status transactions.
  - All other clearinghouses: Ask your clearinghouse to access transactions through Change Healthcare.

15.1.5 Notification of Denial via Remittance Advice

When a claim is denied because of missing or invalid mandatory information, the claim should be corrected, marked as a second submission or corrected claim, and resubmitted within two years of the process date electronically or to the general claim address:

Passport Health Plan
P.O. Box 7114
London, KY 40742

15.1.6 Claims Adjustment/Appeal Requests

If you believe there was an error made during claims processing or if there is a discrepancy in the payment amount, please call the Provider Claims Service Unit (PCSU) at (800) 578-0775, option 2. Our representatives can help you resolve the issue, process a claim via the phone, and advise whether a corrected claim or a written appeal needs to be submitted. Please submit Claims Issue Forms to P.O. Box above.

15.1.7 Claim Submission for New Providers

New providers with Passport awaiting receipt of their Medicaid Identification (MAID) number are subject to the timely filing guidelines and may begin to submit claims once their Passport ID number has been assigned. These claims will initially deny for no MAID number. After Passport receives a provider's MAID number, all claims submitted and initially denied will be reprocessed without resubmission.

15.1.8 Claim Forms and Field Requirements

The following charts describe the required fields that must be completed for the standard CMS-1500 or UB-04 claim forms. If the field is required without exception, an "R" (Required) is noted in the "Required or Conditional" box. If completing the field is dependent upon certain circumstances, the requirement is listed as "C" (Conditional) and the relevant conditions are explained in the "Instructions and Comments" box.

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the required filing deadline of 180 days from the date of service.

Although the following examples of claim filing requirements refer to paper claim forms, claim data requirements apply to all claim submissions, regardless of the method of submission (electronic or paper).

15.1.8.1 Claim Data Sets Billed by Providers

To facilitate timely and accurate claim processing, you must assure billing on the correct form for your provider type. The table below outlines the requirements as defined by Kentucky Medicaid:

	CMS-1500	UB-04 (CMS-1450)
Hospital - Acute Care Inpatient		X
Hospital – Outpatient		X
Hospital - Long Term Care		X
Inpatient Rehabilitation Facility		X
Inpatient Psychiatric Facility		X
Home Health Care		X
Skilled Nursing Facility		X
Ambulance (Land and Air)	X	
Ambulatory Surgical Center	X	
Dialysis Facility (Chronic, Outpatient)		X
Durable Medical Equipment	X	
Drugs (Part B)	X	
Laboratory	X	
Physician and Practitioner Services	X	
Federally Qualified Health Centers	X	
Rural Health Clinics	X	

15.1.8.2 CMS-1500 Claim Form and Required Fields

Use of the CMS-1500 form (02/12) was required as of April 1, 2014. Please see claim form instructions. The form includes several fields that accommodate the use of your National Provider Identifier (NPI).

Required Fields for the CMS-1500 Claim Form

NOTE: *Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

CMS 1500 Claim			
Field	**Field Description**	**Instructions and Comments**	**Required or Conditional***
1	**INSURANCE PROGRAM IDENTIFICATION**	Check only the type of health coverage applicable to the claim. This field indicates the payer with whom the claim is being filed. Select "D", other.	R

1A	**INSURED I.D. NUMBER**	Passport's member identification number as it appears on the member's Passport ID card. EDI details ASC X12 4010A. Subscriber number less than 11 digits. 2010BA, NM108=MI NM109 less than 11 digits. Subscriber is required.	R
2	**PATIENT'S NAME (Last Name, First Name, Middle Initial)**	Enter the member's name as it appears on the member's Passport ID card.	R
3	**PATIENT'S BIRTH DATE / SEX**	MMDDCCYY / M or F	R
4	**INSURED'S NAME (Last Name, First Name, Middle Initial)**	Enter the member's name as it appears on the member's Passport ID card, or enter the mother's name when the member is a newborn.	R
5	**PATIENT'S ADDRESS (Number, Street, City, State, Zip Code, and Telephone, Including Area Code)**	Enter the member's complete address and telephone number (Do not punctuate the address or phone number).	R
6	**PATIENT RELATIONSHIP TO INSURED**	Always indicate self.	R
7	**INSURED'S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code)**	Enter the member's complete address and telephone number (Do not punctuate the address or phone number).	R
8	**RESERVED FOR NUCC USE**		Not Required
9	**OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)**	Refers to someone other than the member. REQUIRED if member is covered by another insurance plan. Enter the complete name of the insured.	C
9A	**OTHER INSURED'S POLICY OR GROUP NUMBER**	REQUIRED if field 9 is completed.	C
9B	**RESERVED FOR NUCC USE**		Not Required
9C	**RESERVED FOR NUCC USE**		Not Required
9D	**INSURANCE PLAN NAME OR PROGRAM NAME**	REQUIRED if # 9 is completed.	C
10A,B,C	**IS PATIENT'S CONDITION RELATED TO:**	Indicate Yes or No for each category.	R

10D	**CLAIM CODES (Designated by NUCC)**	Enter condition codes as approved by the NUCC in this field.	C
11	**INSURED'S POLICY GROUP OR FECA NUMBER**	Required when other insurance is available. Complete if more than one other medical insurance is available, or if "yes" to field 10 A, B, C.	C
11A	**INSURED'S BIRTH DATE / SEX**	Complete information if other insurance is listed in field 11.	C
11B	**OTHER CLAIM ID (Designated by NUCC)**	For worker's compensation or property and casualty enter the qualifier to the left of the vertical dotted line and the identifier number to the right of the vertical dotted line.	C
11C	**INSURANCE PLAN NAME OR PROGRAM NAME**	Enter name of Health Plan. REQUIRED if field 11 is completed.	C
11D	**IS THERE ANOTHER HEALTH BENEFIT PLAN?**	Y or N by check box. If yes, complete 9, 9a and 9d.	R
12	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE**		Not required
13	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE**		Not required
14	**DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)**	Enter the three character qualifier to the right of the vertical dotted line to identify which date is being reported.	C
15	**OTHER DATE**	Enter additional date information about the patient's condition or treatment. Enter the three character qualifier between the vertical dotted lines to identify which date is being reported.	C
16	**DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**		C

17	**NAMEAND QUALIFIER OF REFERRING PHYSICIAN OR OTHER SOURCE**	REQUIRED if a provider other than the member's primary care physician rendered invoiced services. Enter the name of the referring, ordering or supervising provider and the 2-digit qualifier: DN (Referring), DK (Ordering) or DQ (Supervising).	C
17A	**I.D. NUMBER OF REFERRING PHYSICIAN**	Enter Passport provider number for the referring physician. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of field 17A (shaded area). If the other ID number is the Health Plan ID number, enter G2. If the other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. REQUIRED if field 17 is completed.	C
17B	**NATIONAL PROVIDER IDENTIFIER (NPI)**	Enter the NPI number of the referring provider, ordering provider or other source. REQUIRED if field 17 is completed.	C
18	**HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**	REQUIRED when place of service is inpatient. MMDDYY	C
19	**Additional Claim Information (Designed by NUCC)**		C
20	**OUTSIDE LAB CHARGES**	For billing diagnostic tests subject to purchase price limitations.	C
21	**DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E).**	All diagnosis codes must be valid for the date of service. "E" codes are NOT acceptable as a primary diagnosis. List in priority order.	R
22	**RESUBMISSION CODE AND ORIGINAL REFERENCE NUMBER**	For resubmissions or adjustments, enter the appropriate bill frequency code and the claim ID number of the original claim. Original claim ID is required if claim is a corrected or resubmitted claim.	C

23	**PRIOR AUTHORIZATION NUMBER**	Enter the referral or authorization number. Refer to Section 18.6 in this Provider Manual to determine if services rendered require an authorization or referral.	C
24A	**DATE (S) OF SERVICE**	"From" date: MMDDYY. If the service was performed on one day, there is no need to complete the "to" date.	R
24B	**PLACE OF SERVICE**	Enter the CMS standard place of service code.	R
24C	**EMG**	This is an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	C
24D	**PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER**	Procedure codes (5 digits) and modifiers (2 digits) must be valid for date of service. NOTE: Modifiers affecting reimbursement must be placed in the 1st position.	R
24E	**DIAGNOSIS CODE**	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (A-L). All diagnosis codes must be valid for the date of service.	R
24F	**CHARGES**	Enter charges for each line item. Value entered must be greater than zero ($0.01)	R
24G	**DAYS OR UNITS**	Enter quantity for each line item. Value entered must be greater than zero (EDI allows two characters).	R
24H	**EPSDT FAMILY PLAN**		Not required

24I	**ID QUALIFIER**	For taxonomy billing, you should put ZZ as the qualifier	R
24J	**RENDERING PROVIDER ID**	The un-shaded area accommodates the Rendering Provider's NPI and the shaded portion should have the rendering provider's taxonomy.	R
25	**FEDERAL TAX I.D. NUMBER SSN/ EIN**	Physician or supplier's Federal Tax ID number.	R
26	**PATIENT'S ACCOUNT NO.**	The provider's billing account number.	R
27	**ACCEPT ASSIGNMENT**	Always indicate Yes. Refer to the back of the CMS 1500 form for the section pertaining to Medicaid payments.	R
28	**TOTAL CHARGE**	Enter the total of all charges listed on the claim. Value entered must be greater than zero dollars ($0.00).	R
29	**AMOUNT PAID**	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Passport. Medicaid programs are always the payers of last resort.	C
30	**RESERVED FOR NUCC USE**		Not Required

31	**SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS / DATE**	Signature on file, signature stamp, computer generated or actual signature is acceptable.	R
32	**NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office).**	REQUIRED unless field 33 is the same information. Enter the physical location (P.O. Box Numbers are not acceptable here).	R
32A	**SERVICE FACILITY NPI NUMBER**	Required unless rendering provider is atypical and is not required.	R
32B	**SERVICE FACILITY TWO CHARACTER QUALIFIER ID AND CURRENT PROVIDERS ID**		R
33	**BILLING PROVIDER INFO & TELEPHONE NUMBER**	REQUIRED - Identifies the provider that is requesting to be paid for the services rendered and should always be completed. Enter physical location. P.O. boxes are not acceptable.	R
33A	**BILLING PROVIDER NPI NUMBER**	REQUIRED	R
33B	PROVIDER'S GROUP TAXONOMY CODE	Populate field with the ZZ qualifier ID and the Group Provider's Primary Taxonomy Code.	R

15.1.8.3 UB-04 Claim Form and Required Fields

Required Fields UB-04 Claim Form

NOTE: *Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

Required fields for the UB-04 Claim Form				
Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***
1	**Billing Provider Name, Address and Telephone Number**	Line A: Enter the complete provider name. Line B: Enter the complete address or post office number. Line C: City, State, and Zip Code Line D: Enter the area code, telephone number. Left justified.	R	R
2	**Pay-to Name and Address**	Enter the facility Medical Assistance I.D. (MAID) number. Left Justified.	R	R
3A	**PATIENT CONTROL NO.**	Provider's patient account/control number	R	R
3B	**MEDICAL/HEALTH RECORD NUMBER**	The number assigned to the member's medical/health record by the provider.	R	R
4	**TYPE OF BILL**	Enter the appropriate three-digit or four-digit code. 1st position is a leading zero. (Note: Do not include the leading zero on electronic claims.) 2nd position indicates type of facility. 3rd position indicates type of care. 4th position indicates billing sequence.	R	R

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
5	**FED. TAX NO.**	Enter the number assigned by the federal government for tax reporting purposes.	R	R
6	**STATEMENT COVERS PERIOD FROM/ THROUGH**	Enter dates for the full ranges of services being invoiced. MMDDYY	R	R
7	**UNLABELED**	Not used – leave blank.		
8A	**PATIENT IDENTIFIER**	Patient ID is conditional if the number is different from field 60.	C	C
8B	**PATIENT NAME**	Last name, first name, and middle initial. Enter the member's name as it appears on the member's Passport ID card. Use a comma or space to separate the last and first names. Titles (Mr., Mrs., etc.) should **not** be reported in this field. No space should be left after the prefix o a name (e.g. McKendrick). Both names should be capitalized and separated by a hyphen (no space). A space should separate a last name and suffix.	R	R
9A-E	**PATIENT ADDRESS**	Enter the member's complete mailing address. 9A. Street Address 9B. City 9C. State 9D. ZIP Code 9E. Country code (report if other than USA)	R	R
10	**BIRTH DATE**	Member's Date of Birth MMDDYYYY	R	R
11	**SEX**	Enter the member's sex as recorded at the time of admission, outpatient service or start of care. Only M and F are acceptable.	R	R
12A	**ADMISSION 12-15**			

12B	**ADMISSION DATE**	The start date for this episode of care. For inpatient services, this is the date of admission. Right Justified.	R	R
13	**ADMISSION HOUR**	The code referring to the hour during which the member was admitted for inpatient or outpatient care. Left justified.	R	R
14	**ADMISSION TYPE**	A code indicating the priority of this admission/visit.	R	Not required
15	**ADMISSION SRC (Source of Referral for Admission or Visit)**	A code indicating the source of the referral for the admission or visit.	R	C
16	**D HR (Discharge Hour)**	A code indicating the discharge hour of the member from inpatient care.	R	R
17	**Patient Discharge Status**	A code indicating the disposition or discharge status of the member at the end service for the period covered on this bill, as reported in field 6.	R	R
18-28	**CONDITION CODES (the following is unique to Medicare eligible Nursing Facilities; condition codes should be billed when Medicare Part A does not cover Nursing Facility Services)**	A code(s) used to identify conditions or events relating to this bill that may affect processing. Enter one of the following codes in the second column as a Reason Code: • 35 if Medicare benefits are exhausted. • 50 if one of the following applies to why Medicare does not cover the services: ☐ No 3-day prior hospital stay; ☐ Not within 30-days of hospital discharge; ☐ 100 benefit days are exhausted ; ☐ No 60 day break in daily skilled care; ☐ Medical necessity requirements are not met; and/or, ☐ Daily skilled requirements are	C	C

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***

29	**ACCIDENT STATE**	The accident state field contains the two digit state abbreviation where the accident occurred. REQUIRED when applicable.	C	C
30	**UNLABELED FIELD**	Enter DRG on the lower line. REQUIRED when applicable.	C	C
31A, B-34A, B	**OCCURRENCE CODES AND DATES**	Enter the appropriate occurrence code and date. REQUIRED when applicable.	C	C
35A, B-36A, B	**OCCURRENCE SPAN CODES AND DATES**	A code and the related dates that identify an event that relates to the payment of the claims. REQUIRED when applicable.	C	C
37A, B	**UNLABELED FIELD**			
38	**RESPONSIBLE PARTY**	The name and address of the party responsible for the bill.	C	C
39A, B, C, D-41A, B, C, D	**VALUE CODES AND AMOUNTS**	A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization Value Codes and amounts. If more than one value code applies, list in alphanumeric order. REQUIRED when applicable. NOTE: If a value code is populated, then the value amount must also be populated and vice versa.	C	C
42	**REV.CD.**	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.	R	R

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***

43	**DESCRIPTION**	The standard abbreviated description of related revenue code categories is included on this bill. See the NUBC instructions for field 42 for a description of each revenue/code category.	R	R
44	**HCPCS/RATE S/ HIPPS CODE**	1. The Healthcare Common Procedure Coding System (HCPS) is applicable to ancillary services and outpatient bills. 2. The accommodation rate for inpatient bills. 3. Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Enter the applicable rate, HCPS or HIPPS code, and modifier based on the bill type of Inpatient or Outpatient.	R	R
45	**SERV. DATE**	Report line item dates of service for each revenue code or HCPCS/CPT code.	R	R
46	**SERV. UNITS**	Report units of service. A quantitative measure of service rendered by revenue category to or for the patient to include items such as number of accommodations days, miles, pints of blood, renal dialysis treatments, etc.	R	R
47	**TOTAL CHARGES**	Total charges for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non-covered charges. Report grand total of submitted charges. Value entered must be greater than zero dollars ($0.00).	R	R

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***

48	**NONCOVERED CHARGES**	To reflect the non-coverage charges for the destination payer as it pertains to the related revenue code. REQUIRED when Medicare is primary.	C	C
49	**UNLABELED FIELD**		Not required	Not required
50	**PAYER**	Enter the name for each payer being invoiced. When the member has other coverage, list the payers as indicated below. Line A refers to the primary payer; B, secondary; and C, tertiary.	R	R
51	**HEALTH PLAN ID**	The number used by the health plan to identify itself. Passport's Payer ID is 61325.	R	R
52	**REL. INFO**	Release of Information Certification Indicator. This field is required on paper and electronic invoices. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary. It is expected that the provider/ practitioner have all necessary release information on file. It is expected that all released invoices contain "Y."	R	R
53	**ASG. BEN.**	Valid entries are "Y" (yes) and "N" (no).	R	R
54	**PRIOR PAYMENTS**	The A, B, C indicators refer to the information in Field 50.	R	R
55	**EST. AMOUNT DUE**	Enter the estimated amount due (the difference between "total charges" and any deductions such as other coverage).	C	C

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***

56	**NATIONAL PROVIDER IDENTIFIER-BILLING PROVIDER**	The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier. REQUIRED if the health care provider is a Covered Entity as defined in HIPAA Regulation.	R	R
57A, B C	**OTHER (BILLING) PROVIDER IDENTIFIER**	A unique identification number assigned by the health plan to the provider submitting the bill. The UB-04 does not use a qualifier to specify the type of Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan listed in field 50 A, B, C.	C	C
58	**INSURED'S NAME**	Information refers to the payers listed in field 50. In most cases, this will be the member's name. When other coverage is available, the insured is indicated here.	R	R
59	**P. REL**	Enter the member's relationship to insured. For Medicaid programs the member is the insured. (Code 01: Patient is Insured)	R	R
60	**INSURED'S UNIQUE ID**	Enter the member's Passport ID, exactly as it appears on the member's ID card, on line B or C. When other insurance is present, enter the Passport ID on line A.	R	R
61	**GROUP NAME**	Use this field only when a patient has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B, secondary; and C, tertiary.	C	C

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***

62	**INSURANCE GROUP NO.**	Use this field only when a member has other insurance and group coverage applies. Do not use this field for individual coverage. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary.	C	C
63	**TREATMENT AUTHORIZATI ON CODES**	Enter the Passport referral or authorization number. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary.	R	R
64	**DCN**	Document Control Number. New field. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Previously, field 64 contained the Employment Status Code (ESC). The ESC field has been eliminated. NOTE: Resubmitted claims must contain the original claim ID.	C	C
65	**EMPLOYER NAME**	The name of the employer that provides health care coverage for the insured individual identified in field 58. REQUIRED when the employer of the insured is known to potentially be involved in paying this claim. Line A refers to the primary payer; B refers to secondary; and C refers to tertiary.	C	C
66	**DIAGNOSIS AND PROCEDURE CODE QUALIFIER (ICD VERSION INDICATOR)**	The qualifier that denotes the version of International Classification of Diseases (ICD) reported. Not required.	C	C

Field	Field Description	Instructions and Comments	Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X	Outpatient, Bill Types 13X, 23X, 33X
			Required or Conditional*	Required or Conditional*
67	**PRIN. DIAG. CD. AND PRESENT ON ADMISSION (POA) INDICATOR**	The ICD-9-CM codes before 10/01/15 date of service and ICD-10-CM codes after 10/01 describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the member for care). Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, are considered as POA. The POA Indicator is applied to the principal diagnosis as well as all secondary diagnoses reported.	R	R
67 A-Q	**OTHER DIAG. CODES 67A-Q**	The ICD-9-CM diagnosis codes before 10/01/15 date of service and ICD-10-CM diagnosis codes after 10/01 corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.	C	C
68	**UNLABELED FIELD**			
69	**ADM. DIAG. CD.**	The ICD diagnosis code describing the member's diagnosis at the time of admission. REQUIRED for inpatient admissions. Each diagnosis code must be valid for the date of service.	R	C

70	**PATIENT'S REASON FOR VISIT**	The ICD-9-CM diagnosis codes before 10/01/15 date of service and ICD-10-CM diagnosis codes after 10/01 describing the member's reason for visit at the time of outpatient registration. REQUIRED for all unscheduled outpatient visits. Up to three ICD-9-CM codes before 10/01/15 date of service and ICD-10-CM codes after 10/01 may be entered in fields A,B, & C.	C	C
75	**UNLABELED FIELD**			
76	**ATTENDING PROVIDER NAME AND IDENTIFIERS NPI/QUALIFIER / OTHER ID**	Enter the NPI of the physician who has primary responsibility for the member's medical care or treatment in the upper line, and their name in the lower line, last name first. If the attending physician has another unique ID, enter the appropriate descriptive two-digit qualifier followed by the other ID. Enter the last name and first name of the Attending Physician	R	R
77	**OPERATING PHYSICIAN NAME AND IDENTIFIERS NPI/QUALIFIERS NPI/QUALIFIER/ OTHER ID**	Enter the NPI of the physician who performed surgery on the member in the upper line; enter the physician's name in the lower line. (NOTE: The last name should be entered first.) If the operating physician has another unique ID, enter the appropriate descriptive two-digit qualifier followed by the other ID. Enter the last name and first name of the Attending Physician. REQUIRED when a surgical procedure code is listed	C	C

71	**PROSPECTIVE PAYMENT SYSTEM (PPS) CODE**	The PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer. REQUIRED when the Health Plan/ Provider contract requires this information. Up to 4 digits.	C	C
72 A-C	**EXTERNAL CAUSE OF INJURY (ELC) CODE**	The ICD diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect. External Cause of Injury "E" diagnosis codes should not be billed as primary and/or admitting diagnosis. REQUIRED if applicable.	C	C
73	**UNLABELED FIELD**			
74	**PRINCIPAL PROCEDURE CODE AND DATE**	The ICD code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date. Inpatient Facility – ICD-9 before 10/01/15 date of service and ICD-10 after 10/01 is REQUIRED when a surgical procedure is performed. Outpatient Facility or Ambulatory Surgical Center – CPT, HCPCS and ICD-9 before 10/01/15 date of service and ICD-10 after 10/01 is REQUIRED when a surgical procedure is performed.	C R	C R
74 A-E	**OTHER PROCEDURE CODES AND DATES**	The ICD codes identifying all significant procedures other than the principal procedure and the dates (identified by code) on which the procedures were performed. Inpatient Facility – ICD-9 before 10/01/15 date of service and ICD-10 after 10/01 is REQUIRED when a surgical procedure is performed. Outpatient Facility or Ambulatory Surgical Center – CPT, HCPCS or ICD-9 before 10/01/15 date of service and ICD-10 after 10/01 is REQUIRED when a surgical procedure is performed.	C	C

78-79	**OTHER PROVIDER (INDIVIDUAL) NAME AND IDENTIFIERS NPI/QUALIFIER/ OTHER ID**	Enter the NPI of any physician, other than the attending physician, who has responsibility for the member's medical care or treatment in the upper line, and their name in the lower line, last name first. If the other physician has another unique ID, enter the appropriate descriptive two-digit qualifier	C	C
80	**REMARKS**	Area to capture additional information necessary to adjudicate the claim.	C	C

Field	**Field Description**	**Instructions and Comments**	**Inpatient, Bill Types 11X, 12X, 21X, 22X, 32X**	**Outpatient, Bill Types 13X, 23X, 33X**
			Required or Conditional*	**Required or Conditional***
81CC, A-D	**CODE-CODE FIELD**	To report additional codes related to Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.	C	C

Required fields for the UB-04 Claim Form

15.1.8.4 Electronic Data Interchange (EDI) for Medical and Hospital Claims

15.1.8.5 Procedures for Electronic Submission

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs.
The benefits of billing electronically include:

- **Reduction of overhead and administrative costs.** EDI eliminates the need for paper claims submission. It has also been proven to reduce claim rework (adjustments).
- **Receipt of reports as proof-of-claim receipt.** This makes it easier to track the status of claims.
- **Faster transaction time for claims submitted electronically.** An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- **Validation of data elements on the claim form**. By the time a claim is successfully

received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.

- **Faster claim completion**. Claims that do not need additional investigation are generally processed more quickly. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

15.1.8.6 Requirements for Electronic Claim Filing

The following sections describe the procedures for electronic submission for hospital and medical claims, including descriptions of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

15.1.8.7 Hardware/Software Requirements

Providers may use different products to bill electronically. Providers may submit claims electronically as long as their software has the capability to send EDI claims to Change Healthcare (formerly Emdeon) through direct submission or another clearinghouse/vendor.
Change Healthcare has the capability to accept electronic data from numerous providers in several standardized EDI formats. Change Healthcare forwards the accepted information to carriers in an agreed upon format.

15.1.8.8 Contracting with Change Healthcare and Other Electronic Vendors

Providers without Change Healthcare EDI capabilities who are interested in electronic claims submission may contact the Change Healthcare Sales Department at (877) 469-3263, option 6. Providers may also choose to contract with another EDI clearinghouse or vendor who already has EDI capabilities.

15.1.8.9 Certification Requirements

After the registration process is completed and providers have received all certification material, providers must:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact their system vendor and/or Change Healthcare to initiate electronic submissions to Passport. (Be prepared to inform the vendor of Passport's electronic payer identification number 61325.)

15.1.8.10 Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within Section 18 of this Provider Manual. EDI clearinghouses or vendors may require additional data record requirements.

15.1.8.11 Electronic Claim Flow Description

To send claims electronically to Passport, all EDI claims must first be forwarded to Change Healthcare via a direct submission or through another EDI clearinghouse or vendor.

Upon receipt of the transmitted claims, Change Healthcare validates the submitted information against Change Healthcare's proprietary specifications and Passport specific requirements. Claims not meeting the requirements are immediately rejected and returned to the sender via a Change Healthcare error report. The name of this report may vary based on the provider's contract with

its intermediate EDI vendor or Change Healthcare.

Change Healthcare forwards accepted claims to Passport and immediately returns an acceptance report to the sender. Passport immediately validates claims for Change Healthcare for provider identification number requirements. Claims not meeting this requirement are rejected and returned to Change Healthcare. Change Healthcare then forwards this rejection notice to the original sender (i.e. its trading partner, EDI vendor or provider.).

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from Change Healthcare or other contracted vendors must be reviewed and validated against transmittal records daily.

Passport also validates claims containing valid provider identification numbers against member eligibility records before being accepted. If a patient cannot be identified as a member of Passport, a denial letter will be forwarded directly to the provider. This letter is sent to the payment address documented in Passport's provider file. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected for missing or invalid member data.

Since Change Healthcare returns acceptance reports directly to the sender, submitted claims not accepted by Change Healthcare are not transmitted to Passport.
If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Acceptance (Claim Status) reports, contact the Change Healthcare Helpdesk at (800) 845-6592 or the EDI Technical Support Hotline at (877) 234-4275

15.1.8.12 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Passport must first pass Change Healthcare proprietary edits and specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received at Passport. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 180 calendar days from the date of service. It is important for each provider to review the rejection notices (the functional acknowledgements to each transaction set) received from Change Healthcare in order to identify and resubmit these claims correctly. Rejected electronic claims may be resubmitted electronically once the error has been corrected.

15.1.8.13 Plan Specific Electronic Edit Requirements

15.1.8.13.1 Exclusions

Certain claims are excluded from electronic billing. At this time, these claims must be submitted on paper.

- Letters of Agreement (LOA) or Single Case Agreements
- DME requiring invoices (invoice must be attached to claim)
- Sterilization claims accompanied by appropriate MAP forms
- Providers contracted with vendors that are not transmitting through Change Healthcare.

Important: Requests for adjustments may be submitted by telephone to the **Provider Claims Service Unit (PCSU) at (800) 578-0775, option 2** or by mailing to Passport Health Plan P.O. Box 7114 London, KY 40742.

Common Rejections

Invalid Electronic Claims Records – Common Rejections from Change Healthcare
Claim with missing or invalid batch level records
Claim records with missing or invalid required fields
Claim records with invalid (unlisted, discontinued, etc.) codes (CPT, HCPCS, ICD-9 before 10/01/15 date of service and ICD-10 after 10/01/15, etc.)
Claims without provider numbers
Claims without member numbers

Important: Also, unique cases are not HIPAA Compliant.

Invalid Electronic Claims Records – Common Rejections from Passport (EDI Edits Within the Claims System)
Claim for providers who are not approved for EDI submission including test claim
Claims received with invalid provider numbers

Important: Provider identification number validation is not performed at Change Healthcare. Change Healthcare will reject claims for provider information only if the provider number fields are empty.

15.1.8.13.2 Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you have specific EDI technical questions …	Contact EDI Technical Support at: (877) 234-4275
If you have general EDI questions or questions on where to enter required data …	Contact EDI Technical Support at: (877) 234-4275
If you have questions about your claims transmissions or status reports …	Contact your System Vendor - call the Change Healthcare Corporation Help Desk at: (800) 845-6592 or access Change Healthcare's www.changehealthcare.com.
If you have questions about your claim status (receipt or completion dates) …	Contact Provider Claims Service Unit at: (800) 578-0775, option 2
If you have questions about claims that are reported on the Remittance Advice …	Contact Provider Claims Service Unit at: (800) 578-0775, option 2

If you need to know a provider ID number …	Contact Provider Services at: (800) 578-0775, option 3
If you would like to update provider, payee, UPIN, tax ID number, or payment address information … For questions about changing or verifying provider Information.	Notify your Provider Relations Specialist in writing at: Passport Health Plan Provider Network Management 5100 Commerce Crossings Drive Louisville, KY 40229 Fax: (502) 585-6060 Telephone: (502) 585-7943

15.1.8.14 Submitting Member Encounters

As a fiscal agent for DMS, Passport is required to submit encounter data to the Commonwealth of Kentucky. Provider assistance is an essential component of this requirement.

The Commonwealth requires complete, accurate, and timely encounter data in order to effectively assess the availability and costs of services rendered to Medicaid members. The data we provide affects the Commonwealth's funding of the Medicaid Program, including Passport.

Data regarding encounters is also used to fulfill the Centers for Medicare & Medicaid Services (CMS) required reporting in support of the Federal funding of State Medicaid plans.

According to Passport policy, providers must report all member encounters by claims submission either electronically or by mail to Passport.

15.2 Provider/Claim Specific Guidelines

15.2.1 Primary Care Practitioner

15.2.1.1 Allergy Serum

Coverage for Allergy Injections/Serum as well as allergy testing is covered for all members. Authorization of allergy testing and treatment is NOT required.

A referral is required from the PCP to the specialist. Services rendered by a non-participating provider require an authorization. Either an allergist or a PCP may bill the service and serum.

PCPs will be paid based on Passport's fee schedule.

15.2.1.2 Immunization Administration

Immunizations are "Direct Access" services. This means members may go anywhere (i.e. their PCP, their local Department of Health, or another PCP) to receive immunizations.

15.2.1.3 Vaccines Codes and Administration Codes

The immunization and vaccines codes must be billed for the payment of the administration of these services. Practitioners will be reimbursed an administration fee for recommended childhood and adolescent immunizations. For Vaccine For Children (VFC), state-supplied

vaccines, providers must append the SL modifier to the CPT codes. For non-VFC vaccines, providers will be reimbursed for administration as well as the vaccine serum. The payment for the administration is actually generated on claim lines billed with the immunization and vaccine codes.

15.2.1.4 Family Planning Claims

Family planning claims must be submitted to:

Passport Health Plan
P. O. Box 7114
London, KY 40742

All other services (medical) must be billed as normal to Passport. Please note, combined ancillary charges (e.g. supplies, room use, lab/x-ray) do not need to be separated and may be included in the medical claim billed to Passport.

All claims for sterilization procedures must be submitted with the appropriate Sterilization MAP 250 treatment consent form available on the Kentucky DMS web site, http://www.chfs.ky/gov.

Termination requests require an authorization and MAP 235 treatment form available on the Kentucky DMS web site, http://www.chfs.ky/gov.

Members and providers must complete and comply with all terms and conditions of the DMS consent forms thirty days prior to a procedure being provided. Providers must also ensure that individuals with limited English proficiency and visually impaired and/or hearing-impaired members understand what they are signing.

15.2.2 EPSDT

Passport provides all preventive health benefits covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for members from birth to age twenty-one (21).

To submit claims for EPSDT services you must:

1. **Continue to bill using the same codes** for comprehensive history and physical exam you use today. These codes must correspond with the member's age.
    - 99381-99385 – New Patient Series
    - 99391-99395 – Established Patient Series
2. **Add an "EP" modifier to the physical exam code** only when all components of the appropriate EPSDT screening interval have been completed and documented in the member's medical record. Do not add the EP modifier to other service being billed (i.e. immunizations). As a reminder, do not bill lab or testing components individually if they were conducted as part of an EPSDT screening interval.
3. **Acknowledge the following health evaluation services have been completed*** by submitting the appropriate CPT Category II codes, according to the member's age, as outlined below. CPT II codes must include a nominal charge (i.e. $.01 or $1.00, not blank or

zero) in order to adjudicate correctly.

Member Age:	CPT II Code:	Description
Two (2) Years and Above	3008F	To confirm the BMI has been performed and documented in the member's medical record
Nine (9) Years and Above	2014F	To confirm the member's mental status has been assessed and documented in the member's medical record

**Please note this requirement does not apply to EPSDT services rendered prior to October 1, 2010.*

For more information about EPSDT, please see section 9 of this Provider Manual.

15.2.3 Specialists

15.2.3.1 Payment Requirements - Office Related (Place of Service 11)

Services performed in a participating provider's office require a valid referral unless the service is noted as an exception to referral requirements in Section 7 of this Provider Manual. Services performed in a non-participating provider's office require an authorization.

15.2.3.2 Range of Dates on CMS-1500

Date ranges for E/M codes are unacceptable. All days must be submitted separately. For example, if the member receives services ranging from 8/1/12 to 8/5/12, and is being billed with 99232 for $400.00, bill as follows:

Date	Procedure	Quantity	Requested Amount
8/1/12	99232	1	$80.00
8/2/12	99232	1	$80.00
8/3/12	99232	1	$80.00
8/4/12	99232	1	$80.00
8/5/12	99232	1	$80.00

15.2.3.3 Surgeries

If a physician bills an evaluation and management service on the same date of service as a surgical procedure, the surgical procedure is payable and the evaluation and management service is not payable. If more than one surgical procedure is performed, multiple procedures reduction logic will apply.

Many surgeries include a global surgery follow-up period (0, 10 or 90 days). All care provided during the global follow-up period in which a surgery occurred is compensated through the surgical payment.

Visits by the same physician on the same day as the minor surgery or endoscopy are included in

the payment for the procedure, unless a separately identifiable service with an unrelated diagnosis is also performed. The appropriate modified should be used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made upon review against Passport's clinical editing criteria.

The global surgical fee includes payment for hospital observation services unless the criteria for the Appropriate CPT modifiers are met.

15.2.3.4 Obstetrical Services

Referrals are not required for any obstetrical services.

Members may self-refer to any Passport contracted obstetrical practitioner to obtain prenatal care and delivery services; therefore, a referral from the primary care provider is not required.

Submitting the ACOG Form assists Passport in accurately determining a member's risk factors. Upon receipt of the completed ACOG or ACOG-like form, Passport will enroll the member in the Mommy Steps Program. All pregnant members identified will receive educational mailings and, when appropriate, be assigned to a care manager. Participation in the Mommy Steps Program is voluntary, and the member has the right to decline any or all parts of the program.

The Mommy Steps Program hours of operation are Monday through Friday, 8:00 a.m. to 6:00 p.m. EST (except for business-approved holidays).

If a member is seen for a prenatal visit and received diagnostic testing in the participating obstetrical practitioner's office during that visit, the practitioner may bill for both the prenatal visit and the diagnostic test.

No referral or authorization is required for OB ultrasounds done at a participating facility.

For a circumcision to be paid, it MUST be billed under the baby's date of birth. If the claim is billed under the mother's birth date, the claim will deny. Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert "Boy" as the baby's first name; include the baby's last name if it is different than the mother's. Verify that the appropriate last name is recorded for the mother and baby.

15.2.3.5 Delivery and Postpartum Care

For billing of multiple deliveries and/or ultrasounds, payment is made when the designated CPT codes are billed. CPT codes for unique, individual services provided must be billed for all perinatal care, i.e. each prenatal visit, delivery code, and postpartum visit must be billed separately.

15.2.4 Departments of Health (DOHs)

Services conducted by participating Departments of Health are payable without authorizations or referrals.

15.2.5 Chiropractors

Chiropractic services are covered for 26 visits in a calendar year regardless of changes in providers or diagnoses. Please see Section 5 for prior authorization requirements.

15.2.6 Home Health

Home health care is encouraged as an alternative to hospitalization (when medically appropriate), and is utilized for the following types of services:

- Skilled nursing
- Private Duty Nursing
- Occupational therapy
- Infusion therapy
- Social workers
- Physical therapy
- Speech therapy
- Home health aides
- MediPlanner

The Utilization Management Department will coordinate medically necessary home care needs with the PCP, hospital, home care departments, and other providers of home care services.

The home health contract is revenue code based. Claims must be billed with valid revenue and HCPC codes.

15.2.6.1 Nurse Supervision

When home health aides are used, registered nurse (RN) supervision is required at least once every two (2) weeks. This supervised visit is not covered by Passport, as it is considered part of the cost for the home health aides.

15.2.6.2 Services and Visits in Nursing Facilities

Ancillary services (other than room and board charges) billed with POS 31 or 32 are payable for both participating and non-participating providers without an authorization or referral (benefits are not payable for facility charges). Members may be seen by any PCP (regardless of whether the PCP is the member's PCP) and the provider will be reimbursed fee for service.

15.2.6.3 Y1 Indicator (Home Health Services Not Covered by Medicare)

Services not covered by Medicare may be submitted to Passport for payment without submitting to Medicare first. Providers must submit these types of claims with a "Y1"indicator in Field 24 of the UB-04 claim form. An EOB is not required if the "Y1" indicator is on the bill. Passport authorization requirements apply for these services.

15.2.7 Hospice

Payment for hospice care is made at one of four predetermined rates for each day that a member is under the care of hospice. The rates paid for any particular day vary depending on the level of care provided to the member. The four levels of care by which each day is classified are described

below.

15.2.7.1 Hospice Routine Home Care

Hospice is paid the routine home care rate for each day the member is under the care of the hospice without receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the member is receiving outpatient hospital care for a condition unrelated to the terminal condition.

15.2.7.2 Hospice Continuous Home Care

Hospice is paid the continuous home care rate when continuous home care is provided. The rate is paid only during a period of crisis and only as necessary to maintain the terminally ill member at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

Hospice provides a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous (i.e. four hours could be provided in the morning and another four hours could be provided in the evening).

The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide services may be provided to supplement the nursing care.

15.2.7.3 Hospice Inpatient Respite Care

Hospice is paid at the inpatient respite care rate for each day the member stays in an approved inpatient facility and receives respite care. Payment for respite care may be made for a maximum of five continuous days at a time (including the date of admission but not counting the date of discharge). Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than five days each) is allowable in a single billing period. If the member dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. Please see Section 5 for authorization requirements.

15.2.7.4 Hospice General Inpatient Care

Payment at the inpatient rate is made when general inpatient care is provided.

15.2.8 DME

Referrals are never required for Durable Medical Equipment (DME). The DME authorization requirements are based on total billed charges or monthly quantity of items purchased. For a complete list of benefits requiring authorization by quantity, please refer to Section 5 of this Provider Manual.

If the DME item is not mentioned in this Provider Manual, the authorization requirement is

determined by cost as outlined below.

- If the provider's billed charges are greater than $500 for a supply of the same item, **an authorization is required.**

An authorization is required for all nonparticipating providers unless the service is a Medicare covered service and Medicare is primary or the member is in out-of-home placement.

15.2.8.1 DME Rentals

A modifier "RR" should be used for all rented equipment. All mini-nebulizers must be purchased, with the exception of claims involving coordination of benefits. If Passport is secondary to another carrier who has reimbursed the mini-nebulizer as a rental, the benefits are coordinated as a rental.

15.2.8.2 Enteral Therapy

Enteral therapy does not require an authorization unless the billed amount is greater than $500 for a month's supply. Claims should be submitted with an NDC number to receive payment.

15.2.9 Home Infusion

All home infusion services, including nursing visits, require an authorization. Catheter maintenance charges are always reimbursed based on the authorization.

15.2.9.1 Medically Billed Drugs

All claims, paper and electronic, submitted to Passport with drug codes must include valid National Drug Code (NDC) numbers and NDC units. Please see NUCC for NDC formatting requirements (page 45-46).

15.2.10 Physician Services in Hospital Setting

Physician services should be billed on the CMS-1500 for paper claims or the 837P for electronic claims using appropriate CPT/HCPCS codes, NDC codes and ICD-10 diagnosis codes.

15.2.10.1 Initial Observation Care

All related evaluation and management services provided by the physician on the same day are included in the admission for hospital observation. Only one physician may report initial observation services. Do not use these observation codes for post-recovery in regard to a procedure considered to be a global surgical service.

If a member who is admitted to an observation status is subsequently admitted to an inpatient status, only the inpatient service will be paid. Providers may not bill initial observation care codes for services provided on the dates they admit patients on an inpatient status.

15.2.10.2 Observation Care Discharge Service

Observation discharge code 99217 is to be used only when discharge from observation status occurs on a date other than the initial date of observation status.

15.2.10.3 Hospital Inpatient Services

The codes for hospital inpatient services report admissions to a hospital setting, follow-up care provided in a hospital setting, observation or inpatient care for the same day admission and discharge, and hospital discharge day management.

The initial hospital care codes should be used by the admitting physician to report the first hospital inpatient encounter. All evaluation and management services provided by the admitting physician in conjunction with the admission, regardless of the site of the encounter, are included in the initial hospital care service. Services provided in the ER, observation room, physician's office, or nursing facility specifically related to the admission cannot be reported separately.

Codes 99238 and 99239 are for hospital discharge day management, but exclude discharge of the member from observation status. When a physician other than the attending physician provides concurrent care on a discharge day, these services must be billed using the subsequent hospital inpatient or outpatient codes.

15.2.10.4 Consultations

Claims for inpatient consultations and subsequent procedures/treatments are covered without regard to the authorization for the inpatient stay. Consulting physicians must bill both the consultation CPT code and the procedure and/or treatment code to be paid for services rendered during the inpatient stay.

15.2.10.5 Critical Care Services

Critical care codes include evaluation and management of the critically ill or injured member, requiring direct delivery of medical care. Note that 99292 is an add-on code and must be used in conjunction with 99291. Critical care of less than 30 minutes should be reported using an appropriate evaluation and management code. Critical care of less than 15 minutes beyond the first
hour or less than 15 minutes beyond the final 30 minutes should not be reported.

15.2.10.6 Identifying Newborn Inpatient Services

Services for newborns are processed under the newborn's Passport member ID number. Effective July 1, 2016, Passport will not pay claims for newborns without a Kentucky Medicaid ID. Claims for newborns will be back-dated to DMS eligibility date.

15.2.11 Free-Standing Facilities

Free-standing radiology facilities who bill with a place of service of 11 (office) do not require a referral for radiology services.

15.2.12 Ambulance Services

Ambulance services and emergent air transportation do not require authorization for payment. Non- emergent air transportation will require an authorization.

Providers must report an origin and destination modifier for each ambulance trip in accordance with guidelines in the HCPCS manual. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception

of X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha equals origin: the second position alpha code equals destination.

15.2.13 Facility Billing for Hospital Services

Facility claims for inpatient services should be submitted on the hospital's standard billing form (UB-04). The prior authorization number issued at the time of admission notification should appear on the claim form. Inpatient claims must be submitted after the services were rendered or compensable items were provided within the timeframe indicated in the Passport Hospital Agreement.

Claims for outpatient services should be submitted on the hospital's standard billing form (UB-04). The Passport prior authorization number for services (if necessary) should be included on the claim form.

15.2.14 Subcontractor Services

Please refer to billing instructions in the following Sections:

- Behavioral Health Provider Billing – Section 16.6
- Dental Claims Submission – Section 18.2.2
- Vision Claims Submission Requirements – Section 19.8

15.3 Understanding the Remittance Advice

15.3.1 Electronic Remittance Advice (ERA/835)

Remittance Advices explain the payment of a claim and/or any adjustments made. For each claim, there is a remittance advice (RA) that lists each line item payment, reduction, and/or denial. Payment for multiple claims may be reported on one transmission of the RA.

Standard adjustment reason codes are used on remittance advices. These codes report the reasons for any claim financial adjustments, and may be used at the claim or line level. Multiple reason codes may be listed as appropriate.

Remark codes are used on an RA to further explain an adjustment or relay informational messages. Please see the end of this section for a sample Passport remittance advice.

15.3.1.1 Receiving the Electronic Remittance Advice (ERA/835)

If you are interested in receiving ERA/EFT, please register with InstaMed. Once registered, you will be able to access ERAs through the InstaMed Provider Portal.

For additional information or questions, please contact InstaMed at (866) 945-7990 or by email at connect@instamed.com.

15.3.1.2 Adjustment/Denial Codes

Description	Benefit/Service Rule	Denial Valid	Denial Invalid

Correct NDC required for consideration.	Required for J code Infusion Therapy drugs.	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Invalid/Deleted code, modifier or description.	The claim was either billed without a procedure code or billed with an invalid procedure code. Compare the codes billed on the CMS 1500 to the codes processed on the remittance advice.	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Itemized Bill/Date of Service/Charges/ Invoice required.	Usually required for DME misc. codes and Renal Dialysis Claims. We need the itemized bill in order to know how much to reimburse.	Submit copy of the itemized invoice to correspondence.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Received after filing time limit.	The timely filing deadline is 180 days. If COB related, the deadline is 60 days from the notification date on the primary carrier EOB for CMS submissions and 180 days for UB-04 submissions. Verify that all supporting documentation was included in initial claims submission.	Submit proof of timely filing documentation to Passport correspondence.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Diagnosis invalid/ missing/deleted. Requires 4th/5th digit.	The claim was either billed without a DX code or billed with an invalid DX code. Verify that a valid diagnosis code is on the claim.	Submit corrected claim.	Contact Provider Claims Service Unit at (800)578-0775, option 2.

Not enrolled on date of service.	Verify that you have copy of the Medicaid card for the date of service.	The member will have to follow up with his/her caseworker.	Mail copy of Medicaid card to Passport correspondence
Resubmit with EOB from primary carrier	System indicates the member has other coverage. Verify if EOB was included with initial claim submission.	Submit primary carrier EOB to Passport correspondence.	Resubmit claim with primary carrier information.
Carrier of Service - Superior Vision		Submit claim to Superior Vision	Superior Vision Claims & Eligibility at (866) 819-4298 from 9 a.m. to 8 p.m.
Assistant Surgeon Payment	This is a processing explanation code, not a denial.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Combined payment - mother & baby.	This code is used only on claims for a newborn if the facility is paid on a per diem. The newborn claim is written off by the provider, and they receive payment for the mother's delivery claim instead.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Duplicate claim previously paid at correct rate.	Passport has previously processed a claim submitted for the same date of service and from the same provider.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
This is a processing explanation code, not a denial.	Used to signify a payment reduction due to multiple surgical or therapy procedures billed on the same date of service.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Over max procedure/ benefit limit.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Payment reflects coordination of benefits, if $0, max liability met.	COB, secondary payment. If Passport payment is $0, then the primary carrier paid over the Passport allowable amount.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Same procedure paid to a different provider.	Passport has previously paid a claim submitted with the same procedure code for the same date of service to a different provider.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Service not covered.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Services were not provided.	This rejection code is usually used when the provider has called in to request a payment recoupment.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Submit charges to MA fee for service program.	This claim is considered mental health related.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Administrative approval.	This is a processing explanation code, not a denial code. It is usually used when the Medical Review or Appeals department has overturned a previous processing.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

No PCP referral.	No referral on file. Verify if copy of referral was included with initial claim submission.	Submit copy of referral to Passport correspondence.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Pre-cert/Auth not obtained, denied or invalid.	No authorization on file.	Provider may contact the Utilization Management Department at (800) 578-0636 for retro authorization options.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Duplicate of previously submitted EPSDT screening.	This means that a member has already received an EPSDT screening or checkup for the particular interval or timeframe. Verify this member's periodicity schedule with the EPSDT calculator, then review his/her EPSDT screening history.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Provider wasn't the member's PCP.	This member is showing a different PCP for the date of service.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Charges considered included in inpatient admission.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Inappropriate coding for contract agreement.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Carrier of service - MCNA.		Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Carrier of service - AmeriHealth, Inc.		Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Payment included in other billed services.	This denial code could be used for a variety of claim processing scenarios.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 3.
EOB/Attachments were incomplete/ illegible.	This rejection means that there is a complication with the primary carrier EOB.	Review the primary carrier EOB for any inconsistencies.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Need newborn member number.	Resubmit claim with the ID for the newborn.	Resubmit corrected claim.	Contact Provider Claims Service Unit at (800)
Resubmit to primary carrier for appeals process.	Passport can only coordinate secondary payment with a final processing documented on a primary carrier EOB.	Provider must resubmit claim to primary carrier appeals process.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Attending physician ID/name missing/ invalid.	This occurs most frequently when a hospital bills a UB-04 without an attending physician's name or ID. Review claim to verify if physician name/ID was included with initial submission.	Provider must resubmit corrected claim with physician ID/name.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Missing place of service.	This claim wasn't billed with a place of service.	Provider must resubmit a corrected claim with POS.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Member's age not valid for procedure code.	This denial code could be used for a variety of claim processing scenarios. Review member's age.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Member's sex not valid for procedure code.	Review the State system to verify the gender loaded for this member.	Final	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Not covered for presumptive eligibility member.	The particular type of service that is being billed is not a service that is covered for a presumptive eligibility member.	Member will have to contact his/her caseworker for options regarding eligibility reinstatement.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Missing charges/units	This procedure code billed does not include units. Review claim form to verify units billed.	Submit corrected claim.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Inappropriate claim form for professional services.	This occurs when an individual practitioner bills his/her professional services on a UB-04. This mistake most commonly occurs with ER professional fees.	Submit a corrected claim on a CMS-1500 to ACS.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Dates and/or services outside auth.	The information approved on the authorization does not match what was billed on the claim.	Provider may contact the Utilization Management Department at (800) 578-0636 for retro authorization options.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

Authorization expired.	The date of service billed is outside the last approved date on the authorization.	Provider may contact the Utilization Management Department at (800) 578-0636 for retro authorization options.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Group ID not payable.	Claims are not paid when group only information is billed. You are required to bill both individual (rendering) provider NPI and taxonomy as well as their group (billing) provider NPI and taxonomy in order for your claim to be	Provider must submit a corrected claim with the individual provider information.	Contact Provider Claims Service Unit at (800) 578-0775, option 2.
Subset/Incidental Procedure disallow.	The rejected procedure code is considered incidental to another paid procedure code.	Final	Fax in medical records to Provider Claims for medical claim review.
Redundant procedure.	This rejection is very similar to the subset reject.	Final	Fax in medical records to Provider Claims for medical claim review.
Manual Denial.	This is a generic denial code used by adjusters to manually deny a claim. There should be additional denial code information listed explaining the manual denial.	Follow the applicable denial response guideline located on this grid.	Follow the applicable denial response guideline located on this grid.
MAID Missing or Invalid.	Passport does not have the billing provider's Kentucky Medicaid ID (MAID) or the MAID is expired.	Contact your Provider Relations Specialist or Provider Services at (800) 578-0775	Contact Provider Claims Service Unit at (800) 578-0775, option 2.

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PASSPORT HEALTH★PLAN

Passport Health Plan
5100 Commerce Crossings Drive
Louisville KY 40229

EXPLANATION OF PAYMENT

Payment Date:
Payee ID:
Tax ID:
Check Number:
Claim Count:
Total Charges:
Total Payment:
Total Provider Adj:
Payment Amount:

For further inquiries on this remittance advice contact, please call 1 (800) 578-0775.

OOOO189 01 SP 0.460 **SNGLP T1 0 1602 40475-795205-C02-P00000-I 234

John Smith, MD
123 Main Street
Anywhere, KY 40229

Get Paid Faster! Register for ERA/EFT at https://register.instamed.com/eraeft and enter Registration Code.

PROVIDER CLAIM SUMMARY

Dates of Service From To	Procedure	No. of Units	Amount Billed	Allowed	Paid	Patient Responsibility	COB	Not Covered	Adjustment Reason	Remarks
Patient:				Provider:				Member:		
Interest: **$0.00**				Claim ID:						
Total for Claim										

PROVIDER ADJUSTMENTS

Adjustment Reason	Amount
Interest Owed	
Total Adjustments	

Adjustment Reason Codes

Code	Description
CO-45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

Remarks Codes

Code	Description
	Consult our contractual agreement for restrictions/billing/payment information related to these charges.

Get Paid Faster! Register for ERA/EFT at https://register.instamed.com/eraeft and enter Registration Code: Q2MTKN

PASSPORT HEALTH★PLAN

Passport Health Plan
5100 Commerce Crossings Drive
Louisville KY 40229

REPUBLIC BANK & TRUST COMPANY
San 601 W Market St
Louisville, KYÂ 40202

VOID VOID VOID

PAY
TO THE
ORDER
OF

15.4 Denial Reasons and Prevention Practices

15.4.1 Billed Charges Missing or Incomplete
A billed charge amount must be included for each service/procedure/supply on the claim form.

15.4.2 Diagnosis Code Missing Digits
Precise coding sequences must be used in order to accurately complete processing. Review the ICD- 10-CM manual for addition characters.

15.4.3 Diagnosis, Procedure or Modifier Codes Invalid or Missing
Coding from the most current coding manuals (ICD-9-CM before 10/01/15 date of service and ICD-10-CM on or after 10/01/15, CPT or HCPCS) is required to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.

15.4.4 EPSDT Information Missing or Incomplete
All tests and services listed on the Passport EPSDT Program Periodicity and Screening Schedule must be performed within the indicated time periods.

15.4.5 Illegible Claim Information
Information on the claim form must be legible to avoid delays or inaccuracies in processing. Review billing processes to ensure forms are typed or printed in black ink, no fields are highlighted (this causes information to darken when scanned or filmed), no use of white out and spacing and alignment are appropriate. Handwritten information often causes delays or inaccuracies due to reduced clarity.

15.4.6 Incomplete Forms
All required information must be included on the claim form to ensure prompt and accurate processing.

15.4.7 Newborn Claim Information Missing or Invalid
Always include the first and last name of the mother and baby on the claim form. If the baby has not been named, insert "Girl" or "Boy" as the baby's first name; include the baby's last name if it is different than the mother's. Verify the appropriate last name is recorded for the mother and baby. Please include the baby's date of birth.

15.4.8 Payer or Other Insurer Information Missing or Incomplete
Include the name, address and policy number for all insurers covering the Passport member.

15.4.9 Place of Service Code Missing or Invalid
A valid and appropriate two-digit numeric code must be included on the claim form.

15.4.10 Provider Name Missing
The name of the provider of service must be present on the claim form and must match the service provider name and Tax Identification Number (TIN) on file with Passport.

15.4.12 Revenue Codes Missing or Invalid
Facility claims must include a valid revenue code. Refer to UB-04 reference material for a complete

list of revenue codes.

15.4.13 Signature Missing

The signature of the provider of service must be present on the claim form and must match the service provider name and TIN on file with the Passport. See Section 18.1.12.2 CMS-1500 Claim Form and Required Fields for additional information on acceptable signature formats.

15.4.14 Spanning Dates of Service Do Not Match the Listed Days/Units

Span dating is only allowed for identical services provided on consecutive dates of service. Always enter the corresponding number of consecutive days in the days/unit field.

15.4.15 Tax Identification Number (TIN) Missing or Invalid

The Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with the Passport.

15.4.16 Third Party Liability (TPL) Information Missing or Incomplete

Any information indicating a work related illness/injury, no fault, or other liability condition must be included on the claim form. Additionally, if billing via paper, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

15.4.17 Type of Service Code Missing or Invalid

A valid alpha or numeric code must be included on the claim form.

15.4.18 Billing Bilateral Procedures

Modifier '50' is used to report bilateral procedures performed in the same session. The use of modifier '50' is applicable only to services and/or procedures performed on identical anatomical sites, aspects, or organs. The intent of this modifier is to be appended to the appropriate unilateral code as a one-line entry on the claim form indicating that the procedure was performed bilaterally.

When a procedure code is appended with modifier '50', the units box on the claim form should indicate that "1" unit of service was provided, since one procedure was performed bilaterally.

Placing the procedure on two lines will bill for two charges, and will result in a denial for one of the billed lines. When a procedure code is billed with a '50' modifier and a '1' in the unit field, the code will reimburse at 150% of the allowable amount.

Some CPT codes were developed for unilateral and bilateral procedures, so it may not always be appropriate to append modifier '50' if there is a CPT code to report the bilateral procedure.

15.4.19 Billing with Modifiers '25' and '59'

Use modifier '25' when the E/M service is separate from that required for the procedure and a clearly documented, distinct and significantly identifiable service was rendered, or the procedure performed was above and beyond the usual preoperative and postoperative care. The modifier '25' must be placed on the E/M code to assure appropriate review of your claim.

Modifier '59' is used to indicate a procedure or service was distinct or independent from other services performed on the same day. When another already established modifier is appropriate it should be used rather than modifier '59'. Only if a more descriptive modifier is not available, and the use of modifier '59' best explains the circumstances, should modifier '59' be used.

15.5 Timely Filing Requirements

Original invoices must be submitted to Passport within 180 calendar days from the date services were rendered or compensable items were provided.

Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within two years of the last process date.

Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within 180 calendar days from the date of service. Rejected claims are not registered as received in the claims processing system.

15.5.1 Timely Filing Exceptions

- Submission of claims for members retroactively enrolled in Passport by DMS must be submitted within 180 days from the date of notification to Passport of enrollment by DMS.
- Claims with Explanation of Benefits (EOBs) from Medicare Part A must be submitted within
  180 days of the date of the Medicare EOB.
- Claims with Explanation of Benefits (EOBs) from primary insurers other than Medicare Part
  A must be submitted within 60 days of the date of the primary insurer's EOB.
- Out of home placement services are exempt from timely filing guidelines.
- Mommy Steps services are exempt from timely filing guidelines.
- Medicare crossover claims are exempt from timely filing guidelines.

15.6 Corrected Claims and Requests for Appeals and/or Refunds

If you would like to discuss claims payments, you may call the Provider Claims Services Unit (PCSU) at (800) 578-0775, option 2.

Providers have the right to appeal the outcome of a claim. The appeal must be submitted in writing and received within two (2) years of the last process date and include supporting documentation. The Plan will respond to the appeal within thirty (30) days from the receipt date with a determination or status of the review.

The provider will receive written notification of the outcome of the appeal whether it is upheld or overturned. All upheld determinations will be sent to the provider in a letter with the reason the plan upheld the appeal. Any appeals overturned by the plan will be reprocessed and the provider will receive an explanation of benefits (EOB) as notification.

Resubmitted claims should be resubmitted on paper. Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting:

• Claims originally denied for missing/invalid information for inappropriate coding should be submitted as corrected claims. In addition to writing "corrected" on the claim, the corrected information should be circled so that it can be identified.

• Claims originally denied for additional information should be sent as a resubmitted claim. In addition to writing "resubmitted" on the claim, the additional/new information should be attached.

• Corrected and resubmitted paper claims are scanned during reprocessing. Please remember to use blue or black ink only and refrain from using red ink, white out and/or highlighting that could affect the legibility of the scanned claim.

Corrected/Resubmitted paper claims should be sent to:

Passport Health Plan
P.O. Box 7114
London, KY 40742

Following these instructions will reduce the probability of erroneous or duplicate claims and timely filing denials on second submissions.

When the need for a refund is identified, the provider should call the PCSU at (800) 578-0775, option 2, to report the over-payment. Claim details will need to be provided such as reason for refund, claim number, member number, dates of service, etc. The claim will be adjusted, the money will be recovered and the transaction will be reported on the Remittance Advice. **There is no need to submit a refund check.**

If Passport recognizes the need for a refund, a letter outlining details will be sent 30 days prior to the recovery occurring. These adjustments will also be reported on the Remittance Advice.