

Passport Advantage Provider Manual Section 11.0 Claim Filing Instructions

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11.0 Claim Filing Instructions

11.1 Claim Filing

11.1.1 Procedures for Claim Submission

Passport Advantage, hereafter referred to as the Plan, 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 to ensure timely processing of claims.

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

Claims filed with the Plan 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 member eligibility for services under the Plan during the time period in which services were provided.
- Verification that all practitioner or provider information is valid.
- Verification of whether there is any other third party resource and, if so, verification that the appropriate documentation is provided with all claims submitted to the Plan.
- Verification that an authorization has been given for services that require prior authorization by the Plan.

11.1.1.1 Claim Mailing Instructions

The Plan encourages all providers to submit claims electronically. For additional information on electronic claim filing, see section 11.2.1. Please note, corrected claims may not be re-submitted electronically.

All PAD paper claims (including corrected and resubmitted claims) for services must be mailed to Passport Advantage, P.O. Box 152107, Tampa, FL, 33684, using your Passport Health Plan (Medicaid) provider ID number. Please call the Provider Claims Service Unit at (800) 578-0775 or your Provider Relations representative if not familiar with your PHP Plan ID number.

Claims for vision services must be submitted to the following address:

Block Vision
120 West Fayette Street
Suite 700
Baltimore, MD 21201

Telephone calls should be directed to Block Vision Provider Services at (800) 819-4298.

11.1.1.2 Claim Filing Deadlines

Original claims must be submitted to the Plan within one year from the date services were rendered or compensable items were provided.

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

11.1.1.3 Exception

Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 calendar days of the date of the primary insurer's EOB.

11.1.1.4 Claims Status Review

To view claims status, log on to the Passport Advantage web site at www.passporthealthplan.com. To enter the secured site, a provider will need his or her Passport Advantage provider number and provider tax identification number. Once you have entered the secured site, a menu will help you access claims status and member eligibility verification.

Providers who wish to inquire about the status of a previously submitted claim can contact Passport Advantage at (800) 578-0775.

11.1.2 Notification of Denial via Remittance Advice

When a claim is completely denied because of missing or invalid mandatory information and is still within the one (1) year timely filing guideline, the claim may be resubmitted within two years of the process date.

If the claim is partially denied or is between one (1) and two (2) years from the previous submission and some information is missing or invalid, the claim should be corrected and resubmitted through the corrected claims process.

To submit corrected claims to PAD you must:

1. Complete the PAD Corrected Claims Form, available by visiting the Provider Center of our web site, www.passportadvantage.org, and choosing "Provider References" from the menu on the left.
2. Mail the completed form and corrected claim to
Passport Advantage
P.O. Box 152107
Tampa, FL, 33684.

11.1.3 Request for Claim Reconsideration, Adjustments and/or Appeals

Reconsideration and/or Adjustments occur when the provider and/or Plan has identified one or more errors related to payment of benefits. If you disagree with the payment amount or the manner in which your claim was processed, you may call Provider Claims Service Unit (PCSU) at (800) 578-0775 or submit a written request for reconsideration/ appeal. The request must be made within two years of the last process date to the following address:

Passport Advantage
 Attn: PCSU
 305 West Broadway, 3rd Floor
 Louisville, KY 40202

Click [here](#) for the Corrected Claims Form. This form must accompany the submission of corrected claims.

11.1.4 Claim Data Sets Billed by Providers

	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	

11.1.5 Claim Form Field Requirements

The following charts describe the required fields that must be completed for the standard CMS 1500 and 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 one year from the date of service.

11.1.5.1 Required Fields (CMS 1500 Claim Form)

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).

* 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 Form			
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	Plan's member identification number as it appears on the member's Plan 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 Plan 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 Plan 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	PATIENT STATUS	Enter the member's marital status. Indicate if the member is employed or is a student.	R
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	OTHER INSURED'S BIRTH DATE / SEX	REQUIRED if field 9 is completed. MM DD YY / Sex must be indicated by "M" or "F."	C
9C	EMPLOYER'S NAME OR SCHOOL NAME	This field is related to the insured in field 9.	C

Field	Field Description	Instructions and Comments	Required or Conditional*
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	RESERVED FOR LOCAL USE		Not required
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	EMPLOYER'S NAME OR SCHOOL NAME	Required if employment is indicated in field # 10.	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 A-D.	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)	MMDDYY	C
15	IF PATIENT HAS SAME OR SIMILAR ILLNESS. GIVE FIRST DATE	MMDDYY	C
16	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION		C
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	REQUIRED if a provider other than the member's primary care physician rendered invoiced services.	C
17A	I.D. NUMBER OF REFERRING PHYSICIAN	Enter the Plan 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. If the other ID number is the Health Plan ID number, enter N5. 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

Field	Field Description	Instructions and Comments	Required or Conditional*
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	BILLING PROVIDER'S TAXONOMY CODE	Populate field with the ZZ qualifier ID and the Billing Provider's Primary Taxonomy Code.	R
20	OUTSIDE LAB? CHARGES	For billing diagnostic tests subject to purchase price limitations.	C
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE).	All diagnosis codes must be valid ICD-9 codes for the date of service. "E" codes are NOT acceptable as a primary diagnosis. List in priority order.	R
22	MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	For resubmissions or adjustments, enter the claim ID number of the original claim. NOTE: Resubmissions may NOT currently be submitted via EDI. 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 field was originally titled "Type of Service" and is no longer used. This is now an emergency indicator field. Enter Y for "Yes" or leave blank for "No" in the bottom (unshaded area of the field).	R
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

Field	Field Description	Instructions and Comments	Required or Conditional*
24E	DIAGNOSIS CODE	Diagnosis Pointer - Indicate the associated diagnosis by referencing the pointers listed in field 21 (1, 2, 3, or 4). All diagnosis codes must be valid ICD-9 codes for the date of service.	R
24F	CHARGES	Enter charges for each line item.	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	This field was originally labeled "EMG." However, "EMG" is now located in field 24C. If the rendering provider does not have an NPI number, the qualifier indicating what the number represents is reported in the qualifier in field 24I. If the other ID number is the Health Plan ID number, enter N5. If the other ID number is another unique identifier, refer to the NUCC guidelines for the appropriate qualifier. The shaded area allows you to identify the two-character qualifier ID of the Rendering Provider (N5). The un-shaded area is pre-filled with NPI.	R
24J	RENDERING PROVIDER ID	The shaded area allows you to submit the current provider ID number of the Rendering Provider which coincides with the two-character qualifier ID reported in 24I. The un-shaded area accommodates the Rendering Provider's NPI.	Recommended 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 (08-05) form for the section pertaining to Medicaid payments.	R
28	TOTAL CHARGE	Enter charges. Value entered must be greater than zero dollars (\$0.00), including capitated services.	R

Field	Field Description	Instructions and Comments	Required or Conditional*
29	AMOUNT PAID	REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing the Plan. Medicaid programs are always the payers of last resort.	C
30	BALANCE DUE	REQUIRED when field 29 is completed.	C
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS / DATE		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		R
32B	SERVICE FACILITY TWO CHARACTER QUALIFIED ID AND CURRENT PROVIDERS ID NUMBERS		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	R
33A	BILLING PROVIDER NPI NUMBER	REQUIRED	R
33B	BILLING PROVIDER TWO CHARACTER QUALIFIER ID AND PLAN ASSIGNED PROVIDER ID NUMBER	REQUIRED when the Rendering Provider does not have an NPI number. Enter the two-digit qualifier identifying the non-NPI number followed by the provider ID number. Do not enter a space, hyphen, or other separator between the qualifier and the number. EDI instructions 2310B loop, REF01=N5, REF02=Plan's Provider Network Number. Less than 13 alphanumeric digits. NOTE: Do not send the provider on the 2400 loop.	Recommended

11.5.1.2 Required Fields (UB-04 Claim Forms)

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.	C	C
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
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			
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 Plan 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 of 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

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*
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.	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	A code indicating the discharge hour of the member from inpatient care.	R	R
17	STAT	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	C

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*
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: <ul style="list-style-type: none"> • 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 not met. 	C	C
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 FROM/ THROUGH	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

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*
42	REV.CD.	Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements.	R	R
43	DESCRIPTION	The standard abbreviated description of related revenue code categories is included on this bill. See the instructions for field 42 for a description of each revenue category.	R	R
44	HCPCS/RATES/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

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*
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 includes both covered and non-covered charges. Report grand total of submitted charges. Value entered must be greater than zero dollars (\$0.00).	R	R
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 Health Plan's Payer ID is 61129.	C	C
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

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*
55	EST. AMOUNT DUE	Enter the estimated amount due (the difference between "total charges" and any deductions such as other coverage).	C	C
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. REQUIRED on or after May 23, 2007 if NPI is not mandated in field 56. 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.	Recommended	Recommended
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 Plan ID, exactly as it appears on the member's ID card, on line B or C. When other insurance is present, enter the Plan ID on line A.	R	R
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

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*
63	TREATMENT AUTHORIZATION CODES	Enter the Plan 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.	R	R
67	PRIN. DIAG. CD. AND PRESENT ON ADMISSION (POA) INDICATOR	The ICD-9-CM codes 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

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*
67 A-Q	OTHER DIAG. CODES 67A-Q	The ICD-9-CM diagnoses codes 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 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 may be entered in fields A,B,C.	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			

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*
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 is REQUIRED when a surgical procedure is performed. Outpatient Facility or Ambulatory Surgical Center – CPT, HCPCS or ICD-9 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 is REQUIRED when a surgical procedure is performed. Outpatient Facility or Ambulatory Surgical Center – CPT, HCPCS or ICD-9 is REQUIRED when a surgical procedure is performed.	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

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*
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 followed by the other ID.	C	C
80	REMARKS	Area to capture additional information necessary to adjudicate the claim.	C	C
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
	OTHER PROCEDURE CODE AND DATE	Enter the procedure code for the other procedure performed during the period covered by the invoice. Inpatient claims and all surgical procedures require ICD-9-CM codes. Outpatient claims require CPT/ HCPCS codes.	R	not required
82	ATTENDING PHYS. ID	Enter the name of the physician who has primary responsibility for the patient's medical care or treatment in the lower line and the Medical license # in the upper line.	R	R
83	OTHER PHYS. ID	Enter the name of the physician, other than the attending, who has some responsibility for the patient's medical care or treatment in the lower line and the Medical license # in the upper line.	R	R
	OTHER PHYS. ID	Enter the name of the physician, other than the attending, who has some responsibility for the patient's medical care or treatment in the lower line and the Medical license # in the upper line.	R	R
84	REMARKS		C	C
85	PROVIDER REPRESENTATIVE	Authorized Signature	R	R
86	DATE	Indicates the Signature and Billing date	R	R

11.1.6 Common Causes of Claim Rejections or Denials

Rejections- 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 claim processing system. Since rejected claims are not registered in the claim processing system, the provider must resubmit these claims within one year from the date of service. This requirement applies to claims submitted on paper or electronically. Rejected claims are different than denied claims which are registered in the claim processing system but do not meet requirements for payment under the Plan's guidelines.

Denials-claims that are registered in the claim processing system but do not meet requirements for payment under the Plan's guidelines.

Authorization Number Invalid or Missing – A valid authorization number must be included on the claim form for all services requiring prior authorization. See section 5.0 of this Provider Manual for authorization requirements.

Billed Charges Missing or Incomplete – A billed charge amount must be included for each service/procedure/supply on the claim form, even if billed charges equal \$0.

Billing Multiple Modifiers - Under certain circumstances two or more modifiers may be necessary to completely define a service.

Diagnosis Code Missing 4th or 5th Digit – Precise coding sequences must be used in order to accurately complete processing. Review the ICD-9-CM manual for the 4th and 5th digit extensions.

Diagnosis, Procedure or Modifier Codes Invalid or Missing – Coding from the most current coding manuals (ICD-9-CM, CPT, HIPPS or HCPCS) is required to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.

DRG Codes Missing or Invalid – Hospitals contracted for payment based on DRG codes must include this information on the claim form.

EOBs (Explanation of Benefits) from Primary Insurers Missing or Incomplete – A copy of the EOB from all third-party insurers must be submitted with the original claim form. Include pages with run dates, coding explanation and messages.

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

Incomplete Forms – All required information must be included on the claim forms to ensure prompt and accurate processing. Claim forms missing required information will be rejected back to the provider.

Place of Service Code Missing or Invalid – A valid and appropriate two-digit numeric code must be included on the claim form. Refer to CMS 1500 reference material for a complete list of place of service codes.

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 TIN on file with the Plan.

Provider Identification Number Missing or Invalid – The National Provider Identifier (NPI) is required on all claims. The Plan's assigned individual and group identification numbers are highly recommended to be included on the claim form for the provider of service.

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

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.

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.

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 Plan.

Tax Identification Number (TIN) Missing or Invalid – The Tax I. D. number must be present and must match the service provider name and payment entity (vendor) on file with the Plan.

Type of Service Code Missing or Invalid – A valid alpha or numeric code must be included on the claim form. Refer to the CMS 1500 reference material for a complete list of type of service codes.

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, a copy of the primary insurer's explanation of benefits (EOB) or applicable documentation must be forwarded along with the claim form.

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

11.2.1 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.

All the same requirements for paper claim filing apply to electronic claim filing.

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

11.2.1.1 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 Emdeon (through direct submission or another clearinghouse/vendor).

Emdeon has the capability to accept electronic data from numerous providers in several standardized EDI formats. Emdeon forwards the accepted information to carriers in an agreed upon format.

11.2.1.2 Contracting with Emdeon and Other Electronic Vendors

Providers without Emdeon EDI capabilities who are interested in electronic claims submission may contact the Emdeon 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.

11.2.1.3 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 Emdeon to initiate electronic submissions to the Plan. Be prepared to inform the vendor of the Plan's electronic payer identification number 76569 (effective for both professional (CM-1500) and facility/ institutional (UB-04) claims for services rendered on or after January 1, 2010).

11.2.2 Specific Data Record Requirements

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

11.2.3 Electronic Claim Flow Description

To send claims electronically to the Plan, all EDI claims must first be forwarded to Emdeon via a direct submission or through another EDI clearinghouse or vendor.

Upon receipt of the transmitted claims, Emdeon validates the submitted information against Emdeon's proprietary specifications and Plan specific requirements. Claims not meeting the requirements are immediately rejected and returned to the sender via an Emdeon error report. The name of this report may vary based on the provider's contract with its intermediate EDI vendor or Emdeon. Emdeon forwards accepted claims to the Plan, and immediately returns an acceptance report to

the sender. The Plan immediately validates claims for Emdeon for provider identification number requirements. Claims not meeting this requirement are rejected and returned to Emdeon. Emdeon 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 Emdeon or other contracted vendors must be reviewed and validated against transmittal records daily.

The Plan 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 the Plan, a denial letter will be forwarded directly to the provider. This letter is sent to the payment address documented in the Plan'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 Emdeon returns acceptance reports directly to the sender, submitted claims not accepted by Emdeon are not transmitted to the Plan.

If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Acceptance (Claim Status) reports, contact the Emdeon Helpdesk at (800) 845-6592 or the EDI Technical Support Hotline at (877) 234-4275, or by e-mail to edi.php@kmhp.com.

11.2.3.1 Invalid Electronic Claim Record Rejections/Denials

All claim records sent to the Plan must first pass Emdeon 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 the Plan. In these cases, the claim must be corrected and resubmitted within the required filing deadline of 1 year from the date of service. It is important providers review the rejection notices (the functional acknowledgements to each transaction set) received from Emdeon in order to identify and resubmit these claims correctly.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

11.2.4 Exclusions

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

Excluded Claim Categories
Claim records requiring supportive documentation or attachments such as COB claims with a primary insurer's EOB
Claim records for corrected billing or resubmissions (For CMS 1500 claims only)
Claim records for medical, administrative or claim appeals
Claim records with service units of more than three numeric digits

Excluded Provider Categories
Providers/practitioners not transmitting through Emdeon or providers/practitioners sending to vendors that are not transmitting through Emdeon
Nonemergent Transportation
Pharmacy (through Emdeon)

IMPORTANT: Requests for reconsideration/adjustments may be submitted by telephone to:
Provider Claims Service Unit (PCSU)
(800) 578-0775

11.2.5 Common Rejections

Invalid Electronic Claim Records – Common Rejections from Emdeon
Claims 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, etc)
Claims with missing or invalid provider numbers
Claims with missing or invalid member numbers

NOTE: Although Emdeon does not reject the Plan’s unique state and local coding under the CPT coding guidelines, other electronic vendors may have difficulty processing unique coding. Contact the EDI Technical Support Group to discuss any limitations you may encounter.

Invalid Electronic Claim Records – Common Rejections from the Plan (EDI Edits within the Claim System)
Claims for providers/practitioners who are not approved for EDI submission including test claims
Claims received with invalid provider numbers

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

11.2.6 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 Emdeon Corporation Help Desk at: (800) 845-6592 or access Emdeon’s web site, www.Emdeon.com .
If you have questions about your claim status (receipt or completion dates) ...	Contact Provider Claims Service Unit (PCSU) at: (800) 578-0775, option 2
If you have questions about claims that are reported on the Remittance Advice ...	Contact Provider Claims Service Unit (PCSU) at: (800) 578-0775, option 2

If you need to know a provider ID number ...	Contact the Plan at: (800) 578-0775, option 2
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 representative in writing at: Passport Advantage Provider Relations 305 West Broadway, 3rd Floor Louisville, KY 40202 or by Fax: (502) 585-6060 or by telephone: (502) 585-7943

11.3 Reimbursement

Passport Advantage will reimburse providers using the payment methodologies used by Medicare for that type of provider, type of service, and date of service. However, Passport Advantage will not pay providers for amounts obtained from the Medicare program through cost settlement processes. In addition, in some instances, Passport Advantage will apply its own claim editing policies to claims. Please refer to your Provider Agreement for reimbursement information specific to your office/ facility.

Passport Advantage will apply Medicare's national and local benefit and coverage policy. However, it will apply its own medical necessity criteria when providing authorization for services requiring prior authorization.

Passport Advantage member benefits are updated each calendar year. Please refer to the member's Evidence of Coverage for a comprehensive listing, available on the Member Center of www.passportadvantage.org.