Passport Advantage
Provider Manual
Section 13.0
Provider Billing Manual

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PASSPORT ADVANTAGE (HMO SNP)

13.0 Provider Billing Manual

The Provider Claims Service Unit (PCSU) receives providers' calls regarding any issues specific to claims. Representatives can also assist providers with questions about policies, procedures, member eligibility and benefits. The PCSU is available 8:00am to 6:00pm Monday through Friday. We are closed on National holidays. Please see Section 1.

13.1 Claims Submission

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.

Primary vs. Secondary Insurance

Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage. Medicare is also the primary payer in certain instances, provided several conditions are met. Please see the CMS web site for more information on the Medicare Secondary Payer (MSP) rules- www.cms.gov

If Passport Advantage is not the primary payer, you must bill the primary payer first. You must include the primary payer's EOB (explanation of Benefits) with the claim. Remaining charges will be reimbursed up to the maximum Passport Advantage allowed amount less the amount paid by the Primary insurance.

Procedures for Claim Submission

Passport Advantage 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.

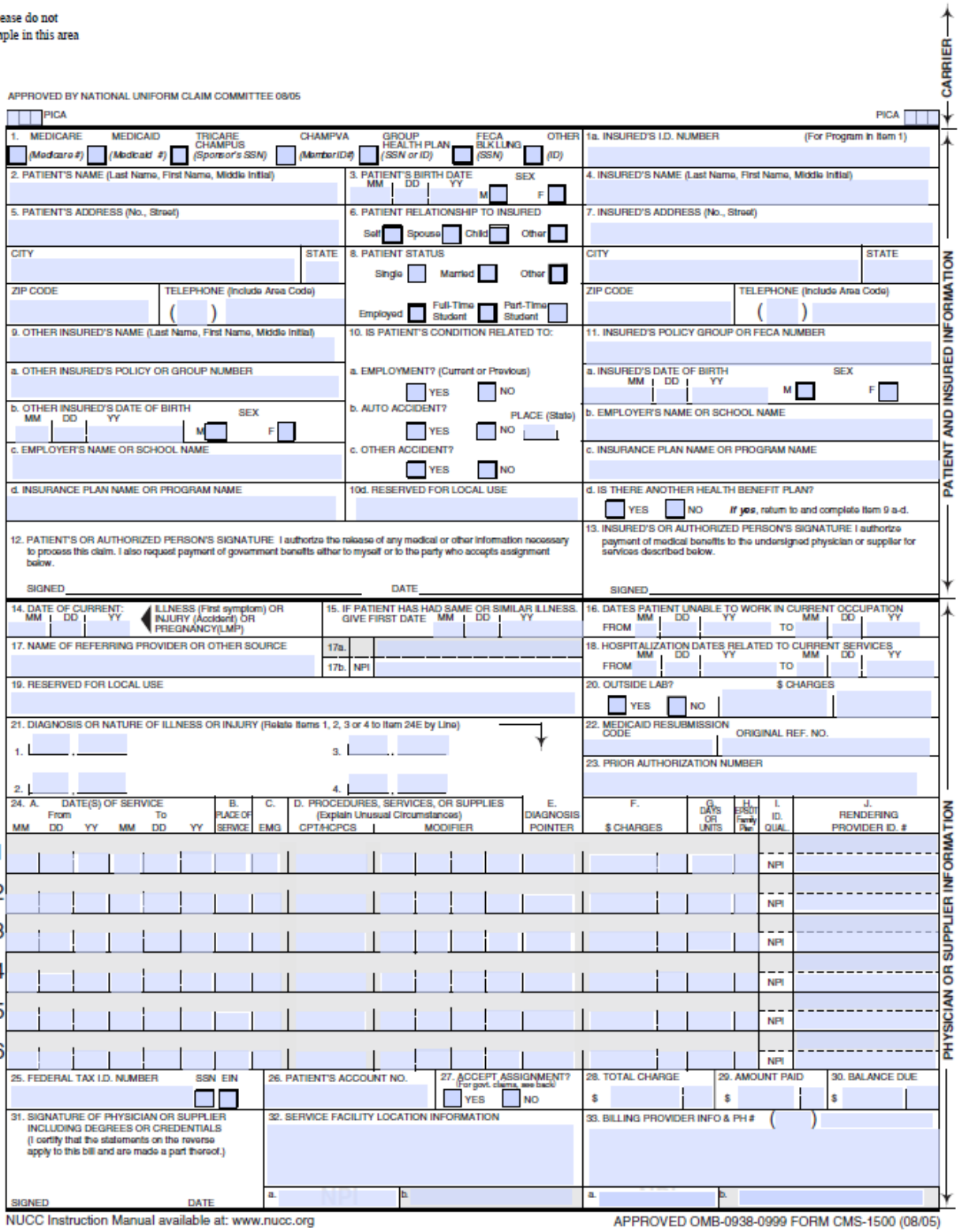
When required data elements are missing or are invalid, claims will be rejected by Passport Advantage for correction and resubmission.

Claims filed with the Passport Advantage are subject to the following procedures:

- Verification that all required fields are completed on the CMS 1500 (please see instructions) 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 Passport Advantage 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 Passport Advantage.
- Verification that an authorization has been given for services that require prior authorization by Passport Advantage.

Paper claims should be submitted to the following address:
Passport Advantage
PO Box 830579

Birmingham AL 35283-0579



Please do not
staple in this area

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH #

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30

31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
														a b

38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
								1
								2
								3
								4
								5
								6
								7
								8
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								17
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								22
	PAGE ____ OF ____	CREATION DATE		TOTALS				23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
							A
						57 OTHER PRV ID	B
							C

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
					A
					B
					C

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
			A
			B
			C

66 DX	67	A	B	C	D	E	F	G	H	65
		I	J	K	L	M	N	O	P	Q

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	QUAL	
							LAST		FIRST	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE		77 OPERATING	NPI	QUAL	
							LAST		FIRST	

80 REMARKS	81CC			78 OTHER	NPI	QUAL	
	a			LAST		FIRST	
	b			79 OTHER	NPI	QUAL	
	c			LAST		FIRST	
	d						

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Passport Advantage 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 Passport Advantage. 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 Emdeon in order to identify and resubmit these claims correctly. Rejected electronic claims can be resubmitted electronically once the error has been corrected.

13.2 Provider/Claim Specific Guidelines

Claim Data Sets Billed by Providers

	CMS 1500	UB-04 (CMS
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	

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

https://passportadvantage.com

13.3 Understanding the Remittance Advice

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 can 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 can be used at the claim or line level. Multiple reason codes can be listed as appropriate.

Remark codes are used on an RA to further explain an adjustment or relay informational messages.

13.4 Denial Reasons and Prevention Practices

Billed Charges Missing or Incomplete
A billed charge amount must be included for each service/procedure/supply on the claim form.
Diagnosis, Procedure or Modifier Codes Invalid or Missing

Coding from the most current coding manuals (ICD-10-CM, CPT 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)
A copy of the EOB from all third party insurers must be submitted with the original claim form if billing via paper. Include pages with run dates, coding explanation and messages.

13.4.1 Incomplete Forms

All required information must be included on the claim form to ensure prompt and accurate processing.
Payer or Other Insurer Information Missing or Incomplete

Include the name, address and policy number for all insurers covering the Passport Advantage member.
Place of Service Code Missing or Invalid

A valid and appropriate two-digit numeric code must be included on the claim form.
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 Advantage.
Provider Identification Number Missing or Invalid

Passport's assigned individual and group identification numbers must be included on the claim form for the provider of service.
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.
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.
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.

13.4.2 Type of Service Code Missing or Invalid

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

Original invoices must be submitted to Passport Advantage 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.

13.4.3 Participating Provider Requests for Reconsideration and/or Refunds

If you would like to discuss claims payments, you can call the Provider Claims Services Unit (PCSU) at (844) 859-6152.

Participating providers may have a dispute with a claim. The dispute must be submitted in writing and received within two (2) years of the last process date and include supporting documentation. Passport Advantage will respond to the dispute within sixty (60) days from the receipt date with a determination or status of the review.

The provider will receive written notification of the outcome of the dispute whether it is upheld or overturned. All upheld determinations will be sent to the provider in a letter with the reason the decision has been upheld. Any disputes overturned by Passport Advantage will be reprocessed and the provider will receive an explanation of benefits (EOB) as notification.

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 (844) 859-6152 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 Advantage 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.

Please see Section 2.8 for non-participating provider appeals.

13.5 Timely Filing Requirements

Original claims must be submitted to Passport Advantage 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 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.

13.5.1 Timely Filing Exceptions

- Submission of claims for members retroactively enrolled in Passport Advantage must be submitted within 180 days from the date of enrollment notification.
- Claims with Explanation of Benefits (EOBs) from primary insurers must be submitted within 60 days of the date of the primary insurer's EOB.

13.6 Corrected Claims and Requests for Reconsideration/Appeals

Reconsideration and/or Adjustments occur when the provider and/or Plan have 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 can call Provider Claims Service Unit (PCSU) at (844) 859-6152 or submit a written request for reconsideration/appeal. Contracted providers does not have appeal rights, however, can submit a provider dispute. The request must be made within two years of the last process date. Non-contracted providers can appeal with a waiver of liability form. Providers appealing on behalf of member can submit their appeal in writing with an authorization of representative (AOR) form.

Corrected Claims should be sent to the following:
Passport Advantage
PO Box 830579
Birmingham AL 35283-0579

Provider Disputes and Reconsideration/Appeals for post service claims should mail to the following:
Passport Advantage
Attn: Appeals Coordinator

5100 Commerce Crossings Drive
Louisville, Kentucky 40229

By Fax: 502-213-8906

Provider Appeals

A provider appeal is a request for review of a Passport Advantage action related to the medical necessity of service provided and the provider has documented and agreed to waive the right to pursue reimbursement from the member. An action is defined as the denial or limited authorization of a requested service, including the type or level of service; reduction, suspension, or termination of a previously-authorized service; failure to provide services in a timely manner; failure to act within specified timeframes; denial of a request to obtain services outside the network for specific reasons. **All appeals must be received in writing.**