PASSPORT News

SUPPORTING OUR PROVIDER PARTNERS THROUGH COMMUNICATION AND COLLABORATION.

Modifications to Behavioral Health Claim Submission Process

From: Passport Health Plan
Sent: October 3, 2014
To: Passport Behavioral Health Providers (non-CMHC)

Background:

Passport Health Plan has recently received clarification from the Kentucky Department of Medicaid Services (DMS) regarding changes for outpatient claims submissions for those under supervision. In addition, in order for our system to accommodate all of the new provider types, we request that you add the correct provider-type modifier to all service codes listed on claims submissions alerting us to the provider type providing the service.

The current designated modifiers by provider type are as follow:

AF = Psychiatrist

AM = Physician

SA = Nurse Practitioner

AH = Licensed Psychologist

U8 = Licensed Psychological Practitioner

AJ = Licensed Clinical Social Worker

HO = Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Licensed Behavioral Analyst (pending CMS approval), Licensed Professional Art Therapist (pending CMS approval)

U4 = Licensed Psychological Associate, Certified Social Worker, Marriage and Family Therapy Associate, Licensed Professional Counselor Associate, Licensed Professional Art Therapist Associate (pending CMS approval), Licensed Behavioral Analyst Associate (pending CMS approval)

U1 = Physician Assistant

HN = Community Support Associate or Non-Bachelors Level Providers

Provider Action Needed:

- NPI, Tax ID, taxonomy, and modifiers are now required on all claims submissions for services provided. The provider information provided on claims submissions must be registered and match the information maintained on the DMS master provider file. Claims submitted without these numbers or information not consistent with the DMS master provider file will be rejected.
- Claims now require use of the NPI number for the billing provider. If the provider is set up as a group, the group NPI will be submitted for the billing provider. If the provider is only set up as an individual and payment will be made directly to them, the provider's personally assigned NPI is submitted for the billing provider.
- Claims now require use of the personally-assigned autonomously functioning provider's NPI number for the rendering provider.
- If a service is provided by a provider under supervision, a group NPI must be submitted for the billing provider.
- If the service is provided by a provider under supervision, the personally-assigned autonomously functioning supervisor's NPI number must be submitted for the rendering provider with the appropriate modifier to indicate the specific provider type of the provider under supervision.
- Modifiers for providers under supervision in the community include:
    - Certified Social Workers=U4
    - Licensed Professional Counselor Associates=U4
    - Marriage and Family Therapy Associates=U4
    - Licensed Psychological Associates=U4
    - Community Support Associate or Non-Bachelors-Level Providers=HN
    - Physician Assistant=U1

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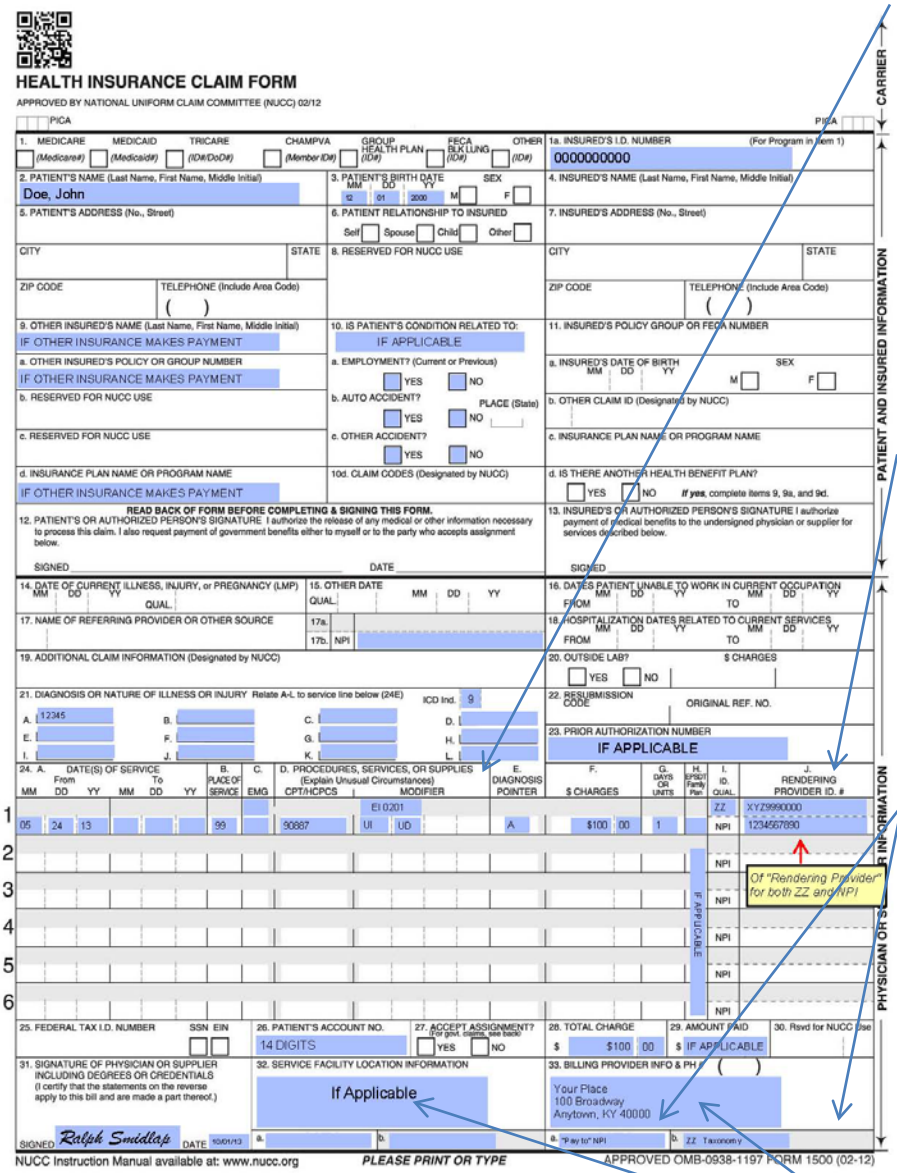

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1): 0000000000
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, John	3. PATIENT'S BIRTH DATE MM DD YY: 12 01 2000 SEX: M
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. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code)	
ZIP CODE / TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): IF OTHER INSURANCE MAKES PAYMENT	10. IS PATIENT'S CONDITION RELATED TO: IF APPLICABLE
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER: IF OTHER INSURANCE MAKES PAYMENT	a. EMPLOYMENT? (Current or Previous) YES / NO
a. INSURED'S DATE OF BIRTH MM DD YY / SEX M / F	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES / NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES / NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME: IF OTHER INSURANCE MAKES PAYMENT	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 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
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE MM DD YY QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9: A. 12345 B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER: IF APPLICABLE

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 05 24 13		99		90887	EI 0201 UI UD	A	$100 00	1		ZZ NPI	XYZ9990000 1234567890
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

IF APPLICABLE

Of "Rendering Provider" for both ZZ and NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.: 14 DIGITS	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES / NO	28. TOTAL CHARGE: $ $100 00
29. AMOUNT PAID: $ IF APPLICABLE	30. Rsvd for NUCC Use		
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 Ralph Smiddap DATE 10/01/13	32. SERVICE FACILITY LOCATION INFORMATION: If Applicable a. b.		33. BILLING PROVIDER INFO & PH #: ( ) Your Place 100 Broadway Anytown, KY 40000 a. "Pay to" NPI b. ZZ Taxonomy

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Please see box 24D on the CMS-1500 Form to indicate the appropriate modifier for the individual rendering the service.

The rendering provider taxonomy and NPI are required in box 24J. For those practicing under supervision, the supervisor is listed as the rendering provider.

The billing provider NPI and taxonomy are included in box 33 on the CMS-1500 form. This will be the group for those under supervision.

The address provided in box 32 and box 33 must include zip code +4 and cannot be a P.O. box.

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To avoid delay or disruption of your claims payment, please share this information with individuals involved with your claims and billing in your organization including billing vendors and/or electronic claims clearinghouses. Please visit our provider website at http://www.passporthealthplan.com to find claim filing instructions, the provider manual, and helpful links.

Questions:

If you have any questions, please contact your Passport Health Plan provider relations representative at PassportBehavioralHealth@passporthealthplan.com or (800) 578-0775.