# Patient Access Network Foundation Medical Claims Webinar

PAN Foundation

*The help you need*

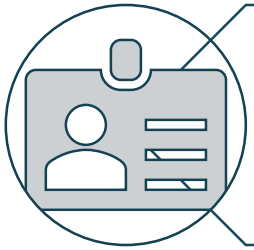
# Meet the Hosts!

**Audrey Quartey**
Senior Manager of Provider Relations

**Joan Zhang**
Manager of Medical Affairs

# Housekeeping Guidelines

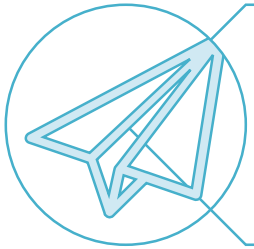
Have questions? Submit them using the questions section!



Our contact information will be available at the end of this presentation.

This webinar is being recorded for future reference and will be shared via email.

# Roadmap



How to submit claims

How to receive payment

How to follow up on denied claims

# Our Mission

# Our Mission and Assistance Programs

**The PAN Foundation is a nonprofit organization dedicated to helping patients with chronic, rare and life-threatening diseases with their out-of-pocket costs.**

| Medication Assistance | Premium Assistance | Travel Assistance |
| --- | --- | --- |
| • Copay<br>• Deductible<br>• Coinsurance | • Health insurance premiums | • Transportation<br>• Ancillary expenses |

# Comprehensive Coverage for Prescription Medications

## PAN Covers

- All prescription medications, including generic or bioequivalent drugs, that are FDA-approved or listed in official compendia or published evidence-based or clinical guidelines

## PAN Does Not Cover

- Medical services, office visits or lab work
- Products not covered by insurance or paid at 100%
- Products billed only to discount cards

# How to Submit Claims

# What to Consider Before Submitting Claims to PAN

PAN is the payor of last resort

Verify that medication and diagnosis are covered

Confirm PAN eligibility

Review grant balance

# Where to Find Diagnosis and Formulary

## Acromegaly

### Get Help with Your Treatment

Apply Online or call **1-866-316-7263**

**Program Status**

Currently Closed

Currently Closed – We are no longer accepting or processing applications for new or renewal patients.

The PAN Foundation's Acromegaly fund is currently closed. As of January 27, 2020, the HealthWell Foundation is accepting applications.

For current information, log in to FundFinder.

**Assistance Amount**

$5,900 per year. Patients may apply for a second grant during their eligibility period subject to availability of funding.

**Eligibility Criteria**

1. The patient must be getting treatment for acromegaly.
2. The patient must have Medicare health insurance that covers his or her qualifying medication or product.
3. The patient's medication or product must be listed on PAN's list of covered medications.
4. The patient's income must fall at or below 500% of the Federal Poverty Level.
5. The patient must reside and receive treatment in the United States or U.S. territories. (U.S. citizenship is not a requirement.)

Calculate Your Federal Poverty Level Percentage Here »

See the list of medications covered in this program View List

Bromocriptine Mesylate (bromocriptine mesylate)
Octreotide Acetate (octreotide acetate)
Sandostatin Lar Depot (octreotide acetate, microspheres)
Somavert (pegvisomant)
Cabergoline (cabergoline)
Parlodel (bromocriptine mesylate)
Signifor Lar (pasireotide pamoate)
Cycloset (bromocriptine mesylate)
Sandostatin (octreotide acetate)
Somatuline Depot (lanreotide acetate)

### Diagnosis Codes:

**ICD-10:** E22.0

# Grant Timeline, Grant Use Policy and Timely Filing

## Grant Timeline

- Grant eligibility period is for 12 months.
- New patients to a disease fund receive a 3-month lookback period.

## Grant Use Policy (GUP)

- Throughout the grant eligibility period, PAN must receive and pay claims every 120 days to keep the grant active.
- If the GUP policy is not followed, the grant is canceled, and the released funds are used to provide grants to other patients who need assistance.

## Timely Filing

- At the end of the grant period, PAN allows 60 days to submit any outstanding claims with dates of services that are within the eligibility period.

# How to Apply for a Second Grant

## To apply for a second grant

1. Check to make sure the disease fund is open at PAN
2. Submit the full amount of the claim for reimbursement.
3. PAN will make a partial payment to zero out the grant balance.
4. Once the grant balance is zero, apply for a second grant.
    - Apply on our provider portal or by calling us
5. PAN will reprocess the partial payment to pay the full amount.

# 3 Different Ways to Submit Claims

Electronic

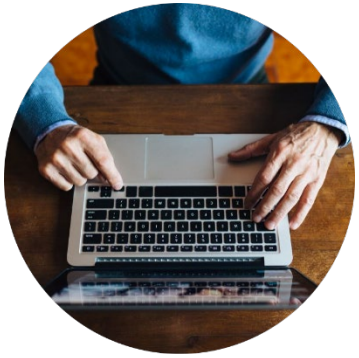
Fax

Mail

# How to Submit Claims Electronically

What you need:

- **Payer ID: 38225** ***(Tied to Trustmark formerly NGS CoreSource)***
- **PAN ID Number**
- **CPT Code**
- **Diagnosis Code**



***Sign up for electronic claim submission through your billing vendor or clearinghouse***

# Benefits of Electronic Claims Submission

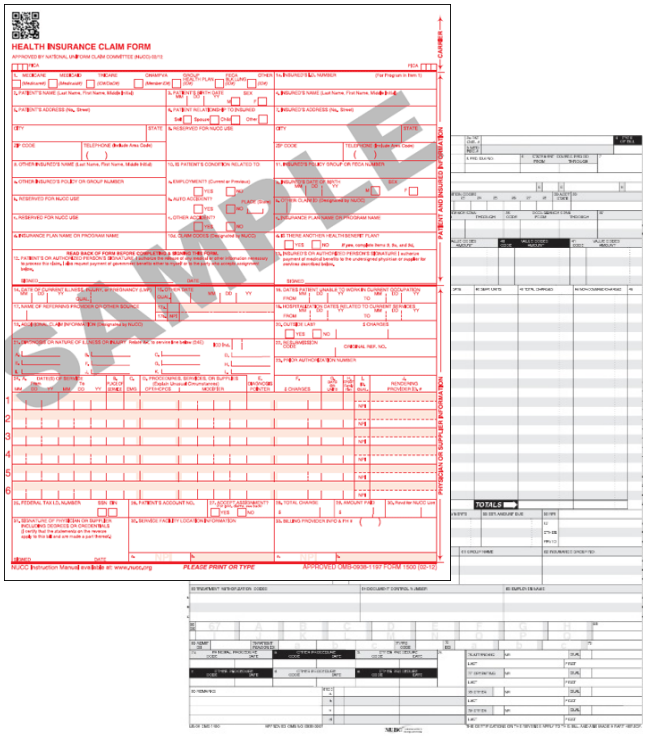
We recommend submitting electronic claims to PAN because it:

- **Ensures clean claims**
- **Fastest mode of claim submission**
- **Reduces turnaround time by 2 business days**
- **Ensures faster payment**

***Sign up for electronic claim submission through your billing vendor or clearinghouse***

# How to Submit Faxed or Mailed Claims

## Gather the following documents:




- **PAN Approval**
  - Billing ID number, Diagnosis and CPT Code
- **Claim Form**
  - CMS 1500 Claim Form
  - UB04 Claim Form
- **Supporting Documentation**
  - Primary Explanation of Benefits (EOB)
  - Secondary EOB (if applicable)
  - W-9 (required if this is the first time your practice is billing PAN)

# Important Fields to Complete on Claim Form

## HEALTH INSURANCE CLAIM FORM

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

PICA

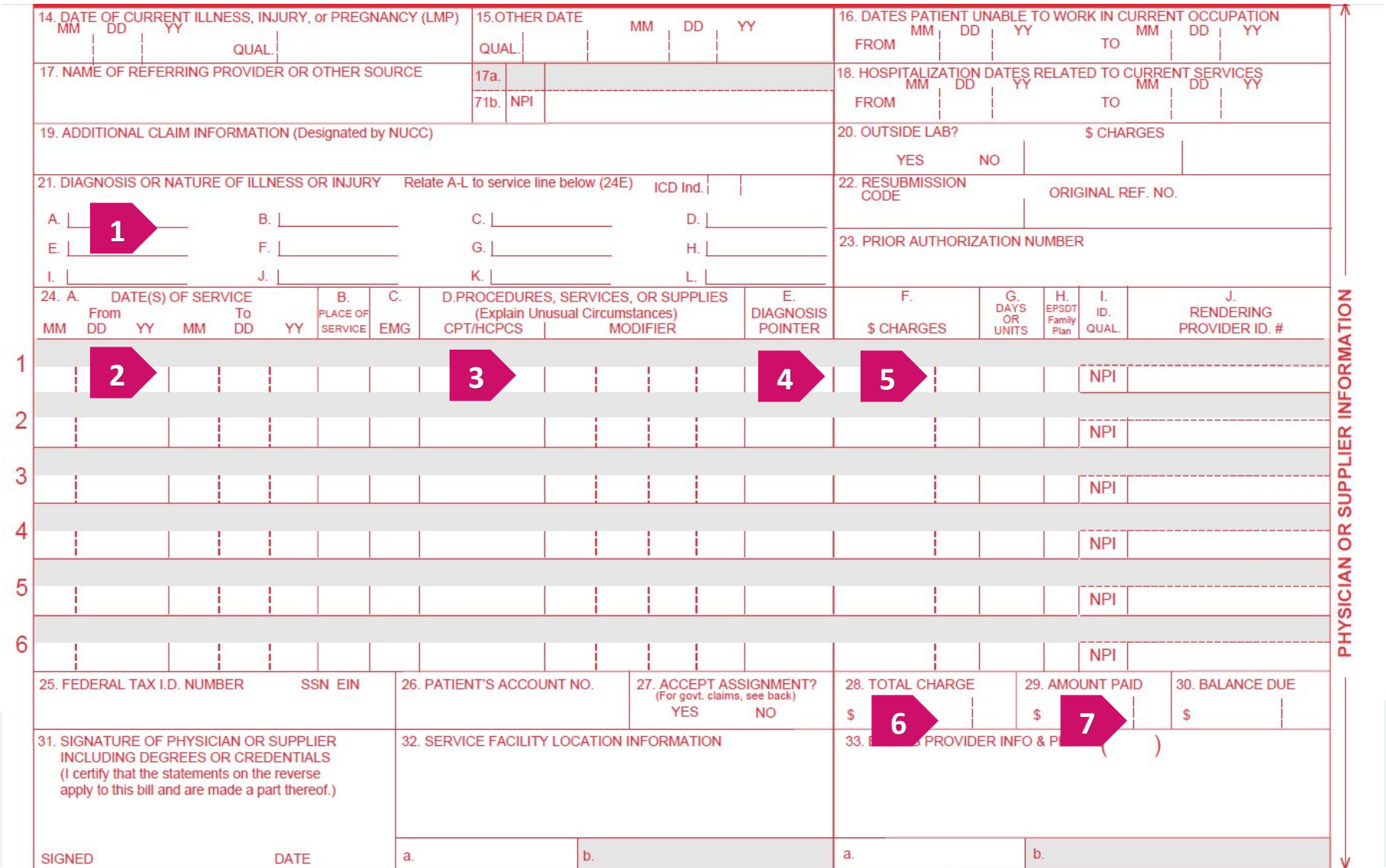
PICA

CARRIER

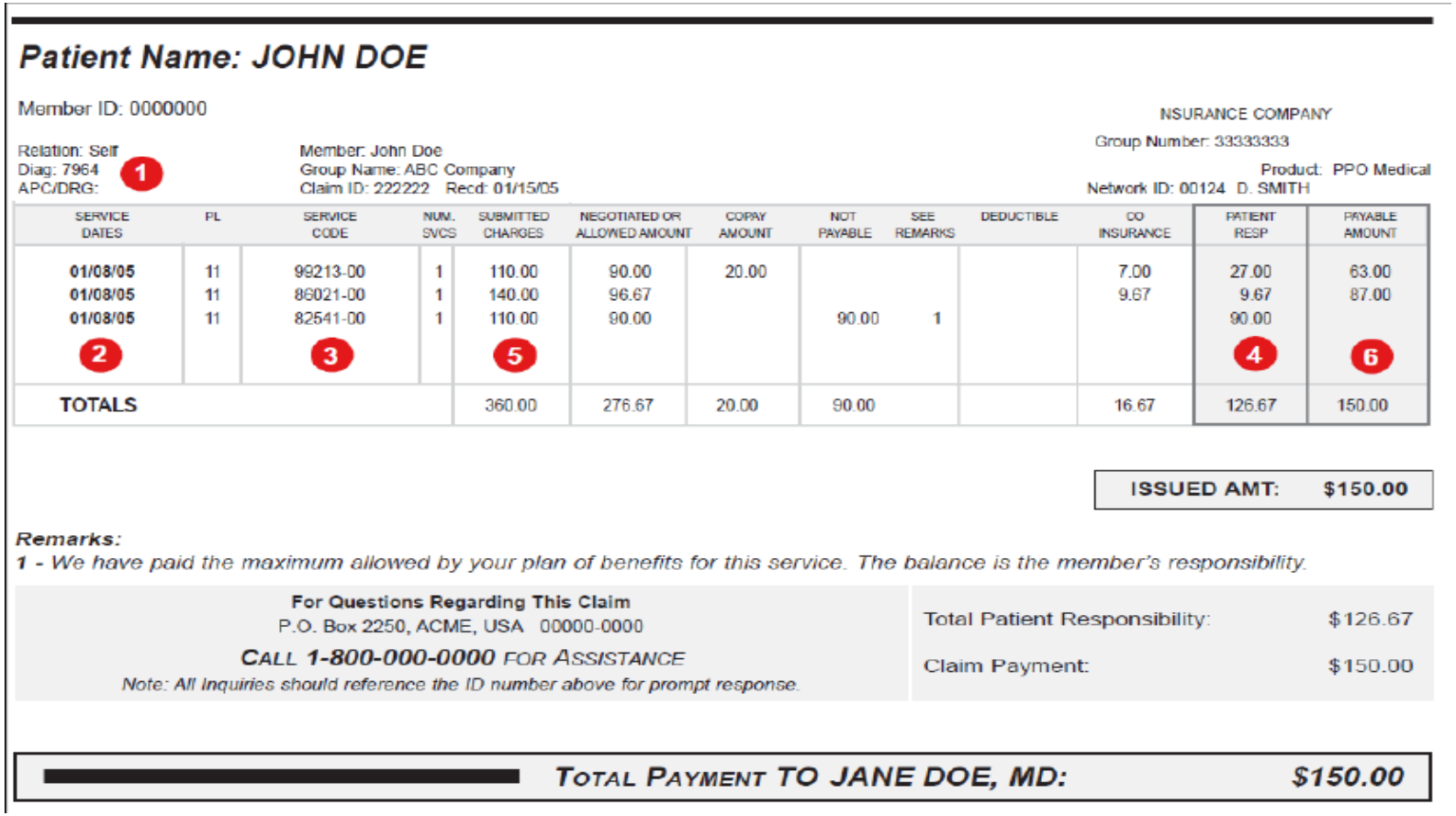
PATIENT AND INSURED INFORMATION

| | | |
|---|---|---|
| 1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) **FOUND ON THE MEMBER'S PAN ID CARD** |
| 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. 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) | 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. 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 | 10d. RESERVED FOR LOCAL USE | 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 |

# Important Fields to Complete on Claim Form (Cont.)



# Add an Explanation of Benefits



**Patient Name: JOHN DOE**

Member ID: 0000000

NSURANCE COMPANY

Group Number: 33333333

Relation: Self
Diag: 7964 (1)
APC/DRG:

Member: John Doe
Group Name: ABC Company
Claim ID: 222222 Recd: 01/15/05

Product: PPO Medical
Network ID: 00124 D. SMITH

| SERVICE DATES | PL | SERVICE CODE | NUM. SVCS | SUBMITTED CHARGES | NEGOTIATED OR ALLOWED AMOUNT | COPAY AMOUNT | NOT PAYABLE | SEE REMARKS | DEDUCTIBLE | CO INSURANCE | PATIENT RESP | PAYABLE AMOUNT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01/08/05 | 11 | 99213-00 | 1 | 110.00 | 90.00 | 20.00 | | | | 7.00 | 27.00 | 63.00 |
| 01/08/05 | 11 | 86021-00 | 1 | 140.00 | 96.67 | | | | | 9.67 | 9.67 | 87.00 |
| 01/08/05 | 11 | 82541-00 | 1 | 110.00 | 90.00 | | 90.00 | 1 | | | 90.00 | |
| (2) | | (3) | | (5) | | | | | | | (4) | (6) |
| TOTALS | | | | 360.00 | 276.67 | 20.00 | 90.00 | | | 16.67 | 126.67 | 150.00 |

**ISSUED AMT: $150.00**

***Remarks:***
***1** - We have paid the maximum allowed by your plan of benefits for this service. The balance is the member's responsibility.*

**For Questions Regarding This Claim**
P.O. Box 2250, ACME, USA 00000-0000

***CALL 1-800-000-0000 FOR ASSISTANCE***
*Note: All inquiries should reference the ID number above for prompt response.*

| | |
|---|---|
| Total Patient Responsibility: | $126.67 |
| Claim Payment: | $150.00 |

***TOTAL PAYMENT TO JANE DOE, MD: $150.00***

# Submit Claims via Fax or Mail

**Fax:** 844-726-4728


**Mail:** PAN Foundation
PO Box 2310
Mt. Clemens, MI 48046

**Portal Upload:** providerportal.panfoundation.org

***All claims are processed within 10 business days***

# Recommendations for Faster Claim Payment

1. **Ensure claims are legible**

   *Illegible claims will be returned to sender*

2. **Use a cover sheet to separate each faxed or mailed claim**

   *Download a copy at www.panfoundation.org or use your own version*

3. **Allow time for follow up. All claims are processed within 10 business days.**

   *To follow up, send secure message on the Provider Portal at www.providerportal.panfoundation.org or call us at 1-866-316-7263*

# How to Receive Payment at PAN

# PAN Offers Multiple Provider Payment Options

**Payments issued through ECHO Health**

- QuicRemit Virtual Credit Card *(default method)*
- ACH *(direct deposit)*
  Email ECHO at EDI@echohealthinc.com for an ACH form
- Paper check

**Contact ECHO Health to switch your payment method at 1-440-835-3511**

# PAN Will Send an EPP Statement to Reconcile Payment

50

**PAN Foundation**
PO Box 2310
Mt. Clemens, MI 48046

PAN Foundation

Questions? Contact us:
Medical: 866-316-7263
Website: http://www.panfoundation.org

PATIENT ACCESS NETWORK FOUNDAT
Group Number NGSPN
Print Date July 31, 2019

***Consolidated Family Explanation of Benefits***
***This is not a Bill***

Page 1 of 2

| Patient's Name Type of Service | Service Date(s) | Billed Charges | Discount Amount | Other Adjust-ments | Other Plan Payment | Patient Responsibility After Payments | | | | Plan Benefit | Plan Paid At | Reason Codes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Ineligible | Co-Pay | Deductible | Co-Ins | | | |
| **Claim #:** **Pat. Acct. #:** **Provider:** **Network: MEDICARE/MEDICAID** **Issued: 7/8/19** | | | | | | | | | | | | |
| INJECTION | 03/01/2019 | 27,947.84 | 20,784.64 | 0.00 | 5,748.48 | 359.82 | 0.00 | 0.00 | 0.00 | 1,054.90 | 100% | /41 ME1 |
| | Totals: | 27,947.84 | 20,784.64 | 0.00 | 5,748.48 | 359.82 | 0.00 | 0.00 | 0.00 | 1,054.90 | | |

**Patient Responsibility**

**Reason Code Descriptions:**
/41 PARTIAL REIMBURSEMENT ISSUED. FUND LIMIT EXHAUSTED
ME1 PROVIDER ACCEPTS MEDICARE ASSIGNMENT.

**www.providerportal.panfoundation.org**
**www.mytrustmarkbenefits.com**

# How to Follow up on Denied Claims

# What to Do if Your Claim is Denied

**Review submitted claim** and denial reason(s)

**Check Billing Guide** for common claim denial steps

**Update claim** and write “corrected claim “ on form

**Resubmit** claim or request a claim review

# Denial Message: Non-Covered Service/Diagnosis

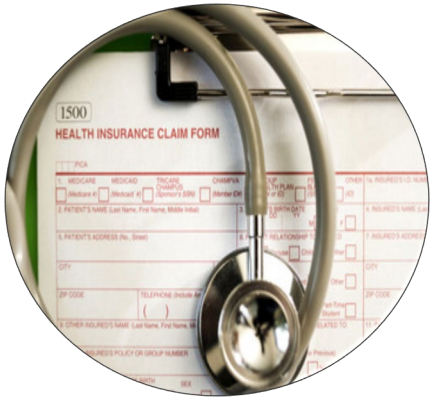
**Reason for Denial:** The DOS, diagnosis code or service code is not covered


**Steps:**

1. *Review Billing Guide section on "Services not covered"*
2. *Verify covered diagnosis code and medication on the PAN website*
3. *If billed incorrectly, correct error and write "corrected claim" and resubmit*
4. *If submitted medication and diagnosis code are covered on PAN website, and DOS is within eligibility period, contact PAN to request a review*

# Denial Message: Secondary Payment Cannot Be Issued

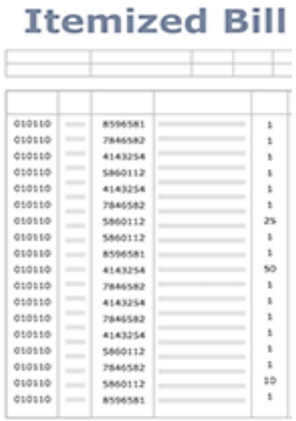
**Reason for Denial:** The Explanation of Benefits was not submitted with a claim form




**Step:** *Resubmit Explanation of Benefits with insurance claim from*

# Denial Message: Itemized Primary EOB Must Be Submitted To Consider Charges

**Reason for Denial:** Explanation of Benefits (EOB) was not itemized; submit itemized EOB




**Steps:**

1. *Contact insurance to obtain an itemized EOB. Write "Corrected Claim" on the claim form before resubmitting*
2. *If an itemized EOB is not available, contact PAN*

# Denial Message: Duplicate Charge Previously Processed

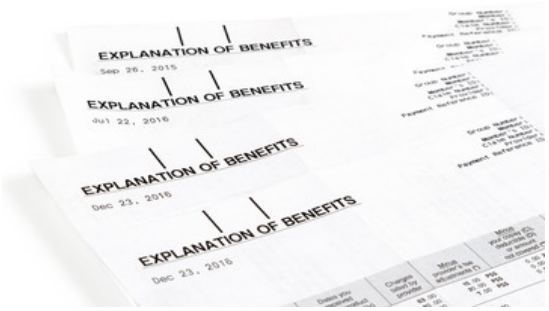
**Reason for Denial:** Claims submitted were previously processed and paid


**Steps:**

1. *Review previously submitted claim to ensure claim was paid*
2. *if initial claim was denied but there is updated information, make the changes and write "Corrected claim" on claim form and resubmit*
3. *If claim was denied in error, contact PAN*

# Denial Message: Resubmit Claim With Copy of The Primary/Secondary EOB

**Reason for Denial:** Both the primary and secondary insurance EOB was not submitted




**Steps:**

1. *Submit claim form and EOBs for patient's primary and secondary insurances*
2. *Write "corrected claim" on the claim form before resubmitting the claim*
3. *If the patient no longer has primary or secondary insurance or one of the insurance does not cover the medication, contact PAN*

# Denial Message: Ineligible Patient, Patient is Responsible For Charges

**Reason for Denial:** Patient's grant was not effective for the date of service billed


**Steps:**

*1. DOS after the eligibility period, check the disease fund status to renew grant*
*2. DOS before the eligibility start date, contact PAN for an exception review*

# Q&A

**Need more assistance?**

**Download our Provider Billing Guide at www.panfoundation.org**

**or contact us at 1-866- 316-7263**


**https://bit.ly/2vNPoOf**

# Thank you for joining us!

*Contact Information*

Audrey Quartey

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