Chapter 4

Provider Billing

Overview

This chapter details general billing and reimbursement procedures that all South Country Health Alliance (SCHA) providers must follow. Refer to the specific service chapter for more detailed information.

Member Eligibility

It is the provider's responsibility to obtain and verify member eligibility. SCHA highly recommends that providers verify member eligibility before rendering service. Providers may verify member eligibility and benefits via the South Country Health Alliance Provider Portal or MN-ITS.

General Billing

SCHA does not assign individual or organizational provider identification numbers. All claims must be submitted using your National Provider Identifier (NPI) or Unique Minnesota Provider Identifier (UMPI).

Minnesota providers are required to submit all claims electronically. Options include using a clearinghouse to submit professional and institutional batch claims via Electronic Data Interchange (EDI) or registering with HealthEC aka MN E-Connect to direct data enter claims. MN E-Connect may be reached at 1-877-444-7194 or https://mneconnect.healthec.com/.

South Country Health Alliance's electronic payer ID is **81600**.

Effective January 1st, 2019, South Country Health Alliance will no longer be accepting paper claims. Any paper claim received will be returned to the provider.

SCHA follows the guidelines outlined by the Administrative Uniformity Committee (AUC) http://www.health.state.mn.us/auc/ and the National Uniform Claim Committee http://www.nucc.org/.

Coding Guides

All providers are required to enter the most appropriate procedural code(s) identifying covered services and the most specific diagnosis code(s) on claims. Providers must use applicable codes and follow the most current guidelines. A non-inclusive list of manuals is noted below:

CPT (HCPCS Level I: Physicians' Current Procedural Terminology) and **HCPCS**

Level II & III (Healthcare Common Procedural Coding System) Available at https://www.optumcoding.com or Level II HCPCS code books may be purchased from a variety of medical book sources or the codes may be downloaded from the CMS Web Site.

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) May be purchased from medical book sources. Files also available for download at Classification of Diseases, Functioning, and Disability.

NDC (National Drug Codes) Review the National Drug Code Directory at http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm, search NDC.

CDT (Current Dental Terminology) Order by calling ADA at 800-947-4746 or at http://www.ada.org/store

HCPCS Modifiers

HCPCS (levels I, II, III) include 2-digit alpha, numeric, and alphanumeric modifiers. Use appropriate modifier(s) to identify:

- A service/procedure altered by a specific circumstance, but not changed in its definition or code
- Rental, lease, purchase, repair or alteration of medical supply
- The origin and destination for medical transportation (1-digit alpha codes).

National Correct Coding Initiative

The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. The Medicaid NCCI program has significant differences from the Medicare NCCI program.

For information about, and edits for, the Medicare NCCI program, visit: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

For information about the Medicaid NCCI Program, visit: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html

The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

Unlisted Codes

Bill unlisted procedure codes only when a specific code is not available to define a service/procedure. When an unlisted code is billed, attach a written description and/or documentation to the claim defining the service/procedure or provide a narrative description on the claim form.

National Drug Code (NDC)

Providers must report NDCs with all non-vaccine drugs billed with a HCPCS code. Claims will be denied that do not contain accurate NDC information. Additional information regarding HCPCS that require an NDC can be found at: https://mn.gov/dhs/partners-and-providers/policies-procedures/minnesota-health-care-programs/provider/types/rx/hcpcs-codes-requiring-ndc.jsp

Claim Status

Providers are encouraged to check the status of their claims electronically through the South Country Health Alliance Provider Portal. Additional claims related questions may be directed to the SCHA Provider Contact Center.

Claim Errors Codes

When a claim is rejected, claim rejection codes and descriptions can be found on our Website under Provider Forms at https://mnscha.org/?page_id=298 and then select Claims. The form name is “Error Codes and Descriptions”

If after reviewing these errors, you still have questions please call the Provider Contact Center at 888-633-4055.

This information is also found on our Provider Portal and can be referenced thru “Forms & Resources” link.Claims Turnaround

SCHA maintains a 30-day turnaround time on all clean claims received. What constitutes a “clean claim” is defined by state and federal law. (See 42 CFR 447.45 and 447.46, and Minnesota Statutes, section 62Q.75).

Timely Filing

In-network providers should refer to their Participation Agreement for requirements concerning the timely submission of claims. Requirements for out-of-network providers are determined by state and federal regulations.

Electronic Claim Attachments

All claims must be submitted electronically, and the Claim Attachment Cover Sheet sent via fax. The steps below explain how to submit claim attachments:

1. Create a unique Attachment Control Number of 50-characters or less.
2. Enter that Attachment Control Number in the paperwork (PWK02) segment in Loop 2300 of the 837.
3. Complete the Attachment Cover Sheet - found at SCHA web page (http://www.mnscha.org/providers_forms.htm) or the AUC’s web site (http://www.health.state.mn.us/auc/forms/index.htm) and print the form.
4. Send a separate Attachment Cover Sheet and Attachment Control Number with each attachment to ensure a proper match to the submitted claim
5. Retain a copy of the Attachment Cover Sheet and all attachments for your records
6. Fax to: (888) 633-4056
7. File claim electronically

Questions regarding the status of submitted claims should be directed to the Provider Contact center.

Remittance Advice (RA)

The purpose of the RA is to report claim activity; it is issued weekly to providers. The RA provides detailed information on how a claim was processed. SCHA recommends retention of Remittance Advice’s according to individual business record retention policies.

Effective January 1st, 2019, SCHA will no longer offer paper remittance advice. Providers interested in receiving the electronic 835 (electronic remittance advice) will need to complete the following form: Electronic Remittance Advice (ERA). Providers can also print copies of claim remittances free of charge from the SCHA provider web portal using your provider login name and password.

In pursuant to section 1128J(d) of the Social Security Act, SCHA's Network Providers are responsible to report to any overpayment received to SCHA. Overpayments must be returned within sixty (60) calendar days after the date on which the overpayment was identified, and to notify SCHA of the reason for the overpayment. Please mail overpayments to:

South Country Health Alliance
Attn: Provider Network
3905 Dakota Street
Alexandria, MN 56038

Electronic Funds Transfer

Providers interested in receiving electronic funds will need to complete the following form: Electronic Funds Transfer (EFT).

Claim Adjustment and Corrected/Replacement Claim

Please use the following criteria to distinguish between a claim adjustment request, or a corrected claim (replacement of previously filed claim):

If resubmitting on a previously denied claim, do not submit the claim as a replacement claim; the corrected claim must be submitted as an original claim.

- Submitting a corrected claim (rebill or replacement claim) with no special instructions:
    - If you are submitting a corrected claim (rebill or replacement claim) where you have changed any information from the original claim and you do not need to communicate any special handling instructions for the resubmitted claim, follow these instructions:
        - Submit a corrected claim when all or a portion of a claim is paid incorrectly (e.g., due to a billing error) or a third-party payment is received after SCHA payment has been made. It is very important to include all lines on the claim, regardless of whether all lines paid incorrectly.
        - To qualify for a replacement, certain identifying information must remain the same. If these values change, the prior claim must be voided, and a new claim must be sent with the appropriate frequency. If these items do not match the claim number referenced, your claim will be rejected. The following information must remain the same on the corrected/replacement claim:
            1. Provider (2010AA Loop)
            2. Patient (2010CA Loop)
            3. Payer (2010BB Loop)
            4. Subscriber (2010BA Loop)
            5. Institutional Statement Period (2300, DTP Segment)

- Corrected or replacement claims must be submitted and received by SCHA within 180 days from the date of incorrect payment. The *Adjustment Request Form* is not needed unless requesting SCHA to recoup a previously submitted claim or need to communicate special handling instructions. Submitting a replacement or voided claim will require you to enter the last known paid claim number in loop 2300, REF, payer claim control number. Failure to do so will result in your claim being rejected.
- Professional (837P) and institutional (837I) replacement claims must have the following fields completed:
    1. The claim frequency type code in CLM05-3 indicates the claim is an original, replacement, or a voided claim. For example, a value of "7" represents a replacement claim and value "8" represents a voided claim. The original SCHA claim number should be entered in Loop 2300, Segment REF, Payer Claim Control Number, when a claim is a replacement or void to a previously adjudicated claim.
    2. If using Office Ally (837P) enter the frequency type of "7" or "8" in Field 22 and the original SCHA claim number.

- Submitting a corrected claim (rebill or replacement claim) with special handling instructions for service dates on/after 1/1/2019:
    - If you need to communicate special handling instructions for the resubmitted claim, you must follow the instructions outlined above under *Electronic Claim Attachments* and include an ***Attachment Cover Sheet***. You will also need to complete and submit the ***Provider Adjustment Request Form*** as the actual attachment with the ***Attachment Cover Sheet*** if it helps explain the reason for resubmission and reduces the possibility of a denial of the resubmission. File the corrected claim electronically.
    - Fax the ***Claim Attachment Cover Sheet*** per instructions and ***Adjustment Request Form*** along with supporting documentation.
- Submitting a replacement or voided claim:
    - If you need to send in a replacement or voided claim for a previously paid claim, change the frequency type for 837P to a "7" to indicate a replacement claim or "8" to indicate a voided claim. For 837I, change the third digit of the bill type to a "7" to indicate a replacement claim or "8" to indicate a voided claim, following the Minnesota AUC best practice documents. Submitting a replacement or voided claim will require you to enter the last known paid claim number in loop 2300, REF, payer claim control number. Failure to do so will result in your claim being rejected.
    - Replacement or voided claims should not be submitted until you have received the remittance advice from the claim you are replacing or voiding. Failure to comply will result in your claim being rejected.
- Submitting a previously unauthorized services claim:
    - If you are requesting an adjustment to a claim that was denied because the service was not authorized at the time and authorization has now been approved,

resubmit the claim as an original claim with the authorization number on the claim

- Skilled Nursing Facility (SNF) claims:
    - If you are requesting an adjustment to a SNF claim that was denied because the communication form was not included or updated, and the communication form is now on file or updated, resubmit the claim as an original claim.
- Submitting an adjustment request (no claim changes):
    - If you are requesting an adjustment to a previously submitted claim that does not require a resubmission of the claim (there are no data changes to the claim) and the above scenarios do not apply, you must complete an ***Provider Adjustment Request Form***. The ***Provider Adjustment Request Form*** must include the SCHA claim number and a description of the adjustment requested.

Claim Appeals

Providers should submit the Provider Appeal Form along with documentation when requesting an appeal of a previously adjudicated claim. Documentation should include such items as a copy of the original claim, remittance notification showing the denial, EDI acceptance reports from your clearinghouse, billing system audit trail and claim follow up as appropriate, clinical records and other documentation that supports the provider's argument for reimbursement.

The Provider Appeal Form along with all supporting documentation must be received by SCHA no later than 90 days from the date of the original remittance advice (RA) for participating providers and 60 days for Non-participating providers.

Pursuant to Federal regulations, a non-participating SCHA provider has 60 calendar days from the remittance notification date to file an appeal for a denied claim. A signed Waiver Of Liability Form holding the member harmless regardless of the outcome of the appeal must be included with the appeal for consideration. Any appeal request received without a signed Waiver Of Liability Form from a non-participating SCHA provider will not be reviewed and the original decision will be upheld.

Coordination of Benefits (COB)

Coordination of benefits is the determination of the primary insurance when two or more health plans cover the same benefits. SCHA requires an Explanation of Payment (EOP) be submitted with a claim in order to coordinate SCHA member benefits. The EOP must be submitted and received within six months of the primary insurance payment or denial date, or within 180 days from the date of service, whichever is greater.

SCHA pays for services after the member has used all other sources of payment. SCHA is the payer of last resort. The order of payers for a SCHA member is:

- Third party payers or primary payers to Medicare (e.g., large and small group health plans, private health plans, group health plans covering the beneficiary with End Stage Renal Disease for the first 18 months, workers compensation law or plan, no-fault or liability insurance policy or plan);
- Medicare;
- SCHA Medical Assistance, MinnesotaCare; and Dual Eligible programs – MSHO – SeniorCare Complete or SNBC - AbilityCare

Medicare Opt-out Option

Providers may choose to opt-out of Medicare (not enroll as a Medicare provider). However, SCHA will not pay for services covered by, but not billed to, Medicare because the provider has chosen not to enroll in Medicare.

Timely Filing- EOP/EOB

When a common carrier is primary, the EOP/EOB from the primary insurance must be submitted and received within six months of the EOP's/EOB's paid date or within 180 days from the date of service; whichever is greater.

Third Party Liability (TPL)

SCHA members may have other health coverage. If a member does not inform a provider of other health coverage, the provider can obtain the information checking eligibility on MN-ITS or contacting SCHA Provider Services at 1- 888-633-4055.

Bill liable third-party payers (including Veteran's Benefits) and receive payment to the fullest extent possible before submitting SCHA claims. Private accident and health care coverage, including HMO coverage held by or on behalf of a SCHA member, is considered primary and must be used according to the rules of the specific plan. A member with more than one level of private benefits must receive care at the highest level available. SCHA will not pay for services that could have been covered by the private payer if the applicable rules of that private plan had been followed.

Unsuccessful TPL Billing

Providers may bill SCHA in cases when three (3) unsuccessful attempts have been made to collect from a third-party payer within 90 days, except where the third party payer has already made payment to the member.

The following information is required for payment to be considered:

1. A copy of the first claim sent to the third-party payer.
2. Documentation of two further billing attempts.
3. Written communication the provider has received from the third-party payer.

SCHA claims must be submitted within 180 days of the date of service to qualify for payment determination.

Member Uncooperative with Third Party Liability (TPL) Billing

If a member fails to complete forms and cooperate in the TPL billing process, contact the SCHA Provider Contact Center at **1-888-633-4055** (toll free) to request assistance.

TPL Partial or Full Payment

When final payment from a third party is for full or partial payment of the charges, a claim must be submitted. Payments from any third party must be indicated on any SCHA claim. Claim submission must include the EOP or any insurance attachments from the third party.

If provider receives payment from the third-party payer after the claim has been finalized with SCHA, send the information with a "Claims Adjustment Form. "

For Child and Teen Checkups, if the primary insurance pays a portion or the full amount of the claim, including the S0302, the provider must continue to coordinate benefits with SCHA. Providers must submit the claim and a copy of the EOB/EOP to SCHA. SCHA will reimburse the provider up to the DHS Global Rate for the completion of a Full Child and Teen Checkup. Providers must bill the S0302 to receive full reimbursement.

Spenddowns, Copays, and Obligations

Providers may bill the *spenddown* amounts to the member and only after providers have received the remittance advice for the service rendered showing the amount of the spenddown.

Providers may bill the *copay* amount to the member before or after providers have received the remittance advice. The copay reference chart may be found on SCHA's website and used to determine copay amounts. https://mnscha.org/wp-content/uploads/4455CopayChart.pdf

Certain members of the Elderly Waiver (EW) program are allowed to keep increased income while remaining eligible for SCHA. This means some EW members will no longer have a medical spenddown. Instead, they will have to pay a portion of their EW service costs through a *waiver obligation*. The payment of the waiver obligation is made to the provider by the member. Only EW services are applied to the obligation. Members may choose the "designated provider" option in order to pay their waiver obligations to one particular provider.

Reimbursement for Covered Services without a fee listed on DHS fee schedule

In-network providers are reimbursed for services without a fee listed on DHS fee schedule according to the terms of their Participation Agreements. SCHA follows DHS methodology which applies a consumer price index back down methodology for codes without a fee listed on the fee schedule.

Reimbursement for Covered Services to Out-of-Network Providers

Out-of-network providers are reimbursed at 100% of the applicable DHS/CMS reimbursement rate and methodology in effect at the time of service. For example, codes without a fee listed on the fee schedule SCHA will follow DHS methodology, which applies a consumer price index back down methodology.

Reimbursement is Payment in Full

A provider must accept SCHA reimbursement as payment in full for covered services provided to a member. A provider may not request or accept payment from a member, a member's relatives, the local human services agency, or any other source, in addition to the amount allowed under SCHA, unless the request is for one of the following:

- Copay
- EW Waiver Obligation
- Insurance payment that was made directly to the recipient. SCHA is liable for the amount payable by SCHA minus the third-party liability amount.

Members Inability to Pay Copay & Deductible

Providers cannot deny service to members eligible for Medical Assistance (Medicaid), based on inability to pay their copays or deductible as long as they inform you that they are unable to pay the copay or deductible.

Providers must continue to accept the member's assertion of inability to pay their copays or deductible.

MinnesotaCare members are exempt from these state and federal laws.

SCHA follows DHS guidelines; please visit the DHS MHCP Billing the Recipient provider manual on how to proceed with these situation.

Non-Covered Services

Providers may bill a member for non-covered services only when SCHA never covers the services, and only if you inform the member before you deliver the services that he/she would be responsible for payment. If SCHA normally covers a service, but the member does not meet coverage criteria at the time of the service, the provider cannot charge the member and cannot accept payment from the member.

Providers should have office procedures in place to prevent misunderstandings about whether you properly informed a member about a non-covered service and the cost of the health service. Providers must have the member sign a statement, indicating the date of service, the non-covered service you will provide, the cost of the services, and any other pertinent information.

The following are acceptable forms of statement for Non-covered services:

Medicare: Advance Beneficiary Notice

Medicaid: Advance Recipient Notice of Non-covered Service/Item (DHS-3640)
Advance Recipient Notice of Non-covered Prescription (DHS-3641)

Billing Members

A SCHA participating provider may bill a member for services if:

- The service is not covered under the member's Member Handbook or Evidence of Coverage (EOC),

  AND

- The provider completed the Advance Beneficiary Notice (ABN) and notified the member in writing prior to providing the service that the member is responsible for the bill.

Under MinnesotaCare, providers may collect applicable co-payment from the member at the time of service.

A non-participating SCHA provider who is a DHS participating provider may bill a member for services if:

- The service is not covered under the member's Member Handbook or Evidence of Coverage (EOC),

  AND

- The provider completed the Advance Beneficiary Notice (ABN) and notified the member in writing prior to providing the service that the member is responsible for the bill.

Non-participating SCHA providers who are also non-participating DHS providers may bill a member for covered or non-covered services. Every effort will be made to contact non-participating providers to avoid billing and/or collection agency activities against a SCHA member. For additional information, see MN Rules, Part 9505.0225, Subpart 3. Non-

participating emergency department providers will be mandated to accept SCHA fee-schedule rates/payments.

Contracted and DHS participating providers cannot deny covered services to an enrollee because of the enrollee's inability to pay the co-payment pursuant to 42 CFR 447.53 and Minnesota Statutes 245D.03, subd. 4(h), for enrollees enrolled in the Medical Assistance program. These state and federal laws do not apply to MinnesotaCare programs.

If a MinnesotaCare member cannot pay the copay at the time of the visit, follow the steps below:

- Inform the member of his or her copay obligation for the services
- Provide services for the current visit
- Inform the members of their debt and give them the opportunity to pay using standard office policies and procedures
- Inform the member of your office policy on serving patients with outstanding debt or unpaid copays
- If it is your standard office policy to refuse services to patients who are unable to pay the copay or have outstanding debt, you may refuse to provide ongoing services because of the member's inability to pay their copay

Claims Auditing and Recovery Program

As required by law, and consistent with sound business practice, SCHA has a program to ensure that it pays only for covered services that have been provided and appropriately billed.

In addition to standard claims processing practices and systems edits, SCHA's efforts include:

- Regular and targeted post-payment claims audits;
- Review of medical records to support claimed services;
- Confirmation with medical providers of services that are related to interpreter or transportation services;
- Obtaining information from government agencies and third-party payers;
- Checking of the Office of Inspector General list of persons and entities excluded from participation from federal health care programs;
- On-site audits of providers facilities; and
- Review of financial and business records related to services provided to SCHA members.

Providers must cooperate with SCHA's audit or investigation consistent with their contract language and with SCHA and applicable laws.

When SCHA determines an overpayment has been made, steps will take place to recover the overpayment. Except for billing errors that have nominal financial impact, providers will be sent a prior notice of monetary recovery. The notice should include sufficient detail that the provider can review to ensure accuracy.

Upon completion of an audit or investigation, SCHA may determine that the provider engaged in abusive or fraudulent billing. Examples of abusive and fraudulent billing include:

- Repeatedly submitting duplicative claims for the same service provided to the same member on the same date;
- Billing for services that were not provided, including future dates of service;
- Billing services at a different level or intensity than that actually provided;
- Billing for medically unnecessary services;
- Using diagnosis codes that are not consistent with medical records;
- Billing certain procedure codes when a global code is more appropriate;
- Billing certain procedure codes in addition to a global code that reflects those procedures;
- Billing for services provided by an individual who is not licensed to provide the service;
- Billing for services not covered by SCHA;
- Failing to follow applicable Minnesota Department of Human Services, Medicare, and standard industry billing guidelines;
- Seeking payment for services that have been, or expect to be, paid by a third party;
- Billing for services that are not reflected in related medical records or for services for which there are no related medical records; and
- Submitting false or fraudulent information in a provider application or in conjunction with seeking authorization for a service.

If SCHA determines that a provider has engaged in abusive billing, overpayments will be recovered and SCHA may take additional action, including but not limited to:

- Making a report to a regulatory agency or licensing board;
- Terminating or suspending the provider's participation and/or contract; Suspending claims for prospective payment review
- Imposing corrective actions or suspending payment for a specified period of time.

In rare cases, SCHA may determine that a provider has committed fraud, which means the provider knew, or reasonably should have known, that a statement or claim submitted to SCHA was false. In cases of fraud, SCHA may impose any of the above-mentioned sanctions, but may also contact the relevant law enforcement agencies.

Provider Updates

If you make any changes to your facility data, you must notify SCHA in writing no less than 30 days before the change by completing the Facility/Change Update form or the Facility Location Add/Remove Form. The forms can be found under the Forms section of the Providers tab at https://mnscha.org/. This critical deadline applies to all facilities, providers, and practitioners.

Changes include, but are not limited to: a new address, the addition of health care professional staff, a new tax identification number, an affiliation change, or a new site.

Sending this information in a timely manner helps prevent payment delays and ensure that records with SCHA are accurate.