Chapter 4

Provider Billing

For Specific COVID-19 Billing Information and requirements, please go to South Country Provider COVID-19 Resources and Information section on our website.

Overview

This chapter details general billing and reimbursement procedures that all South Country Health Alliance (South Country) 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. South Country 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

South Country 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). If you have any questions with information in the Provider Billing chapter, please direct them to the South Country Provider Contact Center at 1-888-633-4055.

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/. Further questions regarding clearinghouses should be directed to South Country's Provider Contact Center at 1-888-633-4055.

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

Claims Address to be used on electronic medical claims:

South Country Health Alliance
6380 West Frontage Road
Medford, MN 55049

South Country will not accept paper claims. Any paper claim received will be shredded and disposed of. See South Country Provider Claims resources webpage for general information on South Country's guidelines of electronic Claim Submission and other helpful resources.

South Country follows the guidelines outlined by the Administrative Uniformity Committee (AUC) Minnesota Administrative Uniformity Committee and the National Uniform Claim Committee National Uniform Claim Committee.

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 website.

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.

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

Providers are to bill unlisted procedure codes only when a specific code is not available to define a service/procedure. When an unlisted code is billed, a detailed description must be included in the charge line description field of the 837 transaction file for the specific unlisted code defining the service/procedure.

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 South Country Provider Contact Center at 1-888-633-4055.

Claim Rejections

After submitting a claim, your vendor or clearinghouse should be returning two levels of rejection reports to track progress of electronic claim submissions:

1. Clearinghouse level: Claims rejected on a clearinghouse level never reach the payer but are returned to you from the clearinghouse for correction and electronic resubmission.

2. Payer level: Claims rejected by South Country do not enter our claim processing systems for adjudication. These claims will be returned electronically on a 277CA (claims acknowledgement) clearinghouse rejection report with instructions on what to correct and subsequently resubmit the claim for adjudication. The claim will also be displayed on South Country's provider portal with a claim number ending in either "I" or "P".

A rejected claim is not the same as a denied claim. A denied claim has been accepted by South Country and adjudicated, while a rejected claim is not accepted and does not enter South Country's claim payment system. If a claim has been rejected for any reason, it must be corrected and resubmitted electronically for acceptance into South Country's processing system for adjudication. Our provider contact center at 1-888-633-4055 can assist with EDI issues and finding claims that may have been rejected by South Country, not those rejected by a clearinghouse.

Finding, correcting, and resubmitting rejected claims is important to avoid timely filing delays or denials, as these rejected claims are not received into our claims system for processing and will not comply with timely filing requirements. If you are not receiving electronic claim reports, contact your vendor or clearinghouse.

South Country claim error/rejection codes and descriptions can be found on our website under Provider Forms at South Country Provider Forms and select Claims. This information is also found on the South Country Provider Portal under "Forms & Resources". If after reviewing these errors and you have additional questions, please call the Provider Contact Center at 1-888-633-4055.

Claims Turnaround

South Country 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

Effective 1/1/2024 claims must be received by South Country no later than 180 days from the date of service. Corrected or replacement claims must be received by South Country within 180 days from the date of the original Remittance Advice (RA). Medicare primary and Third Party Liability (TPL) claims must be received within six (6) months of the primary insurance payment or denial date, or within 180 days from the date of service, whichever is greater.

Non-Contracted Providers

Non-Contracted providers may submit claims to South Country for reimbursement after completing the necessary forms found on South Country Non-Contracted Providers web page. Prior authorization requirements may apply.

Notification of Disruption

Providers shall make every effort to notify South Country at the earliest possibility when they are or know of when they will be experiencing a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Failure to notify South Country may affect compliance with timely filing requirements.

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 (PWK06) segment in Loop 2300 of the 837.
3. Complete the Attachment Cover Sheet under Claims - found at South Country Provider Forms or the Minnesota Administrative Uniformity Committee 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 1-888-633-4056
7. File claim electronically

Questions regarding the status of submitted claims should be directed to the Provider Contact Center at 1-888-633-4055.

Remittance Advice (RA)

The purpose of the RA is to report claim activity; it is issued weekly to providers on the South Country Provider Portal. The RA provides detailed information on how a claim was processed. South Country recommends retention of Remittance Advices according to individual business record retention policies.

South Country does not 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) Authorization Agreement. Providers can also print copies of claim remittances free of charge from the South Country provider web portal using your provider login name and password.

Pursuant to section 1128J(d) of the Social Security Act, South Country's Contracted Providers are responsible to report any overpayment received to South Country. Overpayments must be returned within sixty (60) calendar days after the date on which the overpayment was identified. Please include a description of the overpayment. Please mail overpayments to:

South Country Health Alliance
Attn: Provider Network
3905 Dakota Street
Alexandria, MN 56308

Electronic Funds Transfer

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

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 South Country 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 South Country within 180 days from the date of incorrect payment. The *Adjustment Request Form* is not needed unless requesting South Country 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 South Country 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 South Country claim number.

- Submitting a corrected claim (rebill or replacement claim) with special handling instructions:
    - 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 found under the Claims Tab at South Country Provider Forms
    - You will also need to complete and submit the Provider Adjustment Request form found under the Claims Tab at South Country Provider Forms as the actual attachment with the Attachment Cover Sheet at South Country Provider Forms 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 Claims Attachment Cover sheet per instructions and Adjustment Request Form along with supporting documentation to 1-888-633-4056.
- 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 a Provider Adjustment Request Form found under the Claims Tab at South Country Provider Forms . The Provider Adjustment Request Form must include the South Country claim number and a description of the adjustment requested and may be faxed to 1-888-633-4056.

See South Country Provider Claims resources webpage for general information on South Country's guidelines of electronic Claim Submission and other helpful resources.

Claim Appeals

Providers should submit claim appeals electronically through our Provider Portal along with documentation when requesting an appeal of a previously adjudicated claim. Documentation must include the claim number being appealed and should include when applicable 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 (including but not limited to system issues).

The appeal along with all supporting documentation must be received by South Country no later than 90 days from the date of the original remittance advice (RA) for contracted providers and 60 days for non-contracted providers. Any good cause documentation for late appeal filing should be submitted along with the appeal.

Pursuant to Federal regulations, a non-contracted South Country provider has 60 calendar days from the remittance notification date to file an appeal for an adjudicated 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-contracted South Country provider will not be reviewed and will be dismissed per CMS guidelines.

Coordination of Benefits (COB)

Coordination of benefits is the determination of the primary insurance when two or more health plans cover the same benefits. South Country requires an Explanation of Payment (EOP) be submitted with a claim in order to coordinate South Country member benefits. The EOP must be submitted and received within six (6) months of the primary insurance payment or denial date, or within 180 days from the date of service, whichever is greater.

South Country pays for services after the member has used all other sources of payment. South Country is the payer of last resort. The order of payers for a South Country 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;
- South Country Medical Assistance, MinnesotaCare; and Dual Eligible programs – MSHO – SeniorCare Complete or SNBC - AbilityCare

Primary payer or COB information can be submitted as part of your electronic claims, eliminating the need to submit attachments. If you are submitting this information, you must include the "other payer" paid, and member and provider responsibility amounts, per the Minnesota AUC Companion Guides.

When submitting claims to South Country and South Country is the secondary payer after Medicare, the EDI data must include the Medicare Internal Control Number (ICN). The Medicare ICN is located in the EDI data in Loop 2330B, REF segment "Other Payer Claim Control Number."

When submitting COB claims to South Country, the prior payer's payment information must be included in the 837 claim file sent to South Country to ensure that the claim balances. The only exception to this requirement is when a provider submits the claim to the secondary payer (South Country), knowing that the primary payer does not cover the service. In these instances, the South Country edit requires the COB non-covered amount (AMT02) to be reported, and AMT02 must equal the total claim charge amount (CLM02) included in the 837 claim file.

There are two specific balancing levels that South Country edits for, per the ASC X12 TR3 Guide. The first balancing edit is at the claim level. It determines if the total charges at the claim level equal the prior payer's payment amounts plus all adjustments at the claim and line level. The following is an example of **claim level balancing**. The data in blue shows how the claim level must balance.

Total Claim Amount (CLM02) = sum of the Prior Payer Payment Amounts (AMT02 when AMT01="D") at the claim level (Loop 2320) plus Claim Adjustment Amounts (CAS03) at the claim level (Loop 2320) + Service Level Adjustment Amounts (CAS03) at the service level (Loop 2430).

Claim Level Balancing
CLM*1234567A6*>137***11:B:1*Y*A*Y*Y*P
AMT*D*>47.28
CAS*CO*45**>77.86
CAS*PR*2*11.86
137 = 47.28 + 77.86 + 11.86

The second balancing edit is at the line level. This edit is to verify that each charge line balances with the payment information at the line level. The following is an example of **line level balancing**. The data in red shows how the line level must balance.

Service Level (Loop 2400) Line Item Charge Amount Professional (SV102) or Line Item Charge Amount Institutional (SV203) = the sum of all other payer Service Line Paid Amounts (SVD02) at the service level (Loop 2430) + the sum of all the Service Line Adjustments (CAS03) at the service level (Loop 2430)

Line Level Balancing
SV1*HC:90834*137*UN*1***1:2:3
DTP*472*D8*20130513
SVD*99726*47.28*HC:90834**1
CAS*CO*45*77.86
CAS*PR*2*11.86
137 = 47.28 + 77.86 + 11.86

Medicare Opt-out Option

Providers may choose to opt-out of Medicare (not enroll as a Medicare provider). However, South Country will not pay for services covered by, but not billed to, Medicare because the provider has chosen not to enroll in Medicare. Providers who opted-out of Medicare must refer Medicare eligible members to a Medicare eligible Provider for services.

Timely Filing- EOP/EOB

When a common carrier is primary, the EOP/EOB from the primary insurance must be submitted and received within six (6) 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)

South Country 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, South Country Health Alliance Provider Portal or contacting South Country Provider Contact Center at 1- 888-633-4055.

Bill liable third-party payers (including Veteran's Benefits) and receive payment to the fullest extent possible before submitting South Country claims. Private accident and health care coverage, including HMO coverage held by or on behalf of a South Country 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. South Country 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 will need to submit an appeal for payment to South Country 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.

When submitting the Appeal to South Country please include the following:

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

South Country claims must be submitted within 180 days of the last unsuccessful TPL collection attempt to qualify for payment determination.

Do not appeal to South Country for payment earlier than 100 days after the initial attempt if the unsuccessful billing attempt is for a member that has TPL coverage derived from a parent whose obligation to pay child support is being enforced by DHS.

Member Uncooperative with TPL Billing

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

If payment is received from the third-party payer following South Country's payment, a replacement claim is required with the remittance advice from the primary payer(s).

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 South Country 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 South Country, 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 South Country. Providers must submit the claim and a copy of the EOB/EOP to South Country.

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 South Country's website and used to determine copay amounts. Copay Chart Page Link

Certain members of the Elderly Waiver (EW) program are allowed to keep increased income while remaining eligible for South Country. 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

Contracted providers are reimbursed for services without a fee listed on the DHS fee schedule according to the terms of their Participation Agreements. South Country follows DHS methodology which applies a consumer price index (CPI) back down methodology for codes without a fee listed on the fee schedule.

Reimbursement for Covered Services to Contracted Providers

Contracted providers are reimbursed for services according to the terms of their Participation Agreements. Such reimbursement includes any applicable provider tax, unless otherwise stated in their Participation Agreement.

Reimbursement for Covered Services to Non-Contracted Providers

Non-Contracted providers are reimbursed at 100% of the applicable DHS/CMS reimbursement rate and methodology in effect at the time of service. Such reimbursement includes any applicable provider tax, unless otherwise stated. For example, codes without a fee listed on the fee schedule South Country will follow DHS methodology, which applies a CPI back down methodology.

Reimbursement is Payment in Full

A provider must accept South Country 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 South Country, unless the request is for one of the following:

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

Members Inability to Pay Copay & Deductible

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

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

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

South Country follows DHS guidelines; please visit the DHS MHCP Billing the Recipient provider manual on how to proceed with these situations.

Billing Members

South Country allows providers to request and accept payments from our members for the following limited cost-sharing instances (more details below):

- Copays
- Non-covered Services
- Retroactive eligibility
- EW waiver obligations

South Country does not allow providers to request or accept payments from our members, their families, or others on behalf of the member for any of the following:

- Base rate changes made by South Country (except copays and spenddowns)
- Missed appointments
- The difference between insurance allowed amounts and usual and customary charges (provider contract reductions)
- Services otherwise covered by South Country, unless a copay or cap applies

Non-contracted South Country 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-contracted providers to avoid billing and/or collection agency activities against a South Country member.

Non-contracted emergency department providers are mandated to accept South County fee-schedule rates/payments.

Non-Covered Services

Providers may bill a member for non-covered services only when South Country **never** covers the services, and only if you inform the member **before you deliver the services** that he/she would be responsible for payment, allowing adequate time for the member to make an informed decision. If South Country 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.

You may bill a member for a service only when **all** the following conditions apply:

1. South Country never covers the service or the member does not meet South Country's criteria for the service. A service is considered not covered if:
    - It is never covered by South Country
    - It is being provided by a provider that is non-contracted and a single case agreement has not been established

2. You reviewed with the member:
    - Service limits
    - Reason(s) the service, item or prescription is not covered
    - Available covered alternatives
    - Provider reviewed with member specific codes of services being rendered and the specific cost connected to the services.
3. You inform the member before you deliver the services that the member is responsible for the payment identified in the document
4. You obtain a member signature on the appropriate form (listed below). This Advanced Recipient Notice will remain effective after valid delivery as long as there has been no change in:
    - Care from what is described on the original Advanced Recipient Notice
    - The member's health status which would require a change in the subsequent treatment for the non-covered condition; and/or
    - The South Country coverage guidelines for the services in question (i.e. updates or changes to the policy of a service)

NOTE: If any of the above changes during the course of the service, a new Advanced Recipient Notice must be issued.

For services that are repetitive or continuous in nature, providers should issue another Advanced Recipient Notice to a member after one year for subsequent treatment for the non-covered conditions.

5. You or an authorized health care representative complete the appropriate forms and provider fields as instructed on the form and signs the forms:

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

THE ABOVE PROCESS IS REQUIRED AND MUST BE FOLLOWED. FAILURE TO COMPLY MAY RESULT IN THE PROVIDER BEING RESPONSIBLE FOR APPLICABLE CHARGES.

Non-pharmacy providers must also meet the following conditions:

1. You must request authorization and seek payment from the other insurance or Medicare before you request authorization or payment from South Country or the member.
2. When a service or item requires authorization, request authorization through South Country. If the authorization is denied for other than a billing error or lack of documentation, you may bill the member.
3. You may not request payment from the member for:
    - A service that requires authorization unless authorization was denied as not medically necessary and you have reviewed all other therapeutic alternatives with the member.
    - A service South Country denied for reasons related to billing requirements.
    - Standard shipping or delivery and setup of medical equipment or medical supplies.
    - Services included in the member's long-term care per diem.
    - More than your usual and customary charge for the service or item.

- The difference between what South Country would pay for a less costly alternative service and the upgraded service provided.
- A service when the member is enrolled in the Restricted Recipient Program and the provider is one of the provider types designated for the member's health care services.

4. If South Country makes any payment, you may bill the member only for amounts designated as cost-sharing or EW waiver obligation.

Pharmacy providers should refer to Provider Manual Chapter 21 for additional requirements.

Dental providers may refer to Provider Manual Chapter 20 for additional billing details.

Claims Auditing and Recovery Program

As required by law, and consistent with sound business practice, South Country 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, South Country'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 South Country members.

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

When South Country 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, South Country 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 South Country;
- 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 South Country determines that a provider has engaged in abusive billing, overpayments will be recovered and South Country 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; and
- Imposing corrective actions or suspending payment for a specified period of time.

In rare cases, South Country 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 South Country was false. In cases of fraud, South Country may impose any of the above-mentioned sanctions, but may also contact the relevant law enforcement agencies.

Provider Updates

It is critical that we have correct provider information in our system to ensure claims are processed accurately and timely. This also allows our directories to contain current information about your organization. Provider forms are available at South Country Provider Forms. We request that you use the following forms to notify South Country of any changes: Identify any changes on the Contracted Entity Update Form #5073. If you have added or terminated a location, please use the Contracted Entity Add/Remove Form #5079.

Please notify South Country at least 30 days before the following changes occur:

- Contracted entity/practitioner name
- Contracted entity address
- Billing address/Information
- Contact change for contracting, billing or credentialing
- Ownership
- Tax ID or NPI/UMPI Number
- Addition/removal of a contracted entity or practitioner
- Telephone or fax numbers
- Directory email address
- Website address
- Organization hours of operation
- Accepting new Medicare/Medicaid patients (yes or no)

In the following situations, please submit forms 60-90 days prior to the requested effective date of the change:

- A new site requires organizational assessment
- Ownership changes requiring contracting
- Adding services that are not currently covered under the provider's contract
- Major additions, changes or terminations that apply to a large portion of sites