

# Chapter 4

## Provider Billing

### Overview

This chapter details general billing and reimbursement procedures. Refer to the specific service chapter for more detailed information.

### This chapter includes:

- Billing Members
- Claims Submission
  - 837P (CMS 1500) Claim
  - 837I (CMS 1450/UB-04) Claim
  - Electronic Claims
  - Timely Filing
  - Common Submission Errors
- General Billing
  - Coding Guides
  - HCPCS
  - Urgent Care
  - Emergency Care
  - Unlisted Codes
  - Billing NDC's
  - Hearing Aids
- Provider Reimbursement
  - Claims Payment
  - Reimbursement for Services without a Minnesota DHS or Medicare Rate
  - Claims Adjustments
  - Claim Appeals/Reconsideration
- Coordination of Benefit Issues
  - Coordination of Benefits Claims
  - Timely Filing EOP
  - Third Party Liability (TPL)
    - Definitions:
      - Third Party Payer
      - Third Party Liability (TPL)
      - Unsuccessful Third Party Liability (TPL) Billing
      - TPL Partial or Full Payment
- Durable Medical Equipment (DME)
  - Process
  - Prior Authorization

Rental vs. Purchase  
Replacement  
Repair

- Denial/Termination/Reduction (DTR) of Services Notice
- Non-Covered Services
- Claims Auditing and Recovery Program

## **Billing Members**

A South Country Health Alliance (SCHA) participating provider may balance bill a member for services if:

- The service is not covered under the member's Certificate of Coverage (COC), 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 balance bill a member for services if:

- The service is not covered under the member's Certificate of Coverage (COC), 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 in an effort 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 recipient cannot pay the copay at the time of the visit, follow the steps below:

- Inform the recipient of his or her copay obligation for the services
- Provide services for the current visit

- Inform the recipients of their debt and give them the opportunity to pay using standard office policies and procedures
- Inform the recipient 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 recipient's inability to pay their copay

## **Claim Submission**

Bill **professional** batch claims electronically through approved clearinghouses or through MN E-Connect in the 837P format.

Providers should follow the billing 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/>.

Bill **institutional** batch claims electronically through approved clearinghouses or through MN E-Connect in the 837I format.

Providers should follow the billing guidelines outlined by the Administrative Uniformity Committee (AUC) <http://www.health.state.mn.us/auc/> and the National Uniform Billing Committee <http://www.nubc.org/>.

## **Claim Submission – Electronic Claims**

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 MN E-Connect to direct data enter claims. MN E-Connect may be reached at 1-877-444-7194 or [www.mneconnect.com](http://www.mneconnect.com).

The MMSI electronic payer ID is **41154**.

## **Claim Submission – Timely Filing**

Claims must be submitted correctly and received by MMSI no later than 180 days from the date of service or 180 days from the primary insurance Explanation of Benefits (EOB) whichever is greater.

Replacement claims must be submitted and received by MMSI within 180 days from the date of incorrect payment or within 180 days from the date of service, whichever is greater.

## General Billing

South Country Health Alliance 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).

## Coding Guides

Providers are required to enter the most specific diagnosis code(s) on claims. All providers are required to enter appropriate procedure service codes on claims identifying covered services. 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.

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

**CDT 2016 (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).

## Urgent Care

- Urgent Care Services are defined as services furnished in order to avoid the likely onset of an emergency medical condition. Urgent Care Facilities are defined as a location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
- Urgent Care Facilities may bill with either 837P or 837I format.

## Emergency Care

- Emergency Care Services are defined as services that require immediate attention due to injury or sudden illness.

- Emergency Room Hospitals are defined as a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
- Emergency Room facility charges are billed in 837I format. Professional charges are billed in 837P format.

### **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.

### **Billing with NDC's**

Report NDC's with all non-vaccine drugs billed with a HCPCS code. Claims will be denied that do not contain NDC information. Additional information regarding HCPCS that require an NDC can be found at:

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_147971](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_147971)

### **Hearing Aids**

Include the model number and brand name of the hearing aid on all claim submissions.

Claims for hearing aids not purchased from one of the Minnesota Health Care Programs contracted Hearing Aid Vendors must include a copy of the original manufacturer's invoice to be considered for payment. Invoice must include the purchase price and model number.

### ***Provider Reimbursement***

#### **Claims Payment**

SCHA maintains a 30-day turnaround time on all clean claims received. A clean claim is defined as a claim that has no defect or impropriety, including any lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (42 CFR 447.45 and 447.46, and Minnesota Statutes, section 62Q.75).

SCHA accompanies all payments with a Remittance Advice that outlines billing information submitted and the SCHA claim processing information. Payment/non-payment code explanations are listed at the bottom of each Remittance Advice.

SCHA's Network Providers are to make reports to the SCHA when the Network Providers receive an overpayment, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the SCHA of the reason for the overpayment, pursuant to section 1128J(d) of the Social Security Act.

**Read your Remittance Advice** when received. Address questions to the Provider Service center at 1-800-995-4543, not by resubmission of the claim. SCHA recommends retention of Remittance Advice's according to individual business record retention policies.

THE REVERSE SIDE OF THIS DOCUMENT INCLUDES AN ARTIFICIAL WATERMARK - HOLD AT AN ANGLE TO VIEW

**(Plan Sponsor Name)**  
 4001 41<sup>st</sup> Street NW  
 Rochester, MN 55901-8901  
 Telephone 1-877-285-9920

**No. 00099999**  
12-111 Wells Fargo Bank Minnesota, N.A.  
 999 Rochester, MN

<u>VENDOR NO.</u>	<u>NPI</u>	<u>CHECK DATE</u>	<u>CHECK NO.</u>	<u>AMOUNT</u>
999999999999999	123456789	09/12/11	99999	\$123.45

**1 HUNDRED 23 DOLLARS AND 45 CENTS**

Void 6 months after issue date

TO THE ORDER OF

██  
 VENDOR NAME  
 101 MAIN STREET  
 TEST CITY, MN 99999-9999

MCC983-22R0388      ""0099999"" '-099999999'-999999999""

**R E M I T T A N C E   A D V I C E**

(Plan Sponsor Name)  
 Mayo Clinic Health Solutions  
 4001 41<sup>st</sup> Street NW  
 Rochester, MN 55901-8901  
 Telephone 1-877-285-9920

Date: 09/12/11 Page 1 of 2  
 Vendor ID: 999999999999999  
 Vendor NPI: 123456789

VENDOR NAME  
 101 MAIN STREET  
 TEST CITY, MN 99999-9999

**PROVIDER NUMBER: 999999    NPI:                    PROVIDER NAME: TEST PROVIDER**

Line No.	Service Dates	Service Code	Diag1 DRG	Units	Adj Rsn Codes	Charged NonCov	Allowed Prepaid	Cop/Coi Deduct	COB Discnt	Withhld Interest	Mem Liab PrvLiab	Paid
<b>Member Number</b>		<b>Member Name</b>		<b>Patient Number</b>			<b>Group Number</b>		<b>Claim Number</b>		<b>Network</b>	
99999999901		DOE JOHN		1234567			ABC123		1001010499901		CCN	
001	01/01/04 01/01/04	99212	250.0	1.00	A2	100.00 .00	90.00 .00	9.53 66.18	.00 .00	.00 .00	.00 10.00	14.29
<b>CLAIM TOTALS:</b>						100.00	90.00	9.53	.00	.00	.00	14.29
						.00	.00	66.18	.00	.00	10.00	
<b>Member Number</b>		<b>Member Name</b>		<b>Patient Number</b>			<b>Group Number</b>		<b>Claim Number</b>		<b>Network</b>	
99999999902		DOE JANE		1224456			ABC123		1002050499902			
001	01/31/04 01/31/04	99212	250.0	4.00		99.00 .00	.00 .00	.00 .00	.00 .00	.00 .00	.00 99.00	.00
002	01/31/04 01/31/04	97140-39	719.46 724.2	2.00	A2	45.00 .00	50.00 .00	35.00 .00	.00 .00	.00 .00	.00 5.00	15.00
<b>CLAIM TOTALS:</b>						144.00	50.00	35.00	.00	.00	.00	15.00
<b>PROVIDER TOTALS:</b>						244.00	140.00	44.53	.00	.00	.00	29.29
						.00	.00	66.18	.00	.00	114.00	
<b>VENDOR TOTALS:</b>						244.00	140.00	44.53	.00	.00	.00	29.29
						.00	.00	66.18	.00	.00	114.00	

ASSOCIATED CHECK NUMBER: 99999    PAID DATE: 04/14/04    AMOUNT PAID: 29.29

R E M I T T A N C E   A D V I C E

(Plan Sponsor Name)  
Mayo Clinic Health Solutions  
4001 41<sup>st</sup> Street NW  
Rochester, MN 55901-8901  
Telephone 1-877-285-9920

Date: 09/12/11 Page 2 of 2  
Vendor ID - 9999999999999999

\_\_\_\_\_

|||||  
VENDOR NAME  
101 MAIN STREET  
TEST CITY, MN 99999-9999

PROVIDER NUMBER: 999999      PROVIDER NAME: TEST PROVIDER

Line No.	Service Dates	Service Code	Diagl DRG	Units	Adj Rsn Codes	Charged NonCov	Allowed Prepaid	Cop/Coi Deduct	COB Discnt	Withhld Interest	Mem Liab PrvLiab	Paid
----------	---------------	--------------	-----------	-------	---------------	----------------	-----------------	----------------	------------	------------------	------------------	------

**ADJUSTMENT REASON CODES:**

A2 - Contractual adjustment.  
Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

Processed based on your contractual arrangement with indicated network(s).

A person who submits an application or files a claim with intent to defraud or helps commit fraud is guilty of a crime. If you have concerns about inaccuracy/fraud, please write to the following address:  
Mayo Clinic Health Solutions PO Box 211698 Eagan, MN 55121



## **Reimbursement for Services without a MN DHS or Medicare Rate**

MMSI and SCHA contracted providers will be reimbursed for services without a MN DHS or Medicare rate according to the terms in their participating Provider Agreements. Non-contracted providers will be reimbursed at 40% of billed charges.

### **Electronic Funds Transfer**

Providers interested in receiving electronic funds will need to complete the “Electronic Funds Transfer Authorization” form, located at <https://www.mayoclinichealthsolutions.com>

### **835 Remittance Advices**

Providers interested in receiving the electronic 835 (electronic remittance advice) will need to develop a relationship with Emdeon, ClaimLynx, Rycan Technologies, Inc, or HEALTHEC aka MNeConnect.

Providers can contact Emdeon at [http:// www.emdeon.com](http://www.emdeon.com) or 877-271-0054 if interested in this option.

Providers/organizations interested in receiving ERAs from ClaimLynx should call 1-952-593-LYNX (1-952-593-5969) or visit [www.claimlynx.com](http://www.claimlynx.com).

Providers/organizations interested in receiving ERAs from Rycan Technologies, Inc. should call 1-800-201-3324, or visit [www.rycan.com](http://www.rycan.com).

Providers /organizations interested in receiving ERAs from HEALTHEC aka MNeConnect should call 1-877-444-7194, or follow these steps:

1. Login to HEALTHEC aka MNeConnect portal at [www.mneconnect.com](http://www.mneconnect.com).
2. Click on Billing account admin tab and then click on payer registrations.
3. Under payer registrations, search for MMSI/SCHA.
4. Once the payer name appears, select the ERA check box and save selection by clicking on Save.
5. Once the selection is saved, HEALTHEC aka MNeConnect enrollment department will extract enrollment data and provide access to your ERAs.

### **Electronic Claim Attachments**

The claims must be sent electronically and the attachments sent via fax. How to submit batch claim attachment:

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 Fax Cover Sheet - found at our web page or the AUC's web site - ([http://www.mnscha.org/providers\\_forms.htm](http://www.mnscha.org/providers_forms.htm) or <http://www.health.state.mn.us/auc/attachments.htm>) and print this form.
4. The SCHA Claim Recoupment and Adjustment Fax form ([http://mnscha.org/providers\\_forms.htm](http://mnscha.org/providers_forms.htm)) must accompany the fax cover sheet for adjustments, corrections or replacement claims.
5. Send a separate Fax Cover Sheet and Attachment Control Number with each attachment to ensure a proper match to the submitted claim
6. Retain a copy of the Fax Cover Sheet and all attachments for your records
7. Fax to: (507) 284-9297
8. File claim electronically

Questions regarding the status of submitted claims should be directed to the Provider Service center at 1-800-995-4543.

### **Claim Appeals/Reconsiderations**

Providers should submit the 3535 Claim Reconsideration Form when requesting an appeal/reconsideration of a previously adjudicated claim. The Claim Reconsideration 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 a reconsideration/appeal for a denied Medicare claim. They also must include a signed Waiver Of Liability Form holding the member harmless regardless of the outcome of the reconsideration/appeal. Any Medicare claim appeal/reconsideration 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 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.

#### *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 recipients may have other health coverage. If a recipient does not inform a provider of other health coverage, the provider can obtain the information checking eligibility on MN-ITS or contacting Provider Services at 1-800-995-4543.

Bill liable third party payers (including Veteran's Benefits) and receive payment to the fullest extent possible before submitting SCHA claims to MMSI. Private accident and health care coverage, including HMO coverage held by or on behalf of a SCHA recipient, is considered primary and must be used according to the rules of the specific plan. A recipient 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.

### **Definitions**

Third Party Payer: Any individual, entity, or program, that is or may be liable to pay all or part of the health care costs incurred by recipients, including Medicare, an insurance company, HMO, PPO, Tricare (formerly Champus), Worker's Compensation, and uncontested no-fault automobile insurance.

Third Party Liability (TPL): Payment resources available from both private and public health insurance and other liable third parties that can be applied toward a recipient's health care expenses.

### **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 recipient.

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 to MMSI within 180 days of the date of service to qualify for payment determination.

### **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 submitted to MMSI. Claim submission must include the EOP or any insurance attachments from the third party.

If provider receives payment from the third party payer, send the information with a "Claims Recoupment or Adjustment Form."

**Durable Medical Equipment (DME)** SCHA's processes and procedures related to review and reimbursement of durable medical equipment (DME), orthotics or prosthetics closely mirrors policies established under the Centers for Medicare and Medicaid (CMS). Reference to these policies is found at [www.cms.hhs.gov](http://www.cms.hhs.gov).

### **Prior Authorization**

Refer to the Prior Authorization/Notification Grid for DME and medical supplies that require an authorization.

### **Rental vs. Purchase**

Rental of Durable Medical Equipment will be the general practice. However, if there is evidence the Durable Medical Equipment will be required long enough to justify purchase, reimbursement will be limited to the purchase price. SCHA reserves the right to determine if an item will be approved for rental versus purchase.

### **Capped Rental Items**

- Item is rented primarily on a monthly basis.
- Item is rented through the thirteenth (13) continuous month, at which time the item is considered purchased. No further payments will be made.
- Payment can be made for the purchase of the item even though rental payments may have been made for prior months. This could occur, because of a change in member's condition, the member feels that it would be to member's advantage to purchase the equipment rather than to continue to rent it. Payment will not exceed the total purchase price of the equipment.
- Items that may be included in this category are: insulin pumps, hospital-type bed, wheelchair, continuous airway pressure device (CPAP), and apnea monitoring devices.

### **Replacement**

Durable Medical Equipment that a member owns, is purchasing, or is a capped rental item may be replaced in the event of loss, irreparable damage (due to accident or natural disaster) or irreparable wear (i.e. deterioration due to usage over time, not due to a specific event) or when required because of a change in the member's medical condition. Replacement of equipment due to irreparable wear is not a covered service during the reasonable useful lifetime of the equipment; however repair costs up to the estimated cost of replacement of such equipment may be a covered service. SCHA reserves the right to re-evaluate medical necessity of Durable Medical Equipment associated with a request for replacement of Durable Medical Equipment.

### **Repair**

Separate charges for repair of Durable Medical Equipment are covered services if such equipment is being purchased or is already owned by the member and repair is necessary to make the equipment serviceable. When repair costs exceed the

estimated cost for purchasing or renting the same item for the remaining period of medical need, such excess repair costs are not a covered service. Rental of Durable Medical Equipment while member's own Durable Medical Equipment is being repaired is a covered service.

### **Non-Covered Services**

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

Providers should have office procedures in place to prevent misunderstandings about whether or not you properly informed a recipient about a non-covered service and the cost of the health service. Providers should have the recipient 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.

### **Examples:**

- Herbal products such as ginkgo are never MHCP covered. Thus, pharmacists can charge the recipient for herbal products.
- If a recipient wants brand name Percocet® but does not meet the criteria for getting the brand name product, the pharmacy cannot accept cash from the recipient for Percocet®.

### **Denial/Termination/Reduction (DTR) of Services Notice**

SCHA is required by the Minnesota Department of Human Services (DHS) to issue a Denial/Termination/Reduction (DTR) notice to our Minnesota Health Care Programs (MHCP) members whenever we deny a request for service or claims payment.

SCHA notification format will have the following components:

- The DTR contains a language block to notify our members with limited English proficiency to contact SCHA Customer Service for assistance in translating the information. The front of the DTR document contains the DTR notice in a letter format.
- The document contains information about the type of service and the category of denial specific to the case. The back of the DTR document contains information about the member's appeal rights.

The following is a list of common categories of denials:

- Member not eligible
- No authorization
- Non-covered service
- Not medically necessary.

If you are the billing provider for one of these denied services, you will receive notice of the denial through your Explanation of Payment (EOP). Our Provider Service center is available to answer your questions about this process. Our representatives can be reached at 1-800-995-4543.

### **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 Information Update Forms**

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. The form can be found under Forms on 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.