







# Claims Information

# Claims Information Index

- ❖ How to Submit a Claim to HealthPartners
  - Electronic Claims Submission
  - CMS 1500 Claims Submission
  - UB04 Claims Submission
  - National Provider Identifier
  - Timely Filing of Claims
  - COB – Coordination of Benefits
  - Present on Admission Indicators
  - HealthPartners Remittance Advice and Template
  
- ❖ Commonly Used Forms
  - [Claim Adjustment & Appeal Requests - online](#)
  - [Claim Adjustment Request - Fax Sheet](#) 
  - [Claim Appeal Form - Fax Sheet](#) 
  - [Claim Attachment Submissions - online](#)
  - [Claim Attachment Fax Form - Dental](#) 
  - [Claim Attachment Fax Form - Medical](#) 
  
- ❖ Prompt Payment of Clean Claims
  
- ❖ Medical Cost Management
  - CodeReview®
  - HealthPartners CodeReview® Edit Categories
  - Coding Appeals
  - Appeal Acceptance / Provider
  - Casting Supplies
  - Global Obstetric Package
  - Surgery
    - Assistant Surgery Services
    - Bilateral Billing Guidelines
    - Global Surgical Follow Up Care
    - Multiple Surgery
    - Surgical Trays
  
- ❖ Additional Claims Policies (Alphabetical Listing)
  - Interpreter Services
  - MinnesotaCare Tax
  - Newborn Payment
  - Reporting Suspicions of Fraud and Abuse

## **Subject: Electronic Claims Submission**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners offers many electronic capabilities for our providers.

### **ADMINISTRATIVE PROCESS:**

Minnesota Statute, section 62J.536 requires all health care providers to submit health care claims electronically, including secondary claims, using a standard format effective July 15, 2009.

The law applies to all health care providers that provide services for a fee in Minnesota and who are otherwise eligible for reimbursement under Minnesota Medical Assistance (Medicaid).

Please review the FAQ article on the MDH website for more information regarding applicability of the statute at [www.health.state.mn.us/asa/faq62j536.pdf](http://www.health.state.mn.us/asa/faq62j536.pdf)

For additional information, please visit [www.healthpartners.com/electronicconnectivity](http://www.healthpartners.com/electronicconnectivity)

The entire law is available online at the Minnesota Department of Health (MDH) web site: [www.health.state.mn.us/asa/index.html](http://www.health.state.mn.us/asa/index.html).

HealthPartners offers electronic capabilities for our providers in the following areas:

- Electronic Claims Submission
- Electronic Remittance Advice
- Electronic Eligibility Inquiry
- Electronic Claims Inquiry
- On-line Member Eligibility and Co-Payment Information
- On-line Claim Status Inquiry
- On-line Referral Entry and Inquiry
- On-line Provider Reference Information

Please contact your provider representative at HealthPartners for more details or visit: [www.HealthPartners.com/ElectronicConnectivity](http://www.HealthPartners.com/ElectronicConnectivity).

## **Subject: CMS 1500 Claims Submission**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners follows guidelines outlined in the Minnesota Companion Guides and in the NUCC 1500 manual for submission of claims. The Minnesota Companion Guides can be accessed at [www.health.state.mn.us/auc](http://www.health.state.mn.us/auc). The National Uniform Claim Committee website can be accessed at [www.nucc.org](http://www.nucc.org).

## **Subject: UB04 Claims Submission**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners follows guidelines outlined in the Minnesota Companion Guides and in the NUBC UB04 manual for submission of claims. The Minnesota Companion Guides can be accessed at [www.health.state.mn.us/auc](http://www.health.state.mn.us/auc). The National Uniform Billing Committee website can be accessed at [www.nubc.org](http://www.nubc.org).

## **Subject: National Provider Identification Number (NPI)**

**Effective: May 2009**

**Last Updated: May 2009**

**Reviewed: August 2009**

### **EXPLANATION:**

The attending physician's NPI should be submitted in form locator 76 and any other physician's NPI should be submitted in form locator 77-79

## **Subject: Timely Filing of Claims**

**Effective: January 2000**  
**Last Updated: April 2003**  
**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners contracted providers must submit claims within ninety (90) days of the date of service.

### **ADMINISTRATIVE PROCESS:**

HealthPartners contracted providers have language in their contracts that state as a condition of payment, they must submit all claims for services, other than claims pended for coordination of benefits, to HPI or its Affiliate within ninety (90) days of the date of service. Claims requiring coordination of benefits shall be submitted within sixty (60) days of determining HPI's or its Affiliates' obligation to make payment. In HealthPartners' appeal guidelines, a provider has 60 days from the remit date of the original timely filing denial to submit an appeal. If the appeal is received after the 60 days, a letter will be sent to the provider stating the appeal was not accepted.

## **Subject: COB – Coordination of Benefits**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners follows guidelines for Coordination of Benefits that are outlined in the Minnesota Companion Guides. The Minnesota Companion Guides can be accessed at [www.health.state.mn.us/auc](http://www.health.state.mn.us/auc).

## **Subject: Present on Admission Indicators**

**Effective: January 1, 2009**

**Last Updated: November 2008**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners requires acute care hospitals that are contracted under a DRG methodology to submit a Present on Admission (POA) indicator for all claims involving inpatient admissions. This policy is effective with admissions on or after January 1, 2009.

### **ADMINISTRATIVE PROCESS:**

POA values and submission requirements should follow NUBC billing guidelines.

## **Subject: Remittance Advice**

**Effective: February 2005**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION**

See next page for sample remittance.

For more information on HIPAA Remittance codes visit <http://www.wpc-edi.com>.

HEALTHPARTNERS (A)  
 8170 33<sup>RD</sup> AVE S  
 PO Box 1289  
 Minneapolis, MN 554401289  
 CONTACT: (B)  
 952) 967-6633 or 1-866-429-1474  
 PAYER ID: (B2)  
 SUPPLEMENTAL ID: (BANK) (aa)

PAYEE: PROVIDER ORG NAME (C)  
 ADDRESS 1  
 ADDRESS 2  
 CITY, MN 12345-1234  
 PAYEE TAX ID: (D) 123456789  
 PAYEE NPI: (E) 1234567890  
 PAYEE ID (E1) V12345678900001

PROD DATE: (G) 01312009  
 CHECK/EFT DT (H) 02012009  
 CHECK/EFT : (I) 123456789  
 PAYMENT: (J) 12345678.90  
 PAYMENT METHOD: (J1) (ACH, CHK, NON)

GRP: (K1) 12345 PAT CTRL #: (K) XXXXX CLM #: (M) 12345678901 DRG: (N) CLM CHG: (O) 200.00  
 PATIENT: (U) DOEABCDEFGH, JOHN S MED REC #: (P) 1234567890 CLM DT (R) 01012009 - 01012009 DRG WGHT: (S) CLM PAYMENT (T) 190.00  
 PATIENT ID: (W) 123456789 CLM STATUS: (L) 1 PAID PRIMARY PRIORITY PAYER (Q) BILLING PROVIDER: (ee) PAT RESP: (V) 10.00  
 INSURED: (W1) ORG REF NBR: 123456789 (W5) PRV LIAB (hh)  
 INSURED ID: (W2) CLM FILING IND: (W3) BILL TYPE: (W4) OTHER LIAB (ii)  
 REND PROV ID: (bb) 1234567890 PMI (cc) 123456789 CONTRACT: (dd) PLEASE SUBMIT CLAIM TO CIGNA MNTAX (ff)  
 REMARK CODES: CLM ADJ AMT (GRP CD/CLM ADJ RSN CD): WITHHOLD (gg)  
 (Y) (Z.1(Z.2/Z.3)) COVERED: (f1)

LINE #/CTRL #	DOS	REV	ADJUDICATED PROD/SVC/MOD	SUBMITTED PROD/SVC/MOD	CHARGE	#	APC	ADJ AMT (GRP CD/CLM ADJ RSN CD)	REMARK CODE(S)	REND PROV ID	PAYMENT
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9.1(9.2/9.3))	(10)	(11)	(11)
001	01012009-01012009		C	A	100.00	001		-100.00(CO/94) 10.00(PR/1)	N19 C0213	1234567890	190.00
002	01012009-01012009		C	B	100.00	001		100.00(CO/97)			0.00

PROVIDER ADJUSTMENT(S):

PROV ADJ CD: (12) PROV ADJ ID: (13) PROV ADJ AMT: (14)  
 CS 12849081-81852719 S12345678.90

TOTAL PAYMENT AMT (15) S12345678  
 TOTAL MNTAX (16)  
 TOTAL WITHHOLD (17)  
 =====

(18)

EXPLANATION OF CODE(S):

GRP CD	GROUP CODE DESCRIPTION	ADJ RSN	ADJUSTMENT REASON DESCRIPTION	REMARK CD	REMARK CODE DESCRIPTION
(CO)	provider liability	(125)	xx	[C0213]	xx

(19)  
 Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense.  
 OR  
 FOR REMITTANCE KEY INFORMATION GO TO: www.healthpartners.com/provider

## HealthPartners Paper Remit Field Descriptions:

Element	Field name	Label	Usage	835 element
A	Payer Name and Address,	None	HealthPartners name, address	N102 where N101 = PR and N3, N4
B	Payer contact	CONTACT	HealthPartners contact number(s)	PER
B2	Payer ID	PAYER ID	1 followed by TIN	BPR10 TRN03
'aa'	Supplemental ID	SUPPLEMENTAL ID	Renamed field from BANK to SUPPLEMENTAL ID to match with 835 field name.	BPR11 TRN04
C	Payee Name and Address	PAYEE	Defines the entity to whom payment is directed. Name is pulled from claim application facility record. If HPPFIN is associated to a corporation, line one will be the corporate name and line two will be the facility name.	N102 where N101 = PE and N3, N4
D	Payee Tax ID	PAYEE TAX ID	Federal Tax ID or SSN assigned to payee.	N104 where N103 = FI or REF02 where REF01 = TJ
E	Payee NPI	PAYEE NPI	NPI associated to payee	N104 where N103=XX
E1	PAYEE ID	PAYEE ID	Payer assigned ID -- Payee ID assigned by HealthPartners. ID is a combination of the TIN and HPPFIN. This provides additional identification information critical to vendor balance that is not accommodated by the NPI. A single NPI may have multiple HPPFIN's associated to it.	REF02 where REF01 = PQ
F	Page number		Remittance page number	Na
G	Production End Cycle Date	PROD DATE	The last date HealthPartners adjudicated claims appearing on this remittance advice.	DTM02 where DTM01 = 405
H	Check/EFT Date	CHECK/EFT DT	This is the check issue date or in the case of a non payment remittance this is the date the remittance was generated.	BPR16
I	Check/EFT trace Number	CHECK/EFT	This is the check number or in the case of a non-payment remittance it is the remittance number.	TRN02
J (15)	Payment Amount	PAYMENT	This is the total amount of payment that corresponds to the remittance advice.	BPR02
J1	Payment method	PAYMENT METHOD	Defines if payment was made via check, EFT or no-pay.  Values: CHK, ACH, NON	BRP04
K1	Group or Policy Number	GRP	This is the HealthPartners group number associated to the patient's coverage.	REF02 where REF01 = 1L
K	Patient Control Number	PAT CTRL #	This is the provider assigned identifier submitted on the claim. If identifier was not submitted value will be '0'.	CLP01
L	Claim status	CLM STATUS	Claim status code and narrative.	CLP02

Element	Field name	Label	Usage	835 element
M	Claim Number	CLM #	This is the identifier assigned by HealthPartners that uniquely identifies the claim.	CLP07
N	Diagnosis Related Group Code	DRG	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP11
O	Claim Charge Amount	CLM CHG	This is the total submitted charges for the claim.	CLP03
P	Medical Record Number	MED REC #	This is the provider assigned medical record number that was submitted on the claim.	REF02 where REF01 = EA
Q	Priority Payer	PRIORITY PAYER	This is the name of the payer that has priority over HealthPartners in making payment.	NM103 where NM101 = PR
R	Statement From and To Date	CLAIM DT	This is the service date range that applies to the entire claim.	DTM02 where DTM01 = 232 and 233
S	Diagnosis Related Group Weight	DRG WGHT	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP12
T	Claim Payment Amount	CLM PAYMENT	This is the total amount paid on this claim by HealthPartners. Field will be bolded.	CLP04
U	Patient Name	PATIENT	This is the name that identifies the patient on the claim. Format is last, first middle initial. Field will be in bold. Claims are in alphabetical order by patient name.	NM103,04,05,07 where NM101 = QC
V	Patient Responsibility Amount	PAT RESP	This is the total patient responsibility amount for this claim. Field will be bolded.	CLP05
W	Patient Identifier	PATIENT ID	This is the identifier assigned by HealthPartners that identifies the patient. Field will be in bold.	NM109 where NM101=QC
W1	Insured name	INSURED	Insured/policy holder	NM1*IL
W2	Insured ID	INSURED ID	Insured's member ID	NM109
W3	Claim filing indicator	CLM FILING IND	Coded value, used to identify different product lines within a payer. 16- HMO Medicare Risk 12 - PPO, 15- - indemnity, 14 – EPO HM - HMO.	CLP06
W4	Facility type	BILL TYPE	Populated on institutional claims	CLP08
W5	Original reference number	ORG REF NBR	This number ties adjusted claims to original adjudication.	REF*F8
bb	Rendering provider identifier	REND PROV ID	This is the National Provider Identifier of the provider who performed the service. This will be the NPI value from our dictionary of the rendering provider for the professional and dental claims.	NM109 where NM108=XX Or NM109 where NM108 = PC
cc	Patients Medicaid Identifier	PMI	MEDICAL ASSISTANCE NUMBER	REF 02 where REF01=1W
dd	Contract Code	Contract	The contract that was used between the payer and the provider to determine payment. Populate with CIGNA misdirect message when claim should have been submitted under the CIGNA contract.	REF01 where REF02=CE
ee	BILLING PROVIDER:	BILLING PROVIDER:	Subsidiary provider ID, used when payment is made to other than the billing entity. Vendor type is alternate payee. This is the NPI or TIN of the billing provider.	TS301

Element	Field name	Label	Usage	835 element
Ff	MNTAX	MNTAX	Total MNTax payment amount applied to the claim. The sum of all claim and line level adjustments associated to adjustment reason codes 137	AMT02 where AMT01=T
'f1'	Covered amount	COVERED	This is the amount of charges considered as eligible for coverage.	AMT*AU
gg	Withhold	WITHHOLD	Total withhold amount adjusted from the claim. Sum of claim and line level amounts associated to adjustment reason 104.	na
hh	Provider liability	PRV LIAB	Total provider liability amount applied to the claim other than the MNTAX or withhold amounts. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals CO (excluding adjustment reason codes 137 and 104).	na
li	Other liability	OTHER LIAB	Total other liability amount applied to the claim. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals OA	na
Y	Remark codes	REMARK CODES	<p>This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone or are not associated to a dollar adjustment. Claim can contain up to five claim level remark codes. Available from WPC-edi.com.</p> <p>For Non MN providers' field will contain internal remit remark code. The associated freeform narrative description will be included with remark codes at the end of the remit.</p>	MIA/MOA
Z.1	Claim adjustment amount	CLM ADJ AMT	This is the adjustment amount associated to the adjustment grouping code and reason code. There can be multiple adjustment amounts per claim. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts should equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS

Element	Field name	Label	Usage	835 element
Z.2	Claim Adjustment group code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment. CR Correction and Reversals - Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment. OA Other adjustments PI Payer Initiated Reductions - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments). PR Patient Responsibility	CAS
Z.3	Claim adjustment reason code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount. Narrative values of codes are available at <a href="http://www.wpc-edi.com">www.wpc-edi.com</a>	CAS
1	Line Item control number	LINE CTRL #	Line item identifier submitted by the provider to identify the line or if control number is not submitted than the claim line number	REF02 where REF01 = 6R
2	Dates of Service	DOS	This is the date range of services for each line. Format is MMDDCCYY-MMDDCCYY.	DTM02
3	Revenue Code	REV	Element applies to institutional claims only. This is the revenue code submitted on the claim line. This field will be populated when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in the Adjudicated procedure field. If the claim only referenced an NUBC revenue code than this element is not used.	SVC04 or SVC01-2
4	Adjudicated Product/Service Code/Modifiers	ADJUDICATED PROD/SVC/MOD	This is the adjudicated procedure code and modifiers. Values can be HCPC, Revenue or ADA codes.	SVC01
5	Submitted Product/Service Code/Modifiers	SUBMITTED PROD/SVC/MOD	If the code used for adjudication is different than the submitted value, than the submitted value is contained in this element.	SVC06
6	Provider Charge or Billed Amount	CHARGE	This is the line item charge/billed amount that was submitted on the line.	SVC02
7	Units	#	This is the number of paid units of service.	SVC05
8	APC	APC	Element applies to institutional only. A value is present if adjudication considered the APC.	REF02 where REF01 = 1S
9.1	Claim Adjustment Amount	ADJ AMT	This is the adjustment amount associated to the adjustment grouping code and reason code. There can be multiple adjustment amounts per line. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts should equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS

Element	Field name	Label	Usage	835 element
9.2	Claim Adjustment Grouping Code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment. CR Correction and Reversals - Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of Previous Payment. OA Other adjustments PI Payer Initiated Reductions - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments). PR Patient Responsibility	CAS
9.3	Claim Adjustment Reason Code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount. Narrative values of codes are available at <a href="http://www.wpc-edi.com">www.wpc-edi.com</a>	CAS
10	Remittance Advice Remark Code	REMARK CODE	This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone. Multiple remark codes may apply to a line. Narrative descriptions of the Remittance advice remark codes are available at <a href="http://www.wpc-edi.com">www.wpc-edi.com</a> . If claim line has multiple adjustment reasons the remark code is not in relationship to the adjustment reason across from it but to the line. This is the same relationship as the 835 electronic transmission.  If the facility is outside of MN, we will also supply some legacy codes. These legacy remarks primarily define our National Network utilization.	LQ
11	Payment Amount	PAYMENT	This is the payment amount corresponding to the adjudicated service line. The line item billed amount minus the line item adjustment amounts should equal the line item payment amount.	SVC03
li	Rendering provider ID	REND PROV ID	This is the NPI of the rendering provider if the value is different than the claim level. This will be the NPI value from our dictionary of the rendering provider if it is specific to the line for the professional and dental claims	REF
12	Provider adjustment reason Code	PROV ADJ CD	This is the reason for the provider adjustments that are not specific to a particular claim or service. Multiple adjustments may apply to the payment. Current code(s) in use by HealthPartners: CS – adjustment.	PLB
13	Provider Adjustment Identifier	PROV ADJ ID	ID number assigned by HealthPartners is the original claim/invoice number or the original check/claim number.	PLB

Element	Field name	Label	Usage	835 element
14	Provider Adjustment Amount	PROV ADJ AMT	This is the monetary amount of the adjustment. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	PLB
15	Total payment	TOTAL PAYMENT AMT		na
16	Total mntax amount	TOTAL MNTAX	Total MNTAX payment amount applied to the check for all claims on the remittance. Field will not display if MNTAX did not apply to the remittance.	na
17	Total withhold amount	TOTAL WITHHOLD	Total withhold amount adjusted from check for all claims on the remittance. Field will not display if withhold did not apply to the remittance.	na
18	Explanation of code(s)	EXPLANATION OF CODE(S)	Narrative description of grouping codes, adjustment codes and remark codes contained in remit.	NA
19			Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense. FOR REMITTANCE KEY INFORMATION GO TO: <a href="http://www.healthpartners.com/provider">www.healthpartners.com/provider</a>	

# Commonly Used Forms

Add links to:

Claim Adjustment & Appeal Requests – online

Claim Adjustment Request – Fax Sheet

Claim Appeal Form – Fax Sheet

Claim Attachment Submissions – online

Claim Attachment Fax Form – Dental

Claim Attachment Fax Form - Medical

## **Subject: Adjustment Request Form**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION:**

Claims sent for Adjustment must also be submitted electronically under the new Minnesota Mandates.

HealthPartners follows guidelines for Adjustment Requests outlined in the Minnesota Companion Guides and Best Practices documents. The Minnesota Companion Guides and Best Practices documents can be accessed at [www.health.state.mn.us/auc](http://www.health.state.mn.us/auc)

### **ADMINISTRATIVE PROCESS:**

Adjustment claims must also be submitted electronically under the new Minnesota Mandates.

If additional information is needed to support the submission of an adjusted claim then the NTE segment, PWK segment or Condition Codes should be utilized.

Requests for adjustments without needing a new claim can be submitted through the portal or via the faxable form. These resources can be accessed at [www.healthpartners.com/providers/forms](http://www.healthpartners.com/providers/forms) for providers

## **Subject: Appeal Request Form**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: August 2009**

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### **EXPLANATION:**

Claims appeals must also be submitted electronically under the new Minnesota Mandates.

HealthPartners follows guidelines for Adjustment Requests outlined in the Minnesota Companion Guides and Best Practices documents. The Minnesota Companion Guides and Best Practices documents can be accessed at [www.health.state.mn.us/auc](http://www.health.state.mn.us/auc) or

### **ADMINISTRATIVE PROCESS:**

Requests for adjustments without needing a new claim can be submitted through the portal or via the faxable form. These resources can be accessed at [www.healthpartners.com/providers/forms](http://www.healthpartners.com/providers/forms) for providers

## **Subject: Prompt Payment of Clean Claims**

**Effective: January 2000**

**Last Updated: October 2008**

**Reviewed: August 2009**

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### **EXPLANATION:**

“Prompt Payment of Clean Claims” is a Minnesota law effective for claims submitted on or after January 1, 2001. The law requires health plan companies and third party administrators to pay or deny clean claims within 30 calendar days after the date upon which the claim was received. A clean claim is defined in the law as one “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.” Clean claims that are not paid or denied within the time required are subject to interest. For the full text of this law, check the Minnesota Legislature’s web page at: <http://www.leg.state.mn.us/leg/statutes.htm>. Click on “Retrieve a Section” and enter 62Q.75.

## **ADMINISTRATIVE PROCESS:**

HealthPartners will determine what claims are eligible for interest under the Prompt Payment of Clean Claims law by using the following criteria:

**Received Date:** This is the date HealthPartners receives the claim. For electronic claims, this is the date of EDI file receipt in HealthPartners system. For paper claims, this is the date the claim is received in HealthPartners mailroom.

**Paid Date:** This date is not defined in the law. HealthPartners will calculate using the date of the check plus 3 days for mailing. If you have the postmarked envelope in which the payment was received with a later postmark date, we are willing to accept that as the paid date. If you are consistently experiencing delays beyond the check date plus 3 days, contact your Primary Care Relations and Contracting representative to help resolve the issue.

**Clean Claim:** For a claim to be a clean claim, it must be completed with all necessary data elements, any referrals need to be received by the plan and all needed COB information must be received by the plan. HealthPartners will pay interest for late claims payment (as defined by Minnesota Statute 62Q.75) directly to providers for dates of service beginning January 1, 2003. Providers do not have to submit a bill to HealthPartners for the interest. Interest will be paid for claims with dates of service beginning January 1, 2003. The first check will be issued on a quarterly basis.

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**Note:** HealthPartners will not calculate and pay interest on claims for which the provider is capitated, on payment advances, or on self-insured claims or as otherwise defined in 62Q.75.

**Provider Responsibility**

In order for HealthPartners to pay claims promptly we require that providers:

Submit claims electronically whenever feasible

Submit referral authorizations consistently and timely.3.Attach primary insurer information or an Explanation of Benefits form whenever applicable

Submit complete bills with accurate coding and the correct provider number including NPI.

Reviewed 10/15/2008

# Medical Cost Management

- CodeReview®
- HealthPartners CodeReview® Edit Categories
- Coding Appeals
- Appeal Acceptance / Provider
- Casting Supplies
- Global Obstetric Package
- Surgery
- Assistant Surgery Services
- Bilateral Billing Guidelines
- Global Surgical Follow Up Care
- Multiple Surgery
- Surgical Trays

## **Subject: CodeReview®**

**Effective: January 2000**

**Last Updated: August 2009**

**Reviewed: October 2008**

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### **EXPLANATION:**

HealthPartners uses CodeReview®, a coding software system purchased from an external vendor.

### **ADMINISTRATIVE PROCESS:**

Coding logic is applied to physician and professional claims that include Current Procedural Terminology (CPT) codes and Health Care Financing Administration Coding System (HCPCS) codes. CodeReview® provides consistent, objective claims review by applying the coding criteria outlined in the AMA's CPT-4 manual to all physician services.

The coding software is updated by the vendor in the first quarter of each year. Any new edits generally occur at the end of the first quarter, on or about April 1<sup>st</sup>. Code Review is used in the review of professional claims processed for all HealthPartners products

## HealthPartners CodeReview<sup>®</sup> Edit Categories

EDIT CATEGORY	DESCRIPTION	OUTCOME
<b>Same Day visits</b>	Professional visits [E & M] billed on the same day a surgical procedure is performed.	CodeReview <sup>®</sup> automatically denies same day visits when billed with the allowable surgical procedure. Payment is based on the surgical procedure.
<b>Starred Procedure</b>	CPT identifies certain surgical procedures as 'starred' procedures which indicate the global surgical concept does not apply. CodeReview follows this directive.	N/A
<b>Assistant Surgeon</b>	Surgical procedure in which it is medically necessary to have an assistant assisting the primary surgeon at surgery.	CodeReview automatically denies assistant surgeon charges when the assistant is not medically necessary.
<b>Cosmetic Procedures</b>	Procedures that are generally performed for aesthetic reasons.	These are questioned for Medical Review.
<b>Experimental Procedures</b>	Includes Experimental or unproven procedures.	N/A
<b>Outdated Procedures</b>	Procedures that are no longer in common usage.	N/A
<b>Incidental Procedures</b>	Procedures that may be incidental to or part of the primary global procedure.	N/A
<b>Separate Procedure</b>	Procedures are considered separate by CPT. This indicates the procedure should not be billed with another procedure.	

## HealthPartners CodeReview® Edit Categories

EDIT CATEGORY	EDIT CATEGORY	EDIT CATEGORY
<b>Bilateral Procedures</b>	Codes submitted with a 50 modifier.	CodeReview will question the claim and route to a Medical Review analyst to verify what was actually done.
<b>Replacement codes</b>	Reassignment of the appropriate comprehensive CPT code representing those procedures and/or services billed as performed.	CodeReview automatically replaces and assigns the appropriate CPT code. Payment is based on the replaced code.
<b>Inconsistency of Gender to Procedure</b>	CPT codes that are specific to the patient's gender	CodeReview will generate a questioned claim that is routed to a Medical Review analyst. Medical review will verify the gender of the patient to the procedure being performed.
<b>Inconsistency of Age to Procedure</b>	CPT codes that are specific to the patient's age.	CodeReview will generate a questioned claim that is routed to a Medical Review analyst. Medical review will verify the age of the patient to the procedure being performed.
<b>Relationship of Procedure to place of service</b>	Generally accepted setting where a procedure or service is performed/rendered.	If the place of service submitted is unusual with the procedure being performed CodeReview will question the claim. Medical Review will verify.
<b>Questioned Claim</b>	Those services or procedures in which a review is performed prior to claim adjudication.	All Questioned claims are routed to Medical Review.
<b>Follow up care</b>	Routine follow up visits [E & M] by the surgeon rendered during the established post operative period.	Follow up visits are denied when billed with the surgical procedure with a global follow up period.
<b>Multiple Surgery</b>	Two or more surgical procedures are performed during one operative session by the same physician. Hierarchy is determined by the highest dollar procedure.	Primary procedure is reimbursed at 100% of the fee schedule or billed amount, whichever is less. Secondary, tertiary, etc., are reimbursed at 50% of the fee schedule or billed amount, whichever is less.

## **Subject: Casting Supplies**

**Effective: January 2000**

**Last Updated: July 2003**

**Reviewed: August 2009**

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### **EXPLANATION:**

Casting supplies will be allowed for reimbursement as separately billable charges for initial fracture care and at the time of cast reapplication. An office visit charge is not reimbursable at the time of reapplication.

### **ADMINISTRATIVE PROCESS:**

HealthPartners has adopted the Medicare Part B guidelines for reimbursement of cast supplies.

## **Subject: Global Obstetric Package**

**Number: MCM/O01**

**Approved: MCM**

**Effective date: January 1996**

**Last Updated: July 2004**

**Reviewed: August 2009**

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### **EXPLANATION:**

Global OB package includes all services rendered during the entirety of a patient's uncomplicated pregnancy.

### **Ante-partum care includes:**

Subsequent history

Physical/pelvic examinations

Recording of weight and blood pressures

Fetal heart tones

Routine urinalysis

Supplies and materials generally associated with OB care

Educational supplies and services

**Uncomplicated delivery includes:**

Management of labor  
Cesarean delivery  
Suction of forceps assist of vaginal delivery, with or without episiotomy  
Admission history and physical, hospital visits and discharge  
Induction of labor on the same day of delivery  
Administration of routine anesthesia by the delivering physician  
External and internal fetal monitoring  
Fetal contractions stress tests performed on the day of delivery at the hospital

**Uncomplicated postpartum care/office visits:**

CPT code 59430 should only be used when the physician who performs postpartum care is not the physician who performed the delivery.

Six weeks for vaginal delivery and eight weeks for C-section.

Service includes:

- Pelvic exam
- Suture removal
- Contraceptive management

**Total OB Package**

The initial visit is to be billed separately. The OB package includes all ante-partum care (12 prenatal visits), delivery and postpartum care. All routine urinalysis are included. Any other lab work or procedures can be billed separately. Use the initial visit date and the date of delivery as the "to" and "from" dates of service when submitting the global code.

**COVERAGE:**

Check On Line Benefits for group specific coverage for OB care.

**ADMINISTRATIVE PROCESS:**

Requests for appeal review should include the adjustment request form. Supporting documentation with a copy of the remittance advice showing the last processed date should be included with you request.

**APPLIES TO:**

All products / All providers

## **Subject: Assistant Surgery Services**

**Number: MCM/A02**

**Approved: MCM Steering Committee**

**Effective date: January 1995**

**Last Updated: February 2004**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners' definition of Assistant Surgeon includes MD, RNFAs (RN First Assistants), PAs (Physicians Assistant) and NPs (Nurse Practitioners). HealthPartners follows Medicare guidelines regarding necessity of Assistant Surgeon.

Assistant Surgeon professional services are identified by the following procedure modifiers billed with the surgical CPT code.

80 = Services performed by an MD

81= Minimum Assistant Surgeon

82 = Services performed by a Physician Assistant

AS = Physician Assistant, Nurse Practitioner, or Registered Nurse First Assist for assistant at surgery.

### **COVERAGE:**

HealthPartners will reimburse appropriate Assistant Surgeon services at:

= 20% of the Surgeon's allowed amount

= 16% of the Surgeon's allowed amount

= 20% of the Surgeon's allowed amount

AS = 14% of the Surgeon's allowed amount

### **APPLIES TO:**

All providers / All products

## **Subject: Assistant Surgery Services**

**Effective: January 2000**

**Last Updated: July 2003**

**Reviewed: August 2009**

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### **ADMINISTRATIVE PROCESS:**

Multiple assistant surgeon services will be considered and reviewed for medical necessity.

Claims systems are automated to allow those services appropriate and deny those services not appropriate.

The modifier will automate the correct percentage for pricing.

## **Subject: Bilateral Billing Guidelines**

**Last Updated: September 2009**

**Reviewed: September 2009**

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### **EXPLANATION:**

Generally, Modifier "50" is used to report bilateral diagnostic and surgical procedures. Modifier "50" applies to any procedure performed on both sides during the same session.

HealthPartners prefers bilateral procedures to be reported on one line using modifier "50" with a unit of service of one. If units of service are greater than one, HealthPartners will deny the claim.

However, **HealthPartners will allow a CPT4 code with a bilateral indicator assignment of '1' to be billed on two line items, one with modifier RT and the other with LT. Each line must be billed with a single unit of service. For this particular billing scenario, if modifier 50 is present on either line item, in addition to the RT or LT, HealthPartners will deny the claim.**

### **ADMINISTRATIVE PROCESS:**

Where applicable, HealthPartners would reimburse 150% of the fee schedule amount or billed charges, whichever is less.

**Example - Correct submission:**

69806 with 1 unit of service and modifier 50 (if service is done bilaterally), OR  
69806 LT with 1 unit of service  
69806 RT with 1 unit of service (provided neither line includes modifier 50)

**Example – Incorrect Submission**

69806 billed with 2 units and no modifier, OR  
69806 1 unit  
69806 with modifier 50 + 1 unit, OR  
69806 LT/RT with 2 units

**NOTE:** Use of modifiers applies to services/procedures performed on the same calendar day.

HealthPartners uses the Medicare Physician Fee Schedule Database (MPFSDB) as the basis for determining which CPT codes can be submitted as “bilateral”.

The “Bilateral Surgery Indicator” (Field 22) in the MPFSDB indicates how the bilateral service must be submitted to Medicare.

To access this database, refer to the CMS Web site at:  
<http://www.cms.hhs.gov/apps/pfslookup/step0.asp>.

**Bilateral Surgery Indicators and Claim Submission**

Bilateral Indicator	Definition	Submission Instructions
0	If a CPT4 is not exempt from multiple procedure discounting, then a reduction will occur (100%, 50%, 50% and so on).	It is not appropriate to submit these procedure codes with modifier 50 and to do so will result in a claim denial. If BI is 0 and more than one procedure is performed on the same day, bill two line items with a single unit of service
1	Reimbursement of 150% for bilateral procedure applies	Submit a bilateral procedure on a single detail line with CPT modifier “50” and a quantity of “1.” OR same CPT4 code on two lines, one with modifier LT the other with RT, each line item containing 1 unit of service. However, if modifier 50 is found on either of these lines in addition to the RT/LT modifiers or if the units exceed 1 on either line

		HealthPartners will deny the claim
2	If a CPT4 is not exempt from multiple procedure discounting, then a reduction will occur (100%, 50%, 50% and so on).	It is not appropriate to submit these procedure codes with modifier 50 and to do so will result in a claim denial. If BI is 2 and more than one procedure is performed on the same day, bill two line items with a single unit of service
3	The usual payment adjustment for bilateral procedures does not apply.	Submit the procedure on a single line with a quantity of 2 or on two separate lines with modifiers RT and LT.
9	Bilateral concept does not apply.	It is not appropriate to submit these procedure codes with modifier 50 and to do so will result in a claim denial.

If you have additional questions, please contact your Service Specialist.

**APPLIES TO:**

All contracted providers billing on CMS 1500 format / All products

## **Subject: Global Surgical Follow Up Care**

**Number: MCM/G01**

**Approved: MCM Steering Committee**

**Approved: January 1995**

**Effective date: January 1995**

**Reviewed: August 2009**

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### **EXPLANATION:**

Surgical procedures have a defined "follow up" period. Under this guideline follow up visits performed within the indicated period are considered included as part of the reimbursement for the surgery performed by the same physician/surgeon. HealthPartners follows Medicare surgical follow-up periods.

### **COVERAGE:**

Those visits billed within the follow up period will be denied.

### **ADMINISTRATIVE PROCESS:**

CodeReview<sup>®</sup>/Historical Auditing will deny those visits billed within the global period defined by CPT code. This policy is automated.

### **APPLIES TO:**

All products / All providers

## **Subject: Multiple Surgery**

**Number: MCM/M02**

**Approved: MCM**

**Effective date: July 1993**

**Last Updated: March 1995**

**Reviewed: October 2008 August 2009**

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### **EXPLANATION:**

Allowable multiple surgical procedures are reduced based on highest dollar billed order: 100%, 50%, 50%, 50%, etc., regardless of separate site of multiple incisions.

### **ADMINISTRATIVE PROCESS:**

Allowable secondary, tertiary, etc., surgical procedures will be reduced to allow 50% of the fee schedule or billed amount, whichever is less, regardless of separate site or multiple incisions.

This multiple surgery pricing is automated.

### **APPLIES TO:**

All products / All providers

## **Subject: Surgical Trays**

**Number: MCM/S01**

**Approved: MCM**

**Effective date: June 1994**

**Reviewed: August 2009**

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### **EXPLANATION:**

Surgical supplies are not reimbursable when billed with an allowable procedure.

### **COVERAGE:**

Procedure A4550 is considered to be integral to all surgical procedures listed in the CPT manual, and select medical procedures and radiological exams that require the use of surgical trays and supplies. It is assumed that these procedures will be performed in a hospital, outpatient, or surgicenter setting and that the supplies will be provided by the management of those facilities. When a procedure is performed in a physician's office, hospital surgicenter or outpatient setting, the supplies and materials essential for the performance of the procedure are not considered over and above the basic value of the service being rendered, and additional reimbursement to the physician is not warranted.

### **ADMINISTRATIVE POLICY:**

HCPCS code A4550 Surgical supplies will be denied when billed with a surgical procedure and select medical and radiological procedures.

### **APPLIES TO:**

All products / All providers

# **Additional Claims Policies (Alphabetical Listing)**

- Interpreter Services for HealthPartners Care Members
- MinnesotaCare Tax
- Newborn Payment
- Reporting Suspicions of Fraud and Abuse

## **Subject: Interpreter Services for HealthPartners Care Members (Spoken and Sign Language)**

**Effective: January 2000**

**Last Updated: October 2008**

**Reviewed: August 2009**

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### **EXPLANATION:**

Language interpreter services and sign language interpreter services are covered for members in the HealthPartners Care and Minnesota Senior Health Options (MSHO) plans only.

### **ADMINISTRATIVE PROCESS:**

#### **Coding and Billing:**

Services should be billed on a CMS 1500 form or 837P.

## **Subject: MinnesotaCare Tax**

**Effective: January 2000**

**Last Updated: August 2004**

**Reviewed: August 2009**

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### **EXPLANATION:**

MinnesotaCare allows provider groups to transfer the additional expense generated by MinnesotaCare taxation to third party purchasers, such as HealthPartners

### **ADMINISTRATIVE PROCESS:**

HealthPartners pays the MinnesotaCare Tax to its taxable providers on a claim-by-claim, line-by-line basis.

## **Subject: Newborn Payment**

**Effective: January 2000**

**Last Updated: October 2001**

**Reviewed: August 2009**

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### **EXPLANATION:**

HealthPartners based the Newborn Payment Policy on the following:

- Member choice regarding selection of a physician for obstetrics and pediatrics is important.
- Capitation and expenses for services provided to newborns should be aligned.
- Payment methodologies should be consistent and fair for all medical groups.
- Payment methodologies should be administratively feasible, minimizing risk of inaccurate payment for members and providers.

### **ADMINISTRATIVE PROCESS:**

Newborn expenses will be accrued to the medical group in which he/she was enrolled, back to the date of birth. This policy will apply to all newborns.

## **Subject: Reporting Suspicions of Fraud and Abuse**

**Effective: May 2003**

**Reviewed: August 2009**

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### **EXPLANATION:**

The Fraud Hotline phone number provides members, providers and employer groups the option to report reasonable and good faith suspicions or concerns regarding possible fraudulent claims activity.

The Hotline gives the caller the opportunity to leave a confidential message that will be investigated by the HealthPartners Claims Special Investigations Unit (SIU).

### **ADMINISTRATIVE PROCESS:**

Contact the Claims Fraud Hotline at 952-883-5099 regarding any suspicions or concerns about possible fraudulent claims activity.

You can also call our Member Services number (located on the back of your insurance card) and ask to be transferred to the fraud and abuse hotline. You may remain anonymous.

You may also mail, fax or E-Mail us at:

#### **HealthPartners Special Investigations Unit (SIU)**

Mail route 25110F

P.O. Box 1289

Minneapolis, MN 55440-1289

Fax: 651-265-1333

Email: [reportfraud@healthpartners.com](mailto:reportfraud@healthpartners.com)