CLAIMS INFORMATION

2023 Provider Resource Materials

Claims Information Index

Claims submission – general

HealthPartners contracted providers have language in their contracts stating as a condition of payment that all claims for services must be submitted within a specified period 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.

HealthPartners follows guidelines outlined in the Minnesota Companion Guides and in the NUCC 1500 and NUBC UB04 manual for submission of claims. The Minnesota Companion Guides can be accessed at **health.state.mn.us/facilities/auc.** The National Uniform Claim Committee website can be accessed at **nucc.org**. The National Uniform Billing Committee website can be accessed at **nubc.org**.

For information on electronic capabilities visit: **healthpartners.com/ElectronicConnectivity**.

MNSure Products and Federally Facilitated Marketplace (FFM) Plans in Wisconsin

Apex, Cornerstone, Select ACO, and Peak Plans and Federally Facilitated Marketplace (FFM) Atlas, Robin Select, and Robin Oak Plans in Wisconsin

Advanced Premium Tax Credit (APTC) Grace Period

Members who receive an advanced premium tax credit (APTC) to help with their healthcare premiums are eligible for a grace period of up to three months if they have paid the premium for the first month of coverage. These members are the only HealthPartners members eligible to receive a three-month grace period.

For services provided during month one of grace period:

HealthPartners accepts responsibility and processes claims in a timely manner according to the benefits. HealthPartners claim payment is not dependent on whether or not the member pays the premium.

For services provided during months two and three of grace period:

HealthPartners will pend claims with status code 766: Services were performed during a Health Insurance Exchange (HIX) premium payment grace period.

If the member pays the full premium due before the end of the third month of nonpayment, HealthPartners will process pending claims according to the benefits.

If the member does not pay the full premium due within the required time frame, HealthPartners will deny pending claims and cancel the member retroactively, effective the last day of month one of the grace period. The member is eligible to reenroll at the next open enrollment period.

Non-APTC-eligible members who are responsible for their full premium payment are eligible for a 31-day grace period for nonpayment.

HealthPartners will pend these grace period claims with status code 734: Verifying Premium Payment.

To check claims status, providers use a 276/277 electronic data interchange (EDI) transaction or the Claim Status Inquiry application on the HealthPartners Provider Portal.

Questions and Answers

Q1: Would you provide an example of the three-month grace period in action for an APTC-eligible member?

January	February	March	April	May
Plan is effective 01/01/14.	Premium for February is not paid.	Premium for February and March is not paid.	Premium for February-April is not paid.	Premium for February-April is not paid.
Premium has been paid for this month.	Grace period begins – month one.	Grace period continues – month two.	Grace period continues – month three.	No longer in three-month grace period.
Claims received for January service dates are paid.	Claims received for January and February service dates are paid.	Claims received with January and February service dates are paid.	Claims received with January and February service dates are paid.	Claims received with January and February service dates are paid.
		Claims received with March service dates pend with status code 766.	Claims received with March and April service dates pend with status code 766.	Claims with March and April service dates are reprocessed and denied to member liability.
			Grace period ends on last day of April.	Member is retroactively cancelled effective 02/28/14.

Q2: Is there a unique timely filing requirement for submitting HealthPartners claims for APTC-eligible members who stop paying their premium, but are eligible for the three-month grace period?

We look at the service date to determine our liability. For example, let's say an eligible member pays his or her premiums for January and February only. Claims submitted for January, February and March services will be covered according to the member's benefits as long as the claim is received within the timely filing limit specified in your contract.

Q3: Does HealthPartners recoup the money paid for those claims during the first month of premium nonpayment?

No. HealthPartners assumes liability regardless of whether or not the member pays the premium.

Q4: Can providers collect from APTC-eligible members at the time of services if they haven't paid their premium?

How providers manage patient collection is up to them. APTC-eligible members who do not pay the premium in full within three months are financially responsible for paying for their services during the final two months of nonpayment. Remember:

We assume liability and pay participating providers for services provided during the first month according to the member's benefits. These claims are paid in a timely manner.

If a member eligible for the three-month grace period pays the premium in full before the grace period ends, we process pending claims according to their benefits. Claim payments are sent to participating providers.

Q5: Could an APTC-eligible member receive more than one premium grace period in a calendar year?

Members are eligible for more than one grace period, regardless of whether they are eligible for a 3-month or 31-day grace period. However, if a member reaches the end of the applicable grace period and is terminated for nonpayment of premium, he or she may enroll again with HealthPartners or any other Qualified Health Plan (QHP) only during an open enrollment period.

Q6: How do members present proof of premium payment if requested by our medical facility?

Members may create or sign into their secure web account at healthpartners.com and print or obtain proof of payment. If members require assistance with their web account, they may call the HealthPartners Web Support Help Desk at 952-853-8888 or 877-726-0203.

How to submit a claim to HealthPartners

Subject: Electronic capabilities

Effective: January 2000
Last Updated: August 2009
Reviewed: October 2020

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 section 62J.536 on the Office of the Revisor of Statutes for the Minnesota Legislature website for more information at **Sec. 62J.536 MN Statutes**.

For additional information, please visit **healthpartners.com/electronicconnectivity**.

The entire law is available online at the Minnesota Department of Health (MDH) website: **health.state.mn.us/facilities/ehealth/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
Online Member Eligibility and Co-Payment Information
Online Claim Status Inquiry
Online Referral Entry and Inquiry
Online Provider Reference Information

Please contact your provider representative at HealthPartners for more details or visit **healthpartners.com/electronicconnectivity**

Subject: CMS 1500/5010 837 professional claims submission

Effective: January 2000
Last Updated: August 2009
Reviewed: October 2020

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 **health.state.mn.us/facilities/auc.** The National Uniform Claim Committee website can be accessed at **nucc.org**.

Subject: UB04/5010 837 institutional claims submission

Effective: January 2000
Last Updated: August 2009
Reviewed: October 2020

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 **health.state.mn.us/facilities/auc.** The National Uniform Billing Committee website can be accessed at **nubc.org**.

Subject: Hospice claims submission

Effective: February 1, 2021
Last Updated: January 2021
Reviewed: January 2021

Explanation:
The preferred methods to submit claims for HealthPartners Hospice are by:

Fax: 1-651-430-8505
Email: HomecareHospiceBilling@HealthPartners.com

HealthPartners Hospice claims can also be mailed to:
5803 Neal Avenue North
Attention: HealthPartners Hospice Billing Office
Oak Park Heights, MN 55082

For any claim inquiries please call **952-883-6877.**

Subject: Submitting a Refund to HealthPartners

Effective: January 2021
Last Updated: January 2021
Reviewed: January 2021

Explanation:
When an overpayment is received and a refund needs to be submitted to HealthPartners, please include the following information:

Member name
Member number
Encounter/Claim number
Billed amount of claim
Reason for refund

Submit the refund to:
HealthPartners Attn: Refund/Recovery
PO Box 1289, Minneapolis, MN 55440-1289

Subject: Timely filing of claims

Effective: January 2000
Last Updated: April 2003
Reviewed: October 2020

Explanation:
HealthPartners contracted providers must submit claims within the specified period of the date of service as outlined in their provider contract.

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 a specified period 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: October 2020

Explanation:

HealthPartners follows guidelines for Coordination of Benefits that are outlined in the Minnesota Companion Guides. The Minnesota Companion Guides can be accessed at **health.state.mn.us/facilities/auc**.

Subject: Present on admission indicators

Effective: January 1, 2009
Last Updated: November 2008
Reviewed: October 2020

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 and template, HIPAA version 5010

Document Added: October 2011
Reviewed: October 2020

See next page for sample remittance.
For more information on HIPAA Remittance codes visit **wpc-edi.com.**

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                                                                                                                    (N)
HEALTHPARTNERS (A)                                  PAYEE: PROVIDER ORG NAME (E)                  PROD DATE:       (I)01312009
8170 33RD AVE S                                        ADDRESS 1                                  CHECK/EFT DT:    (J)02012009
PO Box 1289                                            ADDRESS 2                                  CHECK/EFT        (K)123456789
Minneapolis, MN  554401289                           CITY, MN 12345-1234                          PAYMENT:         (L)12345678.90
CONTACT: (B)                                        PAYEE TAX ID: (F) 123456789                   PAYMENT METHOD:  (M)(ACH,CHK,NON)
(952) 967-6633 or 1-866-429-1474                    PAYEE NPI: (G) 1234567890
PAYER ID: (C)                                       PAYEE ID (H)   V12345678900001
SUPPLEMENTAL ID: (BANK) (D)

PAT CTRL#: (1)XXXXXX          CLM #: (2)xxxxxxxx       CLM STATUS: (3)1 PAID PRIMARY        CLM DT (6)01012009-01012009       CLM CHG: (4)     200.00
PATIENT: (5)DOEABCDEFGH, JOHN S                                                                                               CLM PAYMENT (7) 190.00
PATIENT ID: (8)123456789      GRP: (9)12345        CLM FILING IND: (10) BILLING PROVIDER: (29)     PAT RESP: (11)  0.00       PRV LIAB (12)     0.00
REND PROV ID: (13)1234567890  CLM RECEIVED DT: (14) FACILITY TYPE:(15)          FREQ: (16)          OTHER LIAB (17) 0.00       PROVIDER TAX(18)  0.00
MED REC #: (19)1234567890     DRG: (20)                 DRG WGHT: (21)  COV EXP DT: (22)          WITHHOLD (23)   0.00       COVERED: (24)   200.00
CORRECTED PATIENT: (25)                                                CORRECTED PATIENT ID: (26)
CORRECTED PRIORITY PAYER(27)                                           OTHER SUBSCRIBER: (28)
CROSSOVER CARRIER:  (30)                                               ID: (31)
PMI (32) 123456789          CONTRACT: (33)PLEASE SUBMIT CLAIM TO CIGNA

REMARK CODES:                                                          CLM ADJ AMT(GRP CD/CLM ADJ RSN CD):
(34)                                                                          35.1(35.2/35.3)

 LINE                                ADJUDICATED  SUBMITTED     CHARGE          ADJ AMT                    REMARK  REND
_CTRL #_ _ _ _ _ _DOS _ _ _REV_ _PROD/SVC/MOD_PROD/SVC/MOD _ _ALLOWED _#_ APC_(GRP CD/CLM ADJ RSN CD)_ CODES _ PROV ID _ _PAYMENT
(a)              (b)      (c)   (d)            (e)           (f)    (g) (h)     i.1(i.2/i.3)        (j)     (k)      (l)
(m)                                                          (n)
001              01012009-01012009       C            A        100.00  001       -100.00(OA/94)  N19              1234567899   190.00
                                                                 200.00             10.00(PR/1)   C0213
002              01012009-01012009       C            B        100.00  001       100.00(CO/97)                                 0.00
                                                                   0.00
================================================================================================================================================
PROVIDER ADJUSTMENT(S):                                                PROV ADJ CD: (o)PROV ADJ ID: (p)          PROV ADJ AMT: (q)
                                                                       ------------------------------------------------------------
                                                                       CS              12849081-81852719          S12345678.90
                                                                       ------------------------------------------------------------
                                                                                                        TOTAL PAYMENT AMT (r)S12345678
                                                                                                        TOTAL PROVIDER TAX (s)
                                                                                                        TOTAL WITHHOLD (t)
                                                                                                        ==============================
(u)
EXPLANATION OF CODE(S):
GRP CD    GROUP CODE DESCRIPTION      ADJ RSN  ADJUSTMENT REASON DESCRIPTION                  REMARK CD       REMARK CODE DESCRIPTION
(CO) provider liability          (125) xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx                [C0213] xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

                                                    (v)
                Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense.
                                                    OR
                FOR REMITTANCE KEY INFORMATION GO TO:  www.healthpartners.com/provider
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HealthPartners paper remit field descriptions HIPAA version 5010

Element	Field name	Label	Usage	835 Element
A	Payer Name and Address,	none	HealthPartners name, address	N102 where N101 = PR N3, N4
B	Payer contact	CONTACT	HealthPartners name of business contact area and contact phone numbers for local and long distance.	PER where PER01= CX
C	Payer ID	PAYER ID	1 followed by TIN	BPR10 TRN03
D	Supplemental ID	SUPPLEMENTAL ID	Field contains the BANK ID associated to the payment. BANK can be used to identify product line and to reconcile multiple remits to the same vendor.	TRN04
E	Payee Name and Address	PAYEE	Defines the entity to which payment is directed.	N102 where N101 = PE N3, N4
F	Payee Tax ID	PAYEE TAX ID	Federal Tax ID or SSN assigned to payee.	N104 where N103 = FI or REF02 where REF01 = TJ

Element	Field name	Label	Usage	835 Element
G	Payee NPI	PAYEE NPI	NPI associated to payee.	N104 where N103=XX
H	PAYEE ID	PAYEE ID	Payer assigned ID – Payee ID assigned by HealthPartners. This provides additional identification information critical to vendor balance that is not accommodated by the NPI. A single NPI may have multiple HPFIN's associated to it.	REF02 where REF01 = PQ
I	Production End Cycle Date	PROD DATE	The last date HealthPartners adjudicated claims appearing on this remittance advice.	DTM02 where DTM01 = 405
J	Check/EFT Date	CHECK/EFT DT	This is the check issue date or in the case of a non-payment remittance, the date the remittance was generated. Required on the top of each page of a multipage remittance.	BPR16

Element	Field name	Label	Usage	835 Element
K	Check/EFT trace Number	CHECK/EFT	This is a trace number which is used to re-associate payments and remittances; must be a unique number for this business purpose between the payer and the payee. This is the check number, EFT payment ID or in the case of a non-payment remittance, a unique ID assigned to the remit.	TRN02
L	Payment Amount	PAYMENT	This is the total amount of payment that corresponds to the remittance advice. The total payment amount for this remit cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the remit cannot be issued for less than zero dollars.	BPR02
M	Payment method	PAYMENT METHOD	Defines the way payment is transmitted: Check, EFT or no-payment. Values: CHK, ACH, NON	BRP04
N	Page number		Remittance page number	Na
1	Patient Control Number	PAT CTRL #	This is the first 20 bytes of the provider assigned identifier submitted on the claim (CLM01). If an identifier was not submitted the value is defaulted to‘0’. This data element is the primary key for posting the remittance information into the provider’s database.	CLP01

Element	Field name	Label	Usage	835 Element
2	Payer Claim Control number	CLM #	This is the identifier assigned by HealthPartners that identifies the claim submission. For 5010 format this value will be the same on the original, void and the replacement.	CLP07
3	Claim status	CLM STATUS	Claim status code and narrative definition. Usage of Denied status changed for 5010-it is only used if the patient is not recognized and the claim is not forwarded to another payer. Status 23 – not our claim, forwarded to additional payer(s) requires usage of crossover carrier Status 1-3 processed as primary, secondary or tertiary are used regardless of whether any part of the claim was paid.	CLP02
4	Claim Charge Amount	CLM CHG	This is the total submitted charges for the claim. This amount can be positive, zero or negative.	CLP03
5	Patient Name	PATIENT	If claim was submitted in the 5010 837 format, then this is the submitted patient name. Else this is the name that identifies the patient on the claim. Format is last, first middle initial. Field will be in bold.	NM103,04, 05,07 where NM101 = QC
6	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
7	Claim Payment Amount	CLM PAYMENT	This is the total amount paid on this claim by HealthPartners. This amount can be positive, negative or zero.	CLP04

Element	Field name	Label	Usage	835 Element
8	Patient Identifier	PATIENT ID	If claim was submitted in the 5010 837 format, then this is the submitted patient ID. Else this is the identifier assigned by HealthPartners that identifies the patient. Field will be in bold.	NM109 where NM101=QC
9	Group or Policy Number	GRP	This is the HealthPartners group number associated to the patient's coverage.	REF02 where REF01 = 1L
10	Claim filing indicator	CLM FILING IND	Coded value, used to identify different product lines within a payer.	CLP06
11	Patient Responsibility Amount	PAT RESP	This is the total patient responsibility amount for this claim. Amounts correspond to adjustments with grouping code of PR.	CLP05
12	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
13	Rendering provider identifier	REND PROV ID	This is the payer assigned ID number or the National Provider Identifier of the provider who performed the service. Required if the rendering provider identifier is different than the payee ID. Element should contain the NPI or the payer assigned ID number for atypical providers. Field contains either NPI or UMPI.	NM109 where NM108=XX Or NM109 where NM108 = PC
14	Claim received date	CLM RECEIVED DT	Date claim was received by HPI.	DTM02 where DTM01=050

Element	Field name	Label	Usage	835 Element
15	Facility type	FACILITY TYPE	For the 5010-remit format, this element is populated on all claim types. Required when the information was received on the original claim. Professional and dental default to POS from first line.	CLP08
16	Claim Frequency	FREQ	Submitted claim frequency. For 5010 remit format this element is used on all transaction types and is required if submitted on the original claim.	CLP09
17	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
18	PROVIDER TAX	PRV TAX	Total MNTax payment amount applied to the claim. The sum of all claim and line level adjustments associated to adjustment reason codes 137. For this field, the MNtax payment amount is not reflected as a negative, unless it is a voided claim. If no MNtax amount, then the value will equal zero.	AMT02 where AMT01=T
19	Medical Record Number	MED REC #	This is the provider assigned medical record number that was submitted on the claim.	REF02 where REF01 = EA
20	Diagnosis Related Group Code	DRG	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP11

Element	Field name	Label	Usage	835 Element
21	Diagnosis Related Group Weight	DRG WGHT	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP12
22	Coverage expiration date	COV EXP DT	If claim is denied because of the expiration of coverage, this is the date coverage expired.	DTM02 where DTM01=036
23	Withhold	WITHHOLD	Total withhold amount adjusted from the claim. Sum of claim and line level amounts associated to adjustment reason 104. If no withhold amount, then the value will equal zero.	na
24	Covered amount	COVERED	This is the amount of charges considered as eligible for coverage. This is the sum of the original submitted provider charges that are considered for payment under the benefit provisions of the health plan. This excludes charges considered not covered (i.e., per day television or telephone charges) but includes reductions to payments of covered services (i.e., reductions for amounts over fee schedule and patient deductibles).	AMT*AU
25	CORRECTED PATIENT NAME	CORRECTED PATIENT	If claim was submitted in the 5010 837 format and the patient info does not match HealthPartners eligibility, then this field contains the values that are different. Only the elements that are different are populated not necessarily the full name.	NM1*74
26	Corrected patient ID	CORRECTED PATIENT ID	If the claim was submitted in the 5010 837 format and the patient ID does not match HealthPartners eligibility, then this field contains the value from HPI eligibility.	NM109

Element	Field name	Label	Usage	835 Element
27	Corrected Priority Payer	CORRECTED PRIORITY PAYER	This is the name of the payer that has priority over HealthPartners in making payment. For 5010 remit format, this element is only populated when HealthPartners has identified a payer primary to the HPI coverage, and the COB loop was not submitted on claim.	NM103 where NM101 = PR
28	Other subscriber name	OTHER SUBSCRIBER	Populated for 5010 when a priority payer has been identified.	NM103 NM104 Where NM101=GB
29	BILLING PROVIDER:	BILLING PROVIDER:	Subsidiary provider ID, used when payment is made to other than the billing entity. For the 5010-remit format this element is populated when the submitted billing NPI is different than the payee NPI.	TS301
30	Crossover carrier name	CROSSOVER CARRIER	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23).	NM103 where NM101=TT
31	Crossover carrier ID	ID	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23).	NM109 where NM101=TT
32	Patients Medicaid Identifier	PMI	MEDICAL ASSISTANCE NUMBER	REF 02 where REF01=1W
33	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 or the PMAP program code.	REF01 where REF02=CE

Element	Field name	Label	Usage	835 Element
34	Remark codes	REMARK CODES	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. For Non-MN providers, field may contain an internal remit remark code.	MIA/MOA
35.1	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 must 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
35.2	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. OA Other adjustments – avoid using OA except for business situations defined in HIPAA guide. 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. PR Patient Responsibility	CAS
35.3	Claim adjustment reason code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount.	CAS
a)	Line Item control number	LINE CTRL #	Line item identifier submitted by the provider to identify the line or, if control number is not submitted, then the claim line number.	REF02 where REF01 = 6R
b)	Dates of Service	DOS	This is the date range of services for each line. Format is MMDDCCYY-MMDDCCYY.	DTM02

Element	Field name	Label	Usage	835 Element
c)	Revenue Code	REV	Element applies to institutional claims only. This is the revenue code submitted on the claim line.	SVC04 or SVC01-2
d)	Adjudicated Product/Service Code/Modifiers	ADJUDICATED PROD/SVC/MOD	This is the adjudicated procedure code and modifiers. Values can be HCPC or ADA codes.	SVC01
e)	Submitted Product/Service Code/Modifiers	SUBMITTED PROD/SVC/MOD	If the code used for adjudication is different than the submitted value, then the submitted value is contained in this element.	SVC06
f)	Line Item Charge or Billed Amount	CHARGE	This is the line item charge/billed amount that was submitted on the line.	SVC02
g)	Units	#	This is the number of paid units of service.	SVC05
h)	APC	APC	Element applies to institutional only. A value is present if adjudication considered the APC.	REF02 where REF01 = APC
i.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
i.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. OA Other adjustments – avoid using OA except for business situations defined in HIPAA guide. 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. PR Patient Responsibility	CAS
i.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 **www.wpc-edi.com.**	CAS

Element	Field name	Label	Usage	835 Element
j)	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. 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 transaction. If the facility is outside of MN, we will also supply some legacy codes. These legacy remarks primarily define our National Network utilization.	LQ
k)	Rendering provider ID	REND PROV ID	This is the NPI or atypical ID of the rendering provider if the value is different than the claim level.	REF
l)	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 must equal the line item payment amount.	SVC03
m)	Submitted procedure code description	No label	If a description was received on the original service for a not otherwise classified procedure and the adjudicated procedure is different than the submitted value.	SVC06-7
n)	Allowed amount		Allowed amount is the amount the payer deems payable prior to considering patient responsibility.	AMT02 where AMT01=B6
o)	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.	PLB0

Element	Field name	Label	Usage	835 Element
p)	Provider Adjustment Identifier	PROV ADJ ID	For 5010 remit format the ID will vary by reason code: Adjustment codes are used as defined in the HIPAA guide.	PLB
q)	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
r)	Total payment	TOTAL PAYMENT AMT		NA
s)	Total Provider Tax amount	TOTAL PROVIDER TAX	Total MNTAX payment amount applied to the check for all claims on the remittance.	NA
t)	Total withhold amount	TOTAL WITHHOLD	Total withhold amount adjusted from check for all claims on the remittance.	NA
u)	Explanation of code(s)	EXPLANATION OF CODE(S)	Narrative description of grouping codes, adjustment codes and remark codes contained in remit.	NA
v)			Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense. FOR REMITTANCE KEY INFORMATION GO TO: **healthpartners.com/provider**	

Commonly used forms

Subject: Adjustment Request Form

Effective: January 2000
Last Updated: August 2009
Reviewed: October 2020

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 **health.state.mn.us/facilities/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 **healthpartners.com/providerforms** for providers.

Subject: Appeal Request Form

Effective: January 2000
Last Updated: August 2009
Reviewed: October 2020

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 **health.state.mn.us/facilities/auc**.

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 **healthpartners.com/providerforms** for providers.

Provider recommendation for further services

Guidelines for referrals (Recommendation for further services)

HealthPartners offers many types of plans to meet the needs of employers and individuals. Most plans with an open access network do not require referrals, however, some product types and primary clinic-based plans may require referrals to process claims.

Providers are encouraged to check eligibility and contact Member Services to determine if referrals are required. Eligibility may be checked on the Provider Portal at **healthpartners.com/provider**. After logging in, select *Eligibility* from the drop-down menu under the heading *Applications*.

Primary care clinics may enter referrals. The preferred method for referral submission is online through the Provider Portal using the Referral Maintenance Application at **healthpartners.com/provider**. After logging in, select Referral Inquiry or Referral Maintenance to create, update, view and retrieve/answer Referral Authorization Inquiries (RAI). Otherwise a referral can be made by completing a *Provider Recommendation Form* (next page) and faxing or mailing it to the Claims department.

Importance of primary care clinics responding to all RAIs

An RAI is generated when a member receives services outside of their assigned primary clinic's specialty referral network. To process claims primary care providers need to respond to these RAIs even if the care was not referred by the primary clinic care system. RAI notifications are sent to providers via the Provider Portal. There is no indicator on the Portal that an RAI has been sent when you log on, so it is important to check your work queues regularly to view and respond to RAIs.

For the HealthPartners Transplant Centers of Excellence, HealthPartners Direct Access Mental Health Network, HealthPartners Referral Mental Health Network, the WLS (Weight Loss Surgery) Designated Network, Low Back Pain or other designated networks, please note that the current policies and procedures in place regarding prior authorization or referrals (Recommendation For Further Services) remain in effect.

Provider Recommendation Form

General Instructions: _____ **New Referral** _____ **Revision to Current Referral**

- Enter one Provider/Authorization per form — Current Referral # _____
- Please Print
- **Complete all sections. Failure to complete all sections may result in delay of entry of this authorization.**

PATIENT INFORMATION

Name:_____ Date of Birth: _____

Member Number: _____

SERVICE INFORMATION

Start Date for Services: _____ Expiration Date for Services: _____

Type of Visit: (Please check one) _____ Inpatient _____ Outpatient

Number of visits if outpatient: _____

Diagnosis (ICD10 Code): Primary _____

4-digit Service Category Code __ __ __ __ **(Refer to Service Category List on following pages for this 4-digit code.)**

Authorization Status: **(MUST check one)** _____ Approved _____ Denied Auth # _____

Authorizations are considered approved unless otherwise stated. If denying an auth, please fill out below.

Reason for Denial: _____

Please check those that apply:

_____ Workers' Comp _____ MVA _____ Third Party _____ Other Insurance

_____ Medicare Primary Medicare Number: _____

PROVIDER INFORMATION

Referred To:

Facility Name: _____ Federal Tax ID# _____

Facility NPI#: _____

Address or Site:_____

Phone # _____ Professional's Name:_____

Referred By: _____

Professional's Name: _____ Professional's NPI#: _____

Facility Name: _____

Form Completed By:

Name: _____ Phone: _____

Fax : _____ Date: _____

NOTE: Preferred method for referral submission is online via the Provider Portal using the Referral Maintenance Application. After logging into the Portal, select *Referral Maintenance* from the drop down box under *Application* in the header bar **healthpartners.com/provider**. Please fax form to HealthPartners Claims Department, Attn: Referral Entry **651-265-1220** or mail form to HealthPartners Inc., Attn: Referral Entry, P.O. Box 1289, Minneapolis, MN 55440-1289

Service Category List

Consultations

Service Code	Service Category Name	Service Category Definition	Auth Type
1001	Consult Dx, Test, & Treat (No CT/MRI)	In office consultations, diagnostic testing, and treatment (excluding CT Scan & MRI).	OP
1003	Consult-1 visit (No test/treatment)	One visit consultations, follow-up visits, and second opinions-Excluding testing & treatment.	OP
1007	Consult and Treat (No Tests)	In office consultations and treatment, excluding tests.	OP
1008	Consult and Tests (No CT/MRI)	In office consultations and testing (excluding CT Scan & MRI), excluding treatment.	OP
1103	Consult In-Patient Pro-Fees	Inpatient professional visits. An Inpatient facility auth will generate when this category is used by clinic administrative groups.	OP
1104	Same day Procedures & Ancillary Charges	Use for procedures performed on an outpatient basis.	OP
1201	OB Total	Obstetric Care including visits and delivery.	OP

Tests

Service Code	Service Category Name	Service Category Definition	Auth Type
1607	Test-(no CT/MRI)	Tests excluding CT Scan and MRI.	OP
1711	Test-CT Scan	CT Scan testing only.	OP
1803	Test-MRI	MRI Testing only.	OP
2201	Sleep Studies	Sleep Studies performed at sleep centers.	OP

Allergy Testing

Service Code	Service Category Name	Service Category Definition	Auth Type
3701	Allergy Injection Only	Allergy Injection Only	OP
3702	Allergy Serum Only	Allergy Serum Only	OP

Therapies

Service Code	Service Category Name	Service Category Definition	Auth Type
1502	Therapy-Physical	Physical Therapy	OP
1503	Therapy-Chiropractic	Chiropractic Care	OP
1506	Therapy-Speech	Speech Therapy	OP
1509	Therapy-Dialysis	Dialysis Services	OP
1510	Therapy-Rehab	Rehabilitation Therapy	OP
1511	Therapy-Respiratory	Respiratory Therapy	OP
1512	Therapy-Chemo	Chemotherapy	OP
1513	Therapy-Occupational	Occupational Therapy	OP
1514	Therapy-Habilitative	Habilitative services can be PT, OT, ST	OP

Infertility

Service Code	Service Category Name	Service Category Definition	Auth Type
3201	Infertility-DX eval only	Infertility diagnostic evaluation only.	OP
3202	Infertility-Treatment	Infertility treatment only.	OP
3203	Infertility-Artificial Insemination	Infertility-Artificial Insemination	OP

Miscellaneous

Service Code	Service Category Name	Service Category Definition	Auth Type
2502	Facility Charges	Facility charges for outpatient, emergency room, urgent care and holding bed.	OP
2601	Blood Transfusion	Blood transfusion	OP
3301	Interpreter-Language & Sign	Language & Sign Interpreter services	OP
3601	Reconstructive Surgery	Reconstructive Surgery	OP

Prompt payment of clean claims

Subject: Prompt payment of clean claims

Effective: January 2000
Last Updated: October 2008
Reviewed: October 2020

Explanation:

HealthPartners processes claims in compliance with applicable state laws and regulations. For example, Minnesota 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 may be subject to interest.

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: 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 HealthPartners Service Specialist 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 directly to providers as required. Providers do not have to submit a bill to HealthPartners for the interest. Interest will be paid for claims on a quarterly basis.

Note: HealthPartners will not calculate and pay interest on claims for which the provider is capitated, on payment advances or on self-insured claims.

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
- 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

Medical cost management

Subject: ClaimsXten®

Effective: January 2000
Last Updated: May 2018
Reviewed: October 2020

Explanation:

HealthPartners uses ClaimsXten®, 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. ClaimsXten® 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 1st. ClaimsXten® is used in the review of professional claims processed for all HealthPartners products.

HealthPartners ClaimsXten® Edit Categories		
Edit Category	**Description**	**Outcome**
Visit	Professional visits [E & M] billed on the same day as a substantial diagnostic, therapeutic or surgical procedure is performed.	ClaimsXten® automatically denies same day visits when billed with the allowable surgical procedure. Payment is based on the surgical procedure. Claim is routed to Medical Review for review.
Unlisted Procedure	Unlisted services or procedures are defined as those procedures or services performed/ rendered by providers but not found in the appropriate edition of CPT or HCPCs for the date of service. Unlisted procedure codes are not to be used when a more descriptive procedure code representing the service provided is available.	Unlisted procedures are questioned and routed to Medical Review for review.
Assistant Surgeon	Surgical procedure in which it is medically necessary to have an assistant assisting the primary surgeon at surgery.	ClaimsXten® automatically denies assistant surgeon charges when the assistant is not medically necessary. ClaimsXten® will question assistant surgeon charges when documentation is needed to support charges. Claim is routed to Medical Review for review.
CCI-Incidental	Procedure combinations identified in the CMS Column 1/Column 2 edits, formerly the comprehensive/component edits. These are solely based on CMS guidelines.	ClaimsXten® automatically denies CCI-Incidental edits.
CCI-Mutually Exclusive	Procedure combinations identified in the CMS CCI Mutually Exclusive tables. These are solely based on CMS guidelines.	ClaimsXten® automatically denies CCI-Mutually Exclusive edits
Bilateral Duplicate Procedures	The procedure code contains the word “bilateral;” the procedure can be performed *only once on a single date of service.*	ClaimsXten® automatically denies bilateral duplicate procedures. Claim is routed to Medical Review for review.
Unilateral/Bilateral Duplicate Procedures	The procedure code contains the phrase “unilateral/bilateral,” the procedure can be performed *only once on a single date of service.*	ClaimsXten® automatically denies unilateral/bilateral duplicate procedures. Claim is routed to Medical Review for review.

HealthPartners ClaimsXten® Edit Categories		
Edit Category	**Description**	**Outcome**
Duplicate Rebundle/Replacements Duplicate Procedures	The procedure code specifies "unilateral" and there is another procedure whose description specifies "bilateral" performance of the same procedure; the unilateral procedure *cannot* be submitted more than once on single date of service.	ClaimsXten® automatically denies duplicate rebundle/replacement duplicate procedures. Claim is routed to Medical Review for review.
Global Duplicate Value Procedures	The procedure code is assigned the total number of times per date of service that the procedure may be appropriately submitted. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites.	ClaimsXten® automatically denies global duplicate value procedures. Claim is routed to Medical Review for review.
Right/Left Duplicate Value Procedures	The procedure code is assigned a value which is the maximum number of times per side, per date of service that a procedure may be submitted when modifiers –RT and/or –LT are used. Procedures (that clinically can be performed only once per date of service) are limited globally at "1," but are allowed to be reported with the appropriate –RT or –LT modifier for the site- specific designation.	ClaimsXten® automatically denies right/left duplicate value procedures. Claim is routed to Medical Review for review.
Site Specific Duplicate Value Procedures	The procedure code is assigned a value which is the maximum number of times per site, per date of service that a procedure may be submitted when site specific modifiers E1-E4, FA-F9, TA-T9, LC, Ld and RC are used.	ClaimsXten® automatically denies site specific duplicate value procedures. Claim is routed to Medical Review for review.
Reporting Only Procedures	The procedure code is submitted for data collecting only and reimbursement is not warranted.	ClaimsXten® automatically denies the reporting only procedure.
Incidental Procedures	The procedure is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.	ClaimsXten® automatically denies incidental procedures. Claim is routed to Medical Review for review.
Mutually Exclusive Procedures	The edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome. Mutually exclusive edits are developed between procedures based on the following CPT description verbiage: • Limited/Complete • Partial/Total • Single/Multiple • Unilateral/Bilateral • Initial/Subsequent • Simple/Complex • Superficial/Deep • With/Without	ClaimsXten® automatically denies mutually exclusive procedures. Claim is routed to Medical Review for review.

HealthPartners ClaimsXten® Edit Categories		
Edit Category	**Description**	**Outcome**
Bilateral Procedures	Codes submitted with a 50 modifier.	ClaimsXten® will question the claim and route to a Medical Review analyst to verify what was actually done.
Replacement Codes	Reassignment of the appropriate comprehensive CPT code representing those procedures and/or services billed as performed. Reassignment will take place when there is a one-to-one code replacement for an age or gender edit.	ClaimsXten® automatically replaces and assigns the appropriate CPT code. Payment is based on the replaced code.
Inconsistency of Gender to Procedure	CPT codes that are specific to the patient's gender.	ClaimsXten® 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.
Inconsistency of Age to Procedure	CPT codes that are specific to a patient's age.	ClaimsXten® 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.
Relationship of Procedure to Place of Service	Generally accepted setting where a procedure or service is performed/rendered.	If the place of service submitted is inappropriate with the procedure being performed ClaimsXten® will deny the procedure. Medical Review will verify.
Modifier to Procedure Edit	Procedure to modifier validity check to determine if a procedure code is valid with a specific procedure.	ClaimsXten® will question the line item and route to a Medical Review for review.
Pre/Post-Operative Visit	Evaluation and management services are denied when rendered by the surgeon during the established pre/post-operative period.	ClaimsXten® automatically denies pre/post-operative visit procedures. Claim is routed to Medical Review analyst for review.
Multiple Surgery	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: Clear Claim Connection® – C3

Effective: October 23, 2018
Last Updated: NA
Reviewed: October 2020

Explanation:

What is Clear Claim Connection® (also called C3)?

- C3 is a vended application by Change HealthCare/McKesson. This is a web-based solution that enables HealthPartners to share claim auditing rules, payment policy and clinical rationale inherent in code auditing. C3 is designed to make claims payment policies, related rules, clinical edit clarifications and other source information easily accessible and available for viewing via the provider portal. This functionality providers the ability to test "what if" claim scenarios before actually submitting a claim for payment.
- Authenticated users to the Provider portal with C3 assigned to their account can access this through their applications drop-down menus.

Who does this impact?

- The Clear Claim Connection® app has been added to any Provider portal user who has access to our Claim Estimation application and this application will be managed and assigned by site delegates.
- General application announcements will continue to be published to our contracted provider community via the Fast Facts publication.

FYI - Notable information about this application:

- Because this is a vended application, Clear Claim Connection® will open in a new browser tab. Provider portal remains open in original browser (thus two tabs open).
- This vended application has very specific browser and resolution settings which are outlined within the Provider portal Clear Claim Connection® landing page.

If the C3 application will not open properly, please check these settings on your PC:

- Check if a pop-up blocker prevented the new tab from opening
- Add HealthPartners as a trusted site in your browser
- You are using Internet Explorer V11 or higher
- You are using Chrome V4 or higher
- Your screen resolution is at least 1024 x 7678
- A **Help file** is available within the application and on the Provider portal Clear Claim Connection® landing page.

Application support and questions about results:
Check **Frequently Asked Questions(FAQs)**
Claims Customer Service 888-638-6648
Contact your **Service Specialist**

Other Questions? Contact Provider e-Services **x7505 x2** or **providerwebhelp@healthpartners.com**.

Subject: Multiple Procedure Payment Reductions (MPPR)

Effective: January 1, 2022
Last Updated: NA
Reviewed: September 2021

Explanation:

Effective 01/01/2022, HealthPartners will begin applying the MPPR rules through our claims editing software rather than through our modifier table. This will more closely align with the professional claim payment methodology used by the Centers for Medicare and Medicaid Services (CMS) and commercial industry standard procedures.

The MPPR rules apply to all professional claims. At this time, MPPR rules will not be applied to anesthesia claims and institutional claims on a UB or _837 institutional format.

CMS guidelines for professional claims will be applied when multiple procedures are performed for the same patient, on the same date of service (session) by the same provider. Below is a summary of the MPPR rules many of which HealthPartners already has in place and applies through a different mechanism.

Multiple Surgeries/Procedures:
Procedures that are eligible for the Multiple Surgery reduction are defined by a value of 2 or 3 in the multiple surgery indicator of the CMS professional fee schedule. The services with the highest RVU value will be processed at 100 percent of the allowed amount. All subsequent services will receive a reduction of 50 percent.

Bilateral:
Services defined as bilateral by a bilateral indictor of 1 or 3 in the CMS professional fee schedule are subject to a payment adjustment when submitted in a manner that defines the service as bilateral. The claims submission does not require a modifier to be classified as bilateral.

Assistant Surgeons:
HealthPartners will apply MPPR rules dependent upon the modifier used. A reduction of 86 percent will be applied to services billed with the “AS” modifier. A reduction of 84 percent will be applied to services billed with modifiers “80”, “81”, and “82”.

Cardiology:
Procedures eligible for the Multiple Cardiovascular procedure reduction are defined by a multiple procedure indicator of 6 in the CMS professional fee schedule. For the technical component, HealthPartners will process the services with the highest RVU value at 100 percent of the allowed amount. All subsequent services will receive a reduction of 25 percent of the technical component.

Endoscopy:
HealthPartners identifies multiple endoscopy procedures, reported within the same family, and applies the multiple endoscopy reduction, per CMS guidelines. Procedures eligible for the Endoscopic Reductions are defined by a multiple surgery indicator of 3 in the CMS professional fee schedules. HealthPartners will process the procedure with the highest value RVU in the endoscopic family at 100 percent of the allowed amount and any additional endoscopy procedures in the same family at a reduced amount based on the value of the CMS professional fee schedule designated endoscopic base code. In addition, if more than one endoscopy family is reported and/or surgery procedures are reported, the endoscopy codes may be subject to both the endoscopic and multiple procedure reductions.

Ophthalmology:
Procedures eligible for the Multiple Ophthalmology procedure reduction are defined by a multiple procedure indicator of 7 in the CMS professional fee schedule. HealthPartners will process the services with the highest RVU value at 100 percent of the allowed amount All subsequent services will receive a reduction of 20 percent of the technical component.

*Reimbursement values in this example may not accurately reflect the current HPI Fee Schedule and are intended for illustrative purposes only.

Code	Code 99250	Code 92270	Total Reimbursement before MPPR	Total Reimbursement after MPPR	Reduction
Global	$70.00	$150.00	$220.00	$220.00	No reduction taken
Professional Component	$33.00	$66.00	$99.00	$92.40	$66.00 + (.80 x $33.00)
Technical Component	$37.00	$84.00	$319.00	$312.40	$220.00 + $66.00 + (.80 x $33.00)

Radiology:
Procedures eligible for the Multiple Diagnostic Imaging reduction are defined by a multiple procedure indicator of 4 in the CMS professional fee schedule. HealthPartners will process the services with the highest RVU value for the professional and technical component at 100 percent of the allowed amount. All subsequent professional component services will receive a reduction of 5 percent. All subsequent technical components will receive a reduction of 50 percent.

*RVUs values in this example may not accurately reflect the current HPI Fee Schedule and are intended for illustrative purposes only.

Code	Modifier	Non-Facility RVU	Multiple Diagnostic – Imaging Ranking	Reduction
766XX	26	0.78	2 – Secondary	95% reimbursement
768XX	26	0.96	1 – Primary	100% reimbursement

*RVUs values in this example may not accurately reflect the current HPI Fee Schedule and are intended for illustrative purposes only.

Code	Modifier	Non-Facility RVU	Multiple Diagnostic – Imaging Ranking	Reduction
766XX	TC	0.50	2 – Secondary	50% reimbursement
768XX	TC	1.76	1 – Primary	100% reimbursement

Physical, Occupational, and Speech Therapy:
Procedures eligible for the Multiple Therapy reduction are defined by a multiple procedure indicator of 5 in the CMS professional fee schedule. HealthPartners will apply MPPR to rehabilitative services provided by an individual therapist, a group practice or “incident to” a physician’s service. All services furnished to a patient on the same day may have reductions applied. The reductions may apply regardless of whether the services are provided in one therapy discipline or multiple disciplines (physical therapy, occupational therapy or speech pathology).

HealthPartners identifies claim lines which should receive the reduced reimbursement on certain therapy procedures per CMS. When multiple therapy procedures are performed, the primary procedure should receive reimbursement at 100 percent. All secondary and subsequent procedures should have the non-facility Practice Expense reduced by 50 percent.

Modifiers:
The following table lists all modifiers on the HealthPartners standard modifier table that affect payment on Medicare, Medicaid and commercial claims by either increasing or decreasing the allowable amount. HealthPartners follows the CMS modifier increases or decreases or the industry standards for various modifiers. Beginning January 1, 2022, HealthPartners will follow one modifier table, sourced from CMS and industry standards, for all lines of business. HealthPartners will accept and apply up to four billed modifiers and apply reductions and/or increases to the claim.

Modifier	Modifier Description	Percent of Allowable
22	Increased procedural services	110%
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	100% of the allowable amount for the primary CPT code 50% of the allowable amount for the secondary CPT code 0% of the allowable amount for all subsequent CPT codes
50	Bilateral procedure	See MPPR Policy
51	Multiple Surgeries	See MPPR Policy
52	Reduced services	50%
53	Discontinued Procedure	50%
54	Surgical care only	Varies per CMS Rules
55	Postoperative management only	Varies per CMS Rules
56	Preoperative management only	Varies per CMS Rules
62	Two surgeons	Varies per CMS Rules
66	Three or more surgeons	62.50%
78	Unplanned return to operating or procedure room	Varies per CMS Rules
80	Assistant surgeon	See MPPR Policy
81	Minimum assistant surgeon	See MPPR Policy
82	Assistant surgeon (when qualified resident surgeon not available)	See MPPR Policy
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	See MPPR Policy
CO	Outpatient occupational therapy services	85%

Modifier	Modifier Description	Percent of Allowable
CQ	Outpatient physical therapy services	85%
CT	Computed Tomography Services Furnished	85%
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)	0%
FC	Partial credit received for replaced device	100%
FX	X-Ray Taken Using Film	80%
FY	Computer Radiography X-Ray	90%
GZ	Item or service expected to be denied as not reasonable or necessary	0%
PA	Surgical or other invasive procedure on wrong body part	See Never Events Policy
PB	Surgical or other invasive procedure on wrong patient	See Never Events Policy
PC	Wrong surgery or other invasive procedure on patient	See Never Events Policy
PM	Post-Mortem	100%
SH	Second Concurrently Administered Infusion Therapy (non-transportation codes)	50%
SJ	Third or more Concurrently Administered Infusion Therapy (non-transportation codes)	50%
XE	Separate encounter	100%
XS	Separate structure	100%
XP	Separate practitioner	100%
XU	Unusual non-overlapping services	100%

Subject: PSC Table

The following table lists all PSC reductions that affect payment on Medicare, Medicaid and commercial claims by decreasing the allowable amount. All MD/PhD claims are paid at 100% unless noted below.

Medicare PSC Table effective 1/1/2021

Code Value	Code Desc	Price Value
CH	Chemical Health	100%
CNS	Clinical Nurse Specialist	85%
CNSBH	BH Clinical Nurse Specialist	85%
MDWIF	Certified Nurse Midwife	100%
MHPHD	Mental Health Therapist with PhD or PsyD	100%
MHTHER	Mental Health Therapist	100%
NP	Nurse Practitioner	85%
NPBH	BH Nurse Practitioner	85%
OD	Optometrist	100%
PA	Physician Assistant	85%
RN	Registered Nurse	85%

Medicaid PSC Table effective 1/1/2019

Code Value	Code Desc	Price Value
CH	Chemical Health	80%
CNS	Clinical Nurse Specialist	90%
CNSBH	BH Clinical Nurse Specialist	90%
MDWIF	Certified Nurse Midwife	100%
MHPHD	Mental Health Therapist with PhD or PsyD	100%
MHTHER	Mental Health Therapist	80%
NP	Nurse Practitioner	90%
NPBH	BH Nurse Practitioner	90%
OD	Optometrist	100%
PA	Physician Assistant	90%
RN	Registered Nurse	90%

Standard Commercial PSC Table effective 1/1/2022

Code Value	Code Desc	Price Value
CH	Chemical Health	59.2%
CNS	Clinical Nurse Specialist	85%
CNSBH	BH Clinical Nurse Specialist	85%
MDWIF	Certified Nurse Midwife	85%
MHPHD	Mental Health Therapist with PhD or PsyD	62.2%
MHTHER	Mental Health Therapist	59.2%
NP	Nurse Practitioner	85%
NPBH	BH Nurse Practitioner	85%
OD	Optometrist	100%
PA	Physician Assistant	85%
RN	Registered Nurse	85%

Subject: Casting supplies

Effective: January 2000
Last Updated: July 2003
Reviewed: October 2020

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: Codes for data collection and reporting only procedures

Number: CC/U11
Approved: MCM
Effective: July 2010
Reviewed: October 2020

Explanation:

Codes listed below are intended to facilitate data collection or are for reporting purposes only and are not separately reimbursable.

Administrative process:

Deny procedure codes when billed. No review necessary. Claims system is automated.

Codes list:

Procedure Codes
90663 0001F – 7025F (CPT Category II) G8126 – G9140 G9142 S0302

Applies to: All providers and products

Subject: Global obstetric package

Number: MCM/O01
Approved: MCM
Effective date: January 1996
Last Updated: July 2004
Reviewed: October 2020

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 is 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 Online 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 the request.

Applies to:

All providers and products

Subject: Services not billable on a professional format

Number: CC/U10
Approved: MCM
Effective date: July 2010
Reviewed: October 2020

Explanation:

Codes C1300-C9899 are for drugs, biologicals and devices that must be used by OPPS hospitals. These codes cannot be billed on a professional format.

Administrative process:

Deny codes when billed on a professional format. No review necessary. Claim system is automated.

Applies to:

All providers and products

Subject: Services not separately reimbursable

Number: CC/UD8
Approved: MCM
Effective date: July 2010
Reviewed: October 2020

Explanation:

HPI has determined the codes listed below are not separately reimbursable.

Administrative process:

Deny procedure codes when billed. No review necessary. Claims system is automated.

Code list:

Procedure Code
90889 94760, 94761 96110 99000, 99001, 99002, 99026, 99027, 99050, 99051, 99053, 99056, 99058, 99060, 99070, 99075, 99078, 99080, 99082, 99090, 99091 99358, 99359, 99367, 99368 A4550 J2001 Q0091 S0020, S0039, S2055, S2061, S2140, S2150 S3600, S3601, S9088, S9981, S9982

Coverage exceptions:

Code 96110 is allowed for Medicaid members

Applies to:

All providers and products

Surgery

Subject: Global surgical follow-up care

Number: MCM/G01
Approved: MCM Steering Committee
Approved: January 1995
Effective date: January 1995
Reviewed: October 2020

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:

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

Applies to:

All providers and products

Subject: Surgical supplies

Number: MCM/S01
Approved: MCM
Effective date: June 1994
Reviewed: October 2020

Explanation:

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

Coverage:

The following procedure codes are 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 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 process:

HCPCS supply codes listed below will be denied when billed with a surgical procedure and select medical and radiological procedures.

A4206 – A4210	A4575
A4212 - A4223	A4600
A4230 – A4232	A4604 – A4608
A4244	A4614 – A4629
A4246	A4649 – A4930
A4248 – A4255	A5051 – A5200
A4256 – A4258	A6000 – A7027
A4262 – A 4265	A7030 – A7031
A4270 – A4280	A7035 – A7041
A4290 – A4458	A7046 – A7047
A4461 – A4465	A7501 – A8004
A4470 – A4483	A9272
A4520 – A4550	A9279
A4554 – A4559	A9900 – A9999
A4566	

Applies to:
All providers and products

Additional claims policies

Subject: Interpreter services for HealthPartners care members

(spoken and sign language)

Effective: January 2000
Last Updated: October 2008
Reviewed: October 2020

Explanation:

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

Coding and billing:

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

Subject: MinnesotaCare tax

Effective: January 2000
Last Updated: November 2010
Reviewed: October 2020

Explanation:

MinnesotaCare allows provider groups to transfer the additional expense generated by MinnesotaCare taxation to third party purchasers, such as HealthPartners. The State of Minnesota reduced the tax percentage from 2 percent to 1.8 percent in January 2020.

Administrative process:

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

Subject: Reporting suspicions of fraud and abuse

Effective: May 2003
Reviewed: October 2020

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** or **1-855-332-7194** 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 email us at:

HealthPartners Special Investigations Unit (SIU)

8170 33rd Avenue South
Bloomington, MN 55425
Fax: **952-883-9792**
Email: **reportfraud@healthpartners.com**