Claims Information

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/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 product: Peak Plan and Federally Facilitated Marketplace (FFM) Atlas Plan 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.

January	February	March	April	May
		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 2017

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 **health.state.mn.us/asa/faq62j536.pdf**.

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/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 2017

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/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 2017

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/auc**. The National Uniform Billing Committee website can be accessed at **nubc.org**.

Subject: Timely filing of claims

Effective: January 2000
Last Updated: April 2003
Reviewed: October 2017

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 2017

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/auc**.

Subject: Present on admission indicators

Effective: January 1, 2009
Last Updated: November 2008
Reviewed: October 2017

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 2017

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

(N)

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

PAYEE: PROVIDER ORG NAME (E)
ADDRESS 1
ADDRESS 2
CITY, MN 12345-1234
PAYEE TAX ID: (F) 123456789
PAYEE NPI: (G) 1234567890
PAYEE ID (H) V12345678900001

PROD DATE: (I)01312009
CHECK/EFT DT: (J)02012009
CHECK/EFT (K)123456789
PAYMENT: (L)12345678.90
PAYMENT METHOD: (M)(ACH,CHK,NON)

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 CTRL #	DOS	REV	ADJUDICATED PROD/SVC/MOD	SUBMITTED PROD/SVC/MOD	CHARGE ALLOWED	#	APC	ADJ AMT (GRP CD/CLM ADJ RSN CD)	REMARK CODES	REND PROV ID	PAYMENT
(a)	(b)	(c)	(d)	(e)	(f) (n)	(g)	(h)	i.1(i.2/i.3)	(j)	(k)	(l) (m)
001	01012009-01012009	C		A	100.00 200.00	001		-100.00(OA/94) 10.00(PR/1)	N19 C0213	1234567899	190.00
002	01012009-01012009	C		B	100.00 0.00	001		100.00(CO/97)			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

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
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
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

Element	Field name	Label	Usage	835 element
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
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
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

Element	Field name	Label	Usage	835 element
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
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
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

Element	Field name	Label	Usage	835 element
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
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
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 than 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
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, than 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
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
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

Element	Field name	Label	Usage	835 element
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 2017

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/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 2017

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/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: _____ Approved _____ Denied Reason for Denial: _____
(Must check one)

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

Service Category List (continued)

Therapies

Service Code	Service Category Name	Service Category Definition	Auth Type
1501	Therapy-Radiation	Radiation Therapy	OP
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	Chemo Therapy	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 2017

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 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 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: May 2018

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.	ClaimsXtenk® 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: Standard modifier table policy

Effective: As noted below for modifier
Last Updated: February 2014
Reviewed: October 2017

Explanation:

The following table lists all modifiers on the HealthPartners standard modifier table that affect payment on commercial claims by either increasing or decreasing the allowable amount. Some modifiers are addressed in separate policies, so please review the specific policy for additional information on the identified modifiers below.

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	80%
50	Bilateral procedure	See Bilateral Billing Guidelines Policy
52	Reduced services	50%
53	Discontinued Procedure	25%
54	Surgical care only	70%
55	Postoperative management only	20%
56	Preoperative management only	10%
59	Distinct Procedural Service	100%
62	Two surgeons	62.5%
80	Assistant surgeon	See Assistant Surgeon Services Policy
81	Minimum assistant surgeon	See Assistant Surgeon Services Policy
82	Assistant surgeon (when qualified resident surgeon not available)	See Assistant Surgeon Services Policy
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	See Assistant Surgeon Services Policy

Modifier	Modifier Description	Percent of Allowable
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	50%
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%
HQ	Group Setting	50%
XE	Separate encounter	100%
XS	Separate structure	100%
XP	Separate practitioner	100%
XU	Unusual non-overlapping services	100%

Administrative process:

The modifier pricing is automated in the Claims system.

The X-modifiers are effective 1/1/2015 and are in addition to modifier 59, but will not replace modifier 59, which is still active.

Applies to:

All Commercial Products

Effective date per modifier:

22 - 1/1/1995
25 - 1/1/2011
50 - 1/1/2007
52 - 7/1/2006
53 - 1/1/1997
54 - 1/1 /2013
55 - 1/1/2013
56 - 1/1/1984
59 – 1/1/2004
62 - 1/1/1996
80 - 1/1/1995
81 - 1/1/2004
82 - 1/1/1995
AS - 1/1/2004
FB - 1/1/2006
FC - 1/1/2008
GZ - 1/1/2002
HQ - 1/1/2003
PA - 1/1/2011
PB - 1/1/2011
PC - 1/1/2011
PM - 1/1/2014

Subject: Casting supplies

Effective: January 2000
Last Updated: July 2003
Reviewed: October 2017

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 2017

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 2017

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.

Subject: Global obstetric package (continued)

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 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 2017

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 2017

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: Assistant surgeon services

Number: MCM/A02
Approved: MCM Steering Committee
Effective date: January 1995
Last Updated: February 2014
Reviewed: October 2017

Explanation:

HealthPartners' definition of Assistant Surgeon includes MD, RNFAs (RN First Assistants), PAs (Physicians Assistants) 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 = Assistant Surgeon

81= Minimum Assistant Surgeon

82 = Assistant surgeon (when qualified resident surgeon not available)

AS = Physician Assistant (PA), Nurse Practitioner(NP), or clinical nurse specialist services for assistant at surgery.

The modifier will automate the correct percentage for pricing.

Coverage:

HealthPartners will reimburse appropriate Assistant Surgeon services at:

80 = 20% of the Surgeon's allowed amount through 4/30/14
= 16% of the Surgeon's allowed amount effective 5/1/14

81 = 16% of the Surgeon's allowed amount

82 = 20% of the Surgeon's allowed amount through 4/30/14
= 16% of the Surgeon's allowed amount effective 5/1/14

AS = 14% of the Surgeon's allowed amount

Applies to:

All providers and products

Subject: Assistant surgeon services (continued)

Administrative process:

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

Claims systems are automated to allow those services which are appropriate.

HealthPartners uses the Medicare Physician Fee Schedule Database (MPFSDB) "Assistant Surgeon Indicator" field as the basis for determining which CPT codes will be allowed for assistant surgeon reimbursement.

To access this database, refer to the CMS Web site at: **cms.gov/Medicare/**

Subject: Bilateral billing guidelines

Last Updated: September 2009
Reviewed: October 2017

A "bilateral procedure" is defined as a procedure which can be performed on either the right or left anatomic structure or is unspecific as to anatomic location, but can be performed on an anatomically bilateral structure the use of modifier 50 is valid. There are some exceptions to this rule for codes which may be inherently bilateral or for procedures which may involve paired structures, but are not performed bilaterally.

HealthPartners prefers bilateral procedures to be reported on one line using modifier "50" with a unit of service of one.

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.

Administrative process:

Where applicable, HealthPartners would reimburse the lesser of: a) 150% of the fee schedule amount; or b) billed charges.

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: **cms.gov/apps/physician-fee-schedule/**

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.
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.
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.
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.

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

Applies to:

All contracted providers billing on 837P or 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: October 2017

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: Multiple surgery

Number: MCM/M02
Approved: MCM
Effective date: July 1993
Last Updated: February 2017
Reviewed: October 2017

Explanation:

For claims billed on the UB04/5010 837 institutional format, and reimbursement is based on the Ambulatory Payment Classification (APC) methodology, allowable multiple surgical procedures are reduced based on-highest weighted line order : 100%, 50%, 50%, 50%, etc., regardless of separate site of multiple incisions.

For claims billed on the CMS/1500 5010 837 professional format, allowable multiple surgical procedures are reduced based on the-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 providers and products

Subject: Surgical trays

Number: MCM/S01
Approved: MCM
Effective date: June 1994
Reviewed: October 2017

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 process:

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

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 2017

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 2017

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 contracted providers on a claim-by-claim, line-by-line basis.

Subject: Reporting suspicions of fraud and abuse

Effective: May 2003
Reviewed: September 2017

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)

Mail route 25110F
P.O. Box 1289
Minneapolis, MN 55440-1289
Fax: 651-265-1333
Email: **reportfraud@healthpartners.com**