Chapter 9 Claim Submission – Facilities Services

How to submit claims, request adjustments, and/or appeals

Section A **How to Submit Claims**
Subsection 1 Administrative Requirements/Sample UB-04 Claim Form and Completion Instructions
Subsection 2 Submission Information
Subsection 3 Electronic Claim Submission

Section B **Adjustments/Appeals/Refunds/Appeal Request Form**

Section C **Management Fees**

Chapter 9: Claim Submission – Facilities

Section A: How to Submit Claims

Subsection 1: Administrative Requirements

The UB-04 (formerly UB-92) claim form sample indicates which fields are required (if applicable) or optional. Please refer to the sample form and the sample key, found in the below link when you submit a claim. Correctly completing the UB-04 will improve the turnaround time for payment of claims. Non UB-04 claim forms for facility services will not be accepted.

View How to Complete the UB-04 claim form> >

https://www.medica.com/~/media/Documents/Provider/How%20to%20Complete%20UB04.pdf

Participating providers must submit claims on the enrollee's behalf. All claims should include the enrollee's ID number and group number, and must be legible. **Do not ask enrollees to submit claims for services rendered.**

It is important that providers submit claims using the exact demographic data they have provided to Medica. SelectCare/LaborCare does not use provider numbers.

Timely Filing and Late Claims

All **original claim submissions** must be received at the designated claims address no more than **180 days** after the date of service or date of discharge for inpatient claims.

There is a **180-day limit for resubmissions** as well as **adjustments/appeal**:

- If a claim is denied or rejected (one line or all lines), the clean claim must be resubmitted and received within 180 days of the date of the denial or rejection.
- If the claim was paid, and an adjustment/appeal to the payment is being requested, the request must be received within 180 days of the check date on the provider remittance advice (PRA).
- If the claim needs to be submitted with changed information, that adjustment/appeal request must be received within 180 days of the check date on the provider remittance advice (PRA).

All information in this manual applies to both SelectCare℠ and LaborCare® the preferred provider organization (PPO) options in Medica's product portfolio.

Resubmissions are subsequent submissions of a claim where no adjustments are necessary. The claim may have been returned to the provider with a send-back form, rejected electronically, or denied. It is **not** necessary to attach any SelectCare/LaborCare form (e.g., an Appeal Request form) to the resubmission.

An **adjustment/appeal** is a requested change of payment to a claim that was previously submitted and for which payment was made. For more information on adjustments/appeals and the Medica SelectCare/LaborCare Appeal Request form, see Section B of this chapter. For adjustment/appeal requests, the appeal request form is required along with the claim.

If you have questions about SelectCare/LaborCare's timely filing policy, please call the phone number on the enrollee's ID card.

Late claim appeals
If a provider wants to appeal a claim that is more than 180 days after the date of service, the provider should contact the designated payer.

Exceptions
Following is a list of exceptions to the 180-day timely filing limit standard: It is required that claims, resubmissions, adjustments, and/or appeals for these exceptions be received at the designated claims address within 18 months of the date of service or date of discharge for inpatient claims.

- Patient's date of birth is less than one year before the date of service
- Duplicate payment for the same date of service
- Itemized billing for obstetric (OB) care and delivery
- Radiation treatment management services

Reference books and forms: Materials can be purchased directly from AMA at 1-800-621-8335 (http://www.ama-assn.org/ama), AHA at 1-800-261-6246 (http://www.aha.org/), or through a number of other book vendors.

Current Procedural Terminology (CPT-4) code books are updated and published annually by the American Medical Association (AMA).

CPT Assistant is the official coding resource for CPT-4.

The CMS Health Care Common Procedure Coding System (HCPCS) Manual, which includes Level 2 (national HCPCS), Level 3 (Local or Minnesota HCPCS) and Department of Human Services codes, is published locally.

International Classification of Diseases, Ninth Edition (ICD-9-CM), books are updated and published annually by the American Hospital Association (AHA).

International Classification of Diseases, Tenth Edition (ICD-10-CM), books are updated and published annually by the American Hospital Association (AHA).

Coding Clinic: This bulletin is the official coding resource for ICD-9-CM.

DRG Guide Book

UB-04 and CMS-1500 claim forms

Complaint Review Process

A covered person/member complaint is a verbal or written expression of dissatisfaction about the health plan, its providers or any aspect of the health plan operations, including the delivery of health care services.

Participating providers must comply with SelectCare's or the Payer's, as applicable, covered person/member complaint resolution process, as required by state and federal laws governing health maintenance organizations (HMOs), preferred provider organizations (PPOs) and insurance companies. For example, a complaint about a provider concern may be addressed by SelectCare, and a complaint about a coverage issue may be addressed by a Payer in accordance with applicable law. Because the covered person/member complaint resolution process varies by product and entity, participating providers may call SelectCare's Provider Service Center at 952-992-2500, option 1 or 1-800-858-9060, option 1, for information about the covered person/member complaint resolution processes.

Chapter 9: Claim Submission – Facilities

Section A: How to Submit Claims

Subsection 2: Submission Information

Claims submitted with invalid or incomplete information will be returned to the provider for correction and resubmission.

If the information is valid, but not accurate (e.g., an active enrollee number is used, but it does not apply to the enrollee who received the service), the claim may be repriced, but will require a subsequent adjustment/appeal once the payer determines eligibility. To avoid delays, always provide the most accurate information available. Verify SelectCare/LaborCare coverage information **each time** services are rendered by calling the payer or the number identified on the enrollee's ID card.

Methods

Use the current national and state uniform billing guidelines, when applicable.

Participating providers may submit claims to SelectCare/LaborCare by:

- Paper claim: Paper claims must be submitted on the current UB-04 claim form, established by the American Medical Association (AMA).
- Electronic claim: Refer to Subsection 3 in this section.

PLEASE NOTE:
Beginning July 15, 2009, dates of service, Minnesota providers are required to submit all claims electronically. The change had been implemented to adhere to the guidelines set by the Minnesota Administrative Uniformity Committee (AUC).

Submission guidelines

Submit claims for only one enrollee and one facility per form.

It is not advised that delayed claims be resubmitted without first verifying that the original claim is not in the payer's claim system. To do a status check on a claim, call the appropriate payer service center phone number on the enrollee's ID card.

To ensure prompt claim processing, please direct claims to the appropriate address on the enrollee's ID card.

Submission issues

SelectCare/LaborCare does not cover medications "dispensed" by a pharmacy. Claims for prescriptions filled at a pharmacy should be forwarded directly to the payer listed on the enrollees ID card.

A claim that is denied by the payer but is eligible for reimbursement should be corrected and resubmitted as an entirely new claim.

Make sure the correct SelectCare/LaborCare enrollee ID number is on the claim. In addition, use the exact group number as shown on the ID card.

Use the current national and state uniform billing guidelines. Check the various books referred to in the reference section found in section A, subsection 1 to ensure codes are effective for the date of service.

Claim returns

Original claim submissions will be returned for any of the following reasons:

- Group number is missing or invalid or not effective for date of service.
- Enrollee's SelectCare/LaborCare ID number is missing.
- Diagnosis code is missing or invalid.
- Procedure code is missing or invalid.
- Revenue code is missing or invalid.
- CPT-4 code is missing or invalid.
- Unclean claims (e.g., handwriting, correction fluid or tape).
- Non UB-04 claim forms

PLEASE NOTE:

"Send-back" (returned) claims will include a request that the participating provider ***RESUBMIT*** *the claim as an original.*

Questions regarding claim send-backs should be directed to the contact information listed on the send-back letter of the appropriate service center, which can clarify the information needed to ***resubmit a claim*** *for processing. Please refer to the enrollee's ID card for the phone number.*

Chapter 9: Claim Submission – Facilities

Section A: How to Submit Claims

Subsection 3: Electronic Claim Submission

Electronic Claim Submission

SelectCare/LaborCare has its own payer I.D. for electronic claims submissions. To route claims electronically, please use the SelectCare/LaborCare Payer I.D. 00014.

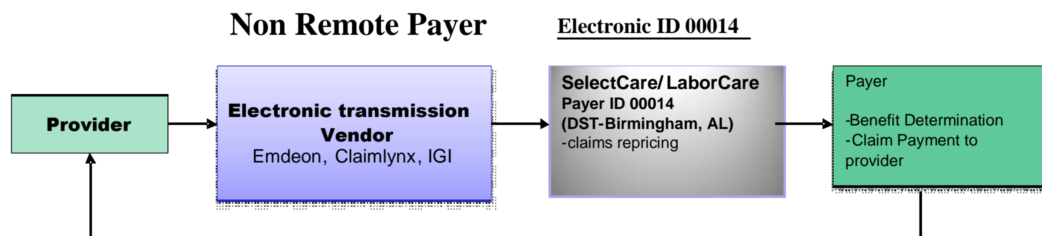
For further information on the ANSI 837 Claim transaction or to obtain the implementation guide, visit the Washington Publishing Company website.

To obtain the electronic ID addresses for various payers, see below or refer to the SelectCare/LaborCare Appeal form.

To problem solve any issues with claims being electronically submitted, please work with your clearinghouse directly. Please be aware that there may be multiple clearinghouses that could be used during the claims submission process.

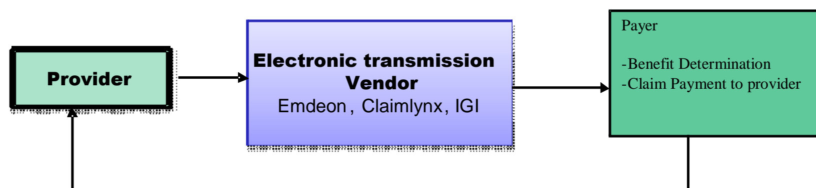
SelectCare/LaborCare Electronic Claim Flow

Non Remote Payer **Electronic ID 00014**



Remote Payer

Name	Electronic ID
Aetna	Refer to enrollees ID card
UHC LaborCare	Refer to enrollees ID card



Online services available from payer websites:

Please check payer websites for other potential online services. Providers and their staff may be able to check:

- Eligibility—dates of coverage, copayments and deductibles
- Claim status—details on payment status, payment amount, service detail
- Claims submission—submit claims directly to the appropriate payer, correct errors online, and/or confirm receipt of claim

Additional services may be available from payer websites, such as a provider search, medical policies, and care coordination.

Chapter 9: Claim Submission – Facilities

Section B: Adjustments/Appeals/Refunds

Although every effort is made to ensure accurate claim processing, occasionally a claim (or group of claims) may be processed incorrectly. It then becomes necessary to adjust the claim(s). The need to adjust a claim may result from any of several factors: the participating provider may be underpaid or overpaid, or the wrong provider may be reimbursed.

The provider, payer, or SelectCare/LaborCare can determine the need for a claim adjustment.

SelectCare/LaborCare's claim audit procedure may uncover the need to adjust claims or SelectCare/LaborCare staff may receive new information about a claim or the agreement under which it is processed. In either case, SelectCare/LaborCare typically performs necessary adjustments without requesting additional information from the participating provider. Please send appeal requests to SelectCare/LaborCare Claims or the appropriate payer within the time frames outlined in the participation agreement.

Please direct questions regarding claim adjustments/appeals to the appropriate service center, which can clarify the information needed to **adjust a claim.** Refer to the enrollee's ID card for the phone number.

For adjustments, appeals, policies, and coding logic for various SelectCare and LaborCare payers, please refer to their specific website found in the PPO Payer List located on medica.com.

SelectCare/LaborCare Appeal Request form

The Claim Appeal Request form can be used to request reconsideration of a previously adjudicated claim. This form, linked below, should be used only for adjustment/appeal requests handled by SelectCare/LaborCare claims repricing vendor in Birmingham, Ala. For adjustments/appeals handled by other payers, contact the appropriate service center number on the enrollee's ID card.

SelectCare/LaborCare Claim Appeal Request Form

Additional copies of the form are available through Medica's Provider Literature Request Line at 952-992-2355 or 1-800-458-5512, provider option 1, option 8, ext. 2-2355. If you are using a printed copy of this manual, you may log on to www.medica.com. Then select "Provider's Tab", "Administrative Resources", "Administrative Manuals" and "SelectCare/LaborCare Provider Administrative Manual".

Adjustment/Appeals time frames

For routine adjustments/appeals:
Requests for adjustments to **underpayment**s and any **overpayments** on claims must be made **to the payer** within ***180 days*** from the reimbursed date.

Other adjustments/appeals:
Adjustments may be made to any previous claim reimbursement when SelectCare/LaborCare determines that a provider was either underpaid or overpaid as a result of erroneous, abusive or fraudulent billing. Payment issues should go to the payer. SelectCare/LaborCare only reprices claims.

Dispute resolution

A participating provider may dispute any finding of underpayment through the dispute resolution procedure set forth in the SelectCare/LaborCare Participation Agreement.

Chapter 9: Claim Submission – Facilities

Section C: Management Fees

Providers in the SelectCare/LaborCare network may be assessed management fees. The fee will be a percentage of the total reimbursement (including deductibles and co-payments) paid to the provider. Hospital fees are assessed on a monthly basis.