Billing Policy Overview

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Providers (including billing organizations) bill for each service they provide and receive reimbursement for each covered service based on a predetermined rate in a fee-for-service (FFS) delivery system. Minnesota Health Care Programs (MHCP) providers and their billing organizations must follow MHCP billing policies as outlined in this section and specific provider type sections of the MHCP Provider Manual for billing services provided to members via FFS.

MHCP members enrolled in a managed care organization (MCO) contracted with MHCP receive their health care services through the MCO. Refer to the MCO contacts for MHCP providers webpage to MCO contact information and to learn about the billing policies for services provided to MCO-enrolled MHCP members.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care providers and payers to use universal standards for electronic billing and administrative transactions (health care claims, remittance advice [RA], eligibility verification requests, referral authorizations and coordination of benefits). Minnesota's Uniform Electronic Transactions and Implementation Guide Standards (PDF) require all Minnesota-based health care claims to be submitted electronically.

This section outlines the following for all MHCP providers:

- Coordination of Services
- Overlapping MHCP and managed care organization (MCO) coverage
- Free-care Policy
- General Billing Requirements
- Timely Billing
- Coding Schemes
- MN–ITS and Electronic Billing
- Billing as a Consolidated Provider
- Billing Organization Responsibilities
- Eligibility Requests and Responses
- Electronic Claims
- Reconsideration of a Claim (Appeals vs. New or Replacement)
- Replacement Claims
- Void Claims
- MN–ITS Mailbox
- Remittance Advice
- Taxes and 1099 Forms
- MHCP Reimbursement is Payment in Full
- Prompt Payment
- Additional Resources
- Legal References

Please also review the following billing policies for all providers:

- Billing the Member (Recipient)
- Medicare and Other Insurance
- Out-of-State Providers
- Payment Methodology – Hospital
- Payment Methodology – Non-Hospital

- Subrogation

Coordination of Services

Providers are responsible to ask MHCP members if they are currently receiving the same health care services from another provider. If the member is receiving the same services from another provider, the providers must coordinate the services and document in the member's record how the services were coordinated. MHCP will not inform providers of services the member is receiving from other providers.

Overlapping MHCP and managed care organization (MCO) coverage

A member could have both Medical Assistance and MinnesotaCare programs overlap for a short span in certain circumstances. Refer to the Minnesota Health Care Programs (MHCP) chart on the Health Care Programs and Services webpage for more information on the programs. The following is an example of verifying eligibility when programs overlap:

Major Programs: this member has eligibility for **MA: Medical Assistance**
Prepaid Health Plan: this member receives (product code) - **MinnesotaCare** delivered through (name of MCO.)

If the member has overlapping coverage for the dates of service provided, bill the MCO as primary and MHCP fee for service as secondary for cost sharing. Refer to the following for billing instructions.

When billing claims to MHCP:

- Send Electronic claim attachment.
- Send cover sheet that states the member has overlapping coverage for dates of service.
- Attach MCO explanation of benefits (EOB).
- Complete the coordination of benefits (COB) information on claim.

When billing for pharmacy claims:

- Enter in the COB information on the claim.
- Submit the claim. The claim will deny with NCPDP reject code of AF.
- Contact the MHCP Provider Resource Center at 651-431-2700 or 800-366-5411 to create a case to be sent to the Claims unit.
- The pharmacy will be contacted with payment information after the Claims unit reprocesses the claim.

Free-care Policy

MHCP pays for covered services even when the provider offers the same service for free to any other patient. Services must still meet all other MHCP coverage criteria to be eligible for reimbursement.

General Billing Requirements

MHCP providers who render or supervise services are responsible for claims submitted to MHCP:

- Submit claims only after you provide one or more MHCP-covered service.
- Bill only for dates of service when services were provided except in the case of Elderly Waiver (EW) or Alternative Care (AC) for environmental accessibility adaptations. Payments for EW or AC environmental accessibility adaptations must be prorated over several months due to EW or AC budgets and this is specified on the service authorization.
- Bill the provider's usual and customary charge.
- Bill only one calendar month of service per claim.
- Submit claims electronically.

Timely Billing

Follow these requirements for timely billing:

- Submit claims correctly, including Medicare crossover and third-party liability claims, so that MHCP receives them no later than 12 months from the date of service.
- Submit replacement claims so that MHCP receives them within six months of the date of incorrect payment, or within 12 months from the date of service, whichever is greater.
- Submit Medicare crossover claims that do not automatically cross over so that MHCP receives them within six months of the Medicare determination or adjudication date, or within 12 months of the date of service, whichever is greater.
- Resubmit claims MHCP denied erroneously (due to system error or incorrect information from county) within 12 months of the date of service or up to six months from date of county correction, whichever is greater.
- Submit claims over one year old with appropriate, dated documentation. Refer to the Electronic claim attachments webpage for instructions. MHCP will review documentation but does not guarantee payment.

Coding Schemes

Use applicable HIPAA-compliant codes and follow the most current guidelines. Providers are not required to purchase all of the manuals. Determine which of these manuals are appropriate for the services you provide:

- **CDT:** (Current Dental Terminology) Order by contacting American Dental Association at 800-947-4746 or purchase from various medical book sources.
- **CPT:** (HCPCS Level I: Physicians' Current Procedural Terminology) Contact the American Medical Association at 800-621-8335 or purchase from various medical book sources.
- **HCPCS:** (Healthcare Common Procedural Coding System) Available online at CMS Alpha-Numeric HCPCS; may also be purchased from various medical book sources.
- **ICD-10-CM:** (International Classification of Diseases 9th Revision Clinical Modification) May be purchased from medical book sources. Files also available for download at Classification of Diseases, Functioning, and Disability.
- **NDC:** (National Drug Codes) Review the National Drug Code Directory, search NDC.
- **UB-04** Data Specifications Manual: Order by contacting NUBC.

Use appropriate HCPCS 2-digit alpha, numeric and alphanumeric modifiers to identify one of the following:

- A service or procedure altered by specific circumstances, but not changed in its definition or code
- Rental, lease, purchase, repair or alteration of medical supply
- The origin and destination for medical transportation (1-digit alpha codes)

HCPCS developed 13 U modifiers for state definition. Refer to the Minnesota-defined U Modifiers table in the MHCP Provider Manual

Bill unlisted procedure codes only when a specific code is not available to define a service or procedure. When billing an unlisted code, include a description defining the service or procedure on electronic claims or send an attachment with a written description or documentation defining the service or procedure (refer to the Electronic claim attachments webpage).

MN–ITS and Electronic Billing

MN–ITS is MHCP's free, web-based, HIPAA-compliant system for claim submission, inquiry and other health care transactions. Submit claims through the following:

- Submit individual, direct data entry claims through MN–ITS Interactive.

- If you use HIPAA-compliant billing software or are a billing organization, submit your transactions through MN–ITS Batch.

Providers must register for MN–ITS to perform any of the following functions:

- Verify active provider enrollment status.
- Verify program eligibility for one or more MHCP members at one time.
- Submit authorization requests for medical or dental services or supplies.
- Submit service agreement (SA) requests for home care services.
- Retrieve your authorization and service agreement letters.
- Submit claims (including claims with Medicare and other insurance).
- Copy previously submitted MN–ITS claims or replace incorrectly submitted paid claims.
- Check a claim's paid or denied status.
- Submit a Pay-for-Performance Results Payment.
- Retrieve your RAs in your MN–ITS mailbox.

Your "Welcome" letter includes your initial user ID and password. When you register, you must agree to the EDI Trading Partner Addendum. This addendum adds to your existing MHCP Provider Agreement and supersedes any existing MHCP EDI Biller Agreements between you and MHCP.

All pay-to providers billing through a billing organization (such as a clearinghouse or billing intermediary) must also register for MN–ITS as the **provider organization**. Providers may assign their billing organization as their MN–ITS administrator, but providers must retain system access to continue to verify eligibility, check the status of their claims and receive their RAs. Providers are responsible for all claims submitted to MHCP and for reconciling their claims.

Billing as a Consolidated Provider

When a provider enrolls with MHCP and has multiple locations or more than one type of service, MHCP will consolidate all the records under a provider type 33 record.

Consolidated providers need to take additional steps when billing so that MHCP can verify which location or service is being provided. Refer to our MN–ITS basic user guides for 837P Professional, 837I Institutional and 837D Dental.

Billing Organization Responsibilities

A provider may not submit claims to MHCP through a factor, which is an individual or entity such as a collection agency or service bureau that advances money to the provider for accounts receivable that the provider has assigned, sold, or transferred to the individual or entity for a fee or for a deduction of a portion of the accounts receivable. Review the Billing Organization/Responsibilities section of the MHCP Provider Manual for additional information.

Eligibility Requests and Responses

MHCP requires providers to verify eligibility before they render services and submit claims. Clearinghouses are out of HIPAA compliance if they conduct eligibility (270) or health claim status (276) inquiries on behalf of provider organizations. Use MN–ITS to request member eligibility and receive eligibility responses. Refer to the Eligibility Verification section of the MN–ITS User Guide. Verify ID numbers or dates of service up to one year before date of inquiry.

Eligibility responses include the following information for each member:

- Major program
- Prepaid health plan (MCO enrollment) status, if applicable
- Other insurance, third party liability (TPL), or Medicare coverage, if applicable

- Special transportation, hospice, living arrangement indicators
- Potential copay indicator
- Spenddown
- Waiver program participation indicator
- Restricted member indicator, if applicable
- Benefit limits (applies to fee-for-service members only)
- Elderly waiver obligation
- Eyeglass payment, if applicable

For eligibility for a date of service that is over a year, contact the MHCP Provider Resource Center at 651-431-2700 or 800-366-5411.

Electronic Claims

Refer to the MHCP provider types webpage and review your provider type for information about claim submissions specific to the services you provide.

Reconsideration of a Claim

MHCP FFS does not accept the AUC appeals form that corresponds to the AUC Best Practices due to regulatory requirements cited in Code of Federal Regulations, title 42, section 447. Follow this process for reconsideration:

1. Review the X12 Standards HIPAA-compliant Claim Adjustment Reason Codes to verify why the claim was denied.
2. Then determine if the claim qualifies for either of the following:
   - Can be corrected and resubmitted, or
   - Meets the MHCP Attachment Criteria to submit an Electronic claims attachment (sent by the end of the next business day of the electronic claim) that includes medical necessity or other forms of documentation that supports the claim
3. If the original claim status is:
   - Paid; submit a replacement claim
   - Denied; submit a new (original) claim or a Copy claim

Original claims submitted via MN–ITS direct data entry (DDE) can be copied or replaced using the Request Claim Status feature in MN–ITS to display the original claim.

Replacement Claims

A replacement claim is a resubmission of an incorrectly paid claim due to a billing error or a third-party payment. Submit a replacement claim only in the following circumstances:

- When all or some of a claim **(including Medicare claims submitted through MN–ITS)** is paid incorrectly due to a billing error
- When you receive a third-party payment after you receive MHCP payment

Claims that have been underpaid must be replaced within 12 months of the date of service or six months from the date of payment. Claims that have been overpaid can be replaced or refunded (voided) electronically.

Replacement claim process

If	Then
The claim is within 12 months from the date of service or six months from the original date of payment	Submit the replacement claim electronically via MN–ITS. Review the Replacement claim user guic for instructions
The claim is over 12 months from the date of	Submit the replacement claim electronically with

service or more than six months from the original date of payment, and your original claim payment was an overpayment due to a billing error or you received other third-party payments	an attachment control number (ACN) and an electronic attachment. Refer to the claim attachment criteria sheet
The claim is over 12 months from the date of service or more than six months from the original date of payment, and your original claim payment was an underpayment due to a billing error	Your request cannot be processed due to timely filing limitations

Void Claims

If you need to return the entire claim payment to MHCP, use MN–ITS to void (take back) the claim. The amount will be deducted from a subsequent remittance advice. Claims that are voided after Timely Billing requirements cannot be resubmitted for payment.

If you need to void a claim because one of the following situations applies, follow the steps that follow this list:

- A claim was originally paid with an MHCP ID (the provider number you used to bill before the NPI or UMPI)
- It has been more than three years since you received payment for a claim
- The provider to whom the claim was paid is no longer an actively enrolled MHCP provider
- The claim is identified as "claim type: gross adj" on your remittance advice (claims display the member name, ID and date of service)

Follow these steps to void a claim for any of the situations noted in the previous bulleted list:

1. Collect the following information:
   - Original payer claim control number
   - Member ID
   - Date of service
   - Total charge billed
   - Total amount paid
   - Contact name and number

2. Call the MHCP Provider Resource Center at 651-431-2700 or 800-366-5411 and a representative will create a work order to review and complete the void process.

After the void is completed, MHCP will report RA01 on your RA in the reversal section.

For a lead agency void request for adjusting service authorizations or agreements, refer to Void ("Take-Back") Waiver and Alternative Care (AC) Service Claims for Fee-for-Service.

Assertive Community Treatment (ACT), adult rehabilitative mental health services (ARMHS), or day treatment: review **Billing** in the ACT section of the MHCP Provider Manual for reversal requests due to denial.

MN–ITS Mailbox

The start and end dates in MN–ITS Quick Search span a rolling 30-day period (today minus 30 days). As content builds, providers are able to search and retrieve content. Refer to the Mailbox MN–ITS user guide for more information and instructions on using the mailbox feature.

Providers must keep appropriate records according to state and federal retention requirements.

Remittance Advice (RA)

HIPAA requires providers and payers to use a standardized electronic RA (835_X12) transaction. MHCP adopted the HIPAA standards for electronic RAs.

RAs provide detailed payment information about health care claims and, if applicable, describe why the total original charges are not paid in full. The 835_X12 is an industry standard electronic file. It contains the format and data content from the 835 for use with an electronic data interchange (EDI). The 835 transaction standards and HIPAA-related adjustment code lists are available through the X12 Standards website.

Remittance advice information is listed alphabetically by member name, unless you request one of the following other remittance sequences upon your initial enrollment with MHCP:

- Patient Account or Own Reference Number Order
- DHS Transaction Control Number Order
- Member MHCP ID Number Order

To request a sequence change in your RA, call the Provider Resource Center at 651-431-2700 or 800-366-5411 and choose option 5 for provider enrollment.

MHCP-enrolled providers receive their RAs in one of the following formats:

- Readable PDF file placed in the provider's MN–ITS mailbox
- X12 835 batch file placed in the provider's MN–ITS mailbox ***Note for X12 835 batch files, software is required to translate the batch file.** DHS does not have the software to translate the file for you.

Use the Electronic Remittance Advice Request (DHS-4087) (PDF) to add or remove an electronic RA on a provider's MN–ITS account, to change the format you will receive your RA, or remove an RA affiliation with a billing organization.

Review How to Read Your RA and Remittance Advice (RA) Guide Chart (DHS-7400) (PDF) for reading PDF file RA information. Also, see the How to Read Your Remittance Advice on-demand video.

Taxes and 1099 Forms

MHCP does not withhold taxes, such as Medicare or Social Security, from payments made to providers. IRS 1099 forms are sent to providers by February of the year following payment. DHS sends a 1099 for payments made by paper check. Minnesota Management and Budget (MMB) sends a 1099 for payments made by electronic funds transfer (EFT).

MHCP Reimbursement is Payment in Full

A provider must accept MHCP reimbursement as payment in full for covered services provided to a member. A provider may not request or accept payment from a member, a member's relatives, the local human services agency, or any other source, in addition to the amount allowed under MHCP, unless the request is for one of the following:

- Spenddown
- Copay
- Family deductible
- Insurance payment that was made directly to the member. MHCP is liable for the amount payable by MHCP minus the third party liability amount

Prompt Payment

MHCP is required to pay or deny clean claims within 30 days and complex claims within 90 days of receipt. Clean claims are MHCP primary claims without attachments. Complex claims are replacement claims, Medicare crossovers, third-party liability claims, claims with information in the notes or comment fields, or claims with attachments.

Additional Resources

Refer to the following sections for additional Billing Policy requirements and resources:

- Authorization
- Fraud

Legal References

Minnesota Statutes, 62Q.75 (Prompt Payment Required)
Minnesota Statues, 256S.18 (Elderly waiver cost limits)
Minnesota Statues, 256b.0913, subdivision 4 (7) (Alternative Care Program–Eligibility for funding for services for nonmedical assistance recipients)
Code of Federal Regulations, title 42, section 447.10 (Prohibition against reassignment of provider claims)
Code of Federal Regulations, title 42, section 447.15 (Acceptance of state payment as payment in full)
Code of Federal Regulations, title 42, section 447.45 (Timely claims payment)