

## Chapter 4

# Billing Policy

IMCare providers (including billing organizations, intermediaries, and/or clearinghouses) must follow the billing policies described in this chapter.

## Definitions

**Assignment or Assignment of Benefits:** The written authorization by a person, the person's authorized representative, a policyholder, or other authorized representative to transfer to another individual, entity, or agency his/her right or the rights of his/her dependents to medical care, support, or other third party payments.

**Billing Intermediary:** Agent, person, or entity that submits claims or transactions and/or receives IMCare payment on behalf of one or more "pay-to" providers under one billing number (this agent can be part of the provider organization or a separate billing organization). Payment may be directed to a billing intermediary (such as an accounting firm or billing service) that furnishes statements and receives payments in the name of the provider **if** the agent's compensation for these services is:

1. Related to the cost of processing the billing;
2. Not related on a percentage (or other basis) to the amount that is billed or collected; and
3. Not dependent on collection of the payment.

**Clean Claim:** Pursuant to [Title 42 Code of Federal Regulations \(CFR\) 447.45](#), [42 CFR 447.46](#), and [MN Stat. sec. 62Q.75](#), a claim 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 on the claim.

**Clearinghouse:** Public or private entity (including, but not limited to, billing services, re-pricing companies, community health management information systems or community health information systems, value-added networks and switching companies) that does either of the following:

1. Processes or facilitates the processing of nonstandard information or data elements into standard data elements or standard transactions
2. Receives a standard transaction from another entity and processes or facilitates the processing of this information into nonstandard format or nonstandard data content for a receiving entity

**Pay-to Provider:** Provider to whom IMCare payment is issued for services provided to a member.

### Private Insurer:

1. Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated and indemnity contracts);
2. Any profit or nonprofit prepaid plan offering either indirect services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; or
3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employers, employee benefit plans, and any similar organization offering these payments for services, including self-insured and self-funded plans.

**Third Party Payer:** Any individual, entity, or program that is or may be liable to pay all or part of the health care costs incurred by members, including Medicare, an insurance company, health maintenance organization

(HMO), preferred provider organization (PPO), TriCare (formerly CHAMPUS), Workers' Compensation, and uncontested no-fault automobile insurance.

**Third Party Liability (TPL):** Payment resources available from both private and public health insurance and other liable third parties that can be applied toward a member's health care expenses.

## Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all health care providers and payers nationwide to use a universal set of standards for electronic billing and administrative transactions (e.g., health care claims, remittance advice [RA], eligibility verification requests, referral authorizations, and coordination of benefits). HIPAA affects IMCare providers and billing organizations in the following ways:

1. In order to meet HIPAA requirements and improve customer service to providers and electronic billers, IMCare has grouped all electronic claim submission processes into a Federally mandated HIPAA-compliant electronic format
2. Federal HIPAA rules for information privacy (outlined in [Minnesota Department of Human Services \[DHS\] Provider Update](#)) change the ways in which protected health information is stored and shared within and between health care organizations
3. IMCare requires the same information for electronic claim submissions as for paper claim submissions

## Eligibility

IMCare strongly encourages providers to verify member eligibility prior to rendering services and submitting claims. IMCare also encourages providers to verify Minnesota Health Care Programs (MHCP) eligibility on **all** patients they see.

### Eligibility Verification

Access member eligibility information through any of the following:

- a. [HealthX](#) web portal. Prior registration is required using by calling 1-800-843-9536, extension 2529
- b. [DHS Minnesota Information Transfer System \(MN-ITS\) web portal](#)
- c. DHS Enrollment Verification System (EVS) Line: **1-651-431-2700** or **1-800-657-3613** (toll free)

## Claim Status/Adjustment Requests/Remittance

IMCare strongly encourages providers to check the status of a claim electronically, without manual intervention, or confirm claims receipt. Benefits to electronic claim status inquiry and response include the following:

1. Less staff time spent on phone calls and websites
2. Increased ability to conduct targeted follow-up
3. More accurate and efficient processing and payment of claims
4. Ability to locate and print remittance advice
5. Real time submission of claim adjustment requests

### Claim Status Inquiry

Access member claim status information through our [HealthX](#) web portal:

1. IMCare's [HealthX](#) web portal. Prior registration is required before using the web service.

## Spenddowns

### Elderly Waiver (EW) Obligations

Certain members of the Elderly Waiver (EW) program are allowed to keep increased income while remaining eligible for IMCare. This means some EW members will no longer have a medical spenddown. Instead, they will have to pay a portion of their EW service costs through a waiver obligation. The payment of the waiver obligation is made to the provider by the member. Only EW services are applied to the obligation.

### Spenddowns and Copays

Providers should bill the spenddown and copay amounts to the member.

## Authorization

When a service requires authorization, the information submitted on the claim must match the information on the authorized [Service Agreement](#), including procedure codes, modifiers, and service units. The authorization number is not required on the claim submission.

When a member has private health or dental insurance, authorization and other rules that apply to the primary insurance must also be followed.

An approved authorization does not guarantee payment; all other IMCare requirements must be met.

## Free-Care Policy

IMCare takes into account all resources ([Title 42 United States Code \[USC\] Section 1396a](#)) available to members, including free services. The Centers for Medicare & Medicaid Services (CMS) “free-care” policy, or [Title 42 Code of Federal Regulations \(CFR\) Part 411.8](#), does not reimburse providers for services given to Medicaid recipients if the same services are offered for free to non-Medicaid patients.

## Coordination of Services

Each provider is responsible to ask the member if he/she is currently receiving the same health care services from another provider. If the member is receiving the same services from another provider, the people providing services must coordinate the services and document, in the member’s record, that coordination occurred. IMCare does not make this information available to providers.

## Expectations for Clearinghouses and Billing Intermediaries

### Use Only HIPAA-Compliant Electronic Billing Formats

#### Clearinghouses (X12 Billers)

1. IMCare accepts electronic health care transactions in the appropriate X12 batch format.
2. IMCare will accept interactive (direct data entry) transmissions from a clearinghouse

#### Billing Intermediaries

IMCare accepts electronic health care transactions as individual (direct data entry) claims in the appropriate X12 batch format.

## General Billing Requirements and Claims Submission

Providers who render or supervise services are responsible for claims submitted to IMCare.

1. Submit claims only after you provide IMCare-covered services
2. Use date spans only when you have provided services for all dates in the span
3. A claim cannot be submitted if a member doesn't show up for the appointment
4. Bill only one calendar month of service per claim
5. Bill the provider's usual and customary (U&C) charge
6. All claims require a valid diagnosis (*International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification [ICD-10-CM]*) code
  - a. As part of the [2011 Minnesota Legislative session](#), all claims for supplies or services that are based on an order or referral must include the ordering or referring provider's National Provider Identifier (NPI) ([MN Stat. sec. 256B.03, subd. 5](#)). The ordering or referring provider must also be enrolled in MHCP. Claims submitted without this information will deny as "referring/ordering provider is not registered with MHCP."
  - b. If attending, rendering, or referring providers are present in the claim transaction, the NPI or Unique Minnesota Provider Identifier (UMPI) must be present in order for IMCare to pay the claim. If not present, the claim will be rejected back to the provider.
7. Submit all claims electronically
  - a. All claims being submitted to IMCare by health care providers providing services for a fee in Minnesota must be transmitted electronically. IMCare offers two methods of free online direct claims submission through a web-based program, Infotech Global, Inc. (IGI) (aka [MN E-connect](#)) or [Office Ally](#).
    - i. These clearinghouses are available to submit claims electronically to IMCare:
      - Availity
      - Change Healthcare (Emdeon)
      - Change Healthcare (Relay Health)
      - EDS
      - IGI – MneConnect
      - Office Ally
      - TruBridge
    - ii. Follow [HIPAA EDI](#) standards as outlined in the [X12](#) or [National Council for Prescription Drug Programs \(NCPDP\) Implementation Guides](#)
    - iii. Follow standards outlined in the [Minnesota Uniform Companion Guides](#)
    - iv. IMCare does not have any specific File naming conventions when submitting claim
8. IMCare will be following CMS on the ordering/referring provider enrollment requirement. If the ordering/referring provider listed on claims for Medicare Part B services, Durable Medical Equipment (DME), or Part A home health agency (HHA) services is not enrolled with CMS, your claim will be denied. If this information is missing or incorrect, the following types of claims will be denied:
  - a. Claims from laboratories for ordered tests
  - b. Claims from imaging centers for ordered imaging procedures
  - c. Claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for ordered DMEPOS
  - d. Claims from Part A HHAs
9. IMCare uses a claims editing system (CES) in processing claims. The CES incorporates Medicare Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) policies in claim processing. IMCare's CES is continuously updated to remain in compliance with State and Federal regulatory mandates as well as general industry standards.

## National Correct Coding Initiative in Medicaid

The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid

claims. For information about, and edits for, the Medicare NCCI program, visit <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>. The Medicaid NCCI program has significant differences from the Medicare NCCI program.

The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.
2. Medically Unlikely Edits (MUEs) define for each HCPCS/CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

### Timely Filing Requirements

1. Claims must be submitted correctly and received by IMCare no later than 180 days from the date of service (DOS). **Exceptions to this rule:** Medicare Primary (MSHO) claims must be submitted correctly and received by IMCare no later than 365 days from the date of service (Medicare Covered services only). Medicare crossover claims and TPL claims must be received within 180 days of payment resolution with the primary payer.
2. Corrected claims must be submitted and received by IMCare within 180 days from the date of the Remittance Advice (RA)
3. Claims that do not automatically cross over from Medicare must be submitted and received by IMCare within 180 days from the Medicare determination or adjudication date or within 180 days from the DOS, whichever is greater
4. Claims denied due to enrollment changes may be submitted to IMCare within 180 days from DOS or date of county correction, whichever is greater
5. Claims that are over 180 days:
  - a. Submit your claim to IMCare for Timely Filing denial
  - b. Appeal Timely Filing denial using our [Provider Appeal Form](#) only after the denial is received
  - c. Appeals must be received within **90 days** of the denial for Timely Filing
  - d. The Appeal must have appropriate, dated documentation attached
  - e. Documentation will be reviewed, but does not guarantee payment. Appropriate documentation may include, but is not limited to:
    - i. Proof of eligibility verification through the EVS, [MN-ITS](#), or the IMCare [HealthX](#) web portal
    - ii. Printout from Provider's Practice Management Software that confirms claim was submitted within 180 days of the DOS
    - iii. Documentation of timely follow-up of the previous claim submission(s)
    - iv. Copies from the Provider's EDI submission report indicating the claim was transmitted to **and accepted by** IMCare. (Please note that your facility will usually receive two reports. The first will typically indicate that your claim was "Forwarded" to IMCare and the second should state that your claim was "Accepted" by IMCare.)
    - v. Documentation that fully explains extenuating circumstances for the delay in claims submission
  - f. IMCare follows the guidelines for Appeals found in the [Minnesota Administrative Uniformity Committee \(AUC\) Companion Guides](#)
6. Provider Appeals on claims should be faxed to **1-218-327-5545**.

## Appeals

Appeal requests by a participating provider must be made within 60 days from the date of the claim or Service Authorization request for covered services was denied by IMCare. Non-participating providers must make such an Appeal request within 60 days. IMCare will not make corrective adjustments after the allowed time frame.

Pursuant to the Federal regulatory authorities, a non-participating provider, on his/her own behalf, is permitted to file a standard Appeal for a denied Medicare claim.

1. Non-contracted providers have 60 calendar days from the remittance notification date to file the Appeal
2. Non-contracted providers must include a signed **Waiver of Liability form** holding the member harmless regardless of the outcome of the Appeal
3. Non-contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement
4. Non-contracted providers must either mail or fax the Appeal to IMCare at:

IMCare  
 Attn: Provider Appeals  
 1219 SE 2<sup>nd</sup> Ave  
 Grand Rapids, MN 55744  
**Fax: 1-218-327-5545**

## Coding Schemes

Providers are required to enter the most specific diagnosis code(s) on claims submitted to IMCare. All providers are required to enter the appropriate procedure/service codes on claims identifying covered services. Providers must use applicable codes and follow the most current guidelines from the following manuals:

<b>ICD-10-CM</b>	International Classification of Diseases, 10 <sup>th</sup> Revision, Clinical Modification
<b>CPT</b>	Physicians' Current Procedural Terminology: HCPCS Level I
<b>HCPCS</b>	Healthcare Common Procedural Coding System: HCPCS Level II National Codes
<b>NDC</b>	National Drug Codes: <a href="#">Review the National Drug Code Directory</a> . Click <i>Search National Drug Code Directory</i> .
<b>NUBC</b>	<a href="#">National Uniform Billing Committee</a> : For UB-04 reporting
<b>CDT</b>	Current Dental Terminology

Providers are not required to purchase all of the manuals listed above. Determine which manuals are appropriate for the services you provide.

## Modifiers

HCPCS (Levels I and II): include 2-digit alpha, numeric, and alphanumeric modifiers. Use appropriate modifier(s) to identify:

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

## Unlisted Codes

Bill unlisted procedure codes only when a specific code is not available to define a service/procedure. When an unlisted code is billed, a detailed description must be included in the charge line description field of the 837 transaction file for the specific unlisted code defining the service/procedure.

The following are some examples of unlisted codes that require descriptions (please note this is not an all-inclusive list):

1. T2029: Specialized medical equipment, not otherwise specified (NOS), waiver
2. A9999: Miscellaneous DME supply or accessory, NOS

## Document Retention

Providers must retain documentation of services provided and claims (paper and electronic) submitted for at least 10 years. Documentation of services provided must include all relevant information to support the services billed. Documentation of claims submitted must include payments, settlements, or denials, including those from other payers.

## Remittance Advice (RA)

The purpose of the RA is to report claim activity; it is issued weekly to providers.

You can print copies of claim remittances free of charge from the [IMCare provider web portal](#) using your provider login name and password. If you do not have a login name, you can self-register through the [web portal](#).

You can view a **List of Explanatory (EX) Codes** listed on the Explanation of Payment (EOP).

**Electronic Remittance Advice (ERA) (835) is available.** To register to receive your remittance electronically for IMCare medical claims, please complete the [Electronic Remittance Advice \(ERA\) Authorization Agreement](#) and follow the instructions on the form. You can also complete the form electronically through the IMCare [provider web portal](#). **You should also contact your billing software vendor and clearinghouse vendor to confirm setup.** Paper RAs will continue for 3 – 4 remittances after the 835 electronic remittance is set up. IMCare will work with you if there are any major technical issues.

If you have questions about the ERA 835, call 1-800-843-9536 extension 2133.

For more information on these mandates, please see [MN Stat. sec. 62J.536](#) or visit the [Minnesota AUC website](#).

## Electronic Funds Transfer (EFT)

IMCare offers providers the option to receive their payment by EFT. The EFT process will replace the paper check providers currently receive by mail for services rendered. This process is a free and secure way for providers to receive their payments.

To register, complete the [Electronic Funds Transfer \(EFT\) Authorization Agreement](#) following the step-by-step instructions included with the form. The form must be mailed to the address on the form (faxed forms will not be accepted) along with a voided check or confirmation of account number on financial institution letterhead.

Once all the required information is received, please allow 30 days for the enrollment process to be completed. EFT payments are typically deposited into your registered bank account within 2 – 3 business days following the claim payment process date.

IMCare will not produce any additional reports to accompany an EFT payment. The ERA will be your office's notification of payment. If you are using the [HealthX](#) web portal, you will need to log in and verify payments using the provider payment search function. Providers should confirm with their bank that the bank will deliver the Corporate Credit or Debit (CCD+) Addenda, which includes a trace number that will give the provider the information needed to re-associate EFT payments with the ERA 835 trace number (TRN02) or re-associate the claim payment information found on the IMCare [HealthX](#) web portal (trace number and payment date).

If you have questions related to the EFT registration process, please call the IMCare Claims Department at **1-800-843-9536** (toll free) (ext. 2133).

## Resolving Late/Missing Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Transactions

Late or missing is defined as a maximum elapsed time of four business days following the receipt of either the EFT or ERA.

If you have received the EFT credit from your financial entity but have not received your ERA, follow the steps below:

1. Contact your clearinghouse to attempt to locate the missing ERA
2. If your clearinghouse is unable to locate the file, contact the IMCare Claims Department at **1-800-843-9536 (toll free)** (ext. 2529) for assistance.

If you have received your ERA, but are unable to locate the EFT, follow the steps below:

1. Contact your financial entity to assist in locating the payment
2. If your financial entity is unable to locate the EFT payment, contact the IMCare Claims Department at **1-800-843-9536 (toll free)** (ext. 2133) for assistance

## Adjustment Requests, Corrected/Replacement Claims, Attachments, and Coordination of Benefits (COB)

**Important:** Please use the following criteria to distinguish between an adjustment request, corrected claim (replacement of previously filed claim), or claim attachment. Please note: Replacing **denied** claims using a frequency type of "7" or resubmission code of "406" will result in a claim rejection. If you are resubmitting on a previously denied claim, you are not required to submit the claim as a replacement claim and IMCare encourages you to submit the corrected claim as an original claim.

1. Submitting a claim (original submission) with an attachment:
  - a. If you are submitting an original claim, you must follow the instructions outlined below under *Claim Attachment Instructions* and include a [Claim Attachment Cover Sheet](#).
2. Submitting a corrected claim (rebill or replacement claim) with no special instructions:
  - a. If you are submitting a corrected claim (rebill or replacement claim) where you have changed any

- information from the original claim and you do not need to communicate any special handling instructions for the resubmitted claim, follow the instructions under *Corrected Claims*.
3. Submitting a corrected claim (rebill or replacement claim) with special handling instructions:
    - a. If you need to communicate special handling instructions for the resubmitted claim, you must follow the instructions outlined below under *Claim Attachment Instructions* and include a [Claim Attachment Cover Sheet](#). Fax this sheet along with special handling instructions to **218-327-5545** (This does not apply to COB primary payments).
  4. Submitting a replacement or voided claim:
    - a. If you need to send in a replacement or voided claim for a previously paid claim, change the frequency type for 837P to a “7” to indicate a replacement claim or “8” to indicate a voided claim. For 837I, change the third digit of the bill type to a “7” to indicate a replacement claim or “8” to indicate a voided claim, following the Minnesota AUC [best practice documents](#). Submitting a replacement or voided claim will require you to enter the **last known paid claim number** in loop2300, REF, payer claim control number. Failure to do so will result in your claim being rejected.
    - b. Replacement or voided claims should not be submitted until you have received the remittance advice from the claim you are replacing or voiding, or until the remittance is reviewable on the IMCare [HealthX](#) web portal. Failure to comply will result in your claim being rejected.
  5. Submitting a previously unauthorized services claim:
    - a. If you are requesting an adjustment to a claim that was denied because the service was not authorized at the time and authorization has now been approved, we encourage you to resubmit the claim as an original claim with the authorization number on the claim
  6. Skilled Nursing Facility (SNF) claims:
    - a. If you are requesting an adjustment to an SNF claim that was denied because the communication form was not included or updated and the communication form is now on file or updated, resubmit the claim as an original claim.
  7. Submitting an adjustment request (no claim changes):
    - a. If you are requesting an adjustment to a previously submitted claim that does not require a resubmission of the claim (there are no data changes to the claim), you must complete a *Claims Adjustment Request Form* in the IMCare [HealthX](#) web portal.

### Corrected/Replacement Claims

Submit a corrected claim when all or a portion of a claim is paid incorrectly (e.g., due to a billing error) or a third party payment is received after IMCare payment has been made. It is very important to include all lines on the claim, regardless of whether or not all lines paid incorrectly.

To qualify for a replacement, certain identifying information must remain the same. If these values change, the prior claim must be voided and a new claim must be sent with the appropriate frequency. If these items do not match the claim number referenced, your claim will be rejected. The following information must remain the same on the corrected/replacement claim:

1. Provider (2010AA Loop)
2. Patient (2010CA Loop)
3. Payer (2010BB Loop)
4. Subscriber (2010BA Loop)
5. Institutional Statement Period (2300, DTP Segment)

Corrected or replacement claims must be submitted and received by IMCare within 180 days from the date of incorrect payment. You no longer need to complete a *Claims Adjustment Request Form* in the IMCare [HealthX](#) web portal unless you are requesting that IMCare recoup a previously submitted claim or need to communicate special handling instructions (see items 2 and 3 above). Submitting a replacement or voided claim will require you to enter the **last known paid claim number** in loop 2300, REF, payer claim control number. Failure to do so will result in your claim being rejected.

1. Professional (837P) and (837I) replacement claims must have the following fields completed:
  - a. The claim frequency type code in CLM05-3 indicates the claim is an original, replacement, or a voided claim. For example, a value of “7” represents a replacement claim and value “8” represents a voided claim. The original IMCare claim number should be entered in Loop 2300, Segment REF, Payer Claim Control Number, when a claim is a replacement or void to a previously adjudicated claim.
  - b. If using Office Ally (837P) enter the frequency type of “7” or “8” in Field 22 and the original IMCare claim number.

**Please note:** Replacing denied claims using a frequency code of “7” or resubmission code of “406” will result in a claim rejection. If you are resubmitting on a previously **denied** claim, you are not required to submit the claim as a replacement claim. IMCare requires you to submit the corrected claim as an original claim.

### Claim Attachment Instructions

On your EDI claim, complete the PWK segment, Loop 2300, with a unique biller-created attachment control number. This number must be unique for each attachment submitted to IMCare in order for us to match it to the number indicated on the [Claim Attachment Cover Sheet](#). **Each claim attachment must be submitted via a unique fax submission with a unique control number and cover sheet. If you are not familiar with the PWK segment, Loop 2300, contact your billing system vendor.**

If you use Office Ally for your 837P, 837I, and 837D claims submissions, the EDI attachment process is now available. Attachment fields are available in the Online Entry tool and are listed as *Attachment Report Type Code*, *Attachment Transmission Code*, and *Attachment Control Number*. These fields will populate the PWK01, PWK02, and PWK06 segments.

1. Submit your EDI claim to IMCare
2. Complete the [Claim Attachment Cover Sheet](#), including the attachment control number. The attachment control number on the [Claim Attachment Cover Sheet](#) should match the attachment control number on the EDI claim.
3. Fax the corresponding [Claim Attachment Cover Sheet](#) and the attachment(s) to **1-218-327-5545**. You may submit the attachment information at the same time as you submit your claim(s).

IMCare will match the faxed documents to the identifiers/attachment control number submitted on the EDI claim and process accordingly. Failure to submit the faxed attachment in a timely manner (defined as three days from submission date of the claim) may result in delayed claims processing, including eventual denial of claims.

IMCare is following the Minnesota AUC’s “best practice” guidelines for submitting attachments. You can find the complete instructions for submitting attachments on the [Minnesota AUC website](#).

### Coordination of Benefits (COB)

Primary payer or COB information must be submitted as part of your electronic claims, eliminating the need to submit attachments. If you are submitting this information, you must include the “other payer” paid, and member and provider responsibility amounts at the **claim line level**, per the [Minnesota AUC Companion Guides](#).

When submitting claims to IMCare and IMCare is the secondary payer after Medicare, the EDI data will need to include the Medicare Internal Control Number (ICN). The Medicare ICN is located in the EDI data in Loop 2330B, REF segment “Other Payer Claim Control Number.”

### Refund of Payment

Providers may refund payments to IMCare when the entire amount paid for a claim needs to be returned or a portion of the payment needs to be returned due to an overpayment (receipt of third party payment, billing error, etc.). The preferred method for refund is a corrective adjustment on a future remit initiated by submitting a Replacement/Void claim.

If you are a provider who **infrequently** submits claims to IMCare, the following option is available. Send a check with a copy of the Remittance Advice (RA) highlighting the paid claim(s) and attach an explanation for the refund.

Mail checks with Remittance Advices (RAs) for credit adjustment to:

IMCare  
Attn: Claims Department  
1219 SE 2<sup>nd</sup> Ave  
Grand Rapids, MN 55744

## Medicare

Medicare is the Federal health insurance program for people 65 or over, and certain people with disabilities. It is administered by CMS.

Medicare is primary to IMCare with the exception of the Medicare Advantage Special Needs Plans (SNP) offered by IMCare under the group IMCare Classic (HMO SNP) (the State's name for this program is Minnesota Senior Health Options [MSHO]). For all Medicare Advantage SNP enrollees, claims are submitted to IMCare as the payer for their Medicare and Medicaid on one claim.

For members not enrolled in an IMCare Medicare Advantage Special Needs Plan, services that are covered by Medicare must be provided by a Medicare-enrolled provider and billed to Medicare first. Any balance remaining after Medicare payment must be billed to other liable third party payers with IMCare being the payer of last resort.

If Medicare pays a claim and the claim fails to automatically cross over from Medicare, providers must bill IMCare in **exactly** the same way Medicare was billed and include the COB information on the EDI claim.

If Medicare denies a claim, bill IMCare using IMCare guidelines. Include the COB information on the EDI claim at the **claim line level**.

For members that are enrolled in the IMCare Classic (HMO SNP) programs where IMCare is the payer for their Medicare and Medicaid, you will only need to submit a claim to IMCare for payment with the exception that if a member has a policy primary to Medicare, you would need to bill that insurer as primary and then bill IMCare.

When billing for Medicare-covered services, follow CMS guidelines. If the member does not have a policy primary to Medicare, but does have a supplemental Medicare plan, you do not need to bill the supplemental insurer. IMCare will process and pay the claim as both Medicare and Medicaid.

The Medicare Revenue Enhancement Program (MREP) is responsible for the development of Medicare maximization in all areas where IMCare is the payer of last resort. Medicare maximization requires providers to bill Medicare prior to billing IMCare if the member has Medicare benefits but is not a Medicare Advantage SNP enrollee. Be sure to indicate when the member is not covered by Medicare.

## Third Party Liability (TPL)

IMCare members may have other health coverage. If a member does not inform you of other health coverage, obtain the information by using [MN-ITS](#) or [HealthX](#) web portal.

Bill liable third party payers (including Veterans Benefits) and receive payment to the fullest extent possible before billing IMCare.

Private accident and health care coverage, including HMO coverage held by or on behalf of an IMCare member, is considered primary and must be used according to the rules of the specific plan. A member with more than one level of private benefits must receive care at the highest level available.

IMCare will not pay for services that could have been covered by the private payer if the applicable rules of that private plan had been followed.

### **Subrogation**

When IMCare receives notice that a member has other insurance after a provider has billed and received payment from IMCare, IMCare has the right to subrogate the payment by billing the private accident or health care coverage and be reimbursed for IMCare funds that were paid on behalf of a member for medical services to an enrolled IMCare provider.

If IMCare asserts this right, after the private accident or health care coverage reimburses IMCare, the payment responsibility is satisfied. Providers must accept the amount originally paid by IMCare as payment in full and must not bill the other health insurer or member for any additional payment. This includes attempting to replace or void claims with IMCare and then bill the other insurance.

The amount of the original IMCare payment substitutes for the TPL payment amount, even if the TPL payment would have been higher.

### **Unsuccessful Third Party Liability (TPL) Billing**

Providers may bill IMCare in cases where three unsuccessful attempts have been made to collect from the third party payer within 90 days, except where the third party payer has already made payment to the member.

A copy of the first claim sent to the third party payer, documentation of two further billing attempts, and any written communication the provider has received from the third party payer must be attached to the IMCare claim.

Claims must be billed to IMCare within 180 days of the last successful attempt to qualify for payment consideration.

### **Member Uncooperative with Third Party Liability (TPL) Billing**

If a member fails to complete forms and cooperate in the TPL billing process, contact the IMCare Claims Department at 1-800-843-9536.

### **Reporting Health Insurance Termination Dates**

Notify IMCare of health insurance terminations and denials for persons not covered by the policy. Send a copy of the termination notice/denial or include all of the following information on office letterhead:

1. Member's name
2. IMCare ID number
3. Insurance company name

4. Termination date
5. Whether the termination applies to the policy or individual
6. Name and phone number of the person contacted to obtain the termination information.

Mail or fax this information to:

IMCare / COB Department  
1219 SE 2<sup>nd</sup> Ave  
Grand Rapids, MN 55744  
Fax (218) 327-5544

### **Request for Billing Statement**

Billing statements submitted to member (upon their request) must clearly state that it is not a bill, and payment has been made or could be made by IMCare. Providers must report the request in writing to IMCare.

### **Prohibition Against Refusing to Furnish Services or Requiring Member to Bill Insurance**

Providers must not refuse to furnish IMCare-covered services to a member because of a third party payer's potential liability for payment of the service. Providers may not require IMCare members with primary insurance coverage to bill their insurance carrier. However, members must cooperate by completing and signing required forms.

### **Assignment/Request for Direct Payment**

Providers may obtain an assignment of benefits from the member to ensure direct payment for services. When a dependent child is insured under a group contract pursuant to a court order, providers should request that payment be made directly to them pursuant to Minnesota Statutes. If an IMCare member is insured by a plan approved in Minnesota, providers may request direct payment from the insurance plan pursuant to Minnesota Statutes. The provider must indicate on the insurance claim form that the person is receiving benefits through IMCare.

### **Liability Not Established or Benefits Not Payable**

When probable liability is not established, or benefits are not available at the time a claim is submitted, IMCare will pay the maximum allowable except when Medicare has denied payment on the basis of secondary payer. The provider must accept IMCare payment as payment in full and must not continue to seek payment from third parties with pending liability. If IMCare learns of the existence of a liable third party, or benefits become available, IMCare may recover payment directly from the third party payer.

### **Prompt Payment**

IMCare is required to pay or deny clean claims within 30 days.

### **Payment Cycle**

Providers are paid on a weekly payment cycle.

### **IMCare Reimbursement is Payment in Full**

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

the following:

1. Copay
2. Insurance payment that was made directly to the member. IMCare is liable for the amount payable by IMCare minus the TPL amount.
3. EW waiver obligation

## Prohibition Against Seeking Payment from Member

You must not request or accept payments from IMCare members, their families, or from others on behalf of the member for any of the following:

1. Base rate changes made by IMCare
2. Missed appointments
3. The difference between insurance payments and U&C charges
4. Services otherwise covered by IMCare, unless a copay or cap applies

## Billing the IMCare Member

IMCare allows a limited number of instances when you can bill a member for services you provided. These limited instances include (additional details below):

1. Non-covered services (only if you inform the member in writing before you deliver the services that he/she would be responsible for payment) Providers may use the DHS forms listed below to notify members of non-covered services. Providers should complete the form according to the instructions and include the member's signature on the form.
  - a. [Advance Recipient Notice of Non-Covered Service/Item \(DHS-3640\)](#)
  - b. [Advance Recipient Notice of Non-Covered Prescription \(DHS-3641\)](#)
2. Retroactive eligibility
3. EW waiver obligations
4. Copays

Federally funded Medical Assistance (Medicaid) members are protected from denial of service based on inability to pay as long as they inform the provider that they are unable to pay the copay. Providers must continue to accept their assertion of inability to pay.

Other State-funded Medical Assistance (Medicaid) programs are not affected by the Federal statute.

## Copay and Family Deductible Exclusions

Copays and deductibles do not apply to the following:

- Children under 21 years of age
- Copays that exceed one per day per provider for non-preventive visits and non-emergency visits to a hospital-based emergency department
- Family planning services and prescriptions
- Pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy
- Recipients expected to reside for at least 30 days in a hospital, nursing facility, or ICF/DD
- Recipients receiving hospice care
- Services paid by Medicare, resulting in MHCP payment of coinsurance and deductible
- 100 percent federally funded services that Indian Health Services (IHS) provides
- Preventative services

- Smoking cessation treatments and prescriptions
- Immunizations
- In addition, the family deductible does not apply to the following:
- Access services (access and special transportation services and interpreter services)
- Chiropractic services
- Dental services
- Inpatient claims based on an emergency admission
- Prescription drugs
- Recipients residing or expected to reside more than 30 days in medical institutions (hospitals, nursing facilities and ICF/DDs)
- Transportation services authorized through the home and community-based waiver or Alternative Care (AC) programs
- Volume purchase contracted items (eyeglasses, hearing aids, oxygen)

### **Copay and Family Deductible Limitations**

Medical Assistance (MA) recipients have their copays limited to 5 percent of their monthly (family) gross income. For recipients with countable income of less than 100 percent of the Federal Poverty Guidelines (FPG) the following apply:

- Some of these MA recipients (with a 5 percent of income copay maximum) may not have a copay or family deductible amount.
- MHCP will continue to reduce a provider's payment by the copay or family deductible amount (if any).
- MHCP will show the copay or family deductible amount the provider may collect (if any) on the provider's remittance advice (RA).

Recipients with countable income greater than 100 percent of the Federal Poverty Guidelines must manually track their cost sharing charges. They will need to call the MHCP Member Help Desk to request a refund of excess cost sharing payments if the cost sharing charges are more than 5 percent of their monthly family gross income.

The American Recovery and Reinvestment Act (ARRA) prohibits the following providers from charging MHCP copays to American Indian recipients, regardless of whether the recipients are enrolled in an MCO:

- Tribal health care providers
- Federal Indian Health Service (IHS)
- Urban Indian Organizations
- IHS-contracted health services (CHS) when there is an IHS referral

### **Copays**

You may bill a member for a copay before or after you receive notification on the Remittance Advice (RA) from IMCare about the amount of the copay.

2018 Fee-for-Service Copays		
	Medical Assistance:	MinnesotaCare:
	Adults	Adults over age 21
Nonpreventive* visit	\$3.00; no copays for mental health visits	\$15.00; no copays for mental health visits
Emergency room when not an emergency**	\$3.50	\$50.00
Emergency room when an emergency	\$0	\$50.00
Outpatient Hospital	\$0	\$25.00 per visit
Radiology	\$0	\$25.00 per visit
Prescriptions	\$1.00 generic \$3.00 brand name \$12.00 max per month No copays for certain mental health drugs	\$6.00 generic \$20.00 brand name \$60.00 maximum per month No copays for certain mental health drugs
Eyeglasses	No copay	\$25.00
Inpatient hospital	No copay or limit	\$150 per admission

Items or services provided by a volume purchase contract are exempt from subscriber copays and deductibles.

\*Non-preventive visits are visits that are the result of a recipient's symptoms, diagnosis, or established illness and delivered in an ambulatory setting by one of the following:

- Advanced practice nurse
- Audiologist
- Chiropractor
- Nurse midwife
- Optician
- Optometrist
- Physician
- Physician ancillary
- Podiatrist

\*\*Hospital emergency rooms providing care must conduct appropriate medical screening to determine that the recipient does not need emergency services. Before providing non-emergency services, the hospital must:

- Notify the recipient of the copay
- Give the recipient the name and location of an available and accessible alternative non-emergency provider
- Determine the non-emergency provider can provide the services in a timely manner
- Provide a referral to coordinate scheduling the recipient's treatment by the non-emergency provider

If you are unable to locate a non-emergency provider for referral, you may not charge the recipient a copay.

### Member's Inability to Pay Copay and Deductible

Providers cannot deny service to recipients eligible for Medical Assistance, based on inability to pay their copays or deductible as long as they inform you that they are unable to pay the copay or deductible.

Providers must continue to accept a recipient's assertion of inability to pay their copays or deductible. These state and federal laws do not apply to MinnesotaCare programs.

If a Medical Assistance recipient cannot pay the copay at the time of their visit, follow the steps below:

- Provide services for the current visit
- Inform the recipient of their debt and give them the opportunity to pay using your standard office policies and procedures

- Do not deny future or ongoing service to the recipient

If a MinnesotaCare recipient cannot pay the copay at the time of the visit, follow the steps below:

- Inform the recipient of his or her copay obligation for the services
- Provide services for the current visit
- Inform the recipients of their debt and give them the opportunity to pay using standard office policies and procedures
- Inform the recipient of your office policy on serving patients with outstanding debt or unpaid copays

If it is your standard office policy to refuse services to patients who are unable to pay the copay or have outstanding debt, you may refuse to provide ongoing services because of the recipient's inability to pay their copay.

### **Non-Covered Services**

You may bill a member for **non-covered services** only when IMCare never covers the services, and only if you inform the member before you deliver the services that he/she would be responsible for payment. Providers should use a written notification form that includes the service in question, the current date and DOS (if different), cost of the services, any other pertinent information, and the member's signature attesting that he/she understands that he/she may be billed. If IMCare normally covers a service, but the member does not meet coverage criteria at the time of the service, the provider cannot charge the member and cannot accept payment from the member.

You should have office procedures in place to prevent misunderstandings about whether or not you properly informed a member about a non-covered service and the cost of the health service.

### **Third Party Liability (TPL) and Copays**

1. Members with private health insurance primary to IMCare are responsible to pay only the IMCare copay for covered services. Providers must bill in the usual manner, reporting the insurance payment on the claim with the balance due. If the IMCare allowable covers all or part of the balance billed, IMCare will pay up to the maximum IMCare allowable, minus any applicable IMCare copay. The IMCare copay will be deducted from the IMCare payment amount and reported as the copay amount. Bill the member copay amount to the member.

## **Fee-For-Service Payment Methodology**

IMCare pays claims based on legislative increases or decreases. All Claims are paid the lesser of billed charges (per line) or current fee schedule rates.

## **Copay Guidelines**

### **Billing Requirements for Medical Assistance (Medicaid)**

#### **Non-Emergency Visit to a Hospital-Based Emergency Room (ER)**

The non-emergency visit to a hospital-based ER copay will be deducted from the outpatient hospital facility claim. IMCare will use the type of admission in conjunction with the revenue code to determine whether or not the visit was considered an emergency visit or a non-emergency visit. IMCare will consider a type of admission equal to "1" in conjunction with a 45x revenue code to be an emergency.

#### **Non-Preventive Visit Copay**

After the exclusions stated in [Chapter 2, Health Care Programs and Services](#), are taken into consideration, a combination of variables determines whether or not a copay is deducted from a claim. These variables include the following:

1. Provider type

2. Place of service (POS) code
3. Diagnosis code
4. Procedure code
5. Modifier

**Provider types**, determined by header information based on pay-to provider, that are subject to the non-preventive copay deductions are:

<b>Medical Assistance (Medicaid)</b>	
<ul style="list-style-type: none"> <li>• Audiologist</li> <li>• Chiropractor</li> <li>• CNS</li> <li>• Community Health Clinic (CHC)</li> <li>• Federally Qualified Health Center (FQHC)</li> <li>• Hospital</li> <li>• IHS</li> <li>• Nurse Midwife</li> <li>• Nurse Practitioner (NP)</li> </ul>	<ul style="list-style-type: none"> <li>• Optician</li> <li>• Optometrist</li> <li>• Physician</li> <li>• PA</li> <li>• Podiatrist</li> <li>• Public Health Clinic</li> <li>• Public Health Nursing Organization</li> <li>• Rural Health Clinic (RHC)</li> </ul>

Unless the member or the service comes under one of the exemptions listed above, the following **POS codes** are subject to a copay deduction (Medical Assistance [Medicaid]):

- 05 – IHS free-standing facility
- 06 – IHS provider-based facility
- 07 – Tribal 638 free-standing facility
- 08 – Tribal 638 provider-based facility
- 11 – Office
- 20 – Urgent care
- 22 – Outpatient
- 24 – Ambulatory Surgery Center (ASC)
- 50 – FQHC
- 71 – State or local public health center
- 72 – RHC
- 99 – Other unlisted facility

**Modifiers:** When the following **modifiers** are billed by the provider types, in the POS, etc., listed above, the non-preventive copay deduction does not apply to (Medical Assistance [Medicaid]):

- 80 – Assistant surgeon
- 81 – Minimum assistant surgeon
- 82 – Assistant surgeon
- AS – PA, NP, or CNS services for assistant-at-surgery
- ET – Emergency service. The “ET” modifier should be submitted for services that comply with the emergency services definition above. IMCare will not deduct a copay on the service date on which an ET modifier is billed.
- G8 – Monitored anesthesia care
- G9 – Monitored anesthesia care

A copay deduction will be applied to the first “62” or “66” modifier on a claim processed by IMCare. Subsequently processed “62” and “66” modified claims will not have a copay deducted, as only one copay is

deducted per surgical procedure.

## Inpatient Hospital Services

The Minnesota inpatient hospital payment system under Medical Assistance (Medicaid) is authorized by [MN Stat. secs. 256.9685 – 256.9695](#) and [MN Rules parts 9500.1090 – 9500.1140](#).

Payment rates are prospectively established on a per admission or per day basis under a Diagnosis Related Group (DRG) system that condenses Medicare categories into Minnesota diagnosis categories with the exception of Critical Access Hospitals (CAHs).

CAHs are paid at a rate that is designated by CMS and based on each hospital separately. Payment for outpatient, emergency, and ambulatory surgery hospital services provided by a CAH as designated under [MN Stat. sec. 144.1483](#) are made on a reasonable cost basis under the cost finding and allowable costs determined under the Medicare program according to [MN Stat. sec. 256B.75\(b\)](#). Every fiscal year the rates change for providers, but rates can also change quarterly or monthly as well.

It is the provider's responsibility to submit their CAH rates to IMCare and update IMCare with any changes of the rates **prior to the submission of claims** for that rate period. Once IMCare receives the updated rates, please allow up to 30 days for programming of the rates to be completed. **We do not reprocess claims received prior to the date the change is made in our system.**

Please fax all CAH rate updates or changes to **1-218-327-5545** or mail them to:

IMCare  
1219 SE 2<sup>nd</sup> Ave  
Grand Rapids, MN 55744  
Attn: Claims

## Legal References

[MN Stat. sec. 62J.536](#) – Uniform Electronic Transactions and Implementation Guide Standards

[MN Stat. sec. 62Q.75](#) – Prompt Payment Required

[MN Stat. sec. 144.1483](#) – Rural Health Initiatives

[MN Stat. secs. 256.9685 – 256.9695](#) – Inpatient Hospital Payment System

[MN Stat. sec. 256B.03](#) – Payments to Vendors

[MN Stat. sec. 256B.03, subd. 5](#) – Payments to Vendors: Ordering or referring providers

[MN Stat. sec. 256B.04](#) – Duties of State Agency

[MN Stat. sec. 256B.041](#) – Centralized Disbursement of Medical Assistance Payments

[MN Stat. sec. 256B.75](#) – Hospital Outpatient Reimbursement

[MN Stat. sec. 256D.03](#) – Responsibility to Provide General Assistance

[MN Stat. sec. 550.37, subd. 14](#) – Property Exempt: Public assistance

[MN Rules parts 9500.1090 – 9500.1140](#) – Hospital Medical Assistance Reimbursement

[MN Rules part 9505.0070, subp. 5](#) – Third-Party Liability: Provider billing; department

[MN Rules part 9505.0110](#) – Periods of Eligibility

[MN Rules part 9505.0190](#) – Recipient Choice of Provider

[MN Rules part 9505.0225](#) – Request to Recipient to Pay

[MN Rules parts 9505.0450 – 9505.0475](#) – Billing Procedures

[MN Rules part 9505.2190](#) – Retention of Records

[MN Rules part 9505.5010](#) – Prior Authorization Requirement

[MN Rules part 9505.5030](#) – Criteria for Approval of Prior Authorization Request

[42 CFR 411.8](#) – Services paid for by a Government entity

[42 CFR 447.10](#) – Prohibition against reassignment of provider claims

[42 CFR 447.15](#) – Acceptance of State payment as payment in full

[42 CFR 447.45](#) – Timely claims payment

[42 CFR 447.46](#) – Timely claims payment by MCOs

[42 CFR 447.53](#) – Applicability; specification; multiple charges

[42 USC 1396a](#) – State plans for medical assistance

[Minnesota 2011 Session Law, Chapter 9, article 6, section 24](#)