Life of a Claim

Purpose
Participants will learn about the submission of claims in both a paper and electronic format, and the process claims go through during processing (excluding Medica individual family business). Minnesota providers are required to submit all claims electronically.

Objectives
Upon completion of this session, participants will be able to:

- understand Medica claim submission requirements, claims process and claims output (for Commercial and Government business)
- use medica.com as a resource

Session Content

<table>
<thead>
<tr>
<th>Topics</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Submission</strong></td>
<td></td>
</tr>
<tr>
<td>• Data Entry</td>
<td>4</td>
</tr>
<tr>
<td>• EDI Submission</td>
<td>6</td>
</tr>
<tr>
<td>• Common Reasons for Claim Rejections</td>
<td>9</td>
</tr>
<tr>
<td>• Electronic Claim Submission</td>
<td>10</td>
</tr>
<tr>
<td>• Electronic Transactions</td>
<td>11</td>
</tr>
<tr>
<td>• Regional Mail Operations (RMO)</td>
<td>15</td>
</tr>
<tr>
<td>• Send Backs</td>
<td>16</td>
</tr>
<tr>
<td><strong>Claims Processing</strong></td>
<td></td>
</tr>
<tr>
<td>• System Claim Flow – High Level (Physician Claims)</td>
<td>17</td>
</tr>
<tr>
<td>• Hospital Claim Entry Flow</td>
<td>18</td>
</tr>
<tr>
<td>• Claim Edits</td>
<td>19</td>
</tr>
<tr>
<td>• Timely Filing</td>
<td>21</td>
</tr>
<tr>
<td>• Coordination of Benefits</td>
<td>23</td>
</tr>
<tr>
<td>• Auto-Adjudication</td>
<td>25</td>
</tr>
<tr>
<td>• Claim Edits</td>
<td>25</td>
</tr>
<tr>
<td>• Referrals</td>
<td>27</td>
</tr>
<tr>
<td>• Utilization Management (UM) Policies, Prior Authorization, Coverage Policies, and Drug Management Policies</td>
<td>29</td>
</tr>
<tr>
<td>• Reimbursement Policies</td>
<td>31</td>
</tr>
<tr>
<td><strong>Claim Output</strong></td>
<td></td>
</tr>
<tr>
<td>• Provider Remittance Advice (PRA) / ERA</td>
<td>32</td>
</tr>
<tr>
<td>• Electronic Provider Remittance Advice (EPRA)</td>
<td>37</td>
</tr>
<tr>
<td>• Disallow/Denial Codes</td>
<td>39</td>
</tr>
<tr>
<td>• Adjustments</td>
<td>39</td>
</tr>
<tr>
<td>• Appeal Requests</td>
<td>40</td>
</tr>
<tr>
<td>• Recovery</td>
<td>46</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>47</td>
</tr>
</tbody>
</table>
## Methods of submitting claims

Minnesota providers are required to submit all claims electronically. Other participating providers may submit claims to Medica by paper or electronically. Go to medica.com at this location for details about submitting claims:

Providers>Administrative Resources>Administrative Manuals>Medica Provider Administrative Manual>Billing and Reimbursement>Electronic Transactions

Paper claims must be submitted on the CMS-1500 Claim Form—established by the American Medical Association (AMA)—or the invoice accepted by the Minnesota Department of Human Services (MDHS) for professional services and for facility services claims must be submitted on the UB-04 claims form established by the National Uniform Billing Committee (NUBC).

Electronic claims are accepted through various vendor systems. (Please check with vendors to determine if they have a direct connection with Medica). Go to medica.com at Providers>Administrative Resources>Claim Tools for the following information on Electronic Claims Submission:

- AUC Initiative
- Delta Dental of Minnesota
- HIPAA 5010 FAQ
- MN E-Connect Registration

## Where to submit paper claims

All paper Medica claims go to:

Medica
PO Box 30990
Salt Lake City, UT 84130

## Minnesota provider requirement

To adhere to the guidelines set by the Minnesota Administrative Uniformity Committee (AUC) and to be consistent with Minnesota law to standardize electronic healthcare transactions, Minnesota providers are required to submit all claims electronically, including professional, institutional, dental and pharmacy claims. For additional information on the AUC, click on the AUC Initiative on medica.com or go to [http://www.health.state.mn.us/auc/profguide.htm](http://www.health.state.mn.us/auc/profguide.htm)

Medica electronic payer ID: 94265

## Claim submission requirements

Each claim submitted to Medica, regardless of submission method, must include information covered in this section.

- Patient’s name, address, sex, date of birth
- Primary member’s name and ID number
- Name, signature, ‘remit to’ address, and phone number of the physician or health care provider performing the service, as described in the participation agreement
- Physician’s or health care provider’s National Provider Identifier (NPI) and federal tax ID number
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT-4 and HCPCS procedure codes with modifiers where appropriate
- Current ICD-9-CM (or its successor) diagnostic codes by specific service code to the highest level of specificity and following the Official ICD-9-
CM/ICD-10-CM Guidelines for Coding and Reporting

- Referring physician’s name and tax ID number (if applicable)
- Charges per service and total charges
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Submit one attachment, (i.e. Explanation of Medicare Benefit or primary carrier’s Explanation of Benefit statement) per member per provider per form.

All Minnesota providers need to submit attachments following Minnesota AUC Companion Guide and best practice for submission of attachments.

Each claim submitted to Medica, regardless of submission method, must include information covered in accordance with the section listed below:

- [http://www.x12.org/](http://www.x12.org/) - ASC X12 Version 5010 and NCPDP Version D.0 – May be used by mutual trading partner agreement as the Guides are adopted into rule and are required for use starting 1/1/2012.

- For paper claims the required elements listed below must be completed:
  - [How To Complete - CMS 1500 Claim Form](#) (professional claims)
  - [How To Complete - UB-04](#) (facility claims)
**Miscellaneous Data Entry Information – Professional and Facility Claims**

<table>
<thead>
<tr>
<th>Missing or invalid information</th>
<th>For both physician and facility claims Medica is going to enter fields as they are submitted. If a field contains invalid information or information is missing, a send-back letter for &quot;the required information&quot; is going to be sent back to the provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>COB/recovery</td>
<td>If the claim has missing or invalid data elements, claims should not be sent back to the provider if the other insurance has paid on the claim in the approved ANSI ASC X12 837I/P format. This applies for both Medicare and any commercial payer.</td>
</tr>
<tr>
<td>Member numbers (baby claims)</td>
<td>Often a claim will be submitted for a newborn before the baby has been entered as a Medica member. In these cases, a letter will be sent to both the member and the provider and the claim will not be returned.</td>
</tr>
<tr>
<td>Referring physician</td>
<td>A referring physician NPI is required in accordance with CMS guidelines.</td>
</tr>
<tr>
<td>Negative charges and zero charges</td>
<td>If a claim is submitted with a negative charge, it will be returned to the provider. If a claim is submitted with a zero charge, the system will change it to one penny to enable processing of the claim.</td>
</tr>
<tr>
<td>Modifiers</td>
<td>Modifiers should be utilized when appropriate. If the modifier is invalid, the provider will receive a send-back letter.</td>
</tr>
<tr>
<td>Assignment of benefits</td>
<td>Claims submitted by a participating provider always have the benefits assigned to the provider and not the member. Medica does not accept assignment of benefits for claims for service from non-network providers unless the services have been prior-authorized for in-network benefits or it is an emergency, although this may vary according to the member’s plan.</td>
</tr>
<tr>
<td>Missing codes</td>
<td>For both physician and facility claims, Medica enters fields as they are submitted. For all Medica Products that have missing or invalid diagnosis or CPT/HCPCS codes, claims will be entered with 999.99 for a missing or invalid diagnosis code and XXXXXX should be entered for a missing or invalid CPT/HCPCS code. A Department of Labor send-back letter will be sent to the provider requesting the additional information. The claim will remain closed in our system until the information is received.</td>
</tr>
<tr>
<td>Units</td>
<td>If units submitted are more than 999, 999 will be entered in the units field, and in the description field the actual number of units will be entered. If units are less than one, 1 unit will be entered. If units are submitted as a decimal (example 1.25), enter a 99 modifier and a 1 in the units field. The description field will open and the processor will enter the correct number of units in the description field.</td>
</tr>
</tbody>
</table>
### Miscellaneous Data Entry – Specific for Facility Services

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Health Care &amp; some public health services</strong></td>
<td>All claims from Home Health Care providers and charges for home health billed by a Public Health provider should be submitted in the approved ANSI ASC X12 837I format.</td>
</tr>
<tr>
<td><strong>COB/recovery</strong></td>
<td>If the claim has missing or invalid data elements, claims should not be sent back to the provider if the other insurance has paid on the claim in the approved ANSI ASC X12 837I/P format. This applies for both Medicare and any commercial payer.</td>
</tr>
<tr>
<td><strong>Missing codes</strong></td>
<td>Applies for all Medica products that have missing or invalid diagnosis or CPT/HCPCS codes. Claims will be entered with 999.99 for a missing or invalid diagnosis code and XXXXX should be entered for a missing or invalid CPT/HCPCS code. A Department of Labor (DOL) send-back letter will be sent to the provider requesting the additional information. The claim will remain closed in our system until the information is received.</td>
</tr>
<tr>
<td><strong>Zero charge lines</strong></td>
<td>If a claim is submitted with a negative charge, it will be returned to the provider. If a claim is submitted with a zero charge, the system will change it to one penny to enable processing of the claim.</td>
</tr>
</tbody>
</table>
**Electronic Data Interchange Submission**

<table>
<thead>
<tr>
<th><strong>Electronic Data Interchange (EDI) overview</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Centers for Medicare and Medicaid Services (CMS) mandated that all payers, physicians and hospitals exchange key business transactional data by January 1, 2012, using the HIPAA 5010 format for electronic data interchange (EDI) transactions. For additional information, go to Medica.com at Providers&gt;Administrative Resources&gt;Claim Tools&gt; <a href="#">HIPAA 5010 FAQ</a>. Medica encourages the use of electronic transactions and electronic claim submission whenever possible. For more information on HIPAA and the transactions for Minnesota providers and health plans, as well as information on getting started, tools and companion documents, refer to the Minnesota Administrative Uniformity Committee web site at: <a href="http://www.health.state.mn.us/auc/">http://www.health.state.mn.us/auc/</a>. Several product offerings can be incorporated into an existing Accounts Receivable or Practice Management System already in place within the provider’s office. By embedding EDI transactions within the provider’s existing system, a <strong>vendor interface</strong> increases cost savings through expanded transaction capabilities, reduces staff hours, and streamlines efficient processes. A vendor interface may connect to a clearinghouse to submit transactions to a variety of payers. The <strong>clearinghouse</strong> then routes claims and other transactions for many payers to the appropriate destination. Or a vendor interface may use other connectivity mechanisms, such as an Internet application, to submit transactions electronically.</td>
</tr>
</tbody>
</table>
EDI Claim Submission

Medica Payer ID

Medica has its own payer ID for electronic claims submissions. To route claims electronically, please use the Medica Payer ID 94265.

For further information on the ANSI 837 Claim transaction or to obtain the implementation guide for other transactions, visit the X12 web site at http://store.x12.org/store/

Acknowledgements and Rejected Claims

Electronic claim submitters receive acknowledgements to confirm successful submission of claim files and notification of errors or claim rejections. Providers must correct and resubmit claims that are rejected by the EDI submission process.

Rejected claims are not available for adjustment. Acknowledgements act as a receipt for electronic claim submission. We strongly encourage providers to review all acknowledgements because they are responsible for verifying their own claim submissions and correcting rejected claims within timely filing limits.

Generally speaking, acknowledgements are returned to the submitter using the same channels as electronic claims. Time frames for receiving these reports typically are 24 hours to three business days.

The provider’s Practice Management vendor or clearinghouse can help identify and understand the acknowledgements they receive. In addition, help with rejected claims can be obtained from UnitedHealthcare (claims processor for Medica) at the following:


UnitedHealthcare EDI support: 1-800-842-1109

Email: supportedi@uhc.com
Common Reasons for Claim Rejections

<table>
<thead>
<tr>
<th>Reason</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID not on carrier files</td>
<td>▪ Verify the correct Medica ID#. Eligibility information is available via medica.com at Providers&gt;E-Flex Trans. Transactions.</td>
</tr>
<tr>
<td></td>
<td>▪ Contact the enrollee to obtain the current insurance information.</td>
</tr>
<tr>
<td>No coverage for the type charges submitted</td>
<td>▪ Verify Medica liability for the date of service. Eligibility information is available via medica.com.</td>
</tr>
<tr>
<td></td>
<td>▪ If the patient is the subscriber, verify the Patient Relationship to Insured field is “self” and the Insured Name field is the patient name.</td>
</tr>
<tr>
<td>Insured name/address does not match carrier files for SSN/Insured ID</td>
<td>▪ Verify that accurate information in the Insured Name field is submitted. The insured’s name must match the Medica membership database.</td>
</tr>
<tr>
<td></td>
<td>▪ Situations to keep in mind: Has the member recently married? Is their last name hyphenated? Does the child have a different last name than the Medica member?</td>
</tr>
<tr>
<td></td>
<td>▪ Verify that accurate information in the Insured Address field is submitted. The insured’s address must match the Medica membership database.</td>
</tr>
<tr>
<td>Coverage has been canceled for this insured</td>
<td>▪ Verify eligibility for dates of service. Eligibility information is available via medica.com.</td>
</tr>
<tr>
<td>Claim returned to provider, no further updates to follow</td>
<td>▪ No further electronic updates will be received. However, the claims processing site will follow up with a letter of explanation as to why they were not able to process this specific claim.</td>
</tr>
<tr>
<td></td>
<td>▪ The letter is sent to the billing address submitted on the claim.</td>
</tr>
</tbody>
</table>
Electronic Claim Submission

Who do you contact for support?
For Medica EDI questions, please call 1-800-458-5512 or email medica.electroniccommerce@medica.com

UnitedHealthcare EDI support - 800-842-1109

Email: supportedi@uhc.com
(UnitedHealthcare is the claims processor for Medica)

Minnesota Administrative Uniformity Committee (AUC) creates companion guides for the State of Minnesota: http://www.health.state.mn.us/auc/

Where can you go to get more information?
- Visit medica.com at Providers> News and Training for Medica Connections® and Provider Alerts. To receive this information electronically, click on subscribe now. The Providers tab also has links to the online Administrative Manuals. It is located on medica.com at Providers>Tools and Forms>Administrative Manuals>Medica Provider Administrative Manual> Billing and Reimbursement. Go to medica.com at Providers>Administrative Resources>Administrative Manuals to view the following manuals:
  - Medica Provider Administrative Manual
  - SelectCare and LaborCare Provider Administrative Manual
  - United HealthCare LaborCare Administrative Manual
  - United HealthCare Wisconsin Medicaid Administrative Manual

- The Minnesota Administrative Uniformity Committee is an organization that provides companion guides and other useful information: http://www.health.state.mn.us/auc/

- For more information on HIPAA or to review an Implementation Guides for a HIPAA mandated transaction, go to http://store.x12.org/store/
medica.com - Electronic Transactions

Electronic Transactions

Providers

Administrative Referral Entry

Admission Notification

Claim Adjustment Request

Claim Status Inquiry

Clinic Demographics Provider Demographic Online Tool (PDOT)

Electronic Payments and Statements (EPS)

Eligibility Inquiry

Fee Schedule Download

Fee Schedule Lookup

Prior Authorization and Notification

Provider Search

Note: The Provider Demographics Online Update Tool (PDOT) is only accessible to primary or secondary administrators for a provider group.
Electronic Transactions is located on medica.com at Providers> Electronic Transactions. Providers login to electronically administer patient and claims information, to set up electronic transfers, for electronic payments and statements, in addition to a number of other transactions listed in the table below:

- Administrative Referral Entry
- Admission Notification
- Claim Adjustment Request
- Claim Status Inquiry
- Clinic Demographics
- Electronic Payments and Statements
- Eligibility Inquiry
- Fee Schedule Download
- Fee Schedule Lookup
- Provider Search
- Referral Status Inquiry and Modification
- Online Provider Demographic Update Tool (PDOT) – link is only available to Provider Portal Primary and Secondary Administrators

To access Electronic Transactions, providers select a Primary Administrator who is responsible for setting up those in their organization who need access to the system. If providers need to know who their Primary or Secondary Administrator is, they should call the Medica Provider Center at 1-800-458-5512. If a provider is not registered, they should go to medica.com at Providers> Electronic Transactions> and click on the “Create account” button.

Administrative referral entry

Providers use this screen for Care System referrals. (Examples: Medica Elect®, Medica Essential®)

Admission notification

Hospital admitting offices use the admission notification transaction in order to submit their hospital inpatient notification to Medica.

Claim adjustment request

Non-Minnesota Providers use this screen for Claim Adjustment Requests. This transaction allows providers to submit an adjustment request electronically. Currently this transaction is not a true HIPAA transaction, it is an email to the processing sites instructing the processors that an adjustment needs to be done. Providers enter notes in the comments section indicating what the adjustment is.

Claim status inquiry

All providers use this screen for claim status inquiries, except for chiropractic, mental health and non-participating providers. It gives a summary and details of the claim, but if a claim is denied, it will not tell the reason why it was denied.

Clinic demographics (Online Provider Demographic Update Tool)

Provider primary or secondary provider portal administrators use this screen to view or modify clinic demographic data. The clinic demographic information is shown in the Provider Directory. The clinic address should match how a provider is contracted. If the information is incorrect for the clinic/practitioner, Providers can make updates online using the Online Provider Demographic Update Tool on medica.com. The User Guide for Provider Demographic-Update Online Tool (PDOT) is on medica.com at Providers> Administrative Resources> Demographics> Demographic Change Requests. To enter the electronic tools section, a username and
password is required. Portal registration questions or requests to establish a username/password can be emailed to portalregistration@medica.com. This online tool provides the ability to:

- Add currently credentialed practitioners to sites
- Terminate practitioners from sites
- Change demographics for
  - Billing address
  - Care delivery site address
  - Directory address
  - Check name
  - Care delivery site name
- Change federal tax ID
- Add sites
- Terminate sites
- Add Personal Care Assistants (PCA) to sites
- Change demographics for current PCAs

Contact Medica Contract Management to submit the proper paperwork to ensure claims payment accuracy for the following changes:

- Total Contract Terminations
- Care System or Care Grouping Changes
- Merger Acquisition Activities

Requested changes will appear on the web site once reviewed and processed. Providers who have questions may call the Medica Provider Service Center at 1-800-458-5512.

Electronic payments and statements (EPS)

Providers are able to receive payments by electronic funds transfer and so will not receive paper statements or paper check payments. EPS allows for a faster payment, easier reconciliation, less paperwork and greater efficiency. Providers can see payments records online, such as a provider Explanation of Benefits (EOB) statements, with claims payments information grouped by tax ID number, or electronic provider remittance advices (EPRAs) for 835 transactions, compliant with HIPAA. Providers must register to access EPS. There are two ways to register: (1) Register online by selecting your Federal Tax ID and clicking submit, or (2) Complete and fax the Electronic Payments and Statements Medica Enrollment Form AND a copy of a voided check to 1-800-765-6766. For additional information on Electronic Payments and Statements, go to medica.com at Providers>Electronic Commerce.

Eligibility inquiry

Registered Providers use this screen for eligibility inquiries. The following is required:

Date of Birth is required and either
- Patient/Member ID number (Group/Policy number is optional)
- OR-
- Last Name and First Name

Note: For “Date of Service,” choose today’s date or earlier.

The member eligibility inquiry transactions allows providers another
Fee Schedule Download

Currently available for use by all providers who are paid based on the Premier Fee Schedule with the exception of the following provider types: anesthesia, mental health, durable medical equipment, transportation, home health care, IV therapy, orthotics and prosthetics, facilities and out-of-network providers.

Fee schedule lookup

Providers use this to look up physician’s fee maximums for Medica Choice®, Medica Elect, and Medica Essential. (This is not for facility lookup.) Please note: The Fee Schedule Look-Up transaction is currently available for use by all providers with the exception of the following types: anesthesia, mental health, durable medical equipment, transportation, home health care, IV Therapy, orthotics and prosthetics, facilities and non-par providers. Please contact the Medica Provider Service Center at 1-800-458-5512 with questions.

Provider search

Providers use this to assist in locating other providers and to assist in referring patients to other providers. (NOTE: This search will not validate the member’s Certificate of Coverage or eligibility information.)

Referral status inquiry and modification

Providers can check the status of a referral, the units approved and the care level of the authorization through this transaction. A referral that has already been entered can also be modified.
**Regional Mail Operation (RMO)**

| What is an RMO? | An RMO is a central location that initially receives all claim documents. In an effort to improve mail operations, Medica uses a professional mail organization for its mail operations. The mail operation site has a tracking database that assigns claim documents a unique ID number, scans the claim documents and records the status of all the critical process steps. The RMO is responsible for completing several preparatory steps to claim documents and then sending images to UnitedHealthcare processing sites or data entry vendors for payment or review. This system allows for detailed reporting as well as identification of the employee and or equipment responsible for completing each step of the process. Essentially, the system allows Medica to account for and track every step of the claim, resulting in fewer lost or missing claims. |
| Where is it located? | Medica  
PO Box 30990  
Salt Lake City, UT 84130 |
Send Backs

Sending back a claim

Medica, on occasion, will “send back” or return a claim requesting that the participating provider resubmit the bill as an original claim. Medica does not input or track claims that have been returned to a provider due to improper claim information. Medica maintains no information about send-back claims in its system.

Reasons original claim submissions will be returned and the solutions for getting the claim corrected:

<table>
<thead>
<tr>
<th>Reason</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handwritten claims</td>
<td>- The data on the claim must be typewritten or computer printed on an official CMS-1500 or UB-04 form. Please type the claim or computer print the data and submit for processing. Minnesota providers are required to submit all claims electronically.</td>
</tr>
<tr>
<td>Invalid or incorrect member information</td>
<td>- Verify the Medica member ID number for the date of service and submit a corrected claim.</td>
</tr>
<tr>
<td>Missing required information</td>
<td>See the following Minnesota Uniform Companion Guides:</td>
</tr>
<tr>
<td></td>
<td>-  <a href="http://www.x12.org/">http://www.x12.org/</a> - ASC X12 Version 5010 and NCPDP Version D.0 May be used by mutual trading partner agreement as the Guides are adopted into rule and are required for use starting 1/1/2012.</td>
</tr>
<tr>
<td></td>
<td>- For paper claims submission use the appropriate guide (<em>CMS-1500 or UB-04</em>), determine which fields require data. All required fields must be populated with valid data.</td>
</tr>
</tbody>
</table>
System Claim Flow – High Level

1. Enter Claim
2. Verify by DOS
3. Assign Provider Panel and Contract
4. Get Provider Panel and Contract
5. Assign Service Code
6. Determine Member Benefits
7. Calculate PCR
8. Assign Reviews
9. Checkwrite

Panel from Marketing Package of Group

Group Contract Effective Date, Member Effective Date and Provider Effective Date

Group Fee Schedule, Provider Contract and Procedure fees

Benefit Package Log OOP/DED/LM

Adjudipro, Tables

Provider Contract

Authorization, Tables
(How UB-04 goes through the system)

**Hospital Claim Entry Flow**

1. **Enter Hospital Claim**
2. **Verify by DOS**
3. **Initial Calculation**
   - Assigns a Valid PAC or RTS, if appropriate
4. **Assigns Panel & Contract/pulls contracted amount**
5. **Assigns a service code and determine member benefits**
6. **Assign Select Reviews**
7. **After reviews are cleared the claim is picked up in another calculation and the process is repeated**
8. **Checkwrite**
### Overview of Claim Edits

| What type of edits are there at Medica? | • Hard coded logic  
| | • Auto-Adjudication  
| | • Manual Claims Edits  
| What is a hard coded edit | Hard coded edits are also referred to as auto deny edits. They contain criteria that are used by the computer to automatically deny a service/claim. Auto denial edits are established with the highest or first priority. It is a review that is set up via tables to deny without processor intervention or review.  
| What is auto-adjudication? | Claims that a processor does not need to touch.  
| What are manual claims edits? | Manual claims edits are policies and procedures driven and require processor intervention.  

## Pre-Existing Conditions (hard-coded)

~ Subject to change due to legislation ~

### Topic overview
A “Pre-Existing Condition” is described as a physical or mental condition, other than pregnancy, present before a member’s enrollment date under the Contract, for which medical advice, diagnosis, care or treatment was recommended by or received from a physician or other provider within the member’s “look back” period immediately preceding the member’s enrollment date.

### Who does a review apply to?
A *pre-existing condition* review is applied to:
- Small employer groups (2-50).
- It is also applied to some Self-Insured groups.

### Exceptions
For children under the age of 19, pre-existing conditions does not apply.

### Length of hold
The length of the pre-existing hold is generally 12 months (18 months for a late entrant); however, it will depend on the member’s prior coverage.

### HCR impact on pre-ex
Due to Health Care Reform (HCR) changes, as groups renew on and after 1/1/14, members with a pre-ex limitation will have their pre-ex limitation expire on the group’s renewal date.

A Pre-existing condition limitation applies to all Fully Insured small employer groups (2-50) and Self-Insured groups that elect it.

**Note:** Any claims received prior to the expiration dates are still subject to the pre-ex review process.
**Timely Filing (hard-coded)**

<table>
<thead>
<tr>
<th>Topic overview</th>
<th>“Timely Filing” is a term used to reference the amount of time providers or members have to submit claims or adjustment requests to Medica for consideration.</th>
</tr>
</thead>
</table>
| Policy details | **Submissions** All original claims 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 for *all* Medica and Medica SelectCare℠/LaborCare® products except Medica Select Solution® and Medica Prime Solution®.  

For Medica Select Solution and Medica Prime Solution, when Medicare is the payer, the timely filing limit is 180 days after the payment date on the explanation of Medicare benefits (EOMB) statement. When Medica is the payer, the timely filing limit is 180 days after the date of service or date of discharge for inpatient claims.  

**Exceptions** Following is a list of exceptions to the 180-day timely filing limit standard for all Medica and SelectCare/LaborCare products (except when Medicare is the payer for Medica Select Solution or Medica Prime Solution claims): Medica requires that claims, resubmissions and/or adjustments 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. In addition, SelectCare/LaborCare claims must be directed to the appropriate payer.  

- Patient’s date of birth 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  
- Member enrollment delays for COBRA continuation coverage. (This is limited to 180 days after the member is enrolled. It should be further noted that it may take up to 60 days for complete enrollment).  

For more information on timely filing and the Medica late claims policy, go to medica.com at Providers>Administrative Resources>Claim Tools>**Timely Filing and Late Claims Policy**
Note: The following adjustment and resubmission process forms are located on medica.com at Providers>Administrative Resources>Claim Tools.
Coordination of Benefits

Topic overview
Coordination of Benefits (COB) applies for all commercial and Medicaid products (does not include Medica Prime Solution and Medica Select Solution products).

Topic details
When Medica is the secondary plan, Medica will reimburse for the balance of expenses up to the primary plan’s fee maximum or the primary plan’s contracted rate for the service. The same policy will apply when Medica is the tertiary plan. This COB policy change does not apply to government products.

If the primary plan excludes the service or line item on the claim as member liability, Medica will pay that claim or line item per the member’s contract. (as if Medica was the primary payer in the absence of the other coverage).

In order to appropriately coordinate benefits with a primary payer, the claims processor must have valid primary payer information.

Acceptable formats for the primary payer information are:
- Explanation of Benefits (EOB) or
- Electronic 837 payment information

Medica can accept and adjudicate electronic COB information utilizing data submitted on an electronic 837I or 837P transaction.
Coordination of Benefits with Medicare

**Topic overview**
Coordination of Benefits (COB) with Medicare (includes Medica Prime Solution and Medica Select Solution).

**Topic details**
When Medicare is the primary carrier, Medica will coordinate up to 100% of the Medicare allowable and pick up the member’s Medicare deductible and coinsurance. Member copayments will still apply.

If Medicare excludes the services or line item on the claim, Medica will pay that claim or line item per the member contract (as if Medica was the primary payer in the absence of other coverage).

In order to appropriately COB with a primary payer, the claims processor must have valid primary payer information.

The acceptable formats for primary payer information are:
- Explanation of Medicare Benefits (EOMB)
- Medicare Summary Notice
- Crossover Claim
- Electronic 837 payment information
Auto-Adjudication

Overview of claims edits

Auto-Adjudication (AA) is the term used to indicate that a claim was paid or pending without the need for manual review by a processor; the claim was instead automatically adjudicated according to specific criteria within the claim processing system. Advantages of AA include reduced claim processing turn around time and increased consistency in claims payment.

Examples of Reimbursement Policies with specific auto-adjudication criteria:

- Anesthesia
- Assistant Surgeon Services
- Bilateral Procedures
- Global Days
- Laboratory Services
- Multiple Procedure
- Professional and Technical Components
- Rebundling

A comprehensive list of all Medica Reimbursement Policies can be accessed on medica.com at Providers>Policies and Guidelines>Reimbursement Policies

Manual Claims Edits

Overview of Claims Edits

Manual Claims Edits are set up in a priority, logical sequence for processors to clear in the “pended” order.

Many different combinations or considerations can be placed within one manual claims edit.

- CPT codes
- ICD-9 Diagnosis codes
- ICD-9 procedure codes
- HCPCs codes
- Revenue codes
- Age ranges
- Gender
- Product category
- Place of service
- Benefit level
- Provider specialty
Sequence of Claim Edits

**Data Validation (Automated)**

- **CPT/ICD-9 mismatch**
  - Identifies inappropriate ICD-9 diagnosis and CPT code combinations
    (Example: denies preventive Evaluation/Management (E/M) with illness diagnosis)

- **CPT/POS (Place of Service) mismatch**
  - Identifies incorrectly coded claims based on place of service
    (Example: denies hospital E/M submitted with “office” place of service)

- **CPT/provider specialty mismatch**
  - Identifies incorrectly coded claims based on provider specialty
    (Example: denies transvaginal ultrasound submitted by an ophthalmologist)

**Benefit Review**

For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services according to national coding guidelines (ICD-9/ICD-10). It is particularly important to accurately code because a member’s level of coverage under his or her benefit plan may vary for different services. Providers must submit a claim for services, regardless of whether they have collected the copayment, deductible or coinsurance from the member at the time of service.

**Referral Requirements**

- Determines if a referral has been received from the Primary Care Clinic for services. Claim payment is then made at the appropriate benefit level. Applies to products such as Medica Elect®, Medica EssentialSM, and MSHO products. Timely submissions of referrals are important. For additional information on referral processes, go to medica.com at Providers>Administrative Resources>Claims Tools (under the referral processes heading)

**Prior Authorizations**

- Determines if an authorization request has been submitted and approved. Claim payment is then made accordingly. Prior Authorization information can be accessed on medica.com at Providers>Policies and Guidelines>UM Policies and Prior Authorization and view the full prior authorization list.

**Customized Self-Insured Employer Group Contracts**

- Manually applies non-standard co-payments and benefits.
## Administrative Referral

### Definition of an administrative referral
Permission from a primary care provider/clinic to receive medically necessary care or services from a provider outside of the member’s primary care clinic or care system when such care or services are not available within the primary care clinic.

### When is an administrative referral required?
Medica products that require an administrative referral:
- Medica Elect
- Medica Essential
- Medica DUAL Solution® - MSHO (Minnesota Senior Health Options), MSC+ (Minnesota Senior Care Plus), SNBC (Special Needs Basic Care)

Note: Member ID card will indicate product type

### Services not requiring an administrative referral
No administrative referral is required for the following:
- Emergency ambulance
- Emergency services
- Urgent care
- Ophthalmologist/optometrist
- Mental health/substance abuse
- Chiropractic Services

### Care levels for referrals
A level of care is designated by the Primary Care Physician (PCP) giving the specialist direction as to what care to provide:
- Level I: Consultation only
- Level II: Consultation, and diagnosis
- Level III: Consultation, diagnosis and treatment

Referrals submitted without a care level will default to Level II.

### Administrative referrals
No referrals required for services if care is ordered by member’s Primary Care Clinic or a specialist with a Care Level 3 referral.

- All Rehab Therapy (PT, SP & OT)
- Non ER ambulance
- Anesthesiologist
- Audiologist
- Homecare
- Out-patient hospital services/surgi-centers
- Radiology
- Reference Labs/Pathology
- Skilled Nursing Facility
- Surgicenters
- Therapeutic Radiology

### Referral guidelines
- Services should be authorized in advance by the member’s primary care provider.
- All referrals must originate from the Medica member’s primary care physician/clinic.
- Approved referrals are valid for the date(s) of service specified on the referral request form.
- All referrals are subject to the member’s Medica eligibility status and plan benefits for the date(s) of service indicated on the referral.
• A referral request is valid for a period not to exceed six months.
• Referral guidelines and referral forms are available on medica.com at Providers> Administrative Resources>Claim Tools (under the “Referral Processes” heading):
  o Care System Referrals – FAQs
  o County Partners, Care Systems and Agencies - Phone and Fax Numbers
  o Referral Guidelines - Elect / Essential
  o Referral Guidelines - MSHO, MSC+, SNBC
  o Referral Guidelines – Restricted Recipient Program
  o Referral Request Form - Elect / Essential / ACO
  o Referral Request Form - Restricted Recipient Program

Referral submission
Submit online electronically through the secure Electronic Transaction option on medica.com.
Submit via paper by using the Referral Request Forms that are available on medica.com at Providers> Administrative Resources>Claim Tools under the Referral Processes heading and fax to the number shown on the bottom of the form.

Contact information for referral questions
For questions, changes or corrections to a referral, call the Medica Administrative Referral Inquiry Line at 1-800-458-5512, option 1, 4, and 1.
E-mail: referralinquiry@medica.com

Utilization management policy

A utilization management (UM) policy is a document containing clinical criteria used by Medica staff members for prior authorization, appropriateness of care and coverage determination. The criteria are specific to the clinical characteristics of the population that will benefit from the treatment or technology. The needs of individual patients who may not meet these criteria must be considered and are addressed by the process in the section labeled “Coverage Issues” on the UM policy.


How Medica develops UM policies

Documents are developed using an evidence based approach, which includes analysis and consideration of scientific literature and input from practicing physicians, Utilization Management and Clinical Appeals staff and Medica Medical Directors. UM policies are endorsed by the Medical Policy Committee, which is composed of network practicing physicians.

Prior authorization

The purpose of prior authorization is to evaluate the appropriateness of a medical service based on coverage criteria and medical necessity. Prior Authorization information is located on medica.com at Providers>Policies and Guidelines>UM Policies and Prior Authorization>Prior Authorization to view the Request Forms or view the full prior authorization list for medical services that require prior authorization. Some services have specific forms to help providers in submitting prior authorization requests for review.

Medica requires the following information:
- Name and phone number of the provider who is making the request.
- Name, phone number, address and type of specialty of the provider to whom the patient is being referred, if applicable.
- Services being requested and the date those services are to be rendered (if scheduled).
- Specific information related to the patient’s condition (clinical rationale for service being requested).

To begin the prior authorization process or for questions regarding the Medica prior authorization process, providers may call the Provider Service Center (PSC) toll-free at 1-800-458-5512.

Providers may also fax the prior authorization information listed above to the Medica Utilization Management and Clinical Appeals Department at 952-992-3556 or 952-992-3554.

Prior authorization does not guarantee coverage.
**Coverage Policies**

A coverage policy is a document that is developed to communicate decisions about coverage and benefits for various medical services. Each coverage policy contains a description of the medical service, as well as the coverage determination, product application, coding considerations and requirements for prior authorization.

Coverage policies can be found on medica.com at Providers > Policies and Guidelines > Coverage Policies

Note: Information on High-Tech Imaging is located on medica.com at Providers > Administrative Resources > Claim Tools > Overview of High-Tech Imaging Process.

**Drug Management Policies**

See the Drug Management Policies located on medica.com at Providers > Policies and Guidelines for drug coverage policies and prior authorization policies for pharmacy and medical settings.

**Obtaining Prior Authorization and Exceptions for Pharmacy Benefit Drugs**

**Medica requires the following information:**

- Name, phone and fax number of the provider who is making the request.
- Provider specialty, if applicable.
- Specific information related to the request:
  - Diagnosis the drug is being requested to treat
  - Previously tried medications for that indication, including dates of use (if known/available) and reason for discontinuing (ex: intolerance or ineffective)
  - If applicable, rationale to document why formulary medications are not appropriate (ex: contraindication to the drug due to “X”)
  - Other clinical/laboratory information required for the specific service or medication being requested.
  - If requesting a brand drug where an identical generic is available, a copy of the completed MedWatch form which has been faxed to the FDA per the form to document the failure of the generic formulation.
### Reimbursement Policies

**Medica Reimbursement Policy Overview**

Medica reimbursement policies provide payment methodology guidelines for medical, surgical and associated services submitted.

Reimbursement Policies are developed through a committee process with consideration of the following resources:
- Centers for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI)
- National Physician Fee Schedule Relative Value File (NPFS)

**Policy Review Process**

Reimbursement policies are reviewed on an annual basis.

Periodic updates can also be performed based on the following:
- Quarterly CPT/HCPCS releases
- Quarterly NPFS file releases
- AUC 5010 Guide

**Policy Location**

View Medica policy documents and applicable code lists on medica.com:
- Providers > Policies and Guidelines > Reimbursement Policies

**Coding/Reimbursement Tools and Resources**

The [Roadmap to Coding/Reimbursement Tools and Resources](#) guide is located on medica.com at News and Training>Provider College
**Provider Remittance Advice**

**Interpreting the Provider Remittance Advice (PRA) / Electronic Remittance Advice (ERA)**

| Overview | A Provider Remittance Advice (PRA)/Electronic Remittance Advice (ERA) is a summary of reimbursements made on all claims submitted. This statement is also called an explanation of benefits (EOB) when sent to members.  
A ERA/PRA is issued for each unique provider number for which a claim was reimbursed.  
A ERA/PRA is included with each check sent to a provider. |
|---|---|
| Content | The ERA/PRA is a member-by-member accounting of the amount billed, the amount disallowed (if any), any copayments, coinsurance or deductible amounts and reserves as well as the amount reimbursed. Reason codes that explain why a claim is processed in a particular fashion are explained at the end of each PRA.  
Members are listed alphabetically by last name, and identified by the provider’s own in-house patient account number if this information was included on the original claim at submission.  
The following pages offer a sample Provider Remittance Advice along with explanations of each PRA information field. It is also posted on medica.com at Providers>Administrative Resources>Claim Tools>Cosmos Platform PRA |
| What fields can be billed to the member? | Field 35 is an accumulation of member copay, deductible and ineligible amounts billable to the member. |
**MEDICA®**
P.O. BOX 30990
SALT LAKE CITY
UTAH UT 84130

**PAYEE**
HENRY GEORGE
MEDICAL CENTER
3256 EPIPHENOMENAL AVENUE
MINNEAPOLIS MN 55416

**Contact:** MEDICA
Tel: 800-458-5512

**PROV NO.** 01-C0006  **NAME** HENRY GEORGE

**CLM #** 63347943-00  **REND Prov** HENRY GEORGE

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<th>CTRL #</th>
<th>DOS</th>
<th>REV</th>
<th>ADJ PROD</th>
<th>SUB PROD</th>
<th>SVC/MOD</th>
<th>CHG</th>
<th>ADJ INT CD</th>
<th>GRP CD</th>
<th>CLM ADJ</th>
<th>REMARK</th>
<th>CLM PAYMENT</th>
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<td>10/02/07 10/03/07</td>
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<td>10000</td>
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<td>7.00</td>
<td>032</td>
<td>CO</td>
<td>055</td>
<td>2.10</td>
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**CLM CHG** .00  **PAT RESP** .00

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<th>TOTAL</th>
<th>PAYMENT</th>
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<td>PROVIDER TOTAL</td>
<td>80.00</td>
<td>22.40</td>
<td>76.00</td>
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<tr>
<td>PAYEE TOTAL</td>
<td>80.00</td>
<td>22.40</td>
<td>57.60</td>
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**PROV ADJ CD**
20011002 6334790900

**PROV ADJ ID**
.32-
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<tr>
<th>Field</th>
<th>Explanation</th>
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<tbody>
<tr>
<td>1. PAGE XXX OF XXX</td>
<td>Identifies the page number and total number of pages.</td>
</tr>
<tr>
<td>2. CHECK/EFT DT</td>
<td>Date the check was issued.</td>
</tr>
<tr>
<td>3. REF #</td>
<td>Used internally to identify the site, schedule and system cycle number for the report.</td>
</tr>
<tr>
<td>4. CHECK/EFT</td>
<td>Check, warrant, draft or electronic funds transfer number associated with the remittance advice report.</td>
</tr>
<tr>
<td>5. PAYMENT</td>
<td>Total amount of payment as it corresponds to the entire remittance advice.</td>
</tr>
<tr>
<td>6. PAYEE TAX ID</td>
<td>Provider’s federal tax identification number.</td>
</tr>
<tr>
<td>7. PAYEE ID</td>
<td>National Provider Identifier or the payer assigned payee ID.</td>
</tr>
<tr>
<td>8. PAYEE</td>
<td>The name identifying the payee organization to whom payment is directed.</td>
</tr>
<tr>
<td>9. CONTACT</td>
<td>Payers contact name and phone number.</td>
</tr>
<tr>
<td>10. PROD DT</td>
<td>Production end cycle date. The last date claims on the remittance advice was adjudicated.</td>
</tr>
<tr>
<td>11. PROV NO.</td>
<td>Seven-digit provider number used by the claim processing system.</td>
</tr>
<tr>
<td>12. NAME</td>
<td>Name of the provider who performed the service(s).</td>
</tr>
<tr>
<td>13. UP IN NO.</td>
<td>Provider’s unique identification number.</td>
</tr>
<tr>
<td>14. PATIENT</td>
<td>Name of the member receiving service(s). The subscriber’s address is printed below this field.</td>
</tr>
<tr>
<td>15. GRP-PATIENT</td>
<td>Assigned group number and policy number that uniquely distinguishes the patient’s coverage in the payer’s system.</td>
</tr>
<tr>
<td>16. PAT CTRL</td>
<td>Member’s account number assigned by the provider.</td>
</tr>
<tr>
<td>17. CLAIM NO. REND PROV DRG</td>
<td>Identification number assigned by the payer to the claim. Name of the provider who performed the service. Diagnosis Related Group based on the patient’s illness.</td>
</tr>
<tr>
<td>18. CLAIM DT REND PROV ID DRG WGH</td>
<td></td>
</tr>
<tr>
<td>19. ICD-9 DIAG MED REC # AUTH/REF #</td>
<td>Diagnosis code (up to four codes) indicated by the provider. Provider assigned medical record number. Authorization or referral number.</td>
</tr>
<tr>
<td>20. LINE CTRL #</td>
<td>Identifier assigned by the submitter/provider to identify a claim line.</td>
</tr>
<tr>
<td></td>
<td>Description</td>
</tr>
<tr>
<td>---</td>
<td>-------------</td>
</tr>
<tr>
<td>21. DOS</td>
<td>Date of service for each line item.</td>
</tr>
<tr>
<td>22. #</td>
<td>Number of Units for each detail line.</td>
</tr>
<tr>
<td>23. REV</td>
<td>Revenue code identifies a specific accommodation and/or ancillary service or billing calculation.</td>
</tr>
<tr>
<td>24. ADJ PROD</td>
<td>Adjudicated Procedure Code identifying services provided. Service modifier(s) identify special circumstances related to the service.</td>
</tr>
<tr>
<td>SVC/MOD</td>
<td></td>
</tr>
<tr>
<td>25. SUB PROD</td>
<td>Submitted Procedure/Service code/Modifiers as submitted by the payer.</td>
</tr>
<tr>
<td>SVC/MOD</td>
<td></td>
</tr>
<tr>
<td>26. CHG</td>
<td>Provider charge/billed amount for each line as submitted.</td>
</tr>
<tr>
<td>27. ADJ</td>
<td>The claim level adjusted amount for the associated reason code.</td>
</tr>
<tr>
<td>28. INT CD</td>
<td>Internal code used by Medica.</td>
</tr>
<tr>
<td>RSN CD</td>
<td></td>
</tr>
<tr>
<td>31. REMARK CD</td>
<td>Code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone.</td>
</tr>
<tr>
<td>32. PAYMENT</td>
<td>Payment amount corresponding to the adjudicated service line.</td>
</tr>
<tr>
<td>33. CLM CHG</td>
<td>The monetary amount for the submitted charges for this claim.</td>
</tr>
<tr>
<td>34. CLM PAYMENT</td>
<td>Total payment amount corresponding to the charges adjudicated on a claim.</td>
</tr>
<tr>
<td>35. PAT RESP</td>
<td>Total patient responsibility.</td>
</tr>
<tr>
<td>37. PROVIDER TOTAL CHARGES</td>
<td>Total charges billed on this claim.</td>
</tr>
<tr>
<td>38. PROVIDER TOTAL ADJUSTMENT</td>
<td>Monetary amount of the provider adjustment.</td>
</tr>
<tr>
<td>39. PROVIDER TOTAL PAYMENT</td>
<td>Total payment amount as it corresponds to the charges adjudicated on the claim.</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>40. PAYEE TOTAL CHARGE</td>
<td>The reason for the provider adjustments that is not specific to a particular claim or service.</td>
</tr>
<tr>
<td>41. PAYEE TOTAL ADJUSTMENT</td>
<td>Payee ineligible amount</td>
</tr>
<tr>
<td>42. PAYEE TOTAL PAYMENT</td>
<td>Total amount paid</td>
</tr>
<tr>
<td>43. PROV ADJ CD</td>
<td>The reason for a provider adjustment not specific to a particular claim or service.</td>
</tr>
<tr>
<td>44. PROV ADJ ID</td>
<td>This number is the same as the Patient Control number that the provider assigns to their patients account.</td>
</tr>
<tr>
<td>45. PROV ADJ AMT</td>
<td>The monetary amount of the provider adjustment. <strong>Note:</strong> positive adjustment amounts decrease payment and a negative amount increases payment.</td>
</tr>
</tbody>
</table>
Electronic Provider Remittance Advice
Interpreting the Electronic Provider Remittance Advice (EPRA)

Overview
EPRA is another HIPAA transaction supported by the Electronic Commerce (EC) Department. By receiving EPRA, the provider has the opportunity to reduce staff hours by automating the account posting process. Receiving EPRA tightens the circle for a completely automated claims process.

The v.5010 file is routed to either ENS or the UnitedHealthcare® (UHC) business to business (B2B) for distribution to the provider.

Providers then use the EPRA file to automatically post payments into their Practice Management System.

Some EPRA receivers continue to receive paper remittance if not enrolled in Electronic Payments and Statements (EPS). Recipients of EPRA files are solely responsible for ensuring that appropriate audit and accounting practices are in place within their organization to handle automated posting.

To receive EPRA files, connectivity either with ENS or the UHC B2B must first be established. Often, the provider’s Practice Management Systems vendor or clearinghouse will obtain this connectivity to facilitate receipt of files and accommodate automated posting of accounts. Once connectivity is in place, complete the necessary registration forms at your vendor or clearinghouse. The vendor or clearinghouse will send the necessary registration forms on to their business partners in order to complete the set up process. To facilitate automated posting, providers are encouraged to work with their systems vendor or internal systems staff to make any needed updates to their Accounts Receivable system. Many vendors charge for these updates and ongoing maintenance.

Whenever possible, the electronic remit will mirror the paper remit. However, there are instances when this is not possible. Because the EPRA file is formatted as an ANSI transaction, the disallow and denial codes on the EPRA are as mandated within the ANSI X12 835 Implementation Guide. Therefore, the disallow/denial codes on the electronic remittances are not identical to those found on paper remittances.

The HIPAA compliant file
The HIPAA compliant file, ANSI 835 v.5010, available to new and existing EPRA clients, is also created during the checkwriting process, and then formatted in to the compliant ANSI 835 v.5010 format. The v.5010 file is routed to either ENS or the UHC B2B for distribution to the provider.
Disallow/Denial codes
Disallow/denial codes (remarks) used on the Provider Remittance Advice (PRA) / ERA

Descriptions

**Denial reason code** – is a three-digit reason code that describes why the entire billed amount is not being reimbursed.

**Disallow reason code** – is a three-digit reason code that describes why all or a portion of the billed amount is not being reimbursed.

ANSI Codes
The American National Standards Institute (ANSI) X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. Implementation guides for each ANSI X12N transaction adopted as a HIPAA standard can be found at [http://www.wpc-edi.com](http://www.wpc-edi.com)

Adjustments
Adjustments are found on the Provider Remittance Advice (PRA) / ERA

Overview

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 such as the participating provider may be underpaid or overpaid, or the wrong provider may be reimbursed. The need for a claim adjustment can be determined by either the provider or Medica.

The Medica claim audit procedure may uncover the need to adjust claims or the Medica staff may receive new information about a claim or the agreement under which it is processed. In either case, Medica typically performs necessary adjustments without requesting additional information from the participating provider. The provider will see the adjustment on the Provider Remittance Advice. Whenever corrected or additional information that is significantly different from the original claim submission is needed, Medica will ask the provider to complete a Claim Adjustment Request Form and send it to Medica.

When a payment has already been made on a claim but a change to it is necessary, providers should use the Medica Claim Adjustment Request Form. When the adjustment request form is completed, the audit number of the claim to be adjusted must be indicated on the form. This allows for the processor to match the adjustment request with the original claim submission and confirms they are adjusting the correct claim. Minnesota providers should follow AUC guidelines and submit a void or replacement claim, as appropriate.

Here are some situations where adjustments may be needed:

- A claim did not pay according to correct contracted rate (or fee schedule)
- Incorrect provider was paid
- Medica paid as primary payer in error
- A line was denied as unbundled service

Providers can find the Adjustment Request form online on medica.com at Providers> Administrative Resources>Claim Tools > [Claim Adjustment Request Form](http://www.wpc-edi.com)
| **Timely Filing and Late Claims Policy** | The Medica timely filing and late claims policy which includes adjustments, resubmissions, final filing limit, and late claim appeals is located on medica.com at Providers> Administrative Resources> Claim Tools > Timely Filing and Late Claims Policy. |
| **Adjustment timeframes** | **Adjustments (Medicare claims and all other claims, except for SelectCare/LaborCare claims)**  
There is a 12-month limit for adjustments:  
- If a claim is denied or rejected (one line or all lines), the clean claim must be resubmitted and received within 12 months of the date of the denial or rejection.  
- If the claim was paid, and an adjustment to the payment is being requested, the request must be received within 12 months of the check date on the provider remittance advice (PRA)/ERA.  
  
  Note: For Medica SelectCare/LaborCare claims, the 180-day time limit for adjustments to paid or denied claims remain. |
| **Description of an adjustment reason code** | **Adjustment reason code** – is a three-digit reason code that describes why the claims needed to be corrected or adjusted. Adjustment codes are found on the Provider Remittance Advice (PRA)/ERA and are used for error trending and afford an opportunity for provider education/feedback. |
| **Appeal Requests** | **Claim Appeal Form**  
This form is to be used when a provider is requesting a reconsideration of a previously adjudicated claim but there is no additional or corrected data to be submitted. The Claim Appeal Request Form is located on Medica.com at Providers> Administrative Resources> Claim Tools> Claim Appeal Form  
**Claims Submission Terminology**  
It is important to understand claims and claim terminology, especially as these relate to practices and guidelines of the Health Information Portability and Accountability Act (HIPAA) 837 transaction. The following grid outlines related terms, definitions, examples, and practices. |
Claims Submission Terminology

<table>
<thead>
<tr>
<th>Question</th>
<th>Definition</th>
<th>Examples</th>
<th>How to Submit the Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is a Replacement (or &quot;corrected&quot;) Claim?</td>
<td>A replacement claim is sent when an element of data on the claim was either &quot;missed&quot; or needs to be &quot;corrected&quot; on the claim.</td>
<td>Incorrect date of service (DOS) - Incorrect units - Procedure code missing - Diagnosis code change or addition - Revenue code change - Line being added</td>
<td>- If submitted by paper, send replacement via paper to Medica's claims address. - If submitted electronically, submit the replacement electronically and follow AUC Best Practice for replacement/voided claims.</td>
</tr>
<tr>
<td>What is a Voided (or &quot;canceled&quot;) Claim?</td>
<td>When identifying elements change, a void submission is required to eliminate the previously submitted claim.</td>
<td>Incorrect provider - Incorrect patient - Incorrect payer - Incorrect insured and statement period on an institutional claim</td>
<td>- Whether original claim was submitted by paper or electronically, the void may be sent electronically. The void should be sent along with the new original claim. - Follow AUC Best Practice for replacement/voided claims.</td>
</tr>
<tr>
<td>What is a Claim Appeal?</td>
<td>A provider is requesting a reconsideration of a previously processed claim but there is not any additional or corrected data submitted.</td>
<td>Timely filing - High-tech imaging - Clinical appeal</td>
<td>Continue to utilize Medica’s forms until further notice.</td>
</tr>
<tr>
<td>How are coordination of benefits (COB) claims submitted electronically?</td>
<td></td>
<td></td>
<td>If submitting a paper copy of an explanation of benefits (EOB) statement, providers will need to follow the paperwork (PWK) segment process, completing the new uniform cover sheet in its entirety and faxing it to the Medica dedicated fax line or mailing it to the Medica claims address. *Note: Providers need to work with their vendor to ensure they have the capability to submit COB claims electronically. Medica is able to accept COB claims electronically.</td>
</tr>
</tbody>
</table>

* From the date of submitting the electronic claim, providers have three days to fax related paperwork to the Medica dedicated fax line at 801-994-1076 (or, if providers choose to mail it in, Medica needs to receive it at its claims address within 10 calendar days). This process is to be used when the PWK segment has been populated in loop 2300 on the electronic claim. When submitting paperwork to Medica, providers must fill out the “Uniform Cover Sheet for Health Care Claim Attachments” (http://www.health.state.mn.us/auc/forms.htm) in its entirety. Standard timely filing guidelines will apply. **Note:** Providers are encouraged *not* to resubmit electronic claims in this situation as this can delay proper claims processing. More information about submission of both professional and institutional claims is available online from the Minnesota Administrative Uniformity Committee at http://www.health.state.mn.us/auc/index.html
Closed/Rejected Claims

Clarification regarding what documents are required when a claim has a missing or invalid data element

If a missing or invalid data element denial is received on a:

- Provider Remittance Advice (PRA) / ERA – For non-Minnesota providers, an appeal request form with the corrected information should be submitted. A corrected claim is not required. Minnesota providers must submit an electronic correction when data elements are invalid or missing.

- Department of Labor (DOL) letter – the provider should return the letter with the items requested. A corrected claim is not required.

- Send-back letter – the provider should follow the instructions on the letter indicating whether an adjustment request form or a new claim with the corrected information is needed.

Example
Claim closes 085-Records Related to Charges Needed. (This occurs when prior authorization is required, but not obtained prior to the service being rendered.) A letter is sent to the provider office requesting information to be submitted to Medica. Information should be attached to a Claim Appeal Request Form (additional information to have the claim considered, when no data elements on the claim are changing) for review/reconsideration.

Minnesota providers must follow the AUC guidelines for electronic submission of replacement claims.
CLAIM ADJUSTMENT REQUEST FORM

This form is to be used when a provider has additional data that should have been submitted on the original claim or has a need to correct data that was input incorrectly on the original claim.

NOTE: Minnesota providers must follow the MN AUC guide for electronic submission of void/replacement claims.

☐ For Medica members with group policy #IFS, send to:
  Medica
  PO Box 951617
  El Paso, TX  79998-1647
  Or fax this form to: 952-992-1427

☐ For all other Medica members, send to:
  Medica
  PO Box 30990
  Salt Lake City, UT  84130
  Or fax this form to: 1-801-994-1076

PROVIDER INFORMATION:
Provider Name: 
Provider Number (10 or 11 digits): 
Patient Account Number: 

CLAIM INFORMATION:
Member Name: 
Member Group and ID Number: 
Date(s) of Service: 
Claim Number(s): 

REASON FOR ADJUSTMENT REQUEST: 

SUPPORTING DOCUMENTATION ATTACHED:
☐ New completed claim (CMS 1500/UB 04) ☐ Refund ☐ Remittance Advice
☐ Medical Records ☐ Other 

CONTACT INFORMATION:
Requester: 
Phone Number: 
Date: 

TOTAL NUMBER OF PAGES: 

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**REASON FOR APPEAL:**

- [ ] Timely Filing – claims submitted beyond 180 days from DOS or 12 months from the disallow date
- [ ] Pricing – Incorrect payment or application of benefits
- [ ] Eligibility – Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- [ ] Medical Policy – Appeal a determination of medical necessity or a denial for failure to obtain prior authorization. 60 days in the case of lack of prior authorization. Supporting documentation required.
- [ ] Code Review – Appeal of coding decision; supporting documentation required
- [ ] Other – Provide a detailed description

Description of Claim Appeal:

**SUPPLEMENTAL DOCUMENTATION ATTACHED:**

- [ ] Remittance Advice
- [ ] Refund
- [ ] Medical Records
- [ ] Other (e.g. timely filing documentation such as practice management notes)

**CONTACT INFORMATION:**

Requester: 
Phone Number: 
Date: 

**TOTAL NUMBER OF PAGES: 

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We have received an Adjustment/ Service Request regarding the above-described claim. We are unable to process this service request because of either missing information, or because of the explanation listed below. Please include a copy of this letter with your Service Request resubmission. Thank you.

<table>
<thead>
<tr>
<th>BILLING PROVIDER:</th>
<th>PATIENT INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>x1</strong> Federal ID number missing or invalid. <strong>freeform1</strong></td>
<td><strong>x3</strong> Please submit with National Drug Code (NDC) and dosage.</td>
</tr>
<tr>
<td><strong>x2</strong> Provider number missing or invalid for date of service. <strong>freeform2</strong></td>
<td><strong>x4</strong> Place of service invalid or missing. <strong>freeform4</strong></td>
</tr>
<tr>
<td><strong>x5</strong> Date of service invalid or missing. <strong>freeform5</strong></td>
<td></td>
</tr>
</tbody>
</table>

Note: Member number includes: 5-digit group number + 9-digit subscriber Social Security number + 2 digit relationship code.

**x7** The member/group ID number is missing or invalid. **freeform7**

**x8** Please resubmit claim on a correct HCFA 1500 form
**x9** Please resubmit claim on a correct UB92 form.
**x10** Please resubmit claim with a legible copy.
**x11** No adjustment necessary, per records Medica is prime **freeform11**.
**x12** Claim was previously processed on **adate1** with the check number **cknbr1**.
**x13** No adjustment necessary per **freeform13**.
**x14** We are unable to adjust this claim due to the age of the claim, you will be contacted regarding the refund of any outstanding overpayment via a separate letter.
**x15** The adjustment request you submitted for your patient, **mename** for date of service, **dos** **freeform15**.

If you have questions or need further clarification, please call the Medica Provider Service Center at 1-800-458-5512.

PLEASE RETURN TO: **procflinit**

Medica
PO Box 30990
Salt Lake City, UT 84130
Recovery

The following chart is on medica.com at Providers>Administrative Resources>Claim Tools>
Overpayment Adjustment Guidelines

<table>
<thead>
<tr>
<th>Overpayment Adjustment Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Overpayment</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Medica paid as primary and should be secondary</td>
</tr>
<tr>
<td>Duplicate payments</td>
</tr>
<tr>
<td>Medicare Paid in Error-70000 Groups</td>
</tr>
<tr>
<td>Medica initiated adjustment</td>
</tr>
<tr>
<td>Medica and provider initiated adjustment and goes into negative payee status</td>
</tr>
<tr>
<td>Provider initiated adjustments for any amount.</td>
</tr>
<tr>
<td>Retro member terminations</td>
</tr>
<tr>
<td>Subrogation</td>
</tr>
<tr>
<td>Fraud and abuse</td>
</tr>
</tbody>
</table>

Recovery

Medica will attempt to recover overpayments with participating providers by withholding payments on a future provider remittance advice when possible. When overpayments are identified for providers where withholding was not possible, a letter is sent to the provider requesting a payment for the amount of the overpayment.

Credit Balance

The vendor performs audits on site with approval from the provider. The auditors perform credit balance audits in Minnesota. The top three recoveries of credit balances for Medica have been as follows:

- COB
- Change in hospital billing
- Multi payments

Subrogation

Our subrogation vendor works to identify dollars paid out by other parties such as an auto insurance carrier, home owner’s insurance, worker’s compensation, etc. When the vendor discovers a third party has made payment on a claim that Medica has also paid on, a letter may be sent to the provider requesting a payment for the amount of the overpayment.

For any of the scenarios listed above, when the provider refunds the overpayment, claim information is forwarded back to the claims processors to adjust the claim(s).
## Summary of Resources

<table>
<thead>
<tr>
<th>Topic</th>
<th>Medica Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment Request Form</td>
<td>medica.com at Providers&gt; Providers&gt;Administrative Resources&gt;Claim Tools&gt; <a href="#">Claim Adjustment Request Form</a></td>
</tr>
<tr>
<td>Claim Appeal Request Form</td>
<td>medica.com at Providers&gt; Providers&gt;Administrative Resources&gt;Claim Tools&gt; <a href="#">Claim Appeal Form</a></td>
</tr>
<tr>
<td>Coding/Reimbursement Tools and Resources</td>
<td>medica.com at Providers&gt;News and Training&gt;Provider College&gt; participant guide</td>
</tr>
<tr>
<td>EDI questions</td>
<td>email <a href="mailto:medica.electroniccommerce@medica.com">medica.electroniccommerce@medica.com</a></td>
</tr>
<tr>
<td>Medica Administrative Manuals</td>
<td>medica.com at Providers&gt; Administrative Resources&gt; <a href="#">Administrative Manuals</a></td>
</tr>
<tr>
<td>Medica Clinic Demographics</td>
<td>medica.com at Providers&gt; Administrative Resources&gt; <a href="#">Demographic Change</a></td>
</tr>
<tr>
<td>Medica Electronic Commerce</td>
<td>medica.com at Providers&gt;Administrative Resources&gt;Claim Tools&gt; <a href="#">Electronic Commerce</a> or email <a href="mailto:medica.electroniccommerce@medica.com">medica.electroniccommerce@medica.com</a></td>
</tr>
<tr>
<td>Medica Claims Submission Information</td>
<td>medica.com at Providers&gt; Administrative Resources&gt; <a href="#">Claim Tools</a></td>
</tr>
<tr>
<td>Medica Electronic Transactions</td>
<td>medica.com at Providers&gt; <a href="#">Electronic Transactions</a>, For additional information go to Providers&gt; Administrative Resources&gt; <a href="#">Administrative Manuals</a></td>
</tr>
<tr>
<td>Medica Provider Service Center</td>
<td>1-800-458-5512</td>
</tr>
<tr>
<td>Medica Provider Analysts</td>
<td>Through the Medica Provider Service Center</td>
</tr>
<tr>
<td>Medica UM Policies or Medica Coverage Policies or Drug Management Policies or Reimbursement Policies</td>
<td>medica.com at Providers&gt;Policies and Guidelines&gt; <a href="#">Coverage Policies</a> or <a href="#">Drug Management Policies</a> or <a href="#">Reimbursement Policies</a> or <a href="#">UM Policies and Prior Authorization</a></td>
</tr>
<tr>
<td>Minnesota provider requirement</td>
<td>medica.com at Providers&gt;Administrative Resources&gt;Claim Tools&gt; <a href="http://www.health.state.mn.us/auc/index.html">AUC Initiative</a> or <a href="#">http://www.health.state.mn.us/auc/index.html</a></td>
</tr>
<tr>
<td>Prior Authorization information</td>
<td>medica.com at Providers&gt;Policies and Guidelines&gt; <a href="#">Prior Authorization List and Request Forms</a></td>
</tr>
<tr>
<td>Provider Demographic Online Tool (PDOT) User Guide</td>
<td>medica.com at Providers&gt;Administrative Resources&gt;Demographic Change &gt;Demographic Change Requests&gt; <a href="#">User Guide for Provider Demographic Online Tool (PDOT)</a></td>
</tr>
<tr>
<td>Referral Processes</td>
<td>Submit online electronically at medica.com at Providers&gt;Electronic Transactions or via paper at medica.com at Providers&gt; Administrative Resources&gt; <a href="#">Claim Tools</a> (under the Referral Process heading)</td>
</tr>
<tr>
<td>Referral questions</td>
<td>Call the Medica Administrative Referral Inquiry Line at 1-800-458-5512 or email <a href="mailto:referralinquiry@medica.com">referralinquiry@medica.com</a></td>
</tr>
<tr>
<td>Reimbursement Policies</td>
<td>medica.com at Providers&gt;Policies and Guidelines&gt; <a href="#">Reimbursement Policies</a></td>
</tr>
<tr>
<td>Timely Filing, Payment Resources, High-Tech Imaging and other Claim resources</td>
<td>medica.com at Providers&gt; Providers&gt;Administrative Resources&gt; <a href="#">Claim Tools</a></td>
</tr>
<tr>
<td><strong>Other Resources</strong></td>
<td><strong>Location</strong></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Accredited Standards Committee</td>
<td><a href="http://www.x12.org/">http://www.x12.org/</a></td>
</tr>
<tr>
<td>ANSI 837 claim transaction information or to obtain implementation guide for other transactions</td>
<td><a href="http://store.x12.org/store/">http://store.x12.org/store/</a></td>
</tr>
<tr>
<td>Minnesota Administrative Uniformity Committee</td>
<td><a href="http://www.health.state.mn.us/auc/">http://www.health.state.mn.us/auc/</a></td>
</tr>
<tr>
<td>Uniform Cover Sheet for Health Care Claim Attachments</td>
<td><a href="http://www.health.state.mn.us/auc/forms.htm">http://www.health.state.mn.us/auc/forms.htm</a></td>
</tr>
<tr>
<td>UnitedHealthcare Online</td>
<td><a href="http://www.unitedhealthcareonline.com">http://www.unitedhealthcareonline.com</a> or 1-866-UHC-FAST (842-3278)</td>
</tr>
<tr>
<td>UnitedHealthcare EDI support:</td>
<td>1-800-842-1190 or email <a href="mailto:supportedi@uhc.com">supportedi@uhc.com</a></td>
</tr>
<tr>
<td>Help with rejected claims can be obtained from UHC (claims processor for Medica):</td>
<td>See page 8 of participant guide</td>
</tr>
</tbody>
</table>