

Chapter 6

Claims Submission Information

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Electronic Data Interchange (EDI)

UCare has selected McKesson RelayHealth ("RelayHealth") as its pre-adjudication software partner to prepare for 5010 and manage EDI connectivity in an effort to expand electronic services for providers (e.g., real-time services) as well as support administrative simplification, administrative cost reduction, and regulatory compliance initiatives (i.e., HITECH). The transition/change to RelayHealth was effective 5/1/11.

A letter was faxed to all contracted providers on 2/16/11 advising them of the transition/change to RelayHealth. If you didn't receive a letter from us regarding this change and would like a copy of the letter, [click here](#). We have also put together a FAQ for your convenience. You may access the FAQ by [clicking here](#).

If you have questions or would like additional information regarding RelayHealth solutions, you may contact RelayHealth directly by calling **1-888-743-8735** or visit their web site at www.relayhealth.com.

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MN State Statute 62J.536

Effective 07-15-09

Minnesota State Statute, section 62J.536, requires all health care providers to submit all health care claims electronically for, including secondary claims, using a standard format. If you currently submit paper claims, you must explore your options for electronic claim submission and prepare to be in compliance.

Please access the entire law available online at Minnesota Department of Health (MDH) web site at <http://www.health.state.mn.us/asa/rules.html> or the Minnesota Office of the Revisor of Statutes at <https://www.revisor.leg.state.mn.us/statutes/?id=62J.536>.

This statute affects all UCare members enrolled in Minnesota Health Care Programs. UCare will only accept paper claims for members with any Medicare programs and out of state providers.

Submission Requirements

For further information regarding the submission requirements, see the Administrative Uniformity Committee (AUC) companion guides. Click on this link to view the companion guides: <http://www.health.state.mn.us/auc/guides.htm>. You can also click [here](#) to get UCare's quick reference guide for claim submission.

Electronic Attachments

UCare will except electronic attachments for any claims submitted electronically. All attachments need to be faxed to UCare. To assure that a good image is received please make sure your fax settings are the following: **Resolution of 1712 w x 2195 h @ 200 DPI (with 200 DPI for both horizontal and vertical)**. The fax number to be used for this is:

New Claim Attachments: 612-884-2261.

Adjustment Claim Attachments: 612-884-2186.

UCare follow best practices guidelines set forth by the AUC. Their web site is: <http://www.health.state.mn.us/auc/index.html>.

All attachments must include an Attachment Cover Sheet. The Attachment Cover Sheet is similar to a fax cover sheet and contains information such as member number, provider name, and Attachment Control Number (ACN). To view a copy of the attachment cover sheet click the below link: <http://www.health.state.mn.us/auc/bstprac08b.doc>.

Attachment Control Number

The Attachment Control Number (ACN) is found on the attachment cover sheet and helps in assuring that an EDI claim is matched up with any relevant attachment information associated with that claim. This number is created by the billing provider and can be up to 50 characters in length. This number is also added to the EDI submission allowing UCare to link the two related items together. UCare will accept related attachments up to 3 days after the claim submission.

For information on adjustment requests please see the [Adjustment section](#) of this chapter.

PAPER CLAIMS/ATTACHMENTS

UCare will only accept paper claims for members with any Medicare programs and out of state providers.

UCare utilizes an optical character reader (OCR) for the entry of claims.

The following instructions for completing the CMS-1500 and UB-04 forms must be followed:

1. Use only the official Drop-Red-Ink forms. We cannot accept black-and-white or photocopies.
2. Providers who reprint their name and address in field 33A should use a 10 or 12 character font size.
3. Print requirements:
 - Ink should be dark, which may require frequent ribbon changes.
 - Ink should be dense.
 - Use UPPERCASE characters only.
 - Use 10 or 12 font size.
 - Use a standard font such as Arial or Universal.
 - Do not hand write on the claim form.
 - Do not use slashes, dashes, decimal points, dollar signs or parentheses.
4. Enter all information on the same horizontal line.
5. Left justify all fields.
6. Do not fold claims.
7. A maximum of six line items is allowed in field 24A.
8. Line items must be double-spaced.
9. If an unlisted procedure code is used, a narrative description is required. In this case, single space and submit the narrative on the next available line in field 24D through 24K.
10. Do not use staples.

Use current Revenue Codes, CPT, ICD-9-CM, and HCPCS coding.
Consult current coding guidelines for modifier usage, especially for surgical billings.

All services should be billed line-by-line and identified by Revenue, CPT or HCPCS codes, ICD-9-CM codes, modifiers (when appropriate), location codes, and units.

Each service must be itemized by date on separate lines unless the services were delivered on consecutive dates. If service dates are consecutive, they can be combined on one service line,

referencing the date span (e.g., 1-10-06 through 1-15-06), correct number of units (e.g., 5), and charge amount. PCA providers must bill each date separately. Only one PCA will be accepted per claim.

Do not stamp over billing data—claims must be legible and all data must be readable.

If the member has other insurance, submit an EOP/EOB from the primary insurance carrier with the claim.

One claim per UCare member. One claim per UCare provider.

Mail Claims to:

UCare
Attention: Claims
P.O. Box 70
Minneapolis, MN 55440-0070

Health Tradition Claims:

UCare
Attention: Claims
PO Box 1210
Minneapolis, MN 55440-1210

Claims Status Adjustments:

UCare
Attention: Claims
PO Box 405
Minneapolis, MN 55440-0405

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CMS 1500 PAPER CLAIM FORM

[Sample CMS 1500 form](#)

Field numbers below refer to the current version of the CMS 1500 claim form.

Field 1a, indicate the UCare 11-digit member number, the patient name in field 2, and the date of birth in field 3.

Field 9a-d, if the member has other coverage, enter the policyholder's name, other insured's policy or group number, other insured's date of birth, sex, employer's name or school name and insurance plan name or program name (i.e., a child has coverage under a parent's insurance policy).

Field 11a-c, if member has other coverage and is the policyholder, enter the insurance policy or group number. Complete field 11a—11c.

Field 11d, enter an "X" in the appropriate field. If the recipient has insurance coverage and is not the policyholder, enter an "X" in the "Yes" field and complete items 9 through 9d, otherwise enter an "X" in the "No" field and leave field 9-9d blank.

Field 21, indicate the diagnosis or nature of illness or injury. (Relate Items 1, 2, 3 or 4 to Item 24E by line).

Field 23, indicate the UCare referral or authorization number, if applicable.

Field 24, indicate A-Date of Service, B-Place of Service, C-Type of Service, D- Procedures, Modifier, E-Diagnosis Code, F-Charges, G-Units or Days, H-EPSDT Family Plan.

Field 24H, indicate the appropriate Child & Teen Checkups (C&TC) alpha code, if applicable. Each line item must have an alpha code listed.

Field 24J, indicate the treating provider's rendering NPI provider identification number or UMPI number (not the MA number). One NPI/UMPI per claim.

Field 25, include a Tax Identification Number (TIN).

Field 26, include patient account number.

Field 27 indicates "Yes" if you accept assignment or "No" if you do not accept assignment.

Field 28, the total charges must match the charges in field 24F. Indicate the total (sum) amount of all charges on the claim in field 28 on the last page of a multiple page claim. On all previous pages of a multiple page claim, leave field 28 blank or enter "continued" in the field.

Field 31, signature of physician or supplier including degrees or credentials.

Field 32, indicate the place where services were rendered, not the provider to be paid.

Field 33, indicate the provider group's name, address, and the billing provider's NPI number.

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CMS 1450 / UB-04 PAPER CLAIM FORM

[CMS 1450 / UB-04 form](#)

FL 1, enter the provider of service's name, address, and phone number.

FL 2, Pay to name, address, city, state, ID

FL 3a, enter in the patient control number.

FL 3b, Medical record number

FL 4, enter the bill type.

FL 5, enter the Tax Identification Number (TIN) for the provider of service.

FL 6, enter the from and through date.

FL 8, enter the patient's name.

FL 9, Address of patient

FL 10, Date of birth

FL 12, Admission date

FL 13, Admission hour.

FL 14. Type of admission visit

FL 15, Source of admission

FL 16, Discharge hour.

FL 17, Patient discharge status code

FL 18-28, Condition codes

FL 29, Accident date

UPDATE.

FL 32-35, enter in the occurrence codes and dates if required.

FL 39, enter in the value codes if required.

FL 42, enter the rev codes.

FL 43, enter the description.

FL 44, enter the HCPCS/rates.

FL 45, enter the service dates.

FL 46, enter the service units.

FL 47, enter the total charges. If billing, make sure to indicate the total amount of the claim in field 47 on the last page. On all previous pages, you can leave field 47 blank or put “continued” in that field.

FL 48, enter the non-covered charges.

FL 50, enter the insurance carrier’s information.

FL 51, enter the UCare provider number.

FL 53, indicate “Yes” if you accept assignment or “No” if you do not accept assignment.

FL 58, enter the policyholder’s name.

FL 59, enter the patient responsibility code.

FL 60, enter the UCare member number and other insurance identification number, if applicable.

FL 61, if the member has another insurance carrier, enter the group name.

FL 62, if the member has another insurance carrier, enter the insurance group number.

FL 63, indicate the UCare referral or authorization number, if applicable.

FL 67-75, enter in the diagnosis codes.

FL 76, enter the admission diagnosis code.

FL 80-81, enter in the principal codes.

FL 82, enter in the attending physician NPI.

FL 85, enter the provider representative signature and date.

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COMMON SUBMISSION ISSUES

Commonly missed or incorrectly completed claim forms include:

- Incorrect member or group number. Please include all numeric and alpha characters with no spaces.
- Incorrect or missing individual provider NPI number in field 24J.
- Procedure codes billed with the incorrect units of service.
- Incorrect combinations of fields 24E and field 21 (diagnosis fields on CMS 1500 form).
- Failure to submit all surgical procedures for the same date of service on a single claim.
- Misspelling of the patients name; submit exactly the way it is on their identification card and include the correct date of birth
- Incorrect bill type submitted (see adjustment section of manual)

DUPLICATE CLAIMS SUBMISSION

It is UCare's standard guideline to process clean claims within 30 days of receipt.

Submission of duplicate claims is not necessary and may be considered abusive.

To avoid duplicate claim submission, please consider the following:

- Notify your patient that you will bill their insurance.
- Eliminate "automatic" re-billing.
- Allow 30 calendar days for claim processing.
- Do not send previously submitted claims with new claims, as this practice may delay payment of new claims.
- If you are inquiring about payment please call our Provider Assistance Center at 612-676-3300 or toll free at 1-888-531-1493.
- If a claim has been processed and/or denied, resubmitting a duplicate claim will result in a denial.
- Use the status adjustment (see Claims Adjustment section of this chapter) procedure or TOB XX7 to resubmit claims.

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CLAIMS PAYMENT

UCare maintains a 30-day turnaround time on all clean claims received. A clean claim is defined as 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 (42 CFR 447.45 and 447.46, and Minnesota Statutes, section 62Q.75).

UCare accompanies all payments with an Explanation of Payment (EOP) that outlines billing information submitted and the UCare claim processing information. We list payment/non-payment code explanations at the bottom of each EOP.

Read your EOP's as you receive them. Address questions about an EOP to the Provider Assistance Center at 612-676-3300 or 888-531-1493, not by resubmission of the claim.

UCare recommends that you keep copies of your EOP's according to your business record retention policies.

Timely Filing

Participant shall submit to UCare, in a format approved by UCare and in compliance with state and federal law, claims for Covered Services no more than 12 months from the date the Covered Services were rendered, or from the date Participant had knowledge of Enrollee's coverage under a UCare Certificate of Coverage, whichever is later. Claims submitted after such period shall be denied.

Individual provider contracts may vary, therefore, please refer to your UCare contract.

Timely Filing - Coordination of Benefits (COB)

When a commercial insurance is the primary insurance, an Explanation of Benefits (EOB) from the primary insurance must be submitted and received within 6 months of the EOB's paid date or within 12 months from the date of service; whichever is greater.

When Medicare is primary, the Medicare Summary Notice (MSN) must be received within 12 months of the payment or denial date.

Unsuccessful Third Party Liability (TPL) Billing

Providers may bill UCare in cases when three (3) unsuccessful attempts have been made to collect from a third party payer within 90 days, except where the third party payer has already made payment to the recipient.

The following information is required for payment to be considered:

1. A copy of the first claim sent to the third party payer.

2. Documentation of two further billing attempts.
3. Written communication the provider has received from the third party payer.

Claims must be billed to UCare within 12 months of the date of service to qualify for payment determination.

Fax claims and documentation to:

UCare
Attn: Claims Manager/Supervisor
Subject: Unsuccessful TPL Billing
Fax Number: **612-884-2261**

If the provider receives payment from the third party payer, they will need to send the information to us with a Status Adjustment Form.

CHIROPRACTIC CLAIMS

Chiropractic claims should be submitted electronically through a clearinghouse to ChiroCare. Clearinghouses currently working with ChiroCare to ensure format compatibility include:

- Post-n-Track (payer: LNDMK).
- Emdeon (payer: LNDMK).
- OPTUMInsight/Ingenix (payer: LNDMK).
- Infotech Global, Inc. (IGI)/MN E-Connect (payer: LNDMK).

Based on state statute, paper claims submitted by providers located in Minnesota will be denied by ChiroCare. Providers outside of Minnesota may submit claims electronically or on paper via fax or mail to ChiroCare at:

Fax: **1-866-525-5056**.

Mail: ChiroCare of Minnesota, Inc.
C/O Landmark HealthCare
P.O. Box 254765
Sacramento, CA 95865-4765

If you have questions, please see your Plan Summary document or call ChiroCare's Provider Services Department at **1-888-638-7719** (toll free).

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DENTAL CLAIMS

Dental claims should be submitted electronically through a clearinghouse to DentaQuest.

Medicare dental claims may be sent directly to DentaQuest at:

DentaQuest
Attn: Claims Dept.
12121 North Corporate Parkway
Mequon, WI 53902

If you have questions, please call DentaQuest at **1-800-341-8478** (toll free).

ELDERLY WAIVERED SERVICES

To provide case management, homemaker, respite, adult day care, companion, extended home health, supplies and equipment, personal care, caregiver training/education, home delivered meals, foster care, residential care, assisted living, home modifications, transportation, habilitation, pre-vocational services, supported employment, adaptations, family support, extended state plan services, physical therapy (PT), occupational therapy (OT), speech therapy (ST), hearing and language pathology, independent living skills, residential care, to individuals who qualify for various services depending upon the waived program assigned.

Billing

CMS 1500 forms for waived services should be sent to:

UCare
PO Box 70
Minneapolis, MN 55440-0070

WAIVERED SERVICES

Claims Roster Bill Form Used for Waivered Services

UCare will only accept paper claims for members with any Medicare programs and out of state providers. For most information on going electronic click here.

Claims Roster Bill Form

Member first and last names.

Members UCare ID number, which starts with three 0's and ends with two 0's (Example; #000123456-00)

Dates should be in month-date-year format (Example; mm-dd-yy)

Place of Service

This is a two digit number to represent where the service was provided (Example; service was provided in the member's home: the number would be #12 or Assisted Living Facility would be #13)

UCare Provider ID#

If you have a UCare provider ID#/ UMPI number, enter the # in this box. If this is your first submission to UCare, leave it blank and UCare will assign you a provider #.

It is a requirement that at least one diagnosis code is on the claim for each service. The diagnosis code can usually be found on the service agreement from the member's case worker.

A CPT or HCPCS code is required to represent the service provided. Any unlisted codes require descriptions.

The charge for each service provided.

The number of services provided. This needs to be filled in even if the number is 1. (Example; X5362, Assisted Living Plus –per month the unit would be 1 for the month)

Please see the DHS website for waiver information.

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MEMBER LIABILITY

“Balance billing” occurs when a provider requests that a patient pay the difference between the amount the provider billed and the amount paid by UCare. This includes covered and non-covered services. This does not include coinsurance amounts or co-payments by the enrollee under some benefit packages.

This applies to participating and non-participating providers.

A provider is informed that balance billing of UCare enrollees is prohibited (Minnesota State Statutes, section 256D.03) when an EOP is received. The provider must accept the health plan reimbursement as payment in full for covered services. This notification appears on the UCare EOP accompanying the provider’s check.

This requirement is also included in the provider’s UCare contract language.

Minnesota Health Care Programs (MHCP)

A health plan participating provider may balance bill a member for services if:

1. The service is not covered under the member’s Certificate of Coverage (COC),
2. The provider notified the member in writing prior to providing the service that the member is responsible for the bill. The Department of Human Services (DHS) Minnesota Health Care Programs Provider Manual, the provider should institute procedures to prevent misunderstandings concerning whether a member has been properly informed about the non-covered status of a health service.

Under MinnesotaCare, providers may collect applicable co-payment from the member at the time of service.

A non-participating UCare provider who is a DHS participating provider may balance bill a member for services

1. The service is not covered under the member’s Certificate of Coverage,
2. The provider notified the member in writing to providing the service that the member would be responsible for the bill.

Non-participating UCare providers who are also non-participating DHS providers may bill a member for covered or non-covered services. UCare’s Provider Network Management will attempt to contact non-participating providers in an effort to avoid billing and/or collection agency activities against a UCare member.

For additional information, see MN Rules, Part 9505.0225, Subpart 3.

UCare for Seniors

Section 1876(c)(4)(B) of the Social Security Act requires that Medicare Advantage (formerly Medicare+Choice) Health Maintenance Organization (HMO) or Managed Care Organizations (MCO) assume financial responsibility for all care that Medicare would cover.

When UCare assumes responsibility to pay physician services rendered by out-of-network providers, UCare must also pay balance-billed amounts. These amounts cannot exceed the amount that could have been collected under the Medicare fee-for-service system. In these instances, Medicare's charge limits apply. The maximum amount an out-of-network physician may collect from UCare for out-of-network physician services varies depending upon whether a physician is Medicare participating, nonparticipating, or accepts Medicare Assignment.

In all cases, the enrollee's financial liability is for co-payments or coinsurance amounts imposed by the ***UCare for Seniors*** CMS-approved benefit package. Out-of-network physicians are paid based on the following guidelines.

1. Medicare participating physicians are paid the Medicare rate by UCare and contractually agree not to seek any additional payment.
2. Non-participating physicians (with Medicare) who accept Medicare Assignment are paid 95% of the Medicare rate as determined by the Federal Government.
3. Medicare non-participating physicians who do not accept Medicare Assignment are limited to charging UCare 115% of the non-participating Medicare rate as determined by the Federal Government.

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PRIMARY CARE REIMBURSEMENT

Minnesota Health Care Programs

- The Patient Management Fee is dependent upon clinic compliance with the referral and authorization procedures and effective utilization of referrals and hospital services.
- Vaccine Replacement Program: PCC's participate in the State of Minnesota's vaccine replacement program. UCare reimburses for the administration of the vaccine to the PCC.

DENIAL/TERMINATION/REDUCTION (DTR) OF SERVICES NOTICE

Minnesota Health Care Programs

We are required by the Minnesota Department of Human Services (DHS) to issue a Denial/Termination/Reduction (DTR) notice to our Minnesota Health Care Programs (MHCP) members whenever we deny a request for service or claims payment.

Our notification format will have the following components:

The DTR contains a language block to notify our members with limited English proficiency to contact UCare Customer Service for assistance in translating the information.

The front of the DTR document contains the DTR notice in a letter format.

The document contains information about the type of service and the category of denial specific to the case.

The back of the DTR document contains information about of the member's appeal rights.

The following is a list of common categories of denials:

- Member not eligible;
- No authorization;
- Non-covered service; and
- Not medically necessary.

If you are the billing provider for one of these denied services, you will receive notice of the denial through your Explanation of Payment (EOP).

Our Provider Assistance Center is available to answer your questions about this process. Our representatives can be reached at 612-676-3300 or 888-531-1493 (toll free).

CLAIMS ADJUSTMENTS

Adjustment requests must be appropriate based on contractual guidelines. Individual contracts may vary, so please refer to your UCare contract.

Paper

UCare will only accept paper claims for members with any Medicare programs and out of state providers.

Submit any changes to a previously submitted claim with a “Claim Recoupment / Status Adjustment Request Form” accompanied by a new claim form showing the corrections.

Do not hand write corrections on a copy of the original claim, on the EOP, or on the “Claim Recoupment / Status Adjustment Request Form.”

[Claim Recoupment / Status Adjustment Request Form](#)

Your paper claim with the Claims Recoupment/Status Adjustment Request Form can be sent electronically via fax **612-884-2186**. See the [Electronic Attachments](#) section of this chapter for more info on attachments. A Claims Attachment Cover Sheet should not be sent.

Electronic

If submitting a corrected UB-04 (837I)/HCFA(837P) claim it is required that the 3rd digit on the type of bill is XX7 (replacement) or XX8 (void- no reprocessing is required). An Attachment Cover Sheet is required for any attachments sent with electronically submitted claims.

Replacement Claims

A replacement is sent when an element of data on the claim was either not previously sent or needs to be corrected. Replacement or void of prior claim should not be done until prior submitted claim has reached final adjudication status.

Examples include incorrect dates of service or units. To qualify for a replacement, certain identifying information must remain the same. If these values change then prior claim must be voided, and a new claim would be sent with the appropriate frequency.

- o provider (2010AA Loop)
- o patient (2010CA Loop)
- o payer (2010BB Loop)
- o subscriber (2010BA Loop)
- o institutional statement period (2300, DTP Segment).

Note: When submitting a replacement claim, UCare takes back the entire original claims amount and pays you for the services entered on the new claim. Do not delete lines that previously paid if you want them to pay on the replaced claim.

Voided Claims

A voided claim may be requested when the entire claim needs to be recoups and no reprocessing is necessary. The entire claim must match the original with the exception of the claim frequency code, condition code and the payer assigned claim number. EXAMPLES: incorrect provider, patient, payer, insured and statement period on an institutional claim or patient did not want insurer to be billed for services.

- There is no need to send negative values on a void claim. The claim frequency code indicates that the values are negated.
- Void should be sent along with new original (recommend verifying void is finalized prior to sending new to avoid dup)

Time Limits/Questions

UCare's standard time limit for a claim adjustment is 12-months from the initial claim's payment or denial date.

Questions regarding the status of submitted claims should be directed to the Provider Assistance Center at 612-676-3300 or 888-531-1493.

Helpful Information

The following info will assist with the accuracy and turn around time of your adjustment requests:

- **12 digit** UCare claim number
- Member Number/Name
- UCare Provider Identification Number (six digits)
- Date of Service
- Detailed explanation of what is being requested
- Hard copy of claim
- Replacement Claims: The UCare claim number of the original claim to be replaced
- Any replacement/electronic claims that are sent with attachments should include a completed attachment cover sheet. (see 62J section of this chapter)

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CLAIMS AUDITING AND RECOVERY PROGRAM

As required by law, and consistent with sound business practice, UCare has a program to ensure that it pays only for covered services that have been provided and appropriately billed.

In addition to standard claims processing practices and systems edits, UCare's efforts include:

- Regular and targeted post-payment claims audits;
- Review of medical records to support claimed services;
- Confirmation with medical providers of services that are related to interpreter or transportation services;
- Obtaining information from government agencies and third-party payers;
- Checking of the Office of Inspector General list of persons and entities excluded from participation from federal health care programs;
- On-site audits of providers facilities; and
- Review of financial and business records related to services provided to UCare members.

Providers must cooperate with UCare's audit or investigation consistent with their contract language and with UCare and applicable laws.

When UCare determines an overpayment has been made, we will take steps to recover the overpayment. Except for billing errors that have nominal financial impact, we will send providers prior notice of monetary recovery. The notice should include sufficient detail that the provider can review to ensure accuracy. [Click here to review Recovery letter.](#)

Upon completion of an audit or investigation, UCare may determine that the provider engaged in abusive or fraudulent billing. Examples of abusive and fraudulent billing include:

- Repeatedly submitting duplicative claims for the same service provided to the same member on the same date;
- Billing for services that were not provided, including future dates of service;
- Billing services at a different level or intensity than that actually provided;
- Billing for medically unnecessary services;
- Using diagnosis codes that are not consistent with medical records;
- Billing certain procedure codes when a global code is more appropriate;
- Billing certain procedure codes in addition to a global code that reflects those procedures;
- Billing for services provided by an individual who is not licensed to provide the service;
- Billing for services not covered by UCare;
- Failing to follow applicable Minnesota Department of Human Services, Medicare, and standard industry billing guidelines;
- Seeking payment for services that have been, or expect to be, paid by a third party;
- Billing for services that are not reflected in related medical records or for services for which there are no related medical records; and
- Submitting false or fraudulent information in a provider application or in conjunction with seeking authorization for a service.

If UCare determines that a provider has engaged in abusive billing, we will recover overpayments and may take additional action, including but not limited to:

- Making a report to a regulatory agency or licensing board;
- Terminating or suspending the provider's participation and/or contract;
- Suspending claims for prospective payment review;
- Imposing corrective actions; and
- Suspending payment for a specified period of time.

In rare cases, UCare may determine that a provider has committed fraud, which means the provider knew, or reasonably should have known, that a statement or claim submitted to UCare was false. In cases of fraud, UCare may impose any of the above-mentioned sanctions, but may also contact the relevant law enforcement agencies.

CODING

Providers are expected to utilize the resources available to them to determine which best suits the claim they are submitting; Appendix A of the MN Companion Guide, ICD-9, CPT, and HCPCS manuals, CMS coding guidelines and the DHS provider manual, etc.

MHCP Provider Manual:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000094

AUC Companion Guide:

<http://www.health.state.mn.us/auc/guides.htm>

Other Related Links:

www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/

www.cms.hhs.gov/HCPCSReleaseCodeSets/

www.cms.hhs.gov/manuals/downloads/clm104c23.pdf

AMBULATORY PAYMENT CLASSIFICATION (APC)

Ambulatory Payment Classifications (APC) is the Outpatient Prospective Payment System (OPPS) reimbursement methodology. UCare follows Medicare (CMS) APC guidelines, rules and edits unless stated in individual contracts.

We encourage providers to visit the CMS website for further details regarding APC claim processing. Listed below are some links to resources that have been beneficial in understanding CMS APC guidelines:

CMS APC information:

Addendum A & B updates where APC status codes are updated:

<http://www.cms.hhs.gov/hospitaloutpatientpps/>

Description of OPPTS Program Transmittals which include APC changes:

<http://www.cms.hhs.gov/hospitaloutpatientpps/>

EXPLANATION OF PAYMENT (EOP) REFERENCE GUIDE

To view a sample copy of UCare's EOP and what each field means, go www.ucare.org, select "Providers," and then "Resources." Click on the link "UCare Explanation of Payment (EOP) Reference Guide" to see the document.

ANSI CROSS WALK LIST INCLUDING EX CODES

The EX code is what is used in UCare's claims processing and the ANSI code is the standardized code put on our EOP's. The definition column describes what the EX code means. Click on the title above to see the cross walk list.

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FORMS

[Sample CMS 1500 form](#)

[CMS 1450 / UB-04 form](#)

[Claim Recoupment / Status Adjustment Request Form](#)

[Member Liability & Waiver Reference Sheet/Sample Waiver Form](#)

Provider Information Update Forms

If you make any changes to your facility data, you must notify UCare in writing not less than 30 days before the change.

This critical deadline applies to all facilities, providers, and practitioners. Changes include, but are not limited to, a new address, the addition of health care professional staff, a new tax identification number, affiliation change, or a new site.

Sending this information in a timely manner help prevent payment delays and ensure that your records with UCare are accurate.

The appropriate forms are available in the link below:

[Facility Change/Update Form w/ W-9](#)

[Minnesota Uniform Practitioner Change Form](#)

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UCARE PHONE NUMBERS

Provider Assistance Center: 612-676-3300 or 1-888-531-1493 (toll free)

- Claims/Billing questions.
- Authorization questions.
- Benefit questions.
- General information about UCare.
- Clinic staffs contact.
- Updates/revisions of your staff, patient acceptance, location or available services.
- Access UCare Questions.

UCare's General Fax: 612-676-6501

UCare EDI New Claims Attachment Fax: 612-884-2261

UCare EDI Adjustment Claims Attachment Fax: 612-884-2186

UCare Claims Department Fax: 612-884-2000

- Referral and authorizations entry *only*.

Behavioral Health Care (BHP) Providers: 763-525-9919 or 1-800-361-0491 (toll free)

- Authorizations for mental health & chemical dependency services.
- Authorizations for non-covered benefits or out-of-network providers.

DentaQuest: 1-800-341-8478 (toll free)

- Authorizations for dental services.
- Dental network questions.
- Claims questions for dental services.

ChiroCare of Minnesota, Inc.: 1-888-638-7719 (toll free)

- Authorizations for chiropractic services.
- Chiropractic network questions.
- Claims questions for chiropractic services.

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