

## Chapter 4

# Billing Policy

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

## HIPAA

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

1. In order to meet HIPAA requirements and improve customer service to providers and electronic billers, PrimeWest Health has grouped all electronic claim submission processes into a Federally mandated HIPAA-compliant electronic format.
2. Federal HIPAA rules for information privacy (outlined in DHS Provider Update 145) change the ways in which protected health information is stored and shared within and between health care organizations
3. PrimeWest Health requires the same information for electronic claim submissions as for paper claim submissions

## Eligibility

PrimeWest Health strongly encourages providers to verify member eligibility prior to rendering services and submitting claims. PrimeWest Health also encourages providers to verify Minnesota Health Care Program (MHCP) eligibility on ALL patients they see.

### Eligibility Verification

1. Access member eligibility information by using the PrimeWest Health web portal, Provider Contact Center, or the automated DHS Eligibility Verification System (which includes a telephone service and a web portal within MN-ITS).
2. Verify member eligibility through:
  - a. [PrimeWest Health web portal](#). Prior registration is required using the [Web Portal Registration Form](#).
  - b. PrimeWest Health Provider Contact Center: **1-866-431-0802** (toll free)
  - c. [DHS MN-ITS web portal](#)
  - d. DHS EVS Line: **1-651-431-2700** or **1-800-657-3613** (toll free)
  - e. [Emdeon](#): **1-866-369-8805** (toll free)

## Spenddowns

### Elderly Waiver (EW) Obligations

Certain members of the Elderly Waiver (EW) program are allowed to keep increased income while remaining eligible for PrimeWest Health. This means some EW members will no longer have a medical spenddown. Instead, they will have to pay a portion of their EW service costs through a waiver obligation. The payment of the waiver obligation is made to the provider by the member. Only EW services are applied to the obligation. Members may choose the “designated provider” option in order to pay their waiver obligations to one particular provider. To set up a designated provider, the member must contact his/her county financial worker.

### Spenddowns and Copays

If a copay applies to services in addition to the spenddown amount, a deduction will be made from the payment to the provider. Providers should bill the spenddown and copay amounts to the member.

## Authorization

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

Bill authorized and unauthorized services on separate claims. If authorized services are billed on the same claim as unauthorized services, the claim will deny. When a member has private health or dental insurance, authorization and other rules that apply to the primary insurance must also be followed.

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

## Free-care Policy

PrimeWest Health takes into account [all resources](#) available to members, including free services. The Centers for Medicare & Medicaid Services (CMS) [“free-care” policy](#) does not reimburse providers for services given to Medicaid recipients if the same services are offered for free to non-Medicaid patients.

## Coordination of Services

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

## Claims Requirements

### Definitions

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

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

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

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

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

## Expectations for Clearinghouses and Billing Intermediaries

### Use Only HIPAA-Compliant Electronic Billing Formats

#### Clearinghouses (X12 Billers)

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

#### Billing Intermediaries

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

## General Billing Requirements and Claims Submission

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

1. Submit claims only after you provide PrimeWest Health-covered services.
2. A claim cannot be submitted if a member doesn’t show up for the appointment.
3. Bill only one calendar month of service per claim.
4. All claims require a valid diagnosis (ICD-9-CM) code.
  - a. If there is not an appropriate diagnosis for the service you are providing, we request that you use the diagnosis code of V68.89. This diagnosis code simply states “Other specified administrative purpose.”
  - b. As part of the 2011 Minnesota Legislative session, all claims for supplies or services that are based on an order or referral must include the ordering or referring provider’s National Provider Identifier (NPI). The ordering or referring provider must also be enrolled in the Minnesota Health Care Programs (MHCP). Claims submitted without this information will deny as “referring/ordering provider is not registered with MHCP.”
5. Submit all claims electronically.\*
  - a. All claims being submitted to PrimeWest Health by health care providers providing services for a fee in Minnesota must be transmitted electronically. PrimeWest Health offers two methods of free online direct claims submission through a web-based program, Infotech Global, Inc. (IGI) aka [MN E-connect \(Registration Information\)](#) or [Office Ally](#).
    - i. These [clearinghouses are available to submit claims electronically to PrimeWest Health](#).
    - ii. Follow [HIPAA](#) electronic data interchange (EDI) standards as outlined in the [X12](#) or [NCPDP Implementation Guides](#).
    - iii. Follow standards outlined in the [Minnesota Uniform Companion Guides](#) and the [DHS Companion Guide for the Interchange Control Header/Trailer](#).
    - iv. Use these [file name conventions](#) when submitting batch files

- b. See the [Claims Submission](#) section of our [website](#) for additional details.

\*If you are a provider outside of the State of Minnesota and do not have the ability to submit claims electronically, you have the option to submit paper claims. Paper claims must be on red and white CMS-1500 or UB-04 forms. Do not submit by fax, photocopy, or screen prints. Black and white copies are not accepted. Paper claims must be typed and mailed to the following address (handwritten claims will be denied):

PrimeWest Health  
P.O. Box 69348  
Harrisburg, PA 17106-9348

## Timely Filing Requirements

1. Claims must be submitted correctly and received by PrimeWest Health no later than 180 days from the date of service. Medicare and third party liability (TPL) claims must be received within 180 days of payment resolution with the primary payer.
2. Corrected claims must be submitted and received by PrimeWest Health within 180 days from the date of the remittance advice.
3. Claims that do not automatically cross over from Medicare must be submitted and received by PrimeWest Health within 180 days from the Medicare determination or adjudication date or within 180 days from the date of service, whichever is greater.
4. Claims denied due to enrollment changes may be submitted to PrimeWest Health within six months from date of service or date of county correction, whichever is greater.
5. Claims that are over 180 days:
  - a. Submit your claim to PrimeWest Health for Timely Filing denial.
  - b. Appeal Timely Filing denial using our [Provider Appeal Form](#) only after the denial is received.
  - c. Appeals must be received within **90 days** of the denial for timely filing.
  - d. The Appeal must have appropriate, dated documentation attached.
  - e. Documentation will be reviewed, but does not guarantee payment. Appropriate documentation may include, but is not limited to:
    - i. Proof of eligibility verification through the Eligibility Verification System (EVS), MN-ITS, or the PrimeWest Health web portal
    - ii. Printout from Provider's Practice Management Software that confirms claim was submitted within 180 days of the date of service
    - iii. Documentation of timely follow-up of the previous claim submission(s)
    - iv. Copies from the Provider's EDI submission report indicating the claim was transmitted to **and accepted by** PrimeWest Health (Please note that your facility will usually receive two reports. The first will typically indicate that your claim was "Forwarded" to PrimeWest Health and the second should state that your claim was "Accepted" by PrimeWest Health.)
    - v. Documentation that fully explains extenuating circumstances for the delay in claims submission
  - f. PrimeWest Health follows the guidelines for Appeals found in the [MN AUC Companion Guidelines](#).
6. Provider Appeals on claims should be faxed to **1-320-335-5285**.

## Coding Schemes

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

<b>ICD-9-CM</b>	International Classification of Diseases, 9 <sup>th</sup> Revision, Clinical Modification <a href="#">Files also available for download</a> . Click on ICD-9-CM files via FTP.
<b>CPT</b>	Physicians' Current Procedural Terminology: HCPCS Level I
<b>HCPCS</b>	Healthcare Common Procedural Coding System: HCPCS Level II National Codes
<b>NDC</b>	National Drug Codes: <a href="#">Review the National Drug Code Directory</a> . Search NDC.
<b>NUBC</b>	<a href="#">National Uniform Billing Committee</a> : For UB-04 reporting
<b>CDT</b>	Current Dental Terminology

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

## Modifiers

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

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

## Unlisted Codes

Bill unlisted procedure codes only when a specific code is not available to define a service/procedure. When an unlisted code is billed, a written description and/or documentation must be attached to the claim defining the service/procedure.

## Document Retention

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

## Remittance Advice (RA)

The purpose of the Remittance Advice (RA) is to report claim activity, and is issued weekly to providers.

You can print copies of claim remittances free of charge from the [PrimeWest Health provider web portal](#) using your provider login name and password. If you do not have a login name, contact the Provider Contact Center at **1-866-431-0802** (toll free) to register. You can also register through our website using the provider [Web Portal Registration Form](#).

PrimeWest Health will also honor requests for duplicate copies of remittances via postal mail. Charges for duplicate copies are as follows:

1. 0 – 99 pages: \$5, plus \$0.10 per page
2. 100+ pages: \$10, plus \$0.10 per page

Please mail your request along with payment (in the form of a check payable to PrimeWest Health) to the address listed below. Please also include the Customer Service Application (CSA) reference number you received when you requested the initial copies.

Attn: Provider Contact Center  
PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308

**Claims:** Claims are listed as paid or denied, along with member responsibilities, reason for adjustments, and all other applicable processing information.

### List of EX Codes

**Electronic Remittance Advice (835s) is available.** To register to receive your remittance electronically for PrimeWest Health medical claims, please complete the [835 Registration Form](#) and fax it to **1-320-762-1805**, Attn: EDI Support. You may also email the form to [edisupport@primewest.org](mailto:edisupport@primewest.org). **You should also contact your billing software vendor and clearinghouse vendor to confirm set up.** Paper remittance advices will continue for 3 – 4 remittances after the 835 electronic remittance is set up. PrimeWest Health will work with you if needed to make sure that paper remittances are not discontinued if there are any major technical issues.

For registration information for PrimeWest Health pharmacy claim remittances, please refer to the [Prime Therapeutics electronic remittance information](#) or, for additional assistance, contact Prime Therapeutics at [remittanceservices@primetherapeutics.com](mailto:remittanceservices@primetherapeutics.com) or **1-800-711-9866** (toll free).

If you have questions about the 835 Electronic Remittance Advice, please call the Provider Contact Center at **1-866-431-0802** (toll free).

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

## **Adjustment Requests, Corrected/Replacement Claims, and Attachments**

**IMPORTANT:** Please use the following criteria to distinguish between an Adjustment Request, Corrected Claim (replacement of previously filed claim), or Claim Attachment. Please note: Replacing denied claims using a frequency type of “7” or resubmission code of “406” may result in a processing delay. If you are resubmitting on a previously denied claim, you are not required to submit the claim as a replacement claim and PrimeWest Health encourages you to submit the corrected claim as an original claim.

1. Submitting a claim (original submission) with an attachment:
  - a. If you are submitting an original claim, you must follow the instructions outlined below under *Claim Attachment Instructions* and include a [Claim Attachment Cover Sheet](#).
2. Submitting a corrected claim (rebill or replacement claim) with no special instructions:
  - a. If you are submitting a corrected claim (rebill or replacement claim) where you have changed any information from the original claim and you do not need to communicate any special handling instructions for the resubmitted claim, follow the instructions under *Corrected Claims*.
3. Submitting a corrected claim (rebill or replacement claim) with special handling instructions:
  - a. If you need to communicate special handling instructions for the resubmitted claim, you must follow the instructions outlined below under *Claim Attachment Instructions* and include a [Claim Attachment Cover Sheet](#). You will also need to complete and submit the [Adjustment Request Form](#) as the actual attachment with the [Claim Attachment Cover Sheet](#) if it helps explain the reason for resubmission and

reduces the possibility of a denial of the resubmission. File the corrected claim via EDI electronically and fax the *Claim Attachment Cover Sheet* and *Adjustment Request Form* along with supporting documentation to **1-320-335-5292**.

4. Submitting an adjustment request (no claim changes):
  - a. If you are requesting an adjustment to a previously submitted claim that does not require a resubmission of the claim (there are no data changes to the claim), you must complete an [Adjustment Request Form](#). The *Adjustment Request Form* must include the PrimeWest Health claim ID # and a description of the adjustment requested. The fax number for adjustment requests that DO NOT accompany a claim submission is **1-320-335-5355**.

## Corrected/Replacement Claims

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

Corrected claims must be submitted and received by PrimeWest Health within 180 days from the date of incorrect payment. **You no longer need to complete an [Adjustment Request Form](#) unless you are requesting that PrimeWest Health recoup a previously submitted claim or need to communicate special handling instructions (see items 2 and 3 above).** Please note: Replacing denied claims using a frequency type of “7” or resubmission code of “406” may result in a processing delay. If you are resubmitting on a previously denied claim, you are not required to submit the claim as a replacement claim and PrimeWest Health encourages you to submit the corrected claim as an original claim.

1. Professional (837P) replacement claims must have the following fields completed:
  - a. EDI Claims: NTE segment of Loop 2300; change the frequency type to “7.” If using Office Ally, enter Medicaid Resubmission code (406) in Field 22 and the original PrimeWest Health claim number. You will not have a frequency type to change.
2. Institutional (837I) replacement claims should be submitted with “7” as the third digit of the bill type to indicate that it is a replacement claim and no additional information or comments are required.
3. Paper Claims (non-MN providers only): Field 22; enter Medicaid Resubmission Code (406) and the original PrimeWest Health claim number.

## Claim Attachment Instructions

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

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

1. Submit your EDI claim to PrimeWest Health.
2. Complete the [Claim Attachment Cover Sheet](#), including the attachment control number. The attachment control number on the *Claim Attachment Cover Sheet* should match the attachment control number on the EDI claim.

3. Fax the corresponding *Claim Attachment Cover Sheet* and the attachment(s) to **1-320-335-5292**. You may submit the attachment information at the same time as you submit your claim(s).

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

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

### Coordination of Benefits

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

### Refund of Payment

Providers may refund payments to PrimeWest Health when the entire amount paid for a claim needs to be returned or a portion of the payment needs to be returned due to an overpayment (receipt of third party payment, billing error, etc.). The preferred method for refund is a corrective adjustment on a future remit initiated by submitting an [Adjustment Request Form](#) (refer to Adjustment Request instructions in this chapter).

If you are a provider who infrequently submits claims to PrimeWest Health, the following options are available:

1. Send a check with a copy of the RA highlighting the paid claim(s) and attach an explanation for the refund; or
2. Send a copy of the RA highlighting the paid claim(s) and an [Adjustment Request Form](#) requesting the amount to be deducted from a future remittance.

Mail checks with RAs or RAs only for credit adjustment to:

Attn: Claims Department  
PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308

### Medicare

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

Medicare is primary to PrimeWest Health with the exception of the Medicare Advantage Special Needs Plans (SNP) offered by PrimeWest Health under the groups PrimeWest Senior Health Complete (HMO SNP) and Prime Health Complete (HMO SMP) (the State’s names for these programs are Minnesota Senior Health Options [MSHO] and Special Needs BasicCare [SNBC], respectively). For all Medicare Advantage SNP enrollees, claims are submitted to PrimeWest Health as the payer for their Medicare and Medicaid on one claim.

For members not enrolled in a PrimeWest Health Medicare Advantage Special Needs Plan, services that are

covered by Medicare must be provided by a Medicare-enrolled provider and billed to Medicare first. Any balance remaining after Medicare payment must be billed to other liable third party payers with PrimeWest Health being the payer of last resort.

If Medicare pays a claim and the claim fails to automatically cross over from Medicare, providers must bill PrimeWest Health in **exactly** the same way Medicare was billed and include the COB information on the EDI claim or submit it as an attachment following the guidelines above under *Claim Attachment Instructions*.

If Medicare denies a claim, bill PrimeWest Health using PrimeWest Health guidelines. Include the COB information on the EDI claim or submit it as an attachment following the guidelines above under *Claim Attachment Instructions*.

Submit services that are never covered by Medicare directly to PrimeWest Health. PrimeWest Health does not require a denial from Medicare. PrimeWest Health follows the Medicare Communique's non-covered services code list along with any HCPCS code that begins with H, S, or T.

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

When billing for Medicare-covered services, follow CMS guidelines. If the member does not have a policy primary to Medicare, but does have a supplemental Medicare plan, you do not need to bill the supplemental insurer. PrimeWest Health will process and pay the claim as both Medicare and Medicaid and seek reimbursement, if applicable, from the supplemental insurer after the claim has been processed and paid to the billing provider.

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

## Third Party Liability (TPL)

PrimeWest Health members may have other health coverage. If a member does not inform you of other health coverage, obtain the information by calling **1-866-431-0802** (toll free) or by using MN-ITS or PrimeWest Health's web portal.

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

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

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

## Definitions

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

### **Private Insurer:**

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

**Third Party Payer:** Any individual, entity, or program that is or may be liable to pay all or part of the health care costs incurred by members, including Medicare, an insurance company, HMO, PPO, TriCare (formerly CHAMPUS), Workers' Compensation, and uncontested no-fault automobile insurance.

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

## Unsuccessful TPL Billing

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

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

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

## Member Uncooperative with TPL Billing

If a member fails to complete forms and cooperate in the TPL billing process, contact the PrimeWest Health Provider Contact Center at **1-866-431-0802** (toll free) to request assistance.

## Reporting Health Insurance Termination Dates

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

1. Member's name
2. PrimeWest Health ID number
3. Insurance company name
4. Termination date
5. Whether the termination applies to the policy or individual
6. Name and phone number of the person contacted to obtain the termination information.

Mail or fax this information to:

COB Department  
PrimeWest Health  
2209 Jefferson St, Ste. 101  
Alexandria, MN 56308

Fax: 1-320-762-8750

### **Request for Billing Statement**

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

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

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

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

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

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

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

### **Prompt Payment**

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

**Clean Claim:** as defined in Section 1.6 of the PrimeWest Health *Provider Participation Agreement*, that pursuant to [42 CFR 447.45 and 447.46](#), and MN Stat., [sec. 62Q.75](#), a claim that has no defect or impropriety, including any lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

## Payment Cycle

Providers are paid on a weekly payment cycle.

## PrimeWest Health Reimbursement Is Payment in Full

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

1. Copay
2. Insurance payment that was made directly to the member. PrimeWest Health is liable for the amount payable by PrimeWest Health minus the third-party liability amount
3. Elderly Waiver (EW) waiver obligation

## Prohibition against Seeking Payment from Member

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

1. Base rate changes made by PrimeWest Health
2. Missed appointments
3. The difference between insurance payments and usual and customary charges
4. Services otherwise covered by PrimeWest Health, unless a copay or cap applies

## Billing the PrimeWest Health Member

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

1. Non-covered services (only if you inform the member in writing before you deliver the services that he/she would be responsible for payment)
2. Retroactive eligibility
3. Elderly Waiver (EW) waiver obligations
4. Copays

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

Other State-funded MA and MinnesotaCare programs are not affected by the federal statute.

## Non-covered Services

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

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

## Copays

You may bill a member for a copay before or after you receive notification on the Remittance Advice (RA) from PrimeWest Health about the amount of the copay. Refer to the Copay Guidelines found in [Chapter 2, Health Care Programs and Services](#), to determine copay amounts.

1. **Copays:** If a copay applies to services, a deduction will be made from the payment to the provider. Providers may bill the copay amounts to the member.
  - a. Services cannot be withheld or refused to a member because of the member's inability to pay the copay pursuant to 42 CFR 34 § 447.53 and MN Stat. Chap. 245D.03, subd. 4(h), for members enrolled in the Medical Assistance program and MinnesotaCare's Basic Plus Two and Basic Plus.
  - b. You are allowed to choose not to provide covered services to members enrolled in MinnesotaCare's Basic Plus One program who have outstanding debt. Upon the member's assertion that he/she is unable to pay the copay, you must do the following:
    - i. Not deny service to the member upon his/her first visit
    - ii. Give the member advance notice of the your debt policy
    - iii. Allow the member a reasonable opportunity to make payment
2. **TPL and Copays:** Members with private health insurance primary to PrimeWest Health are responsible to pay only the PrimeWest Health copay for covered services. Providers must bill in the usual manner, reporting the insurance payment on the claim with the balance due. If the PrimeWest Health allowable covers all or part of the balance billed, PrimeWest Health will pay up to the maximum PrimeWest Health allowable, minus any applicable PrimeWest Health copay. The PrimeWest Health copay will be deducted from the PrimeWest Health payment amount and reported as the copay amount. Bill the member copay amount to the member.

## Fee-for-Service Payment Methodology

To determine your payment methodology, refer to Appendix A in the PrimeWest Health *Provider Participation Agreement*.

1. Services provided by a **physician assistant** shall be paid to the supervising enrolled provider at the lower of the:
  - a. Provider's submitted charge; or
  - b. 90 percent of the allowable.
2. Services provided by an **enrolled advanced practice registered nurse** shall be paid at the lower of:
  - a. Provider's submitted charge; or
  - b. 90 percent of the allowable.
3. Services provided by an enrolled **clinical nurse specialist** shall be paid be paid at the lower of the:
  - a. Provider's submitted charge; or
  - b. 90 percent of the allowable.

## Copay Guidelines

### Billing Requirements for MA

#### Non-emergency Visit to a Hospital-based Emergency Room

The non-emergency visit to a hospital-based emergency room copay will be deducted from the outpatient

hospital facility claim. PrimeWest Health will use the type of admission in conjunction with the revenue code to determine whether or not the visit was considered an emergency visit or a non-emergency visit. PrimeWest Health will consider a type of admission equal to “1” in conjunction with a 45x revenue code to be an emergency.

**Non-preventive Visit Copay**

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

1. Provider type
2. Place of service code
3. Diagnosis code
4. Procedure code
5. Modifier

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

<b>MA</b>
<ul style="list-style-type: none"> <li>• Audiologist</li> <li>• Chiropractor</li> <li>• Clinical Nurse Specialist</li> <li>• Community Health Clinic</li> <li>• Federally Qualified Health Center</li> <li>• Hospital</li> <li>• Indian Health</li> <li>• Nurse Midwife</li> <li>• Nurse Practitioner</li> <li>• Optician</li> <li>• Optometrist</li> <li>• Physician</li> <li>• Physician Assistant</li> <li>• Podiatrist</li> <li>• Public Health Clinic</li> <li>• Public Health Nursing Organization</li> <li>• Rural Health Clinic</li> </ul>

Unless the member or the service comes under one of the exemptions listed above, the following **place of service codes** are subject to a copay deduction (MA):

- 05 – Indian Health Service free standing facility
- 06 – Indian Health Service provider based facility
- 07 – Tribal 638 free standing facility
- 08 – Tribal 638 provider based facility
- 11 – Office

- 20 – Urgent care
- 22 – Outpatient
- 24 – Ambulatory surgery center
- 50 – Federally Qualified Health Center
- 71 – State or local public health center
- 72 – Rural health center
- 99 – Other unlisted facility
- blank

Modifiers: When the following **modifiers** are billed by the provider types, in the place of service, etc., listed above, the non-preventive copay deduction does not apply to (MA):

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

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

## Inpatient Hospital Services

The Minnesota inpatient hospital payment system under MA is authorized by MS [256.9685 to 256.9695](#) and MN Rules parts [9500.1090 – 9500.1140](#).

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

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

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

Please fax all CAH rate updates or changes to **1-320-335-5336** or mail them to:

PrimeWest Health  
2209 Jefferson St, Ste 101  
Alexandria, MN 56308

## Legal References

[MS 256B.03](#)

[MS 256B.041](#)

[MS 256D.03](#)

[MS 550.37, subd. 14](#)

MN Rules part [9505.0070](#), subp. 5

MN Rules [9505.0110](#)

MN Rules part [9505.0190](#)

MN Rules part [9505.0225](#)

MN Rules parts [9505.0450 – 9505.0475](#)

MN Rules part [9505.5010](#)

MN Rules part [9505.5030](#)

MN Rules part [9505.2190](#)

[42 CFR 447.10](#)

[42 CFR 447.15](#)

[42 CFR 447.45](#)