Claims Manual

Claims Information Index

- ***How to Submit a Claim to CoOportunity Health***
  - Electronic Capabilities
  - CMS 1500/5010 Professional Claims Submission
  - UB04/5010 Institutional Claims Submission
  - Timely Filing of Claim
  - COB – Coordination of Benefits
  - Remittance Advice and Template, HIPPA Version 5010

- ***Commonly Used Forms***
  - Claim Adjustment Request - Fax Sheet
  - Claim Appeal Form - Fax Sheet
  - Claim Attachment Fax Form - Medical

- ***Prompt Payment of Clean Claims***

- ***Medical Cost Management***
  - ClaimCheck® Review
  - CoOportunity Health ClaimCheck® Review Edit Categories
  - Standard Modifier Table Policy
  - Casting Supplies
  - Codes for Data Collection and Reporting Only Procedures
  - Global Obstetric Package
  - Services Not Billable on a Professional Format
  - Services Not Separately Reimbursable
  - Surgery
    - Assistant Surgery Services
    - Bilateral Billing Guidelines
    - Global Surgical Follow Up Care
    - Multiple Surgery
  - Surgical Trays

- ***Reporting Suspicions of Fraud and Abuse***

How to Submit a Claim to CoOportunity Health

- Electronic Capabilities
- CMS 1500/5010 837 Professional Claims Submission
- UB04/5010 837 Institutional Claims Submission
- Timely Filing of Claim
- COB – Coordination of Benefits
- Present on Admission Indicators
- Remittance Advice and Template, HIPAA Version 5010

Subject: Electronic Capabilities

CoOportunity Health offers many electronic capabilities for our providers, including

- Electronic Claims Submission
- Electronic Remittance Advice
- Electronic Eligibility Inquiry
- Electronic Claims Inquiry
- On-line Member Eligibility and Co-Payment Information
- On-line Claim Status Inquiry
- On-line Remittance Advice

Please contact your provider representative at CoOportunity Health for more details or visit coOportunityHealth.com/eservices.

Subject: CMS 1500/5010 837 Professional Claims Submission

CoOportunity Health follows guidelines outlined in the NUCC 1500 manual for submission of claims. The National Uniform Claim Committee website can be accessed at nucc.org.

Subject: UB04/5010 837 Institutional Claims Submission

CoOportunity Health follows guidelines outlined in the NUBC UB04 manual for submission of claims. The National Uniform Billing Committee website can be accessed at nubc.org.

Subject: Timely Filing of Claims

CoOportunity Health requires providers to submit claims within 365 days of the date of service. Filing all claims from a prior year no later than March 1 is highly encouraged.

In CoOportunity Health's appeal guidelines, a provider has 60 days from the remit date of the original timely filing denial to submit an appeal. If the appeal is received after the 60 days, a letter will be sent to the provider stating the appeal was not accepted.

Subject: COB – Coordination of Benefits

CoOportunity Health follows guidelines for Coordination of Benefits outlined in the Nebraska and Iowa state COB regulations. These regulations will be applied based on the member's state of residence.

For more information on the Iowa statutes, visit legis.iowa.gov/IowaLaw/AdminCode/ruleDocs.aspx?pubDate=04-20-2011&agency=191&chapter=38

For more information on the Nebraska statues, visit sos.state.ne.us/rules-and-regs/regsearch/Rules/Insurance_Dept_of/Title-210/Chapter-39.pdf

Subject: Present on Admission Indicators

CoOportunity Health requires acute care hospitals that are contracted under a DRG methodology to submit a Present on Admission (POA) indicator for all claims involving inpatient admissions.

ADMINISTRATIVE PROCESS:
POA values and submission requirements should follow NUBC billing guidelines.

Subject: Remittance Advice, HIPAA Version 5010

See the following pages for sample remittance and field descriptions.

For more information on HIPAA Remittance codes visit wpc-edi.com.

CoOportunity Health(A)
8170 33RD AVE S
PO Box 38
Minneapolis, MN 55440-9984
CONTACT: (B)
(952) 883-7755 or 1-800-444-4558
PAYER ID: (C)
SUPPLEMENTAL ID: (BANK) (D)

PAYEE: PROVIDER ORG NAME (E)
ADDRESS 1
ADDRESS 2
CITY, MN 12345-1234
PAYEE TAX ID: (F) 123456789
PAYEE NPI: (G) 1234567890
PAYEE ID (H) V12345678900001

PROD DATE: (I)01312009
CHECK/EFT DT (J)02012009
CHECK/EFT : (K)123456789
PAYMENT: (L)12345678.90
PAYMENT METHOD: (M)(ACH,CHK,NON)

PAT CTRL#: (1)XXXXX CLM #: (2)xxxxxxxx CLM STATUS: (3)1 PAID PRIMARY CLM DT (6)01012009-01012009 CLM CHG: (4) 200.00
PATIENT: (5)DOE, JOHN S **CLM PAYMENT (7)** 190.00
PATIENT ID: (8)123456789 GRP: (9)12345 CLM FILING IND: (10) BILLING PROVIDER: (29) **PAT RESP**: (11) 0.00 PRV LIAB **(12)** **0.00**
REND PROV ID: (13)1234567890 CLM RECEIVED DT: (14) FACILITY TYPE:(15) FREQ: (16) OTHER LIAB (17) 0.00 PROVIDER TAX (18) 0.00
MED REC #: (19)1234567890 DRG: (20) DRG WGHT: (21) COV EXP DT: (22) WITHHOLD (23) 0.00 COVERED: **(24)** **200.00**
CORRECTED PATIENT: (25) CORRECTED PATIENT ID: (26)
CORRECTED PRIORITY PAYER(27) OTHER SUBSCRIBER: (28)
CROSSOVER CARRIER: (30) ID: (31)
PMI (32) 123456789 CONTRACT: (33)xxxxxxxxxxxxxxxxx

REMARK CODES:
(34)

CLM ADJ AMT(GRP CD/CLM ADJ RSN CD):
(35.1(35.2/35.3))

LINE CTRL # (a)	DOS (b)	REV (c)	PROD/SVC/MOD (d)	PROD/SVC/MOD (e)	ALLOWED (f)	CHARGE/ # (g)	APC (h)	ADJ AMT (GRP CD/CLM ADJ RSN CD) (i.1(i.2/i.3))	REMARK CODE(S) (j)	REND PROV ID (k)	PAYMENT (l) (m) (n)
001	01012009-01012009	C	A	100.00 001	-100.00(OA/94)	200.00		10.00(PR/1)	N19 C0213	1234567899	190.00
002	01012009-01012009	C	B	100.00 001	100.00(CO/97)	0.00				0.00	

PROVIDER ADJUSTMENT(S):

PROV ADJ CD: (o) PROV ADJ ID: (p) PROV ADJ AMT: (q)
CS 12849081-81852719 S12345678.90

TOTAL PAYMENT AMT (r)S12345678
TOTAL PROVIDER TAX (s)
TOTAL WITHHOLD (t)

(u)
EXPLANATION OF CODE(S):

GRP CD GROUP CODE DESCRIPTION	ADJ RSN ADJUSTMENT REASON DESCRIPTION	REMARK CD	REMARK CODE DESCRIPTION
(CO) provider liability	(125) xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	[C0213]	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

(v) FOR REMITTANCE KEY INFORMATION GO TO: coOportunityhealth.com/provider

CoOportunity Health Paper Remit Field Descriptions HIPAA Version 5010

Element	Field name	Label	Usage	835 Element
A	Payer Name and Address	none	Payer name, address	N102 where N101 = PR N3, N4
B	Payer Contact	CONTACT	Payer name of business contact area and contact phone numbers for local and long distance.	PER where PER01= CX
C	Payer ID	PAYER ID	1 followed by TIN	BPR10 TRN03
'D	Supplemental ID	SUPPLEMENTAL ID	Field contains the BANK ID associated to the payment. BANK can be used to identify product line and to reconcile multiple remits to the same vendor.	TRN04
E	Payee Name and Address	PAYEE	Defines the entity to which payment is directed.	N102 where N101 = PE N3, N4
F	Payee Tax ID	PAYEE TAX ID	Federal Tax ID or SSN assigned to payee.	N104 where N103 = FI or REF02 where REF01 = TJ
G	Payee NPI	PAYEE NPI	NPI associated to payee	N104 where N103=XX
H	PAYEE ID	PAYEE ID	Payer assigned ID -- Payee ID assigned by CoOportunity Health. This provides additional identification information critical to vendor balance that is not accommodated by the NPI. A single NPI may have multiple payers assigned ID's associated to it.	REF02 where REF01 = PQ
I	Production End Cycle Date	PROD DATE	The last date Payer adjudicated claims appearing on this remittance advice.	DTM02 where DTM01 = 405
J	Check/EFT Date	CHECK/EFT DT	The check issue date, or in the case of a nonpayment remittance, the date the remittance was generated. Required on the top of each page of a multipage remittance.	BPR16
K	Check/EFT Trace Number	CHECK/EFT	A trace number which is used to re-associate payments and remittances, must be a unique number for this business purpose between the payer and the payee. This is the check number, EFT payment ID, or in the case of a nonpayment remittance, a unique ID assigned to the remit.	TRN02

Element	Field name	Label	Usage	835 Element
L	Payment Amount	PAYMENT	The total amount of payment that corresponds to the remittance advice. The total payment amount for this remit cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the remit cannot be issued for less than zero dollars.	BPR02
M	Payment Method	PAYMENT METHOD	Defines the way payment is transmitted: Check, EFT or no-payment. Values: CHK, ACH, NON	BRP04
N	Page Number		Remittance page number.	Na
1	Patient Control Number	PAT CTRL #	The first 20 bytes of the provider assigned identifier submitted on the claim (CLM01). If an identifier was not submitted the value is defaulted to'0.' This data element is the primary key for posting the remittance information into the provider's database.	CLP01
2	Payer Claim Control number	CLM #	The identifier assigned by Payer that identifies the claim submission. For 5010 format, this value will be the same on the original, voided, and the replacement claim.	CLP07
3	Claim Status	CLM STATUS	Claim status code and narrative definition.	CLP02
4	Claim Charge Amount	CLM CHG	The total submitted charges for the claim. This amount can be positive, zero or negative.	CLP03
5	Patient Name	PATIENT	For claims submitted in the 5010 837 format, this is the submitted patient name on the claim. Format is last name, first name, and middle initial.	NM103,04,05,07 where NM101 = QC
6	Statement From and To Date	CLAIM DT	Service date range of the claim.	DTM02 where DTM01 = 232 and 233
7	Claim Payment Amount	CLM PAYMENT	This is the total amount paid on this claim. This amount can be positive, negative or zero.	CLP04
8	Patient Identifier	PATIENT ID	For claims submitted in the 5010 837 format, this is the submitted patient ID. For claims submitted in other formats, this is the patient identifier assigned by Payer.	NM109 where NM101=QC

Element	Field name	Label	Usage	835 Element
9	Group or Policy Number	GRP	The Payer group number associated with the patient's coverage.	REF02 where REF01 = 1L
10	Claim Filing Indicator	CLM FILING IND	Coded value, used to identify different product lines within a payer.	CLP06
11	Patient Responsibility Amount	PAT RESP	The total patient responsibility amount for this claim. Amounts correspond to adjustments with grouping code of PR.	CLP05
12	Provider Liability	PRV LIAB	Total provider liability amount applied to the claim other than the Provider Tax or withhold amounts. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals CO (excluding adjustment reason codes 137 and 104).	na
13	Rendering Provider Identifier	REND PROV ID	The payer assigned ID number or the National Provider Identifier of the provider who performed the service. Required if the rendering provider identifier is different than the payee ID. Element should contain the NPI or the payer assigned ID number for atypical providers.	NM109 where NM108=XX Or NM109 where NM108 = PC
14	Claim Received Date	CLM RECEIVED DT	Date claim was received by CoOportunity.	DTM02 where DTM01=050
15	Facility Type	FACILITY TYPE	For the 5010 remit format, this element is populated on all claim types. Required when the information was received on the original claim. Professional and dental default to POS from first line.	CLP08
16	Claim Frequency	FREQ	Submitted claim frequency. For 5010 remit format this element is used on all transaction types and is required if submitted on the original claim.	CLP09
17	Other liability	OTHER LIAB	Total other liability amount applied to the claim. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals OA.	na

Element	Field name	Label	Usage	835 Element
18	Provider Tax	PROVIDER TAX	Total Tax payment amount applied to the claim. The sum of all claim and line level adjustments associated to adjustment reason codes 137. For this field, the tax payment amount is not reflected as a negative, unless it is a voided claim. If tax amount does not apply to the claim then the value will equal zero.	AMT02 where AMT01=T
19	Medical Record Number	MED REC #	This is the provider assigned medical record number that was submitted on the claim.	REF02 where REF01 = EA
20	Diagnosis Related Group Code	DRG	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP11
21	Diagnosis Related Group Weight	DRG WGHT	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP12
22	Coverage Expiration Date	COV EXP DT	The date coverage expired if claim is denied because of the expiration of coverage.	DTM02 where DTM01=036
23	Withhold	WITHHOLD	Total withhold amount adjusted from the claim. Sum of claim and line level amounts associated with adjustment reason 104. If no withhold amount, value will equal zero.	na
24	Covered Amount	COVERED	This is the sum of the original submitted provider charges that are eligible for payment under the benefit provisions of the health plan. This excludes charges that are not covered (i.e., per day television or telephone charges) but includes reductions to payments of covered services (i.e., reductions for amounts over fee schedule and patient deductibles).	AMT*AU
25	Corrected Patient Name	CORRECTED PATIENT	If claim was submitted in the 5010 837 format and the patient info does not match CoOportunity Health eligibility, this field contains only the elements that are different, not necessarily the full name.	NM1*74

Element	Field name	Label	Usage	835 Element
26	Corrected Patient ID	CORRECTED PATIENT ID	If the claim was submitted in the 5010 837 format and the patient ID does not match CoOportunity Health eligibility, this field contains the value from CoOportunity Health eligibility.	NM109
27	Corrected Priority Payer	CORRECTED PRIORITY PAYER	This is the name of the payer that has priority over CoOportunity Health in making payment. For 5010 remit format, this element is only populated when CoOportunity Health has identified a payer primary to the CoOportunity Health coverage and the COB loop was not submitted on claim.	NM103 where NM101 = PR
28	Other subscriber Name	OTHER SUBSCRIBER	Populated for 5010 when a priority payer has been identified.	NM103 NM104 Where NM101=GB
29	Billing Provider	BILLING PROVIDER	Subsidiary provider ID, used when payment is made to other than the billing entity. For the 5010 remit format this element is populated when the submitted billing NPI is different than the payee NPI.	TS301
30	Crossover carrier name	CROSSOVER CARRIER	Required when the claim is transferred to another carrier or coverage (CLP02 = 19, 20, 21 or 23).	NM103 where NM101=TT
31	Crossover carrier ID	ID	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23). .	NM109 where NM101=TT
32	Patients Medicaid Identifier	PMI	MEDICAL ASSISTANCE NUMBER or Medical Assistance Number	REF 02 where REF01=1W
33	Contract Code	CONTRACT	The contract that was used between the payer and the provider to determine payment. Populated with provider network message.	REF01 where REF02=CE
34	Remark codes	REMARK CODES	This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone or are not associated to a dollar adjustment. Claim can contain up to five claim level remark codes.	MIA/MOA

Element	Field name	Label	Usage	835 Element
35.1	Claim Adjustment Amount	CLM ADJ AMT	The adjustment amount associated with the adjustment grouping code and reason code. There can be multiple adjustment amounts per claim. The total submitted charges minus [the sum of the claim level adjustment amounts and the line level adjustment amounts] must equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS
35.2	Claim Adjustment Group Code	GRP CD	Code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Identifies a joint payer/payee contractual agreement or a regulatory requirement that resulted in an adjustment. OA Other Adjustments- avoid using OA except for business situations defined in HIPAA guide. PI Payer Initiated Reductions - Identifies when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer. PR Patient Responsibility	CAS
35.3	Claim adjustment reason code	CLM ADJ RSN CD	Defines the reason for the adjustment amount.	CAS
a)	Line Item Control Number	LINE CTRL #	Line item identifier submitted by the provider to identify the line or the claim line number.	REF02 where REF01 = 6R
b)	Dates of Service	DOS	This is the date range of services for each line. Format is MMDDCCYY-MMDDCCYY.	DTM02
c)	Revenue Code	REV	Element applies to institutional claims only. This is the revenue code submitted on the claim line.	SVC04 or SVC01-2
d)	Adjudicated Product/Service Code/Modifiers	ADJUDICATED PROD/SVC/MOD	This is the adjudicated procedure code and modifiers. Values can be HCPC or ADA codes.	SVC01

Element	Field name	Label	Usage	835 Element
e)	Submitted Product/Service Code/Modifiers	SUBMITTED PROD/SVC/MOD	If the code used for adjudication is different than the submitted value, the submitted value is contained in this element.	SVC06
f)	Line Item Charge or Billed Amount	CHARGE	The line item charge/billed amount submitted on the line.	SVC02
g)	Units	#	The number of paid units of service.	SVC05
h)	APC (Ambulatory Payment Classification)	APC	Element applies to institutional only. A value is present if adjudication used the APC.	REF02 where REF01 = APC
i.1	Claim Adjustment Amount	ADJ AMT	This is the adjustment amount associated with the adjustment grouping code and reason code. There can be multiple adjustment amounts per line. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts should equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS
i.2	Claim Adjustment Grouping Code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Identifies a joint payer/payee contractual agreement or a regulatory requirement that resulted in an adjustment. OA Other adjustments- Identifies for business situations defined in HIPAA guide. PI Payer Initiated Reductions - Identifies when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer. PR Patient Responsibility	CAS
i.3	Claim Adjustment Reason Code	CLM ADJ RSN CD	Defines the reason for the adjustment amount. Narrative values of codes are available at wpc-edi.com.	CAS

Element	Field name	Label	Usage	835 Element
j)	Remittance Advice Remark Code	REMARK CODE	A code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone. If claim line has multiple adjustment reasons, the remark code is not in relationship to the adjustment reason across from it but to the line. This is the same relationship as the 835 electronic transactions.	LQ
k)	Payment Amount	PAYMENT	The payment amount corresponding to the adjudicated service line. The line item billed amount minus the line item adjustment amounts must equal the line item payment amount.	SVC03
l)	Rendering Provider ID	REND PROV ID	This is the NPI or atypical ID of the rendering provider if the value is different than the claim level.	REF
m)	Submitted Procedure Code Description	No label	If a description was received on the original service for a not otherwise classified procedure code, and the adjudicated procedure is different than the submitted value.	SVC06-7
n)	Allowed Amount		The amount the payer deems payable prior to considering patient responsibility.	AMT02 where AMT01=B6
o)	Provider Adjustment Reason Code	PROV ADJ CD	The reason for the provider adjustments that are not specific to a particular claim or service. Multiple adjustments may apply to the payment.	PLB0
p)	Provider Adjustment Identifier	PROV ADJ ID	For 5010 remit format, the ID will vary by reason code. Adjustment codes are used as defined in the HIPAA guide.	PLB
q)	Provider Adjustment Amount	PROV ADJ AMT	This is the monetary amount of the adjustment. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	PLB
r)	Total Payment	TOTAL PAYMENT AMT		NA
s)	Total Provider Tax Amount	TOTAL PROVIDER TAX	Total tax payment amount applied to the check for all claims on the remittance.	NA
t)	Total Withhold Amount	TOTAL WITHHOLD	Total withhold amount adjusted from check for all claims on the remittance.	NA

Element	Field name	Label	Usage	835 Element
u)	Explanation of code(s)	EXPLANATION OF CODE(S)	Narrative description of grouping codes, adjustment codes, and remark codes contained in remit.	NA
v)			FOR REMITTANCE KEY INFORMATION GO TO: coOportunityhealth.com/provider	

Commonly Used Forms

Subject: Adjustment Request Form

Claims sent for Adjustment can be submitted.

ADMINISTRATIVE PROCESS:
If additional information is needed to support the submission of an electronically submitted adjustment claim, the NTE segment, PWK segment, or Condition Codes should be utilized.

Requests for adjustments without needing a new claim can also be submitted via the faxable form.

Subject: Appeal Request Form

Claims appeals can be submitted.

ADMINISTRATIVE PROCESS:
Requests for adjustments without needing a new claim can also be submitted via the faxable form.

Subject: Prompt Payment of Clean Claims

Legislation requires the prompt payment of health claims. Payment or denial of clean claims is required within 30 days after CoOportunity Health's receipt of the claim.

A clean claim

- Is a properly completed billing instrument containing all reasonably necessary information
- Does not involve coordination of benefits for third party liability or subrogation
- Does not involve the existence of particular circumstances requiring special treatment, which prevent a prompt payment from being made
- Does not involve potentially fraudulent or abusive billing practices

Interest shall accrue beginning on the thirty-first day after CoOportunity Health's receipt of all information necessary to establish a clean claim.

When a claim involves coordination of benefits, the requirements to pay a clean claim within 30 days begins when CoOportunity Health's liability has been determined.

ADMINISTRATIVE PROCESS:
CoOportunity Health will determine what claims are eligible for interest using the guidelines outlined and will pay interest for claims payment directly to participating providers on a quarterly basis.

CoOportunity Health will determine what claims are eligible for interest by using the following criteria:

Received Date: This is the date CoOportunity Health receives the claim. For electronic claims, this is the date of EDI file receipt in the CoOportunity system. For paper claims, this is the date the claim is received in CoOportunity Health's mailroom.

Paid Date: CoOportunity Health will calculate using the date of the check plus 3 days for mailing. If you have the postmarked envelope in which the payment was received with a later postmark date, we are willing to accept that as the paid date. If you are consistently experiencing delays beyond the check date plus 3 days, contact CoOportunity Health at providerrelations@coOportunityhealth.com to help resolve the issue.

Clean Claim: For a claim to be a clean claim, it must be completed with all necessary data elements, any referrals need to be received by the plan and all needed COB information must be received by the plan.

Note: CoOportunity Health will not calculate and pay interest on claims for which the provider is capitated, on payment advances, or on self-insured claims.

Provider Responsibility:
To assist CoOportunity Health in paying claims as promptly as possible:

- Submit claims electronically whenever feasible
- Attach primary insurer information or an Explanation of Benefits form whenever applicable
- Submit complete bills with accurate coding and the correct provider number, including NPI

Medical Cost Management

ClaimCheck® Review

CoOportunity Health ClaimCheck Review® Edit Categories

Standard Modifier Table Policy

Casting Supplies

Codes For Data Collection and Reporting Only Procedures

Global Obstetric Package

Services Not Billable On A Professional Format

Services Not Separately Reimbursable

Surgery

- Assistant Surgeon Services
- Bilateral Billing Guidelines
- Global Surgical Follow-Up Care
- Multiple Surgery
- Surgical Trays

Subject: ClaimCheck® Review

CoOportunity Health uses ClaimCheck®, a coding software system purchased from an external vendor. ClaimCheck logic will be applied to your claims as permitted by the terms of your Midlands Choice agreement or your CoOportunity Health addendum.

ADMINISTRATIVE PROCESS:
Coding logic is applied to physician and professional claims that include Current Procedural Terminology (CPT) codes and Health Care Financing Administration Coding System (HCPCS) codes. ClaimCheck® provides consistent, objective claims review by applying the coding criteria outlined in the AMA's CPT-4 manual to all physician services.

The coding software is updated by the vendor in the first quarter of each year. Any new edits generally occur at the end of the first quarter, on or about April 1. ClaimCheck is used in the review of all CoOportunity Health professional claims.

CoOportunity Health ClaimCheck® Edit Categories		
Edit Category	**Description**	**Outcome**
Visit	Professional visits [E & M] billed on the same day as a substantial diagnostic, therapeutic or surgical procedure is performed.	ClaimCheck® automatically denies same day visits when billed with the allowable surgical procedure. Payment is based on the surgical procedure. Claim is routed to Medical Review for review.
Unlisted Procedure	Unlisted services or procedures are defined as those procedures or services performed/rendered by providers but not found in the appropriate edition of CPT or HCPCs for the date of service. Unlisted procedure codes are not to be used when a more descriptive procedure code representing the service provided is available.	Unlisted procedures are questioned and routed to Medical Review for review.
Assistant Surgeon	Surgical procedure in which it is medically necessary to have an assistant assisting the primary surgeon at surgery.	ClaimCheck® automatically denies assistant surgeon charges when the assistant is not medically necessary. ClaimCheck® will question assistant surgeon charges when documentation is needed to support charges. Claim is routed to Medical Review for review.
CCI-Incidental	Procedure combinations identified in the CMS Column 1/Column 2 edits, formerly the comprehensive/component edits. These are solely based on CMS guidelines.	ClaimCheck® automatically denies CCI-Incidental edits.
CCI-Mutually Exclusive	Procedure combinations identified in the CMS CCI Mutually Exclusive tables. These are solely based on CMS guidelines.	ClaimCheck® automatically denies CCI-Mutually Exclusive edits.
Bilateral Duplicate procedures	The procedure code contains the word “bilateral,”, the procedure can be performed *only once on a single date of service.*	ClaimCheck® automatically denies bilateral duplicate procedures. Claim is routed to Medical Review for review.
Unilateral/Bilateral Duplicate procedures	The procedure code contains the phrase “unilateral/bilateral,” the procedure can be performed *only once on a single date of service.*	ClaimCheck® automatically denies unilateral/bilateral duplicate procedures. Claim is routed to Medical Review for review.

CoOportunity Health ClaimCheck® Edit Categories		
Edit Category	**Description**	**Outcome**
Duplicate Rebundle/Replacements Duplicate procedures	The procedure code specifies "unilateral" and there is another procedure whose description specifies "bilateral" performance of the same procedure, the unilateral procedure *cannot* be submitted more than once on single date of service.	ClaimCheck® automatically denies duplicate rebundle/replacement duplicate procedures. Claim is routed to Medical Review for review.
Global Duplicate Value procedures	The procedure code is assigned the total number of times per date of service that the procedure may be appropriately submitted. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites.	ClaimCheck® automatically denies global duplicate value procedures. Claim is routed to Medical Review for review.
Right/Left Duplicate Value procedures	The procedure code is assigned a value which is the maximum number of times per side, per date of service that a procedure may be submitted when modifiers RT and/or –LT are used. Procedures (that clinically can be performed only once per date of service) are limited globally at "1," but are allowed to be reported with the appropriate –RT or –LT modifier for the site specific designation.	ClaimCheck® automatically denies right/left duplicate value procedures. Claim is routed to Medical Review for review.
Site specific Duplicate Value procedures	The procedure code is assigned a value which is the maximum number of times per site, per date of service that a procedure may be submitted when site specific modifiers E1-E4, FA-F9, TA-T9, LC, LD and RC are used.	ClaimCheck® automatically denies site specific duplicate value procedures. Claim is routed to Medical Review for review.
Reporting Only procedures	The procedure code is submitted for data collecting only and reimbursement is not warranted.	ClaimCheck® automatically denies the reporting only procedure.

CoOportunity Health ClaimCheck® Edit Categories		
Edit Category	**Description**	**Outcome**
Incidental Procedures	The procedure is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.	ClaimCheck® automatically denies incidental procedures. Claim is routed to Medical Review for review.
Mutually Exclusive procedures	The edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome. Mutually exclusive edits are developed between procedures based on the following CPT description verbiage: • Limited/Complete • Partial/Total • Single/Multiple • Unilateral/Bilateral • Initial/Subsequent • Simple/Complex • Superficial/Deep • With/Without	ClaimCheck® automatically denies incidental procedures. Claim is routed to Medical Review for review.
Bilateral Procedures	Codes submitted with a 50 modifier.	ClaimCheck® will question the claim and route to a Medical Review analyst to verify what was actually done.
Replacement codes	Reassignment of the appropriate comprehensive CPT code representing those procedures and/or services billed as performed. Reassignment will take place when there is a one-to-one code replacement for an age or gender edit.	ClaimCheck® automatically replaces and assigns the appropriate CPT code. Payment is based on the replaced code.
Inconsistency of Gender to Procedure	CPT codes that are specific to the patient's gender.	ClaimCheck® will generate a questioned claim that is routed to a Medical Review analyst. Medical review will verify the gender of the patient to the procedure being performed.
Inconsistency of Age to Procedure	CPT codes that are specific to a patient's age.	ClaimCheck® will generate a questioned claim that is routed to a Medical Review analyst. Medical review will verify the age of the patient to the procedure being performed.

CoOportunity Health ClaimCheck® Edit Categories		
Edit Category	**Description**	**Outcome**
Relationship of Procedure to place of service	Generally accepted setting where a procedure or service is performed/rendered.	If the place of service submitted is inappropriate with the procedure being performed ClaimCheck® will deny the procedure. Medical Review will verify.
Modifier to procedure edit	Procedure to modifier validity check to determine if a procedure code is valid with a specific procedure.	ClaimCheck® will question the line item and route to a Medical Review for review.
Preoperative/ Postoperative Visit	Evaluation and management services are denied when rendered by the surgeon during the established preoperative/postoperative period.	ClaimCheck® automatically denies preoperative/postoperative visit procedures. Claim is routed to Medical Review for review.
Multiple Surgery	Two or more surgical procedures are performed during one operative session by the same physician. Hierarchy is determined by the highest dollar procedure.	Primary procedure is reimbursed at 100% of the fee schedule or billed amount, whichever is less. Secondary, tertiary, etc., are reimbursed at 50% of the fee schedule or billed amount, whichever is less.

Subject: Modifier Table Policy

The following table lists the CoOportunity Health modifiers that affect claims payment by either increasing or decreasing the allowable amount as permitted under the terms of your CoOportunity Health three-party addendum. Some modifiers are addressed in separate policies, so please review the specific policy for additional information on the identified modifiers below.

Modifier	Modifier Description	Percent of Allowable
22	Increased procedural services	110%
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	80%
50	Bilateral procedure	See Bilateral Billing Guidelines Policy
52	Reduced services	Through 4/30/14 75% Effective 5/1/14 50%
53	Discontinued Procedure	Through 4/30/14 50% Effective 5/1/14 25%
54	Surgical care only	75%
55	Postoperative management only	25%
56	Preoperative management only	10%
62	Two surgeons	62.5%
80	Assistant surgeon	Through 4/30/14 20% Effective 5/1/2014 16%
81	Minimum assistant surgeon	See Assistant Surgery Services Policy
82	Assistant surgeon (when qualified resident surgeon not available)	Through 4/30/14 20% Effective 5/1/2014 16%
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	See Assistant Surgery Services Policy
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)	0%
FC	Partial credit received for replaced device	50%
GZ	Item or service expected to be denied as not reasonable or necessary	0%
HQ	Group setting	50%
PA	Surgical or other invasive procedure on wrong body part	See Never Events Policy
PB	Surgical or other invasive procedure on wrong patient	See Never Events Policy

Modifier	Modifier Description	Percent of Allowable
PC	Wrong surgery or other invasive procedure on patient	See Never Events Policy
PM	Post Mortem	100%
XE*	Separate Encounter	100%
XS*	Separate structure	100%
XP*	Separate practitioner	100%
XU*	Unusual non-overlapping services	100%

ADMINISTRATIVE PROCESS:
The modifier pricing is automated in the Claims system.

*X-modifiers are effective 1/1/2015 and are in addition to modifier 59, but will not replace modifier 59, which is still active

Subject: Casting Supplies

Casting supplies will be allowed for reimbursement as separately billable charges for initial fracture care and at the time of cast reapplication. An office visit charge is not reimbursable at the time of reapplication.

ADMINISTRATIVE PROCESS:
CoOportunity Health has adopted the Medicare Part B guidelines for reimbursement of cast supplies.

Subject: Codes for Data Collection and Reporting Only Procedures

Codes listed below are intended to facilitate data collection or are for reporting purposes only and are not separately reimbursable.

ADMINISTRATIVE PROCESS:
Deny procedure codes when billed. No review necessary. Claims system is automated.

CODES LIST:

Procedure Codes
90663
0001F – 7025F (CPT Category II)
G8126 – G9140
G9142
S0302

Subject: Global Obstetric Package

Global OB package includes all services rendered during the entirety of a patient's uncomplicated pregnancy.

Ante-partum care includes:

- Subsequent history
- Physical/pelvic examinations
- Recording of weight and blood pressures
- Fetal heart tones
- Routine urinalysis
- Supplies and materials generally associated with OB care
- Educational supplies and services

Uncomplicated delivery includes:

- Management of labor
- Cesarean delivery
- Suction of forceps assist of vaginal delivery, with or without episiotomy
- Admission history and physical, hospital visits and discharge
- Induction of labor on the same day of delivery
- Administration of routine anesthesia by the delivering physician
- External and internal fetal monitoring
- Fetal contractions stress tests performed on the day of delivery at the hospital

Uncomplicated postpartum care/office visits:

- CPT code 59430 should only be used when the physician who performs postpartum care is not the physician who performed the delivery.
  Six weeks for vaginal delivery and eight weeks for C-section. Service includes:
  - Pelvic exam
  - Suture removal
  - Contraceptive management

Subject: Global Obstetric Package--continued

Total OB Package

The initial visit is to be billed separately. The OB package includes all ante-partum care (12 prenatal visits), delivery and postpartum care. All routine urinalysis are included. Any other lab work or procedures can be billed separately. Use the initial visit date and the date of delivery as the "to" and "from" dates of service when submitting the global code.

Check online Benefits for group specific coverage for OB care.

ADMINISTRATIVE PROCESS:
Requests for appeal review should include the adjustment request form. Supporting documentation with a copy of the remittance advice showing the last processed date should be included with the request.

Subject: Services Not Billable on a Professional Format

Codes C1300-C9899 are for drugs, biologicals, and devices that must be used by OPPS hospitals. These codes cannot be billed on a professional format.

ADMINISTRATIVE PROCESS:
Deny codes when billed on a professional format. No review necessary. Claim system is automated.

Subject: Services Not Separately Reimbursable

CoOportunity Health has determined the codes listed below are not separately reimbursable.

ADMINISTRATIVE PROCESS:
Deny procedure codes when billed. No review necessary. Claims system is automated.

Code list:

Procedure Code
90889 94760, 94761 96110 99000, 99001, 99002, 99026, 99027, 99050, 99051, 99053, 99056, 99058, 99060, 99070, 99075, 99078, 99080, 99082, 99090, 99091 99358, 99359, 99367, 99368 A4550 J2001 Q0091 S0020, S0039, S2055, S2061, S2140, S2150 S3600, S3601, S9088, S9981, S9982

Subject: Surgery-Assistant Surgeon

CoOportunity Health's definition of Assistant Surgeon includes MD, RNFAs (RN First Assistants), PAs (Physician Assistants) and NPs (Nurse Practitioners). CoOportunity Health *follows Medicare guidelines regarding necessity of Assistant Surgeon.*

Assistant Surgeon professional services are identified by the following procedure modifiers billed with the surgical CPT code.

80 = Assistant Surgeon

81= Minimum Assistant Surgeon

82 = Assistant Surgeon (when qualified resident surgeon not available)

AS = Physician Assistant (PA), Nurse Practitioner (NP), or clinical nurse specialist services for assistant at surgery.

The modifier will automate the correct percentage for pricing.

COVERAGE:
Under the terms of your CoOportunity Health three-party Addendum, CoOportunity Health will reimburse appropriate Assistant Surgeon services at:

80 = 20% of the Surgeon's allowed amount through 4/30/14
= 16% of the Surgeon's allowed amount effective 5/1/14

81 = 16% of the Surgeon's allowed amount

82 = 20% of the Surgeon's allowed amount through 4/30/14
= 16% of the Surgeon's allowed amount effective 5/1/14

AS = 14% of the Surgeon's allowed amount

Multiple assistant surgeon services will be considered and reviewed for medical necessity.

CoOportunity Health uses the Medicare Physician Fee Schedule Database (MPFSDB) "Assistant Surgeon Indicator" field as the basis for determining which CPT codes will be allowed for assistant surgeon reimbursement.

To access this database, refer to the CMS Web site at:
cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13A.html?DLPage=1&DLSort=0&DLSortDir=descending

Subject: Bilateral Billing Guidelines

A “bilateral procedure” is defined as a procedure which can be performed on either the right or left anatomic structure or is unspecific as to anatomic location, but can be performed on an anatomically bilateral structure the use of modifier -50 is valid. There are some exceptions to this rule for codes which may be inherently bilateral or for procedures which may involve paired structures, but are not performed bilaterally.

CoOportunity Health prefers bilateral procedures to be reported on one line using modifier “50” with a unit of service of one.

However, CoOportunity Health will allow a CPT4 code with a bilateral indicator assignment of ‘1’ to be billed on two line items, one with modifier RT and the other with LT. Each line must be billed with a single unit of service

ADMINSTRATIVE PROCESS:
Where applicable, CoOportunity Health would reimburse the lesser of, a) 150% of the fee schedule amount or b) billed charges.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

CoOportunity Health uses the Medicare Physician Fee Schedule Database (MPFSDB) as the basis for determining which CPT codes can be submitted as “bilateral.”

The “Bilateral Surgery Indicator” (Field 22) in the MPFSDB indicates how the bilateral service must be submitted to Medicare.

To access this database, refer to the CMS Web site at: cms.gov/apps/physician-fee-schedule/

Subject: Bilateral Billing Guidelines-continued

Bilateral Surgery Indicators and Claim Submission

Bilateral Indicator	Definition	Submission Instructions
0	If a CPT4 is not exempt from multiple procedure discounting, then a reduction will occur (100%, 50%, 50% and so on).	It is not appropriate to submit these procedure codes with modifier 50.
1	Reimbursement of 150% for bilateral procedure applies	Submit a bilateral procedure on a single detail line with CPT modifier “50” and a quantity of “1.” OR same CPT4 code on two lines, one with modifier LT the other with RT, each line item containing 1 unit of service.
2	If a CPT4 is not exempt from multiple procedure discounting, then a reduction will occur (100%, 50%, 50% and so on).	It is not appropriate to submit these procedure codes with modifier 50.
3	The usual payment adjustment for bilateral procedures does not apply.	Submit the procedure on a single line with a quantity of 2 or on two separate lines with modifiers RT and LT.
9	Bilateral concept does not apply.	It is not appropriate to submit these procedure codes with modifier 50.

This procedure applies to all contracted providers billing on 837P or CMS 1500 format.

Subject: Global Surgical Follow-Up Care

Surgical procedures have a defined "follow-up" period. Under this guideline follow up visits performed within the indicated period are considered included as part of the reimbursement for the surgery performed by the same physician/surgeon. CoOportunity Health follows Medicare surgical follow-up periods.

Those visits billed within the follow up period will be denied.

ADMINISTRATIVE PROCESS:
ClaimCheck®/Historical Auditing will deny those visits billed within the global period defined by CPT code. This policy is automated.

Subject: Multiple Surgery

Allowable multiple surgical procedures are reduced based on highest dollar billed order based on the terms of your CoOportunity Health three-party addendum: 100%, 50%, 50%, 50%, etc., regardless of separate site of multiple incisions.

ADMINISTRATIVE PROCESS:
Allowable secondary, tertiary, etc., surgical procedures will be reduced to allow 50% of the fee schedule or billed amount, whichever is less, regardless of separate site or multiple incisions.

This multiple surgery pricing is automated.

Subject: Surgical Trays

Surgical supplies are not reimbursable when billed with an allowable procedure.

Procedure A4550 is considered to be integral to all surgical procedures listed in the CPT manual, and select medical procedures and radiological exams that require the use of surgical trays and supplies. It is assumed that these procedures will be performed in a hospital, outpatient, or surgicenter setting and that the supplies will be provided by the management of those facilities. When a procedure is performed in a physician's office, hospital surgicenter or outpatient setting, the supplies and materials essential for the performance of the procedure are not considered over and above the basic value of the service being rendered, and additional reimbursement to the physician is not warranted.

ADMINISTRATIVE POLICY:
HCPCS code A4550 Surgical supplies will be denied when billed with a surgical procedure and select medical and radiological procedures.

Subject: Reporting Suspicions of Fraud and Abuse

The Fraud Hotline phone number provides members, providers and employer groups the option to report reasonable and good faith suspicions or concerns regarding possible fraudulent claims activity.

The Hotline gives the caller the opportunity to leave a confidential message that will be investigated by the CoOportunity Health Claims Special Investigations Unit (SIU).

ADMINISTRATIVE PROCESS:
Contact the Claims Fraud Hotline at 1.855.332.7194 or 1.952.883.5099 regarding any suspicions or concerns about possible fraudulent claims activity.

You can also call our Member Services number (located on the back of your insurance card) and ask to be transferred to the fraud and abuse hotline. You may remain anonymous.

You may also mail or fax us at:

CoOportunity Health Special Investigations Unit (SIU)

Mail route 25110F
P.O. Box 38
Minneapolis, MN 55440-9984
Fax: 651.265.1333
Email: reportfraud@healthpartners.com