



Administrative Manual

Claims Processing Guidelines

Chapter 6

HealthLink[®]



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Claim Processing Guidelines

Claims Filing Process

For optimum claim processing and payment:

- File claims within 30 days following the date of service or hospital discharge date.
- Complete standard claim forms utilizing current CPT-4/HCPC and Revenue Code guidelines.
- Submit claims electronically through your local vendor or submit paper claims to the appropriate address located on the back of the enrollee's ID card.
- HealthLink prices the claim based upon contractual allowances.
- The Payor determines benefits and eligibility, and then issues a remittance advice report to the participating physician, hospital or health care professional.

HealthLink encourages hospitals and health care professionals to submit electronic claims. Except CompManagement claims, all claims can be sent electronically to HealthLink resulting in cost efficiencies and faster processing.

To begin sending claims to HealthLink:

HealthLink
P.O. Box 419104
St. Louis, MO 63141

Electronic Payor ID number: 90001

To avoid payments delays, verify the correction Electronic Payor ID numbers and claims addresses.

Exception: State of Illinois claims should be sent to:

HealthLink
P.O. Box 411580
St. Louis, MO 63141

Electronic Payor ID number: 96475

While electronic claim submission is by far the more efficient procedure, HealthLink understands that some providers find it necessary to submit paper claims. Please note the following information to help streamline the process of paper claim submission.

When the scanned data on a paper claim cannot be read by the Optical Character Recognition (OCR) software, the claim has to be handled through a manual process. The transition to the manual process can extend the claim processing time by 150%.

To ensure your claims are handled in the most efficient way possible, please follow these simple steps:

- Submit your paper claim on standard claim forms utilizing current CPT-4/HCPC and Revenue Code guidelines.

- Be sure your toner or ink cartridge is fresh. Use the Claim Print Guide (shown below) to check the shade of the print on the form.
- Check the placement of data on the claim form. Data should print within the fields, not outside the lines.
- Laser and ink jet printers work. Dot matrix printers leave space in between the dots that form each character. The OCR software can misread these characters, causing errors in the electronic data. Handwritten claim data or notes should be avoided as they will cause the claim to be handled manually.

Claim Print Guide

Ideal	Acceptable	Illegible
John Doe	John Doe	John Doe
John Doe	John Doe	John Doe

Claims Processing Guidelines

HealthLink reprices all claims for contracted payors. All repricing and payor adjudication is in accordance with the Provider Agreements. Payors may be insurance companies or other groups such as self-insured employers, trusts, or governments. Usually, benefits for medical services or supplies that are payable under the terms of a benefit plan are paid directly by the payor. For some payors, HealthLink acting as TPA may make benefit recommendations and payments on behalf of the payor using payor funds.

The administrator of the benefit plan retains authority with respect to eligibility, coverage and the benefits under the benefit plan. Coverage recommendations are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Medical claim guidelines neither constitute plan authorization, nor an explanation or guarantee of benefits.

Medical claim pricing and processing services provided by HealthLink are available to a payor. Not all payors purchase such services for the benefit plans they sponsor. For payors who have purchased such services, however, HealthLink processes claims based on its contracts using a proprietary software product licensed from a vendor, *McKesson CodeReview®*. The claims processing logic is annually reviewed and updated by McKesson. HealthLink has the ability to customize portions of the CodeReview® software and utilize various resources in making customization determinations. These include the National Correct Coding Initiative (NCCI), Medicare guidelines, and physician specialty societies.

HealthLink developed a guide to medical claim pricing for your reference including:

- HealthLink Significant Edits
 - Significant Edit Table

- Modifiers 25 and 59 Recognition
- Multiple Surgery Guidelines
- Customized Claims Edits
- Modifiers Reimbursement Methodology

Significant Edits

An edit that is based on experience with submitted claims will cause, on initial review of submitted claims, the denial or reduction in payment for a particular CPT® code or HCPCS Level II code more than two-hundred and fifty (250) times per year.

Descriptions:

Age edit: Age edits occur when the provider assigns an age-specific procedure or diagnosis code to a patient whose age is outside the designated age range.

Anesthesia: Time must be submitted when general anesthesia codes (00100-01999) are billed. When modifiers QY, QK, QX, or AS are billed, the allowance is 50% of the fee schedule allowable.

Assistant Surgeon: Allowance for an assistant surgeon is based on CMS guidelines. HealthLink recognizes modifiers 80, 81, 82, and AS for assistant surgeons. Codes assistant surgeon bills modifiers 80, 81 and 82 are allowed at 16%; codes an assistant surgeon bills modifier AS is allowed at 14% of the allowable. The assistant surgeon must bill his or her own services; he or she cannot be billed by the primary surgeon.

Incidental: An incidental 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.

Modifier use: Certain modifiers are only valid for specific codes (i.e. modifier 25 and 57 are only valid with E&M services, modifier 26 is not valid for surgical procedures as they are inherently professional in nature). As of the date of publication of this manual, HealthLink includes a special coding update section in the HealthLink Provider newsletter, *In Touch*.

Modifier 25

HealthLink generally will recognize modifier 25 for payment purposes, when it is appropriately reported from both a clinical and a coding perspective to identify a significant, separately identifiable Evaluation and Management service by the same physician on the same day of a procedure or other service.

Modifier 59

HealthLink generally will recognize modifier 59 for payment purposes, when it is appropriately reported from both a clinical and coding perspective. However, in certain situations, described below, HealthLink will not recognize modifier 59 for payment purposes.

1. “Duplicate” Procedures. HealthLink will not pay for “duplicate” procedures performed on the same patient on the same date of service, even if a provider reports modifier 59 with these procedures. “Duplicate” procedures, as used in this paragraph, fall into the following categories:
 - a. If the description of a procedure code contains either the word “bilateral” or the phrase “unilateral/bilateral,” the procedure code can be reported only once for a covered procedure performed on a single date of service (and the reporting of any additional such procedures performed on the same date will be considered non-payable “duplicates”);
 - b. If the description of a procedure code specifies “unilateral” procedure, and there is another procedure code that specifies “bilateral” for the same procedure, the “unilateral” procedure code can be reported only once for a covered procedure performed on a single date of service (and the reporting of any additional such “unilateral” procedures performed on the same date will be considered non-payable “duplicates”);
 - c. If the description of a procedure code specifies a “single” procedure, and there is another procedure code that specifies “multiple” procedures for the same procedure, the “single” procedure code can be reported only once for a covered procedure performed on a single date of service (and the reporting of any additional such “single” procedures performed on the same date will be considered non-payable “duplicates”); and
 - d. If the description of a procedure code states that the procedure may be performed a specified number of times on a single date of service, a provider should not report the performance of any such procedure beyond the specified number of times (and the reporting of any additional such procedures performed on the same date will be considered non-payable “duplicates”).

Multiple Surgery Rule Processing: The multiple surgery processing rule is applied when a physician performs separate procedures on the same patient during the same operative session. These separate procedures are not incidental to the primary procedure and are separately payable. The multiple surgery rule is applied as follows: 100% of the fee schedule amount is allowed for the procedure with the highest unit value and 50% of the fee schedule amount is allowed for the second and all subsequent procedures. Add-on Codes listed in Appendix D and Modifier 51 exempt codes listed in Appendix E of the American Medical Association’s Current Procedural Terminology (CPT®)book, are exempt from the Multiple Surgery Processing Rule and are allowed at 100% of the fee schedule allowance. Internal processing guidelines also cause some codes such as spinal injections and cardiac bypass to be allowed at 100% even though they are not add-on or modifier 51 exempt codes. **Multiple Surgery Guidelines**

Venipuncture/Specimen Collection: Drawing blood, specimen collection or conveyance of the specimen is considered to be integral to the performance of a laboratory test, and is not allowed separately.

The following is a link to all Significant Edits for HealthLink: [**Significant Edits Table**](#)

HealthLink Customized Edits

Custom claim edits differ from the standard claims editing software used by HealthLink. At this time, HealthLink does not have any customized edits.

Claim Information

To facilitate prompt processing, please include the following information on the standard claim forms:

- CMS 1500 (Professional)
- UB-04 (Institutional)
- Electronic 837

Place of Service Codes:

- | | |
|--|--|
| 1. Pharmacy | 41. Ambulance – land |
| 2. School | 42. Ambulance – air or water |
| 3. Homeless shelter | 49. Independent clinic |
| 4. Indian Health Service – freestanding facility | 50. Federally qualified health center |
| 5. Indian Health Service – provider-based facility | 51. Inpatient psychiatric facility |
| 6. Tribal 638 – freestanding facility | 52. Psychiatric facility – partial hospitalization |
| 7. Tribal 638 – provider-based facility | 53. Community mental health center |
| 8. Prison/correctional facility | 54. Intermediate care facility/mentally retarded |
| 11. Office | 55. Residential substance abuse treatment facility |
| 12. Home | 56. Psychiatric residential treatment center |
| 13. Assisted living facility | 57. Non-residential substance abuse treatment facility |
| 14. Group home | 60. Mass immunization center |
| 15. Mobile unit | 61. Comprehensive inpatient rehabilitation facility |
| 16. Temporary lodging | 62. Comprehensive outpatient rehabilitation facility |
| 20. Urgent care facility | 65. End-stage renal disease treatment facility |
| 21. Inpatient hospital | 71. Public health clinic |
| 22. Outpatient hospital | 72. Rural health clinic |
| 23. Emergency room – hospital | 81. Independent laboratory |
| 24. Ambulatory surgical center | 99. Other place of service |
| 25. Birthing center | |
| 26. Military treatment facility | |
| 31. Skilled nursing facility | |
| 32. Nursing facility | |
| 33. Custodial care facility | |
| 34. Hospice | |

* Unassigned Codes 9, 10, 17-19, 27-30, 35-40, 43-48, 58, 59, 63, 64, 66-70, 73-80, 82-98

Specialized Claim Procedures

Allergy – when billing for allergy tests or injections, use the appropriate CPT or HCPCS Codes to indicate the type performed. In the description, identify the number of tests or injections. If billing for multiple dates of service on a single claim form, indicate each date of service, CPT, HCPCS Code and itemized charge on a separate line.

Anesthesiology – HealthLink will process anesthesia claims using the anesthesia procedural codes published by the American Medical Association in the current edition of CPT as adapted from the ASA guidelines, published by the American Society of Anesthesiologists:

- Primary anesthesia procedural code – CPT (service descriptor)
- Additional ASA or CPT Codes (e.g., post-operative pain management, arterial catheter, etc.)
- Physical status P3, P4, P5
- Time in minutes (or hours and minutes)
- Charge by service
- Total billed charge

Dental – HealthLink requires dental ADA codes & diagnosis codes for all dental/medical service.

Psychiatry – when billing for individual or group therapy, include the duration of time in the descriptions.

Unlisted codes – when performing services that do not have a code assigned, be prepared to supply supporting documentation for the service. This may be in the form of operative reports, office notes, radiology reports, etc. If a service is defined by a Category III code as listed in CPT, then use the Category III code instead of an unlisted code.

Reimbursement/Overpayment Process

While Payors contracted or affiliated with HealthLink make reasonable efforts to pay claims properly upon receipt, occasionally overpayments may occur. If a health care provider becomes aware of an overpayment or mistake in payment (either through the provider's discovery, from the health plan's claims administrator or health carrier, or through a written notification from HealthLink), the provider is required to refund the amount due to the health plan.

Refund per Written Request from a Claims Administrator or Health Carrier Accessing the HealthLink Network:

A claims administrator (other than HealthLink) or health carrier may send a letter of explanation and request for return of amounts due to an overpayment. In this event, please send the check or money order along with the patient's name, enrollee identification number, and/or claim number to the claims administrator or health carrier who has requested the information. Do not remit payment to HealthLink because HealthLink is not the claims administrator and does not administer the health plan's benefits or claim payments.

Refund per Written Request from HealthLink:

In the event that HealthLink is the claims administrator, HealthLink will send a letter of explanation if an overpayment has been made to a participating HealthLink physician, hospital or health care professional. This letter usually accompanies the health care provider's weekly vendor statement of account with HealthLink. The specific claim and claim payment information appears on the adjustment code remark on the provider's HealthLink remittance advice. The physician should attach a check or money order to a copy of the written request. HealthLink will wait for a refund for thirty (30) days from the post date of the notice.

Please remit payment for the total credit balance to the address listed below in order to reconcile the account.

**HealthLink, Inc.
Attn: Finance-Vendor Refunds
1831 Chestnut Street
St. Louis, MO 63103**

If HealthLink does not receive the requested refund within thirty (30) days, HealthLink will deduct the amount from future remittances until the overpayment is reconciled for the health plan.

When HealthLink makes an overpayment to a participating hospital or facility, HealthLink deducts the amount from future remittance until the overpayment is reconciled for the health plan. When this situation arises, it is typically the result of interim billing processes for extended inpatient care. The specific claim and claim information appears on the adjustment code remark on the provider's HealthLink remittance advice.

Discovery of overpayments or questions regarding an offset or recoupment balance may be addressed by calling HealthLink Customer Service at 800-624-2356.

Reimbursement/Underpayment and Verification Process

General Inquiries:

For general inquiries about claims payment and benefit determinations, physicians, hospitals and other health care professionals should contact the plan administrator identified on the remittance advice or explanation of benefits accompanying the payment. The plan administrator can answer questions about applicable coinsurance and deductible amounts, or other service charges that may be the individual's responsibility. The plan administrator's name and telephone number typically appears on the remittance advice. Also, HealthLink can provide health care providers with the name and telephone number of the plan administrator.

For questions about the HealthLink contract amount, participating providers should contact HealthLink. There are three resources to assist in confirming the HealthLink contract amount:

1. HealthLink Network Service Consultant who works with the practice or facility;
2. HealthLink Customer Call Center Representatives: 1-800-624-2356; or,
3. If the question is specific to a particular claim, access HealthLink ProviderInfoSource: <https://providerinfosource.healthlink.com>.

If HealthLink determines that a pricing error has occurred in relationship to an underpayment, HealthLink's Customer Service or Network Service staff will forward the claim(s) for adjustment and send the adjustment to the applicable payor with notice of the corrected HealthLink allowed amount. If the service or procedure was priced according to the contract amount, HealthLink's Customer Service or Network Service staff member will confirm this fact and assist the participating provider, as appropriate, with confirming the contract rate with the applicable payor, as appropriate.

Formal Grievance Notice and Review Process:

If a participating provider disputes the finding and believes the claim remains underpaid, he or she may initiate a grievance by sending documentation explaining the nature of the complaint. This request for review of the claim payment and HealthLink contract amount must be filed within 90 calendar days of receipt of payment of the disputed claim or HealthLink contract amount.

Participating providers should:

- Submit a formal written request, or print and complete the form below:
Participating Provider Request for Review Form
- Include any substantiating documentation that was not previously reviewed;

- Send the document/form to the address noted below:
HealthLink Grievance & Appeal Department
P.O. Box 411424
St. Louis, MO 63141-1424

HealthLink will acknowledge receipt of all letters and respond with the resolution or action undertaken to resolve the matter. The resolution letter will follow within 30 calendar days after HealthLink’s receipt of the grievance or appeal. As applicable, the payor will be copied on such correspondence and provided necessary information confirming the HealthLink contract amount if a claim adjustment is warranted.

HealthLink offers participating health care providers two levels of internal review. If a participating health care provider remains dissatisfied with the resolution of the issue and has additional relevant information to present, he or she may initiate a second level review by request, including any additional relevant information. Please refer to the process outlined above. The second level review determination is final and binding with respect to the HealthLink contract amount.

Please Note:

- If applicable, contractual provisions that are mutually agreed upon by HealthLink and the participating provider will supersede the processes outlined within these policies.

CompManagement Claims Filing Process

For optimum processing and payment, please submit claims within 60 days following the date of service to the following address or fax:

To submit paper claims send HealthLink claims to the following address:		
Preferred Method:	<i>or</i>	<i>CompManagement</i>
Workers’ Compensation Payor (As listed on the Patient Information Card)		P.O. Box 410980 St. Louis, MO 63141-0980 Fax: (314) 925-6401

The claim filing process is outlined below:

1. Refer to the *CompManagement* listing of employers covered by this program, and ask the patient for the Patient Information Card that was completed at the time of an injury.
2. Contact the insurance payor/adjuster’s office listed on the Patient Information Card to verify eligibility and confirm benefit coverage.
3. Complete standard claim forms utilizing current CPT-4/HCPC and Revenue Code Guidelines. Please include the following information:

- Employer
 - Patients name and social security number
 - Patients diagnosis or symptoms, using ICD-9 CM code and/or written description
 - Date the patient was first seen for the identified diagnosis or condition
 - Date(s) patient received care
 - Description of service(s) using CPT-4 coding and/or HCPCS coding including appropriate modifiers
 - Itemized charges for service(s) rendered (charges should reflect the actual fee for the service described)
 - Tax Identification Number (FEIN) or SSN of the treating physician
 - Name, address and signature of the treating physician
 - Name of referring physician, if patient was referred for diagnosis or treatment
 - Details of accident or occupation-related incident if applicable
 - Description and office/operative notes for any “unlisted service”
 - A copy of operative notes if any surgical procedure was complicated, requiring more than usual time or care, or the procedure is not currently listed in the Physicians Current Procedural Terminology (CPT-4) text
4. *CompManagement* reprices claims based on its contracts using coding policies and procedures based on a software product, McKesson CodeReview.
 5. The claim and repricing worksheets are forwarded to the designated payor for claim adjudication and payment.
 6. The Workers' Compensation plan's third party administrator or Workers' Compensation carrier will determine benefit eligibility and issue payment.
 7. Physicians, facilities and other health care professionals may not balance bill patients in excess of the negotiated discounted fee-for-service amount for services covered by the Workers' Compensation benefit plan.

Claim Status Tools

The following claim status tools are available in the HealthLink Tools/Resources chapter of this Administrative Manual:

- **ProviderInfoSourcesm**, enables contracted providers to access secure information about claim status, member eligibility and payor information.
- **Claim Status Research** – if claim problems arise, physicians may submit a representative sample of the problem to their Network Consultant for research.
- **Claims Interactive Voice Response (IVR)** allows convenient access to patient claim information in a secure environment 5:00 am to 12:00 am daily.