



Administrative Manual

Claims Processing Guidelines

Chapter 6

HealthLink[®]



1831 Chestnut Street • St. Louis, MO 63103-2225
www.healthlink.com • 1-877-284-0101

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 workers' compensation 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. 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

Claim Information

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

Place of Service Codes:

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Pharmacy 3. School 4. Homeless shelter 5. Indian Health Service – freestanding facility 6. Indian Health Service – provider-based facility 7. Tribal 638 – freestanding facility 8. Tribal 638 – provider-based facility 9. Prison/correctional facility 11. Office 12. Home 13. Assisted living facility 14. Group home 15. Mobile unit 16. Temporary lodging 17. Walk-in retail health clinic 18. Place of employment-worksite 19. Off Campus – Outpatient Hospital 20. Urgent care facility 21. Inpatient hospital 22. On Campus – Outpatient hospital 23. Emergency room – hospital 24. Ambulatory surgical center 25. Birthing center 26. Military treatment facility | <ol style="list-style-type: none"> 31. Skilled nursing facility 32. Nursing facility 33. Custodial care facility 34. Hospice 41. Ambulance – land 42. Ambulance – air or water 49. Independent clinic 50. Federally qualified health center 51. Inpatient psychiatric facility 52. Psychiatric facility – partial hospitalization 53. Community mental health center 54. Intermediate care facility/mentally retarded 55. Residential substance abuse treatment facility 56. Psychiatric residential treatment center 57. Non-residential substance abuse treatment facility 60. Mass immunization center 61. Comprehensive inpatient rehabilitation facility 62. Comprehensive outpatient rehabilitation facility |
|--|--|

- | | |
|--|----------------------------|
| 65. End-stage renal disease treatment facility | 72. Rural health clinic |
| 71. Public health clinic | 81. Independent laboratory |
| | 99. Other place of service |

* Unassigned Codes 2, 10, 27-30, 35-40, 43-48, 58, 59, 63, 64, 66-70, 73-80, 82-98

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 Claim Check*. The claims processing logic is annually reviewed and updated by McKesson. HealthLink has the ability to customize portions of the Claim Check 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
 - Multiple Surgery Guidelines
 - Modifier Recognition and Reimbursement Methodology
 - Customized Claims Edits

Claim Edits and Modifier Use

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.

When multiple modifiers that apply a percentage amount to the maximum allowance are reported with a procedure, our claims system will multiply the percentage amounts

together to determine a new percentage amount. When the new percentage amount contains a decimal place our claims system will round the new percentage amount up to the next whole percentage and apply this whole percentage amount to the maximum allowance for the procedure the modifiers are reported with.

- For example, modifier 78 (unplanned return to the operating/procedure room) applies a percentage of 70% and modifier 62 (two surgeons) applies a percentage of 63%. When both modifier 78 and 62 are reported on a single procedure, the claims system will multiply 70% x 63% for a new percentage amount of 44.1%. Because the new percentage amount contains a decimal place, the new percentage amount will be rounded up to 45% and applied to the [maximum allowance]. Note: modifier 50 is not part of these calculations and is handled as bilateral only.

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.

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.

Anesthesia: Should be billed using the anesthesia procedural codes published by the American Medical Association (AMA) in the current edition of CPT as adapted from the American Society of Anesthesiologists (ASA) guidelines:

- 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

Anesthesia (Modifiers AD, P3, P4, P5, P6, QK, QX, QY)

All anesthesia services are reported by use of the five-digit anesthesia procedure code with the appropriate physical status modifier appended.

- AD – medical supervision by a physician: more than four concurrent anesthesia procedures; 50% of the allowable for the procedure.
- P3 – patient with severe systemic disease; 1 additional unit;
- P4 – patient with severe systemic disease that is life threatening; 2 additional units;
- P5 – a moribund patient who is not expected to survive without the operation; 3 additional units;
- P6 – brain dead patient for organ donation; No additional units.
- QK – medical direct of two, three, or four concurrent anesthesia procedures involving qualified individuals; 50% of the allowable for the procedure.

- QX – CRNA service: with medical direction by a physician; 50% of the allowable for the procedure.
- QY – medical direction of one CRNA by an anesthesiologist; 50% of the allowable for the procedure.

Assistant Surgeons (Modifiers 80, 81, or 82)

Assistant Surgeon recommendations follow the guidelines of CMS and the American College of Surgeons.

- 16% of the allowable for the procedure.
- Assistant surgeons are also subject to multiple surgery reductions.

Assistant Surgeons (Modifier AS)

Assistant Surgeon recommendations follow the guidelines of CMS and the American College of Surgeons.

- 14% of the allowable for the procedure.
- Assistant surgeons are also subject to multiple surgery reductions.

Bilateral Surgical Procedures (Modifier 50)

A bilateral surgery that uses a unilateral code should be reported on a single line with modifier 50, using one unit of service. This line item will be considered as one surgery however will be eligible for reimbursement equal to 150% of the amount applicable to the unilateral code on the date of service.

When a bilateral surgery that uses a unilateral code is reported with other surgical procedures, we will increase the RVU for the applicable unilateral code by 150%. HealthLink will then apply our multiple surgical rules 50%. If bilateral surgery using a unilateral code is not reported on a single line with modifier 50 and one unit, the claims system will treat the following coding scenarios as bilateral:

- A single line, no modifier 50, quantity = 2— HealthLink will apply the policy described above related to bilateral surgeries that use a unilateral code.
- When two claim lines are reported with the same procedure code and one line is reported with modifier 50 and the second line is unmodified, HealthLink will apply the policy described above related to bilateral surgeries that use a unilateral code on the line with modifier 50.
- When two claim lines are reported with the same procedure code and both lines are reported with modifier 50, HealthLink will apply the policy described above related to bilateral surgeries that use a unilateral code on the line with modifier 50 and apply any bilateral or multiple surgery reductions for additional procedures.

When a surgical procedure code contains the terminology “bilateral” or “unilateral or bilateral”, modifier 50 should not be used since the description of the code defines it as a bilateral procedure.

Decision for Surgery (Modifier 57)

An Evaluation and Management (E&M) Service resulting in the initial decision to perform surgery. No additional payment, but use of this modifier will cause an E&M to be allowed when submitted with a procedure code.

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

Discontinued Procedures (Modifier 53)

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure.

- 50% of the allowable for the procedure.

Distinct Procedural Service (Modifier 59)

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E&M services performed on the same day.

- 100% of the allowable for the procedure.

Gender Specific: Sex or gender specific edits occur when the providers assigns a gender-specific procedure or diagnosis code to a patient of the opposite sex.

Global Surgery: The global surgery package concept for the reimbursement of surgical services is utilized in the processing of claims related to the surgical service. The global surgical package applies to all surgical procedures. The RBRVS fee schedule from CMS is the source used to determine the pre and postoperative periods associated with each surgical procedure. Services included in the surgical allowance include but are not limited to the pre-operative visits after the decision for surgery, intra-operative services, follow-up visits, anesthesia by the surgeon and other services during the post-operative period.

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.

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.

Increased Procedural Services (Modifier 22)

When the work required to provide a service is substantially greater than typically required.

- 120% of the allowable for the procedure.
- Increased Procedural Services are subject to multiple surgery reductions.

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*.

Multiple Procedures (Modifier 51)

Multiple procedures performed at the same session by the same provider. Some procedures are exempt from modifier 51 and are listed in CPT guidelines. These guidelines do not apply to modifier 51 exempt procedures or to add-on codes; appropriate reductions are taken regardless if modifier 51 is billed or not.

- 100% of the allowable (or the lesser of the actual charge) for the procedure with the highest allowable. The procedure with the highest allowed amount is considered by HealthLink to be the primary procedure.
- 50% of the allowable (or the lesser of the actual charge) for any additional surgical procedure.

Multiple Surgery Guidelines: Multi-surgery pricing is applied when there are two (2) or greater surgical codes submitted on a claim. The allowed amount (herein referred to as the “allowed amount” or “allowable”) is based upon the lesser of either the contracted allowed amount or the physician’s actual billed charge. When multiple procedures are involved, the procedure with the highest allowable is considered to be the primary procedure by HealthLink, unless that procedure is an add-on code or modifier 51 exempt. These guidelines only apply to physician services submitted on the current standard professional claim form, as there are different pricing rules that apply to facility claims when contracted for Ambulatory Surgical Center (ASC) groupers and these will not be addressed in this document.

Mutually Exclusive: Mutually exclusive procedures are two or more procedures usually not performed during the same patient encounter on the same date of service.

Postoperative Management Only (Modifier 55)

When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure.

- 20% of the allowable for the service.

Preoperative Management Only (Modifier 56)

When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure.

- 10% of the allowable for the service.

Procedure Performed on Infants less than 4kg (Modifier 63)

Procedures performed on neonates and infants up to a present body weight of 4kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients.

- 120% of the allowable for the procedure.

Professional Component (Modifier 26)

Certain procedures are a combination of a physical or other qualified health care professional component and a technical component.

- Professional fee allowance

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

Reduced Services (Modifier 52)

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional.

- 50% of the allowable for the procedure.

Significant, Separately Identifiable Service (Modifier 25)

Significant, Separately Identifiable Evaluation and Management (E&M) Service by the same provider or other qualified health care professional on the same day of the procedure or other service. No additional payment, but use of this modifier will cause an E&M to be allowed when submitted with a procedure code.

Surgical Care Only (Modifier 54)

When one physician or other qualified health care professional performs a surgical procedure and other provides preoperative and/or postoperative management.

- 70% of the allowable for the procedure.

Two Surgeons (Modifier 62)

Two (2) surgeons work together performing distinct part(s) of a procedure.

- 63% of the allowable for the procedure.
- Reduction applies only to the common procedure billed by both surgeons.
- In the absence of a common procedure, the reduction is taken on each surgeon's primary procedure.
- Both surgeons are also subject to multiple surgery reductions.

Unbundling: Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a provider. In this instance, the two codes may be replaced with the more appropriate code by our bundling system.

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.

Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedures for a Related Procedure During the Postoperative Period (Modifier 78)

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedures.

- 70% of the allowable for the procedure.

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.

Preventable Adverse Events

Acute Care General Hospitals

Three (3) Major Surgical Never Events – When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Member, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from HealthLink, a Payor or the Member for such events. If acute care general hospital receives any payment from HealthLink, a Payor or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospital shall cooperate with HealthLink, to the extent reasonable, in any initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid, below, occur with respect to a Member, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition / Details
<p>Surgery Performed on the Wrong Body Part</p>	<p>Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</p>
<p>Surgery Performed on the Wrong Patient</p>	<p>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</p>
<p>Wrong surgical procedure performed on a patient</p>	<p>Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</p>

CMS Hospital Acquired Conditions (“HAC”) – HealthLink follows CMS’ current and future recognition of HACs. Current and valid POA indicators (as defined by CMS) must be populated on all inpatient acute care hospital claims.

When a HAC does occur, all inpatient acute care hospitals shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the claim prior to submitting to HealthLink for payment by Payor. In no event shall the charges or days associated with the HAC be billed to HealthLink, a Payor, or the Member.

Participating Provider (excluding Acute Care General Hospitals)

Four (4) Major Surgical Never Events – When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Member, the Participating Provider shall neither bill, nor seek to collect from, nor accept any payment from HealthLink, a Payor or the Member for such events. If Participating Provider receives any payment from HealthLink, a Payor or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Participating Provider shall cooperate with HealthLink, to the extent reasonable, in any initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid, below, occur with respect to a Member, Participating Provider is encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

Preventable Adverse Event	Definition / Details
<p>Surgery Performed on the Wrong Body Part</p>	<p>Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</p>
<p>Surgery Performed on the Wrong Patient</p>	<p>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</p>
<p>Wrong surgical procedure performed on a patient</p>	<p>Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.</p>

<p>Retention of a foreign object in a patient after surgery or other procedure</p>	<p>Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.</p>
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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 and an overpayment has been made to a participating HealthLink physician, hospital or health care professional, HealthLink will deduct the amount from future remittances 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.

Workers' Compensation 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:	
<p>Preferred Method: Workers' Compensation Payor (As listed on the Patient Information Card)</p>	<p><i>or</i></p> <p>Anthem Workers' Compensation P.O. Box 410980 St. Louis, MO 63141-0980 Fax: (314) 925-6401</p>

The claim filing process is outlined below:

1. Refer to the Workers' Compensation 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/HCCPC 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 (**ICD10 Procedure and Diagnosis codes will be utilized for Date of Service/Date of Admission/Date of Discharge after mandated compliance date.)
 - 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. HealthLink reprices claims based on its contracts using coding policies and procedures based on a software product, *McKesson Claim Check*.
 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:

- **ProviderInfoSource**[®] enables contracted providers to access secure information about claim status, member eligibility and payor information.
- **Claims 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.