



1. Title of best practice:

Claims Attachments

2. Who does the best practice apply to:

Providers and Group Purchasers

3. Narrative description as to what is being addressed by this best practice:

This best practice provides guidance on how to complete and send an attachment that is related to a submitted claim. It includes:

- Method to send the attachment
- Timeframe for sending the attachment to avoid a claim denial for missing information
- The cover sheet
- Instructions for completing the required cover sheet

4. The loops, segments and elements, etc. that the best practice applies to:

Loop 2300, Segment PWK

There are references to other loops, segments and elements in the Attachment Sheet Instructions for proper population of the Attachment Cover Sheet.

5. Describe how to do the best practice:

Submission Guidelines:

For claims requiring an attachment, the claim must be sent electronically with the paperwork (PWK) segment in the claim populated in Loop 2300.

The AUC specific cover sheet must be sent with each attachment to ensure a proper match to the submitted claim.

Visit our website at: <http://www.health.state.mn.us/auc/index.html>

The preferred method for submission of the attachment and cover sheet is facsimile (FAX). Other electronic means for submission are acceptable if agreed upon by trading partners. Non-FAX/non-electronic attachments may only be sent if their size, quality or type is not conducive to an electronic means (such as a photo image). For a partial listing of group purchaser FAX numbers, please refer to the AUC website.

Providers must send the attachment by end of next business day after submitting the electronic claim.

Group purchasers must not deny the claim for lack of an attachment, if the electronic method was indicated, until 3 business days after their receipt of the claim. Claims where the method of transmission is non-electronic may be denied if not received by the group purchaser within 10 business days of receipt of claim.

If the group purchaser receives an attachment but does not receive a claim, the group purchaser must not purge the attachment information from their retrieval system until a time period equal to the group purchaser's timely filing requirements.

General Guidelines:

Maximum number of characters allowed in the PWK06 (attachment control number) is 50 to align with the 5010 version of the Implementation Guides.

Attachment control numbers must be unique for a particular attachment within a billing provider.

Use of different qualifiers for multiple types of attachments would dictate sending separate cover sheets/attachment control numbers. Each PWK within a claim should use a different cover sheet and have unique attachment control numbers.

Providers should refer to the Minnesota Common Companion Guides on the AUC website for additional instructions regarding how to use the Attachment Control Number (section 4.2.3.4).

A copy of the cover sheet and the attachment information should be retained by the provider for their records.

The method the provider uses to send the attachment information should match what was indicated on the 837 in Loop 2300, Element PWK02.

6. Examples to illustrate best practice:

PWK*OB*FX***AC*090920080000001~

7. AUC Approval date:

9/9//2009

8. Last reviewed date:

9/3/2008

Attachments:

Cover sheet

Cover sheet instructions

Partial list of Group Purchaser FAX numbers

AUC Attachment Cover Sheet Instructions

Please also refer to the Attachment Best Practice on the AUC website at <http://www.health.state.mn.us/auc/index.html> for additional information.

General Instructions:

Preferred method is to type the information within the fields provided. If completed by hand, the information must be clearly printed within the fields provided using blue or black ink.

All fields on this form are required with the exception of Middle name (which should be populated according to what is on claim) and Property & Casualty Claim Number (which is situational as described below).

Use of different qualifiers for multiple types of attachments within the claim would dictate sending separate cover sheets/attachment control numbers. Each PWK within a claim should use a different cover sheet and have unique attachment control numbers.

Refer to the Minnesota Common Companion Guides on the AUC website for additional instructions regarding how to use the Attachment Control Number (section 4.2.3.4).

A copy of the cover sheet and the attachment information should be retained for your records.

The method that you send the attachment information should match what you indicated on the 837 in Loop 2300, PWK02.

Field Instructions:

1. Attachment Control Number: 50 character limit. This must be the same number that was populated in Loop 2300, PWK06. This number must be unique for each attachment submitted by a Billing Provider.
2. Billing Provider ID: If eligible for a National Provider Identifier (NPI), you **MUST** use NPI in this field. This number must be the same as populated in Loop 2010AA, NM109. If you are ineligible for an NPI, then this number is your atypical billing provider ID utilized by the group purchaser. This number must be the same as populated in Loop 2010AA, REF02. For atypical providers, confirm the appropriate identifier with the group purchaser.
3. Billing Provider Name: This must be the same name used in Loop 2010AA, NM103, NM104 and NM105.
4. Patient ID#: This is the patient's unique identifier as assigned by the group purchaser. This number must be the same as populated in Loop 2010CA, NM109 or Loop 2010BA, NM109. If both are populated within the claim, then the value in Loop 2010CA should be utilized.
5. Patient Name: Patient Name must be populated as reported on the claim. Last name, first name and middle name should be placed in the appropriate box on the form. It is acceptable to use full middle name or initial but the value used should be the same as on the claim record sent to the group purchaser. Please refer to basic character set best practices on the AUC web site for information on punctuation. The purpose of this field is for visual confirmation that the attachment and the claim are for the same person.
6. Property and Casualty Claim Number: If services are related to a Property & Casualty claim, this field is required. It must be the same number as populated in Loop 2010CA, REF02 or Loop 2010BA, REF02.
7. Attachment Send Date: The date that the attachment is sent (fax, postmarked, emailed, etc.). The format is MMDDYY (no punctuation).
8. Number of Pages: The number reported should include the cover sheet. Incomplete transmissions, as indicated by number of pages received compared to this field, may result in claims denials.
9. Contact Name/Phone #: The populated name may be 'service or billing department' and is not required to be an individual. The area code and extension should be included with the phone number if applicable. This field is used by the receiver if there is an error in receipt of attachments (for example, something appears to be missing).



Claim Attachment Cover Sheet

Use the Tab key or Arrow keys to navigate to next or previous text field.

Attachment Control Number:

Billing Provider ID #:

Billing Provider Name:

Patient ID #:

Patient Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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(Last)

(First)

(Middle)

Property and Casualty Claim #:

Attachment Send Date:

Number of Pages:

Contact Name/Phone #:

Disclaimer:



MINNESOTA DEPARTMENT OF HEALTH
DIVISION OF HEALTH POLICY
CENTER FOR HEALTH CARE PURCHASING IMPROVEMENT

Minnesota Uniform Companion Guide

For the Implementation of the

Health Care Claim Payment And Remittance Advice Electronic Transaction (ANSI ASC X12 835)

*Prepared In Consultation With
Minnesota Administrative Uniformity Committee*



**NOVEMBER, 2008
VERSION 2.0**

Appendix C

Workers Compensation Reporting of Reason for a Denial or Reduction of Payment

1. Use reason code 191 to deny payment on the basis that primary liability for the injury or illness being treated is denied. For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02, explain the basis for the adjustment of the charge and cite any applicable statute or rule supporting the adjustment. (See item 8 below for examples of how to use the 2110 loops).
2. Use Reason code 51 or 167 to deny payment on the basis that the treatment or service is for a condition not related to the admitted workers' compensation injury. For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite any applicable statute or rule supporting the adjustment.
3. Use reason code 45 to adjust a charge to 85% of the provider's usual and customary charge according to Minn. Stat. § 176.136, subd. 1b(b) and Minn. R. 5221.0500, subp. 2 (B) (1). For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain that the charge is reduced to 85% of the provider's usual and customary charge and cite Minn. Stat. § 176.136, subd. 1b (b) and Minn. Rules, part 5221.0500, subp. 2.
4. Use reason code 45 and remark code N246 to adjust a charge to 85% of the prevailing charges for similar treatment according to Minn. Stat. § 176.136, subd. 1b(b) and Minn. R. 5221.0500, subp. 2 (B) (2). For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain that the charge is reduced to 85% of the prevailing charge and cite Minn. Stat. § 176.136, subd. 1b(b) and Minn. Rules, part 5221.0500, subp. 2.
5. Use reason code W1, along with any other applicable reason and remark codes, to adjust a charge based on the maximum fee allowed under the workers' compensation relative value fee schedule according to Minn. Stat. § 176.136, subd. 1a and Minnesota Rules, parts 5221.4010 to 5221.4070. For each charge that is adjusted on this basis, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite the applicable statute or rule supporting the adjustment.
6. Use reason codes 50, 56 or 57, as applicable, to adjust a charge on the basis that the service, article or supply is not reasonable and necessary to cure or relieve the effects of the injury or illness. For each charge that is adjusted on this basis:
 - If there is an applicable treatment parameter rule in Minn. Rules, parts 5221.6010 to 5221.8900, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge, cite any applicable treatment parameter rule supporting the adjustment, and add the following language: "Departures may be allowed. See M.R. 5221.6050 subp 8"

- If there is no applicable treatment parameter rule, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite any applicable statute or other rule supporting the adjustment.

7. To adjust a charge based on a statute or rule for reasons other than those described in items 1 to 6, use the reason and remark code that best describes the adjustment. If there is no reason code that accurately describes the adjustment, use reason code A1. For each charge that is adjusted, use the Service Identification Loops (2110 loops) with qualifier RB in REF01. In REF02 explain the basis for the adjustment of the charge and cite any applicable statute or rule supporting the adjustment.

8. Use the Service Identification Loops (2110 loops) to explain the basis for the adjustment of a charge and cite the applicable statute or rule supporting the adjustment as follows:

- In REF01, use qualifier RB
- Of the seven occurrences in REF02, use the first occurrence for the line control number.
- Use the second occurrence to provide the applicable workers' compensation statutory or rule citation in the following format:
 - Cite Minnesota Statutes § 176.135, subd. 1b as "M.S. 176.136 subd 1b"
 - Cite Minnesota Rules, part 5221.0500, subp. 2 (B) as "M.R. 5221.0500 subp 2 B"
- Use up to five additional occurrences (of 30 characters each) to describe in short narrative form the basis for the adjustment.

For example, to adjust a charge because the service or supply for the charge is not paid separately from the facility fee under Minnesota Rules, part 5221.4033, subpart 1a:

- Use the second occurrence to provide the applicable rule citation:
"M.R. 5221.4033 subp 1a"
- Use the remaining five occurrences to describe the basis for the adjustment in narrative format: For example, the narrative could say:
"There is no separate payment for this service. Payment is included in facility fee."

9. If there is not enough space in the Service Identification Loops (2110 loops) to describe the basis for any adjustment, report the adjustment with the most accurate reason code, add remark code M118 and notify the provider and the employee by letter. The letter must:

- Explain the basis for denial;
- Include a citation to any statute or rule that supports the denial or reduction of the charge;
- List the patient control number of the applicable bill (CLM01 from the 837 and CLP01 from the 835); and
- Be mailed within 30 calendar days after receiving the bill and the appropriate record as provided in Minn. Stat. § 176.135, subd. 6 and 7 and Minn. R. 5221.0700, subpart 2.

10. Refer to the AUC "Best Practices" guide available from the AUC website at <http://www.health.state.mn.us/auc/index.html> to identify the best specific reason or remark

codes to identify the basis for denial or reduction of payment under workers' compensation laws and rules.

11. On all 835 transactions, use the 30 character jurisdictional field in the Other Claim Related Identification REF segment in loop 2100. Use qualifier CE in REF01. In REF02 state:

"For work comp see MN835 Guide."

NOTE: This guide does not modify any requirement in the workers' compensation statutes and rules governing the legal bases for denial or reduction of payment or the notice that must be given to the injured employee about payment or denial of medical charges or treatment.