How Providers Get Paid

Magellan New Provider Orientation

Magellan HEALTHCARE

Agenda

- What is required when submitting a claim to Magellan
- How to submit a clean claim
- Your options for claims submission
- What happens when we process your claim
- How our claims resubmission process works
- Some common billing errors
- What is a claims inquiry and how claims resolution works
- Third party liability (TPL) and coordination of benefits (COB) impact on how you are paid

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Claims Requirements

Claims requirements

Prior to submitting claims and/or encounters to Magellan, you should identify the requirements for seeking Medicare, or third-party liability payments, when applicable.

Submit clean claims within 180 days from the date covered services are rendered, **with the following exceptions**:

Substance use disorder (SUD) providers

must submit clean claims within 60 days from the date covered services are rendered.

Medicare claims

must be submitted within 365 days from the date covered services are rendered.

Corrected claims

must be submitted within 60 days of the date on Magellan's explanation of benefits.

Medicaid Indian Health Services (IHS)

Medicaid Indian Health Services (IHS), Tribes and Tribal Organizations, and Urban Indian Organizations (collectively, I/T/U) providers must submit clean claims within 365 calendar days from the date covered services are rendered.

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Clean Claims

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Clean claims

What is a clean claim?

A clean claim has no defect, impropriety, or special circumstance, including incomplete documentation, that delays timely payment. Simply put, **clean claims are claims that can be processed without obtaining any additional information from the provider or from a third party**.

A provider submits a clean claim by:

providing the required data elements on the standard claim forms, along with any attachments and additional elements, or revisions to data elements, attachments, and additional elements, of which the provider has knowledge.

Clean claims

Required elements of a clean claim

Centers for Medicare and Medicaid Services (CMS) developed claim forms that record the information needed to process and generate provider reimbursement. The required elements of a clean claim must be complete, legible, and accurate.

CMS 1450 (UB-04)

Inpatient & facility programs and services

CMS 1500

Individual professional procedures and services

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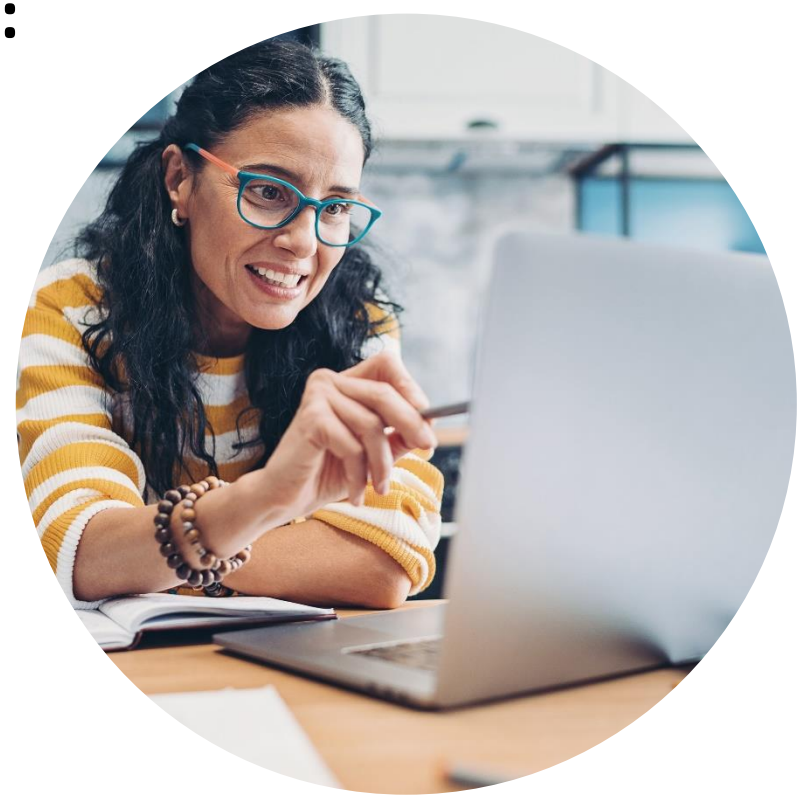
Clean claims

When submitting a claim, consider the following:

- Am I submitting claims correctly?
- Am I submitting claims timely?
- Did I verify member eligibility?
- Do I have the correct service location (rendering address and place of service)?



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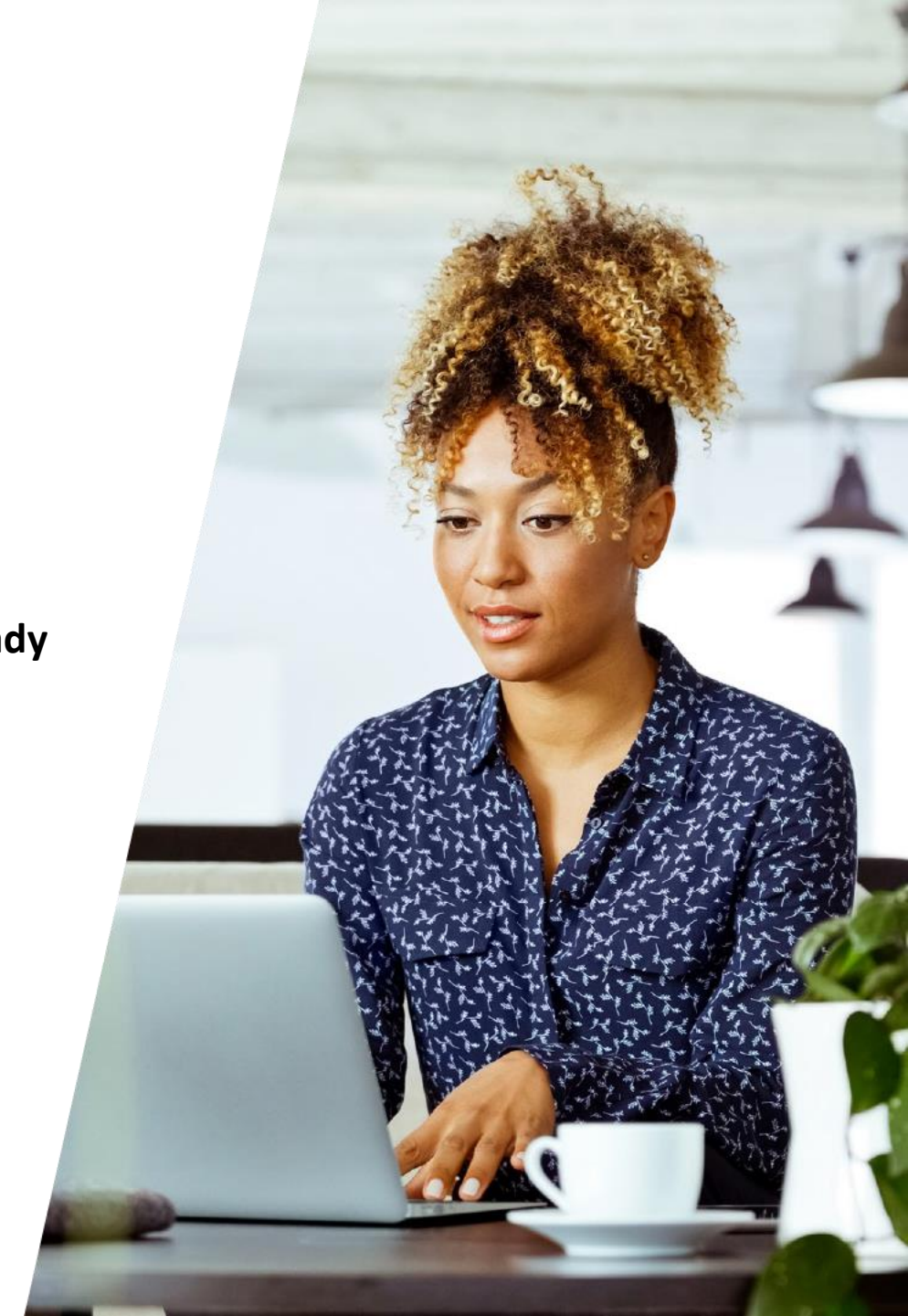
Claims dos and don’ts

- Do give complete information on the member and policy holder
- Do give complete information on you, the provider
- Do include any other carrier’s payment information
- Do include the complete diagnosis information
- Do obtain authorization for services
- Do show your entire charge
- Do submit your claims electronically and timely
- Do monitor your EDI transaction reports

Claims dos and don’ts

- ☒ **Don’t use invalid procedure or diagnosis codes**
- ☒ **Don’t reduce your charge by the copayment or coinsurance amounts paid by the member**
- ☒ **Don't omit information on the claim because you have already provided it on the treatment plan**



Most frequent reasons for claims non-payment

The most frequent Magellan edits, or reasons for claims denial, include:

- ☒ Duplicate claim submission (i.e., the expense was previously considered)
- ☒ The provider didn’t obtain prior authorization
- ☒ The member is ineligible, or coverage has lapsed
- ☒ Untimely claim submission/filing

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Most frequent reasons for claims non-payment

The most frequent Magellan edits, or reasons for claims denial, include **(continued):**

- ☒ Claim form does not follow correct coding requirements
- ☒ The primary insurance carrier's explanation of benefits (EOB) or the member's coordination of benefits (COB) form is needed
- ☒ The claim includes a non-covered diagnosis or service
- ☒ Billing for code combinations that fall outside of the participating provider's contract

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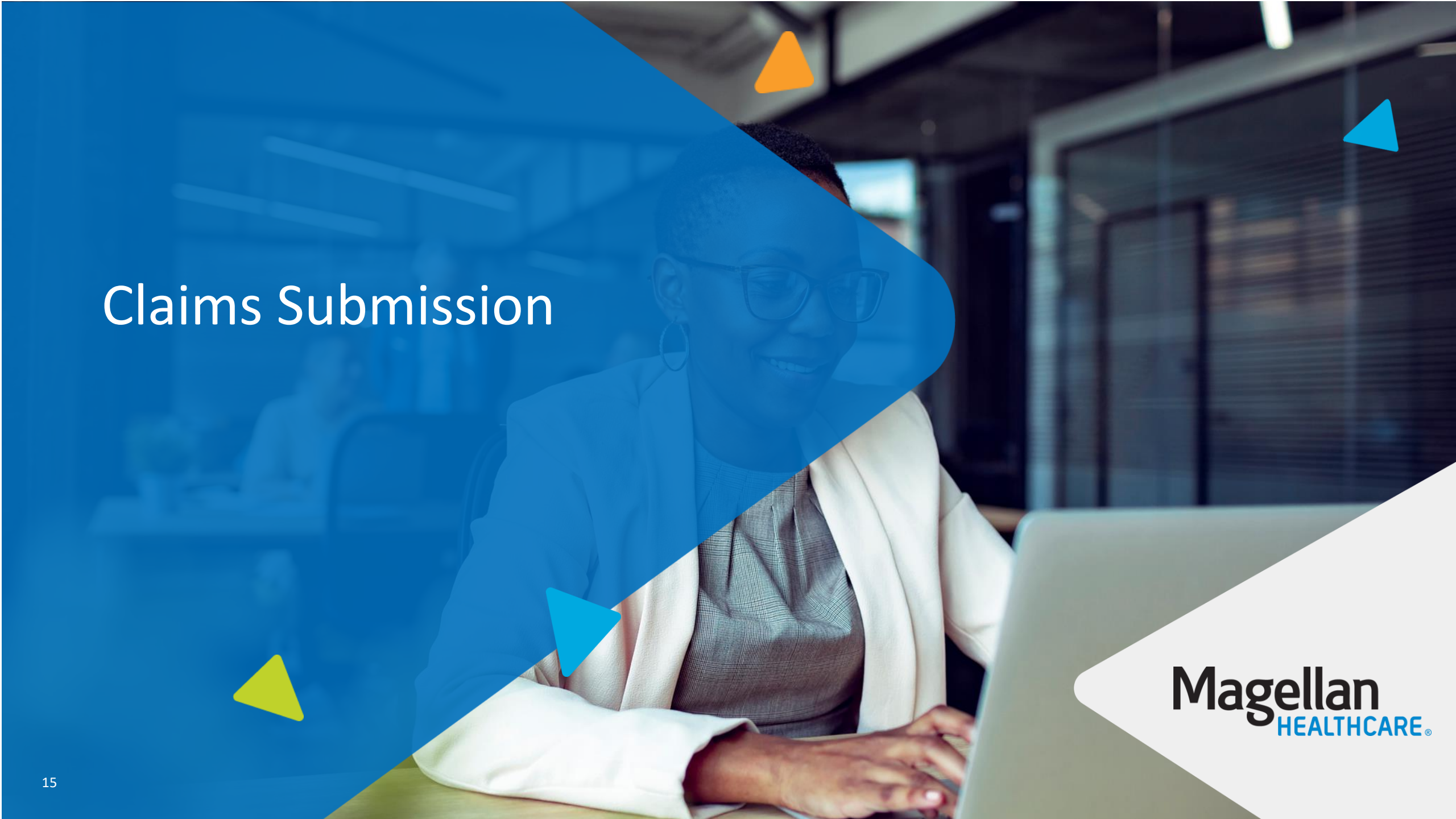
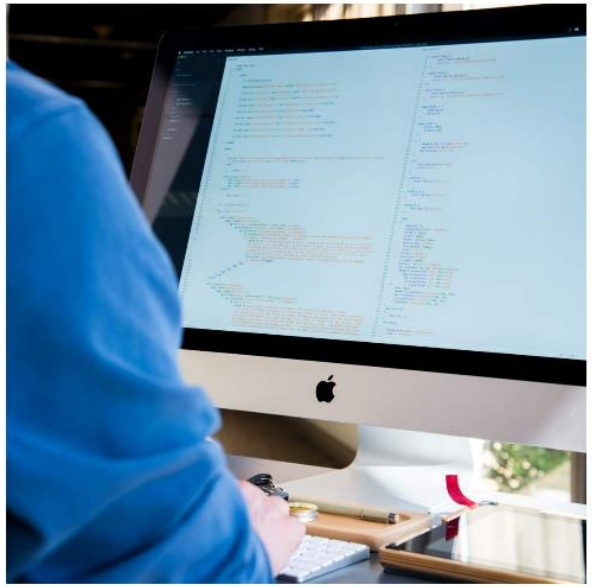
Claims Submission



Options for claims submission



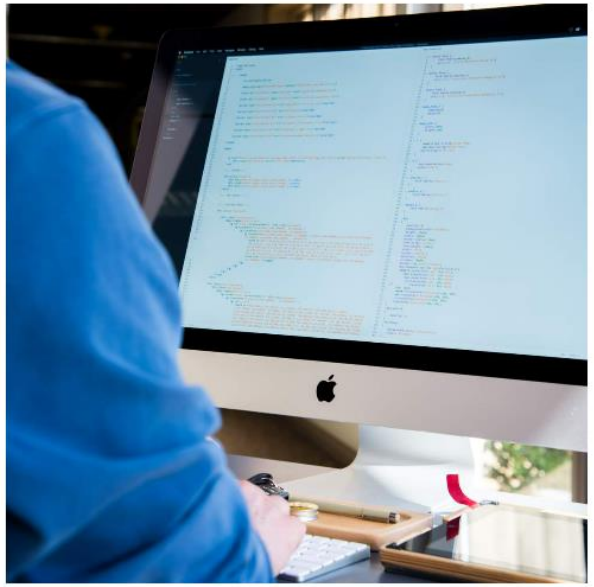
Electronic data interface (EDI) via direct submit

EDI via third-party clearinghouse

Paper claims:
CMS 1500 or CMS 1450 (UB-04)

Electronic data interface (EDI) via direct submit

- Through this free Magellan application, you can send HIPAA-compliant 837 files directly to Magellan in bulk, without accompanying claim data entry or the involvement of a clearinghouse.
- **If you are able to create an 837 in a HIPAA-compliant format**, we recommend EDI direct submission.
- Direct submit supports HIPAA 837P and 837I claims submission files.



EDI via direct submit

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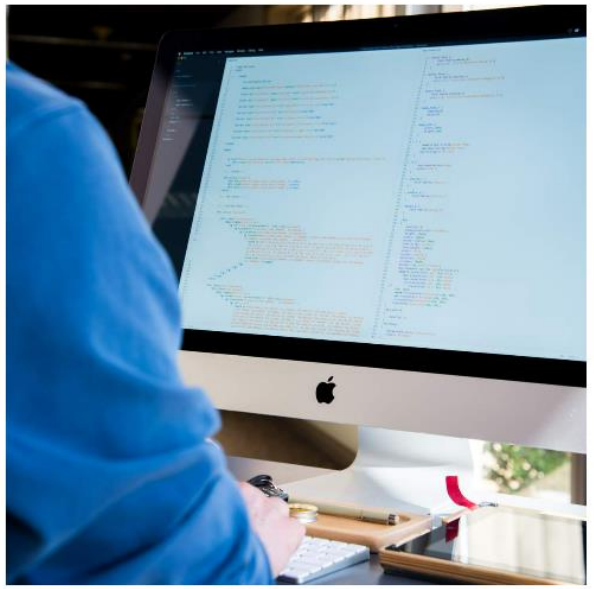
EDI testing center

There is a **simple, no cost, testing process** to determine if direct submit is right for you:

- **The center offers an easy-to-follow, six-step process** to independently validate your EDI test files (837 Professional and Institutional) for HIPAA compliance rules and codes
- **The process includes creating a unique user ID and password**, downloading EDI guideline documentation (companion guides), uploading and testing EDI files, and obtaining immediate feedback regarding the results of the validation test
- **Once you have completed the six-step process**, you will be able to exchange production-ready EDI files with Magellan
- **Feedback is provided immediately** regarding the results of the test
- **The process typically takes about three to four weeks** to complete, so allow ample time to complete your independent testing



EDI via direct submit

You can register to submit EDI claims to Magellan by sending an email to EDISupport@MagellanHealth.com or by contacting Magellan EDI Support at 1-800-450-7281, extension 75890.

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EDI via third-party clearinghouse

- Magellan accepts 837 transactions from a number of clearinghouses.
- Note that there may be charges from the clearinghouses.
- **What does a clearinghouse do?**

  External EDI clearinghouses act as a mediator between the provider and Magellan and **can transform non-HIPAA-compliant formats to compliant 837s.**

EDI via third-party clearinghouse

Paper claims

We encourage providers to submit electronic claims (rather than paper claims), because the electronic process allows for earlier detection of errors, drastically reducing the likelihood of claims being rejected or denied for payment, and often results in faster processing. If you are submitting paper claims, here is some additional information on the non-facility and facility-based claims forms.

CMS 1450 (UB-04)

For facility-based services

For more information about the CMS 1450 form, visit the National Uniform Billing Committee's website. Contact your claim forms vendor to obtain full-color versions of the CMS 1450.

CMS 1500

For non-facility-based services

For more information about the CMS 1500 form, visit the National Uniform Claim Committee's website. Note that Magellan can only accept the current version of the CMS 1500 form.

Paper claims:
CMS 1500 or CMS 1450 (UB-04)

Claims Processing

How we process claims

Claims Receipt

Upon receipt of a claim, Magellan reviews the documentation and makes a payment determination. As a result of this determination, a remittance advice, known as an explanation of payment (EOP) is sent to you. The EOP includes details of payment or the denial.

95% of claims

Magellan pays **95% of clean claims** within 30 days of receipt.

90 Days

Magellan must pay **99% of clean claims within 90 calendar days** of the date of receipt.

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Claims Resubmission & Resolution

Claims with provider billing errors are called “resubmissions”

Resubmissions must be submitted within 60 calendar days from the date of the EOB

Resubmission option 1

You can resubmit claims electronically via an 837 file

- Magellan's claim system requires the use of claim frequency code "7" when resubmitting a claim electronically. Using the appropriate code will indicate that your resubmitted claim is an adjustment of a previously adjudicated (approved or denied) claim.
- The original claim number is required when submitting frequency code "7" on a claim resubmission.

Resubmission option 2

Resubmitted claims sent via paper should be stamped “resubmission” and include:

- Date of original submission
- Original claim number

Resubmission option 3

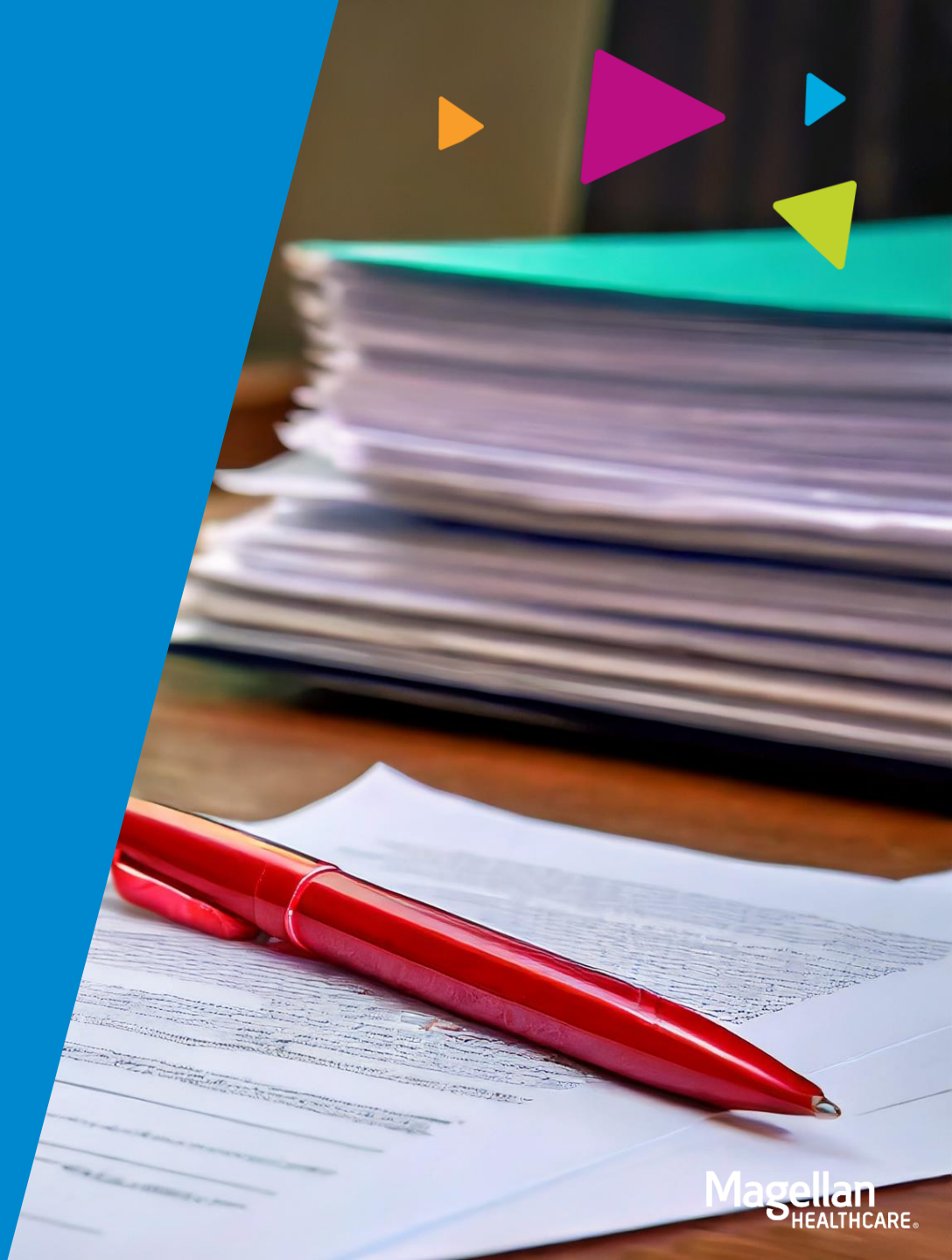
Resubmission of claims via Availity Essentials

- Select Claim & Encounters in Availity and select MAGELLAN HEALTHCARE as the payer to access the correct form. In the claim information section select Frequency Type 7- Replacement of Prior Claim and add the original claim number in the Payer Claim Control Number field.
- The following fields can be amended: Place of Service, Billed Amount, or Number of Units. This functionality is only available for claims with a status of Received/Accepted.
- Corrections to claims other than Place of Service, Billed Amount, or Units must be submitted as a hard copy via postal mail. Please note “Corrected Claim” on the form before sending.

Common claims errors

Double check all claims prior to submission **to avoid delays** due to these errors:

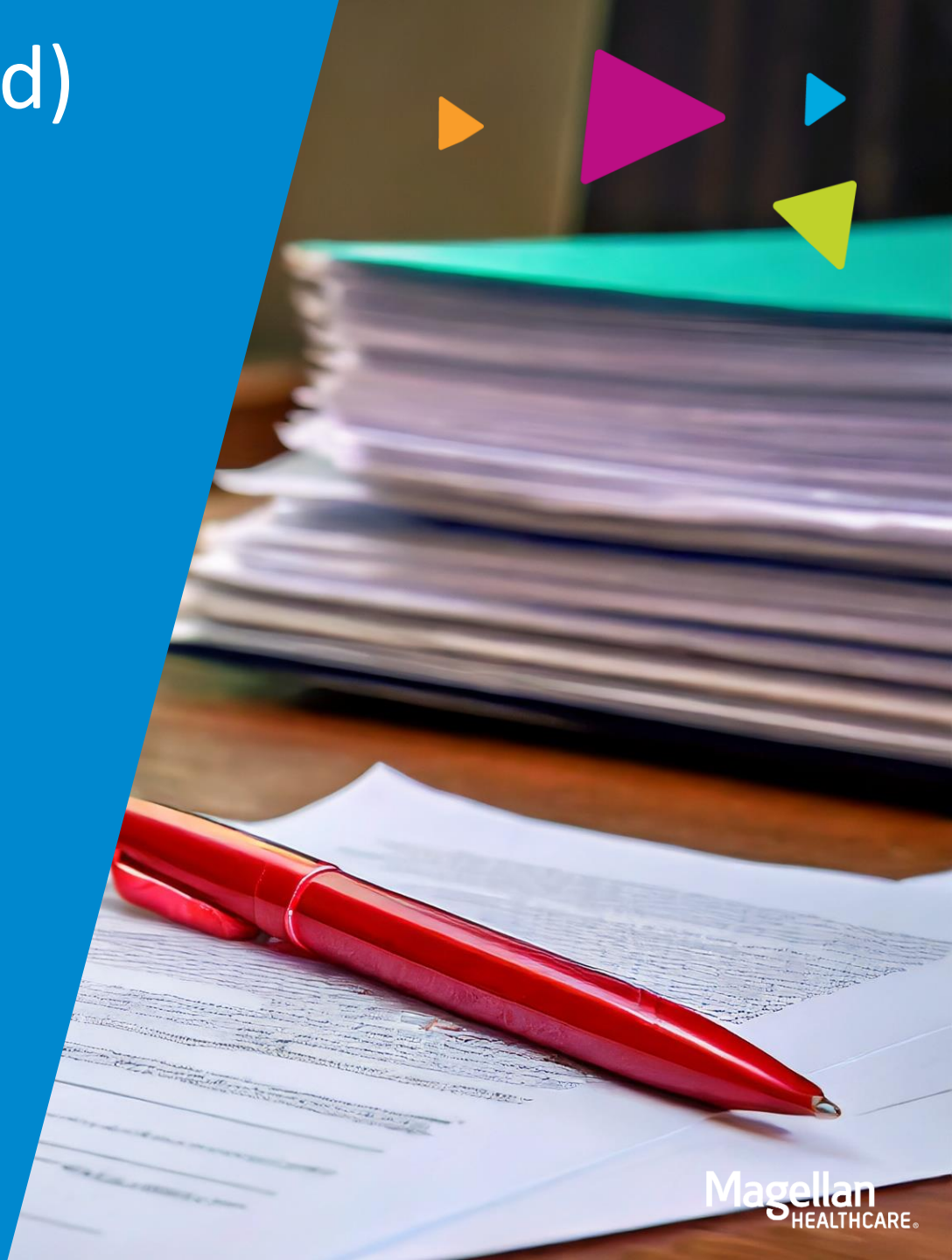
- Authorized units do not match billed units
- More than one month of service is billed on one claim form
- Recipient's ID is missing (member ID can be obtained in Availity Essentials)
- Recipient's date of birth is missing
- Itemized charges are not provided when a date span is used for billing
- EOB is not attached to third-party claim form
- Revenue code, procedure code, and/or modifier(s) are incorrect



Common claims errors (continued)

Double check all claims prior to submission **to avoid delays** due to these errors:

- Duplicate claim submissions are not identified as “resubmissions” or “corrected claims”
- Diagnosis code is not an accepted code (current ICD-10 codes are required)
- Service and/or diagnosis billed is not permitted under the provider’s license
- National Provider Identifier (NPI) is missing
- Service location is incorrect
- Place of Service is incorrect



Claims resolution

If supporting documentation is not required for Magellan to review your claim, you should contact Magellan's provider line, at 855-202-0983, and speak to a customer experience associate (CEA). If necessary, the CEA will submit a service request on your behalf to Magellan's claims resolution team for further investigation.

If you receive a claim denial that cannot be corrected with the help of customer service, you have one year (365 days) from the date of service to file a written inquiry. Your inquiry must include supporting documentation that refutes the reason for the denial, including the Medicaid member ID number(s), claim number(s), date(s) of service, and outstanding amount owed per region.

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Third-Party Liability (TPL) & Coordination of Benefits (COB)

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TPL and COB

- **Medicaid is always the last payer**. Therefore, providers must exhaust all other insurance benefits first before pursuing payment through Magellan IBHP.

- Claims for services provided to IBHP members who have another primary insurance carrier must be submitted to the primary insurer first in order to obtain an EOB. **IBHP will not make payments if the full obligations of the primary insurer are not met**.

- As a Magellan provider, **you are required to hold IBHP members harmless** and cannot bill them for the difference between your contracted rate with Magellan and your standard rate. This practice is called balance billing and is not permitted.

- **If the member needs a service that is not covered by Medicare or another commercial/private health insurance, but is covered by Magellan,** the individual must get the service from a Magellan network provider.

Thank you

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Legal

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