Claims Submission

Idaho Provider Training

Agenda

- Clean Claims
- Claims Submissions
- Claims Processing
- Claims Resubmission & Resolution
- Availity Essentials

Objectives

- Provide an overview of Magellan's claim submission process
- Orient you to processing and resubmission details for claims
- Share details on clean claims and common claims errors
- Show you where to find resources within Availity Essentials for claims submission

Magellan HEALTHCARE®

Clean Claims

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

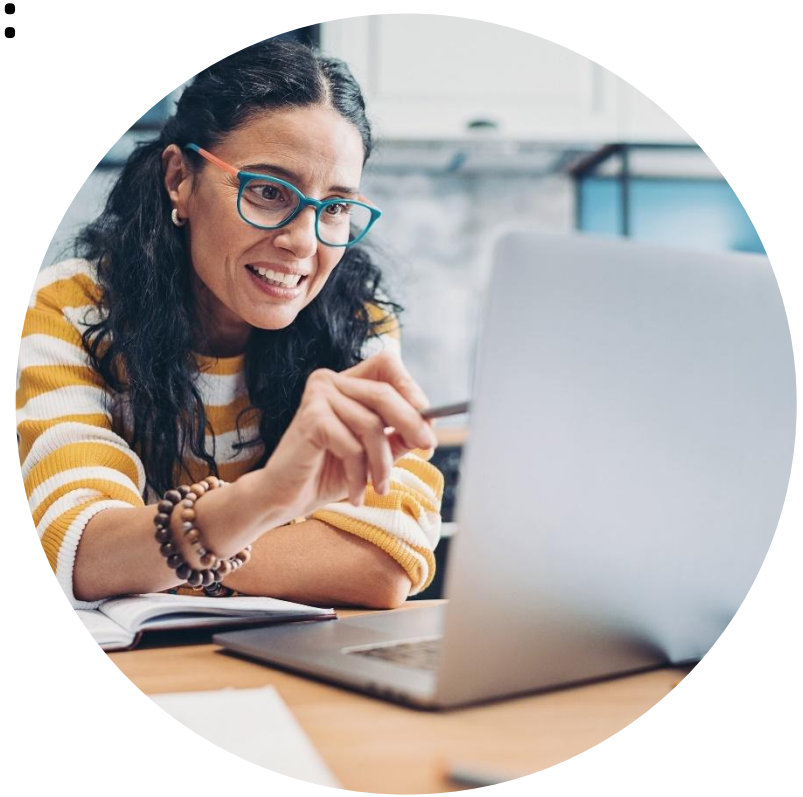
Individual professional procedures and services

Magellan HEALTHCARE

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)?



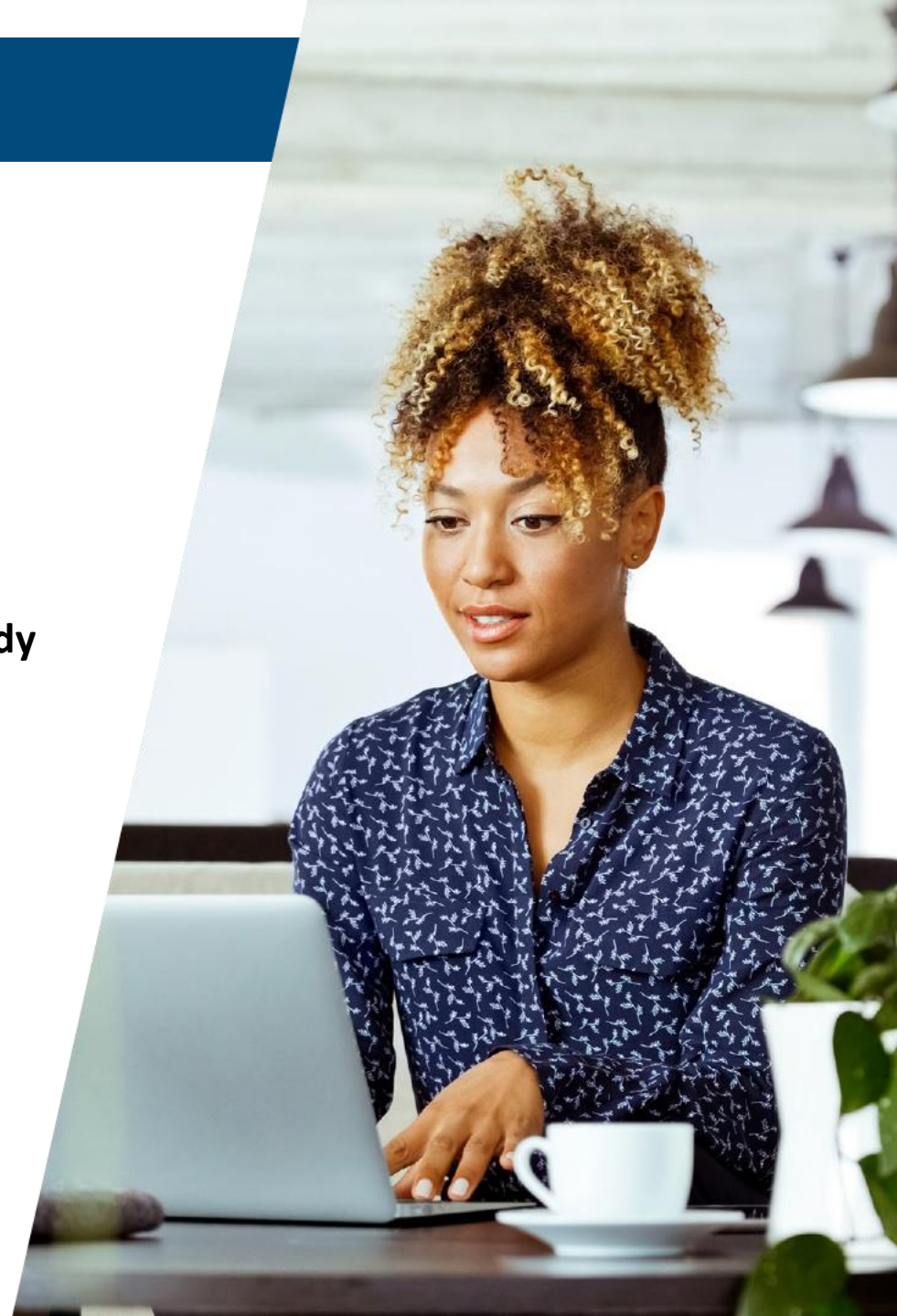
Magellan HEALTHCARE

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
- Do ensure you have the appropriate modifiers as required

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**
- **Don’t bill modifiers out of order**



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

Magellan HEALTHCARE

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

Magellan HEALTHCARE

Claims Submission

Claims submission

- Magellan provider contracts require claims to be submitted within the required timely filing limits

Claims not received within the applicable required timely filing limits will be denied

Magellan HEALTHCARE

Timely claims submissions

- Billing from the date of service
- Medicaid Services: 180 days
- State-funded SUD, Adult Mental Health, Children's Mental Health services (non-Medicaid): 60 days
- Indian Health Services, Tribes and Tribal Organizations, and Urban Indian Organizations (collectively, I/T/U): 365 days
- Corrected claims: 60 days from date on Magellan explanation of benefits (applies to all services and providers)

Claims submission

Claims must contain:

- No defect or impropriety, including a lack of any required substantiating documentation
- HIPAA-compliant coding or other circumstance requiring special treatment that prevents timely payments from being made
- Claims not containing all required information will be subject to denial

Magellan HEALTHCARE

Claims submission options

Providers have many options for submitting claims:

Paper claim

- Mailed to Magellan

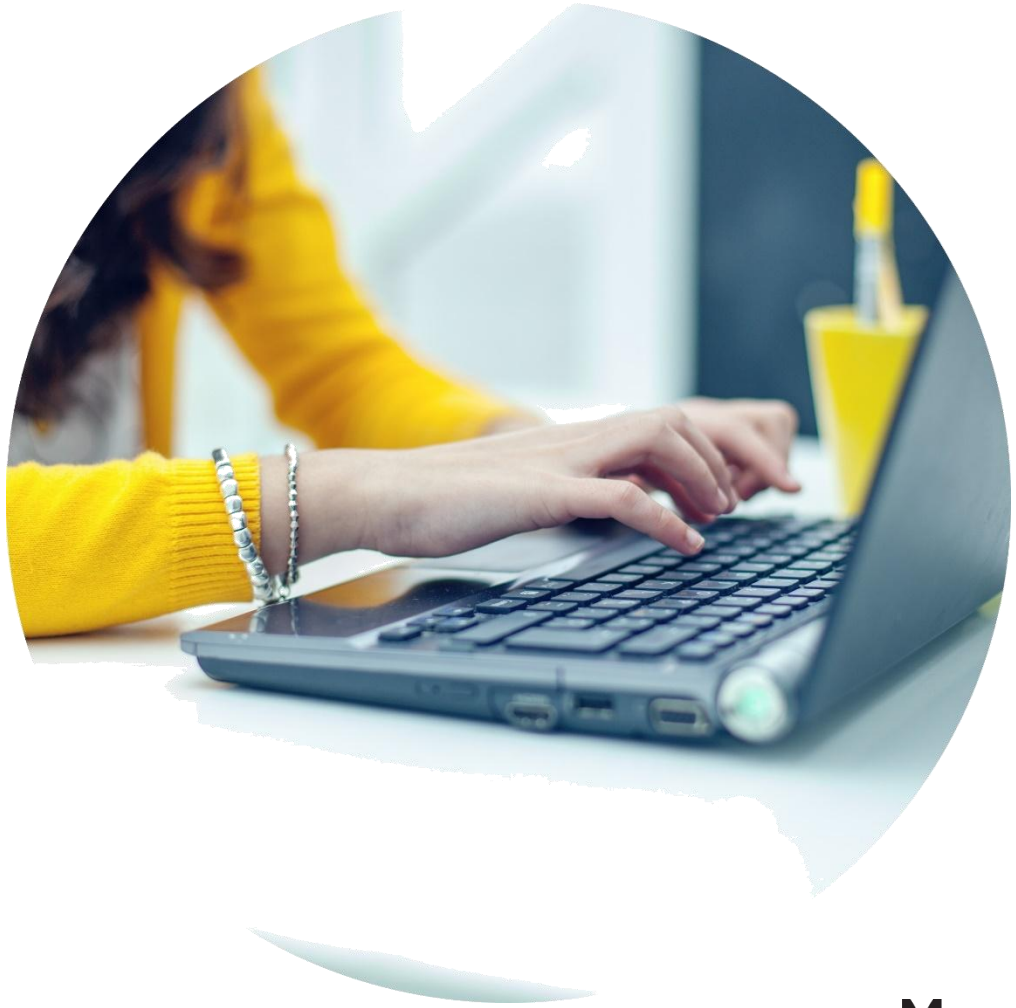
Electronic claim

- Magellan-preferred contracted clearinghouse
- Individual claims submission via Availity Essentials
- Electronic data interface (EDI)
- Other clearinghouses

Magellan HEALTHCARE

Important for electronic claims submissions

- Please ensure you use the proper payer ID for Magellan: **01260**
- Use this payer ID for both:
  - 837P professional claims files
  - 837I institutional claims files
- Claims must be submitted with Claim Office ID - PO Box# 1029
- Magellan requires NPI on electronic transactions



Magellan HEALTHCARE

NPI required on electronic transactions

- Magellan requires providers to submit their National Provider Identifier (NPI) **on all HIPAA-standard electronic transactions.**
- All standard electronic transactions received without NPIs will be rejected.
- NPI numbers replace all government-issued identifiers, Medicaid PINs, and Medicare UPINs (as well as Magellan-assigned MIS numbers) on HIPAA-standard electronic transactions, including provider claims submitted electronically.

Taxpayer Identification Numbers (TINs) continue to be required on all claims – both paper and electronic.

Magellan HEALTHCARE

Electronic claims submission

Magellan-preferred clearinghouse (fastest)

Electronic claims submission process

- Clearinghouse transforms non-HIPAA-compliant formats to compliant format
- Magellan accepts transactions from several contracted clearinghouses
- Proper Payer ID is required for all clearinghouse submissions
  - 837P Professional: 01260
  - 837I Institutional: 01260
- Note there may be charges from the clearinghouse

Magellan HEALTHCARE

Electronic claims submission

Individual claim submission via Availity Essentials

Web-based claims submission

- Web-based claim submission tool via data entry application
  - For credentialed and participating providers
  - Professional claims ONLY (no institutional claims)
  - One claim at a time
- Allows providers to send HIPAA transaction files directly to and receive responses from Magellan *without* a clearinghouse

Magellan HEALTHCARE

Electronic claims submission

Individual claim submission via Availity Essentials

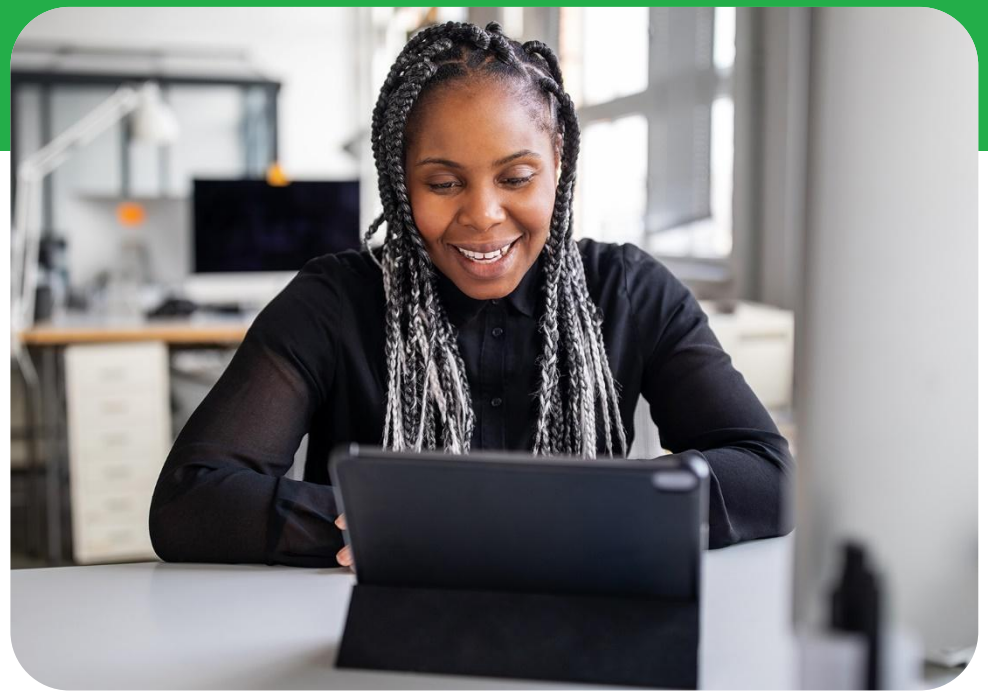
Web-based claims submission

- Claims processed in real-time
- Provides immediate notification of the potential errors in claims submission for quicker resolution and timely resubmissions where required
- Recommended process for providers who submit a low volume of claims
- No cost to providers

Magellan HEALTHCARE

Claims via Availity Essentials

Availity essentials



- Free, real-time access to payer information
- Verify eligibility and benefits prior to submitting a claim
- Check claims status
- View/print remittance advice
- Access Availity Essentials via www.availity.com

Magellan HEALTHCARE

Electronic claims submission

EDI Direct Submit

Electronic claims upload process

- Supports **HIPAA 837P** and **837I** claim submission files
- Allows providers to send HIPAA transaction files directly to and receive responses from Magellan *without* a clearinghouse

Magellan HEALTHCARE

Electronic claims submission

EDI Direct Submit

Electronic claims upload process

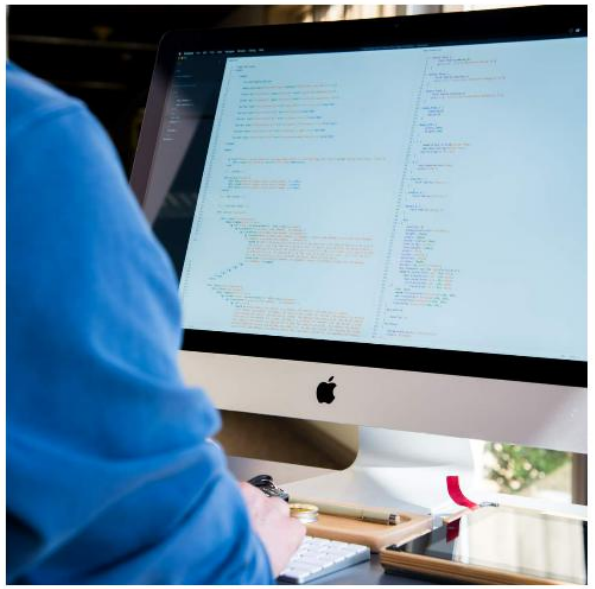
- Recommended if providers can create an 837 in HIPAA-compliant format
- Testing process to determine if Direct Submit is right for you.
- No cost to providers

Magellan HEALTHCARE

EDI testing center

There is a **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 six to eight 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.
Register for an account at: www.edi.magellanprovider.com

Magellan HEALTHCARE

Paper claims submission

Hard-copy submissions physically mailed to Magellan

CMS 1450 (UB) claim form

Used for ***facility-based*** services

CMS 1500 claim form

Used for ***non-facility-based*** services

Magellan HEALTHCARE

Supervisory Billing

Who can bill under supervisory protocol?

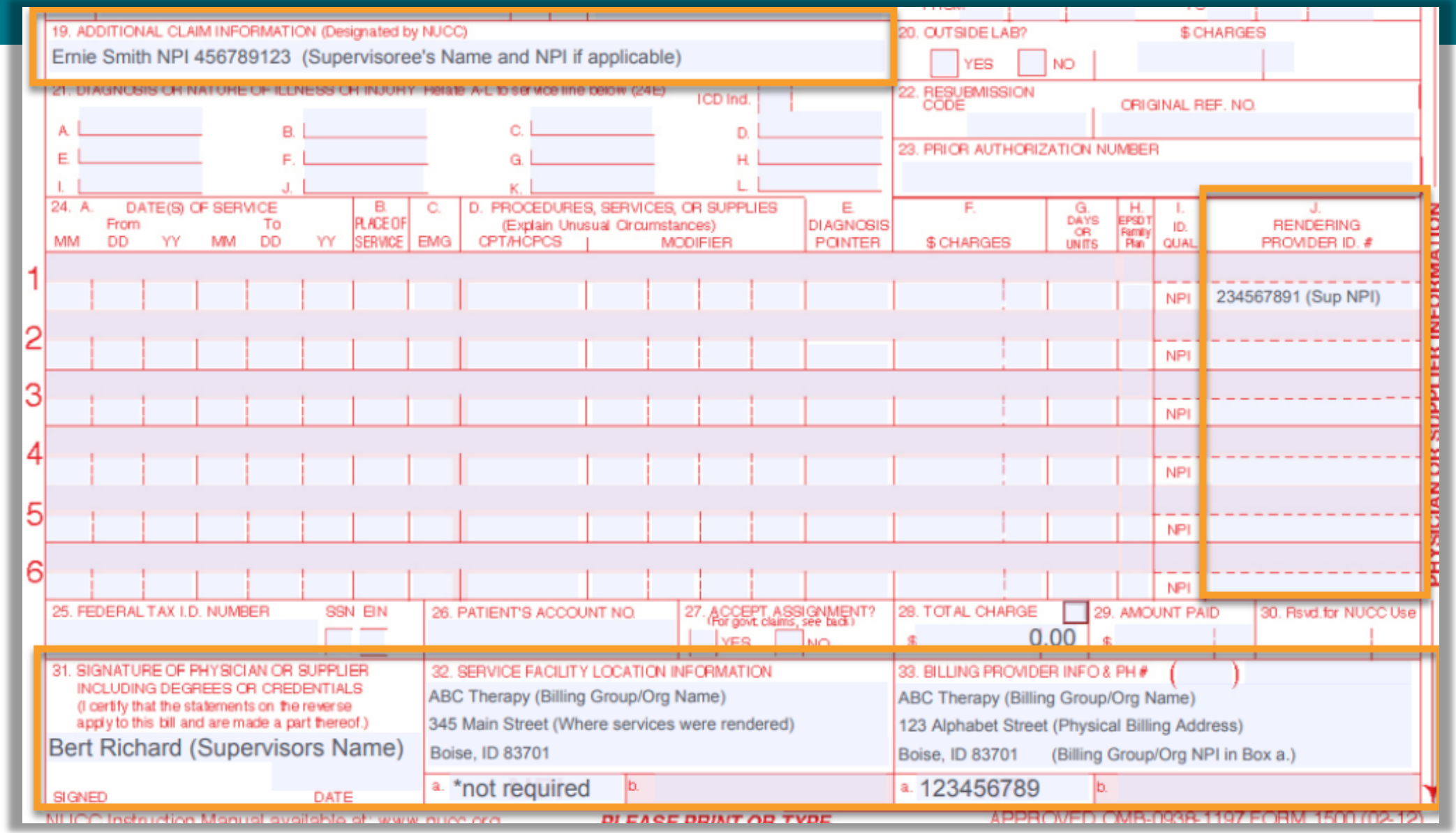
- Your organization must have a **Supervisory Protocol Addendum** on file with **Magellan**
  - A **credentialed provider** is supervising the services
  - The services are provided by a **non-credentialed staff member** under supervision
- Only **group practices or organizations** with a signed addendum may bill under this protocol

Magellan HEALTHCARE

How to bill under supervisory protocol

Box	Description	Required Entry
19	Additional claim info	Name of supervised provider (paraprofessional)
24J	Rendering provider NPI	Supervising provider's NPI
31	Signature of physician or supplier	Supervisor's signature & date
32	Service facility location	Billing group, org name & address for location where services were rendered
32a		NPI for location where services were rendered if different than 33a
33	Billing provider	Billing group or org name & billing address (not PO Box)
33a		Billing group or org's NPI

Example CMS 1500



*Fictitious Data

Supervisory Billing

Modifier	U1	UD	HN	HM
Description	Prescriber under Supervisory Protocol	Master's Degree-level provider under supervision	Bachelor's Degree-level provider under supervision	Less than Bachelor's Degree-level under supervision

Modifier	AF	HP	AH	AJ	TD
License Level	Physician	Ph.D. Psychologist	Ph.D. Clinical Psychologist	Master's Level	Advanced Practice Registered Nurse/ Physician's Assistant

Magellan HEALTHCARE

Supervisory Billing

Who can bill under supervisory protocol?

CREDENTIALED

To be “credentialed” the provider/facility must meet certain minimum standards for education and experience.

CONTRACTED

To be “contracted” the provider/facility has negotiated a contract to be part of a customer’s network. Providers who are contracted have agreed to accept a certain rate, and to follow Magellan’s policies and procedures for rendering quality services.

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.

Magellan HEALTHCARE

Claims reimbursement

Electronic funds transfer (EFT)

Reduced administrative burden benefits your practice

Secure payments directly deposited into your bank

- Magellan network providers must sign up for EFT through our contracted vendor site and receive all payments electronically
- Our vendor will conduct a secured transmission test with your bank to make sure payments transfer properly

Wish to enroll for direct EFT payments for Magellan-only?

If you are enrolled with ECHO but **want to change your method of payment to EFT**, visit https://enrollments.echohealthinc.com/efteradirect/Magellan

To complete the enrollment process, you will **need ECHO draft information from any ECHO payer**

NOTE: For first time enrollment with no fees, you **must call and request to enroll directly with Magellan** (you do **not** want MPS or All Payer)

The **ECHO draft number** received with a payment **serves as a unique identifier** with ECHO to manage your account on the ECHO platform

There is **no fee** for this service

Not enrolled to receive payments electronically from ECHO?

- Receive a **virtual credit card (VCC)** for your first Magellan claims payment
- **Each notification will contain a VCC with a number unique to that payment** transaction and will include an instruction page for processing
- Normal **transaction fees apply** based on your merchant acquirer relationship
- After receiving your first VCC payment, to manage your virtual card payment or elect a different payment method, visit www.echovcards.com or contact ECHO Health at 1-888-686-8314
- The **ECHO draft number** received with the payment serves as a unique identifier with ECHO to manage your account on the ECHO platform

NOTE: Convert VCC payments to check on the website listed on your VCC and avoid fees

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.

Magellan HEALTHCARE

Resubmission option 2

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

- Date of original submission
- Original claim number

Magellan HEALTHCARE

Resubmission option 3

Resubmission of claims via Availity Essentials

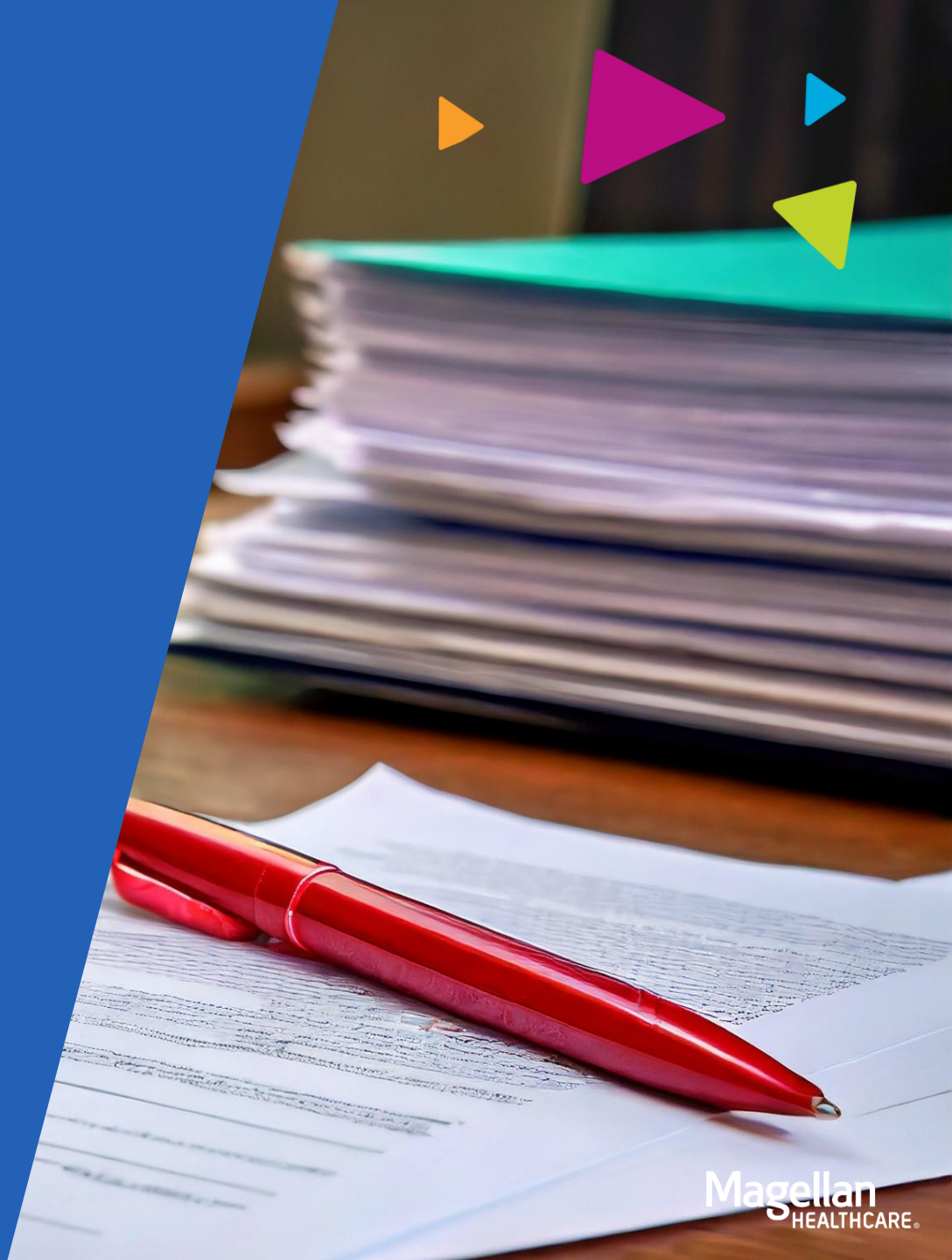
- Select Claim & Encounters in Availity and select MAGELLAN HEALTHCARE as the payer to access the correct form. In the claim information section select Frequency Type 7- Replacement of Prior Claim and add the original claim number in the Payer Claim Control Number field.
- The following fields can be 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.

Magellan HEALTHCARE

Common claims errors

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

- Authorized units do not match billed units
- 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

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

Magellan HEALTHCARE®

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.

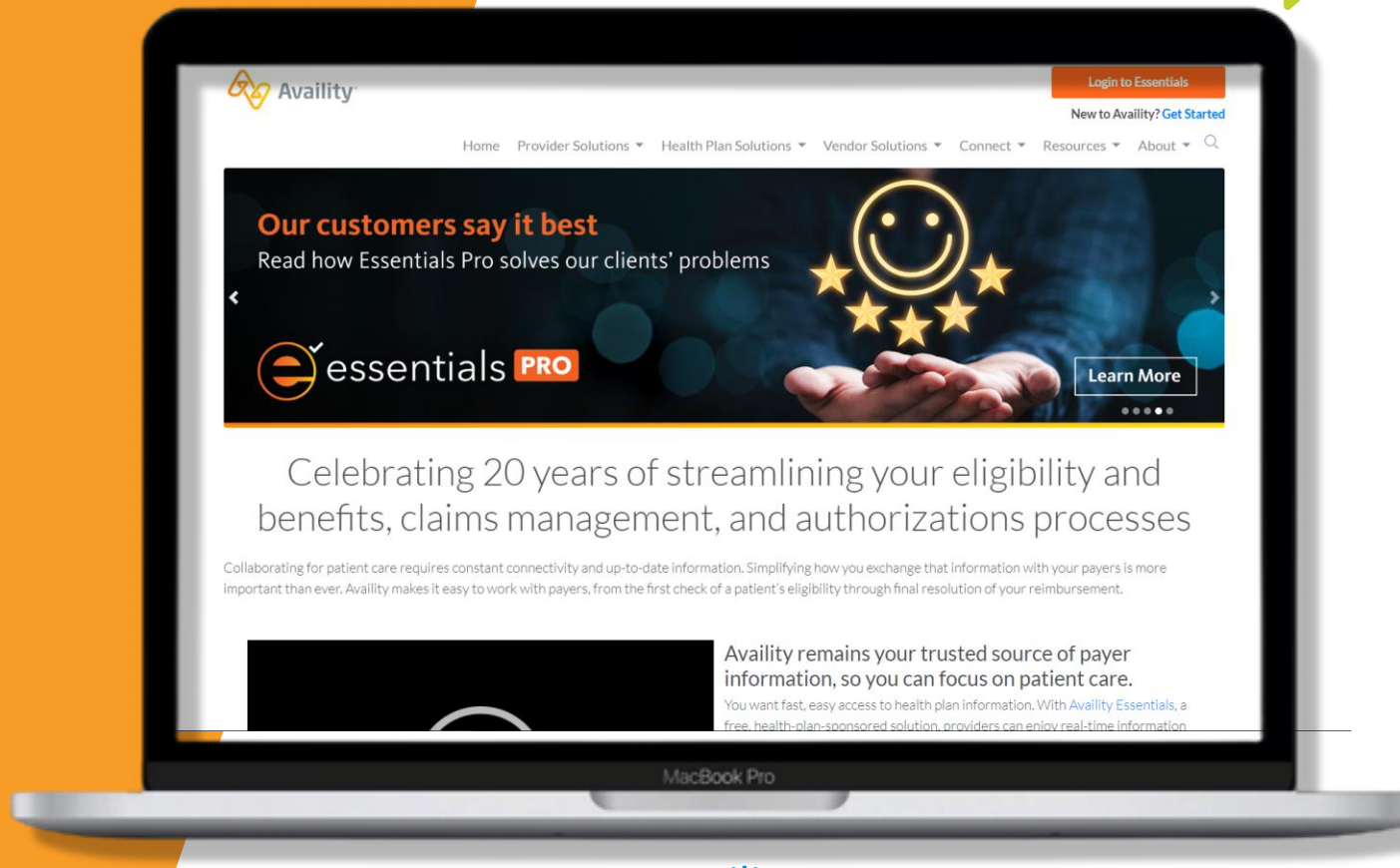
Availity Essentials

Availity Essentials

This free provider portal is a **secure gateway** (website) to tools and allows near real-time access to payer information.

It grants you the ability to:

- Obtain member eligibility and benefit information
- Submit a claim
- Check claim status
- View/print remittance advice, and more



www.availity.com

Magellan HEALTHCARE

Provider support via Availity Client Services (ACS) Essentials

Chat
Available daily via Community Support on www.availity.com

E-ticketing
Available 24/7 on www.availity.com

Phone
1-800-AVAILITY (282-4548)
Monday-Friday 8 a.m.-8 p.m.ET

Magellan HEALTHCARE

Do you have any

Questions?

Thank you

Magellan HEALTHCARE®

Legal

The information presented in this presentation is confidential and expected to be used solely in support of the delivery of services to Magellan members. By receipt of this presentation, each recipient agrees that the information contained herein will be kept confidential and that the information will not be photocopied, reproduced, or distributed to or disclosed to others at any time without the prior written consent of Magellan Health, Inc., a subsidiary of Centene Corporation.

The information contained in this presentation is intended for educational purposes only and should not be considered legal advice. Recipients are encouraged to obtain legal guidance from their own legal advisors.