

Claims Tips – DON'T –

√ **Don't Use Invalid Procedure or Diagnosis Codes**

Only use current code sets (CPT, HCPCS, Revenue and ICD-9) and select the code and diagnosis that most accurately describe the service provided. For diagnosis codes, only add a 4th or 5th digit to the code when necessary to make the diagnosis code HIPAA-compliant. The claim may not be altered by the claims examiner; therefore an incorrect code may result in denial of your claim.

√ **Don't Forget to Include the Authorization Number**

Always be sure to include on the claim the authorization number that appears on the authorization letter. If the billed services involve more than one authorization, please be sure to list all applicable authorization numbers and specify which billing dates pertain to each authorization.

√ **Don't Reduce Your Charge by the Co-Payment or Co-Insurance Amounts Paid by the Member**

Always show your full charge on the claim. The amount that is reimbursed is based on the lesser of the billed charge or the applicable fee schedule.

√ **Don't Omit Information on the Claim Because You Have Already Provided it on the Treatment Plan**

For confidentiality purposes, claims examiners do not have access to member treatment plans; therefore, it is necessary for you to give information on the claim that you may have already provided on the treatment plan. To assist with prompt claims processing, please be sure to provide all information required on the claim form. Do not submit treatment plans with claim forms. Treatment plans are to be mailed to the Care Management Center that authorized the services.

Most Frequent Reasons for Claims Non-payment

For your reference, the most frequent Magellan edits, or reasons for claims denial, include:

- Duplicate claim submission (i.e., the expense was previously considered)
- No preauthorization was obtained by the provider
- The member is ineligible, or coverage has lapsed
- Non-timely claim submission/filing
- Additional information is needed from the primary insurance carrier's Explanation of Benefits (EOB) or from the member's Coordination of Benefits (COB) form
- The claim includes a non-covered behavioral health diagnosis or service.