

## Claims Tips – DON'T –

- ✓ **Don't Use Invalid Procedure or Diagnosis Codes**  
Only use current code sets (CPT, HCPCS, Revenue and ICD) and select the code and diagnosis that most accurately describe the service provided. For diagnosis codes, be sure to use ICD-10 codes for services provided. The claim **may not** be altered by the claims examiner; therefore, an invalid code will result in denial of your claim.
- ✓ **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**  
To assist with prompt claims processing, please be sure to provide all information required on the claim form.

*See Claims Tips – DO – for Required Information About You, the Provider, on Claim*

### **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)
- Preauthorization was not obtained by the provider
- The member is ineligible, or coverage has lapsed
- Untimely claim submission/filing
- 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.