



Claims Filing Instructions



CLAIMS FILING INSTRUCTIONS

Table of Contents

PROCEDURES FOR CLAIM FORM SUBMISSION	3
Claims Filing Deadlines	4
Claim Requests for Reconsideration, Claim Disputes and Corrected Claims	5
Claim Payment	6
PROCEDURES FOR ELECTRONIC SUBMISSION	6
Filing Claims Electronically	7
<i>How to Start</i>	7
<i>Specific Data Record Requirements</i>	8
<i>Electronic Claim Flow Description & Important General Information</i>	8
<i>Invalid Electronic Claim Record Rejections/Denials</i>	9
<i>Our companion guides to billing electronically are available on our website at www.magnoliahealthplan.com. See section on electronic claim filing for more details.</i>	9
<i>Exclusions</i>	10
<i>Electronic Billing Inquiries</i>	11
Important Steps to a Successful Submission of EDI Claims	12
EFT and ERA.....	12
PROCEDURES FOR ONLINE CLAIM SUBMISSION	13
CLAIM FORM REQUIREMENTS	14
Claim Forms	14
Coding of Claims	14
Code Auditing and Editing	14
CPT® Category II Codes	21
Code Editing Assistant.....	22
Billing Codes	22
<i>Claims Mailing Instructions</i>	23
REJECTIONS VS. DENIALS	24
Common Causes of Upfront Rejections	24
Common Causes of Claim Processing Delays and Denials	25
Important Steps to a Successful Submission of Paper Claims	25
Resubmitted Claims	26

Table of Contents

Appendix Table	27
APPENDIX I: COMMON REJECTIONS FOR PAPER CLAIMS	28
APPENDIX II: COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS	29
APPENDIX III: EOP DENIAL CODES AND DESCRIPTIONS	31
APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION	35
CMS-1500 (8/05) Form, Shaded Field 24A-G.....	35
APPENDIX V: HIPAA COMPLIANT EDI REJECTION CODES.....	38
APPENDIX VI: SUBMITTING EPSDT SERVICES	40
APPENDIX VII: ANESTHESIA SERVICES	41
APPENDIX VIII: NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS	42

CLAIMS FILING INSTRUCTIONS

PROCEDURES FOR CLAIM SUBMISSION

Magnolia Health Plan, Inc., (Magnolia) is required by State and Federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary rejections and/or denials. **Claims will be rejected or denied if not submitted correctly.** In general, Magnolia follows the CMS (Centers for Medicare & Medicaid Services) billing requirements. For questions regarding billing requirements, contact a Magnolia Provider Services Representative at 1-866-912-6285.

When required data elements are missing or are invalid, claims will be rejected or denied by Magnolia for correction and re-submission.

- Rejections happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- Denials happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).

Claims for billable services provided to Magnolia members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

All claims filed with Magnolia are subject to verification procedures. These include but are not limited to verification of the following:

- All required fields are completed on an original CMS 1500, UB-04 paper claim form, or EDI electronic claim format.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for the date of service.
- All Diagnosis, Procedure, Modifier, and Location (Place of Service) Codes are valid for provider type/specialty billing.
- All Diagnosis, Procedure, and Revenue Codes are valid for the age and/or sex for the date of the service billed.
- All Diagnosis Codes are to their highest number of digits available (4th or 5th digit).
- Principal Diagnosis billed reflects an allowed Principale Diagnosis as defined in the volume of ICD-9 CM or ICD-9 CM update for the date of service billed.

CLAIMS FILING INSTRUCTIONS

- Member is eligible for services under Magnolia during the time period in which services were provided.
- Services were provided by a participating provider or if provided by an "out of network" provider, authorization has been received to provide services to the eligible member (excludes services by an "out of network" provider for an emergency medical condition; however authorization requirements apply for post-stabilization services).
- An authorization has been given for services that require prior authorization by Magnolia.
- Medicare coverage or other third party coverage.

Claims Filing Deadlines

Original claims must be submitted to Magnolia within 90 calendar days from the date services were rendered or compensable items were provided. The filing limit may be extended where the eligibility has been retroactively received by Magnolia up to a maximum of 180 calendar days. When Magnolia is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

All corrected claims, requests for reconsideration, or claim disputes must be received within 45 calendar days from the date of notification of payment or denial. Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes received outside of the 45 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- Catastrophic event that substantially interferes with normal business operations of the provider or damage or destruction of the provider's business office or records by a natural disaster.
- Mechanical or administrative delays or errors by Magnolia or the Mississippi Division of Medicaid (DOM).
- The member was eligible however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
 - o The provider's records document that the member refused or was physically unable to provide their ID card or information.

CLAIMS FILING INSTRUCTIONS

- o The provider can substantiate that he continually pursued reimbursement from the patient until eligibility was discovered or Health Safety Net, if applicable.
- o The provider can substantiate that a claim was filed within 180 days of discovering Plan eligibility.
- o The provider has not filed a claim for this member prior to the filing of the claim under review.

Claim Requests for Reconsideration, Claim Disputes, and Corrected Claims

All claim requests for reconsideration, corrected claims, or claim disputes must be received within 45 calendar days from the date of notification of payment or denial is issued.

If a provider has a question or is not satisfied with the information they have received related to a claim, there are four (4) effective ways in which the provider can contact Magnolia.

1. Contact a Magnolia Provider Service Representative at 1-866-912-6285
 - Providers may discuss questions with Magnolia Provider Services Representatives regarding amount reimbursed or denial of a particular service.
2. Submit an Adjusted or Corrected Claim to Magnolia Health Plan, Attn: Corrected Claim, PO Box 3090, Farmington MO 63640-3800
 - The claim must clearly be marked as **“RE-SUBMISSION” and must include the original claim number or the original EOP must be included with the resubmission.**
 - Failure to mark the claim as a resubmission and include the original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.
3. Submit a “Request for Reconsideration” to Magnolia Health Plan, Attn: Reconsideration, PO Box 3090, Farmington MO 63640-3800
 - A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.

CLAIMS FILING INSTRUCTIONS

- For more information about how to submit a medical necessity dispute, refer to the Grievances and Appeals section of this provider manual.
 - The request must include sufficient identifying information which includes, at minimum, the patient name, patient ID number, date of service, total charges and provider name.
 - The documentation must also include a detailed description of the reason for the request.
4. Submit a “Claim Dispute Form” to Magnolia Health Plan, Attn: Dispute, PO Box 3000, Farmington MO 63640-3800
- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
 - The Claim Dispute Form can be located on the provider website at www.magnoliahealthplan.com.

If the corrected claim, the request for reconsideration, or the claim dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Magnolia shall process and finalize all adjusted claims, requests for reconsideration, and disputed claims to a paid or denied status within 45 business days of receipt of the corrected claim, request for reconsideration, or claim dispute.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 98% within 30 business days of the receipt of the electronically filed claim
- 98% within 45 business days of the receipt of paper claims.

PROCEDURES FOR ELECTRONIC SUBMISSION

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry’s efforts to reduce administrative costs.

The benefits of billing electronically include:

CLAIMS FILING INSTRUCTIONS

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim re-work (adjustments).
- Receipt of clearinghouse reports as proof of claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim format. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker. Reports have shown that a large percentage of EDI claims are processed within 10 to 15 days of their receipt.

All the same requirements for paper claim filing apply to electronic claim filing. Claims that are not submitted correctly or containing the allowed field data will be rejected and/or denied.

Filing Claims Electronically

How to Start

- **First**, the provider will need to meet specific hardware/software requirements. There are many different products that can be used to bill electronically. As long as you have the capability to send EDI claims, whether through direct submission to the clearinghouse or through another clearinghouse, you can submit claims electronically.
- **Second**, the provider needs to contact their clearinghouse and confirm they will transmit the claims to one of the clearinghouses used by Magnolia. For a list of vendors used by Magnolia, please visit our website at www.magnoliahealthplan.com. Go to the Provider page and click on Resources.
- **Third**, the provider should confirm with their clearinghouse the accurate location of the Magnolia Payer ID number.
- **Last**, the provider needs to verify with Magnolia that their provider record is set up within the claim adjudication system (Amisys).

CLAIMS FILING INSTRUCTIONS

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com. At times, a voicemail will have to be left on the EDI line. You will receive a return call within 24 business hours.

The companion guides and clearinghouse options are on the Magnolia website at www.magnoliahealthplan.com.

The following sections describe the procedures for electronic submission for hospital and medical claims. Included are a high level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within the Claim Filing section of this booklet. Please contact the clearinghouse you intend to use and ask if they require additional data record requirements. The companion guide is located on the Magnolia website at www.magnoliahealthplan.com

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Magnolia, all EDI claims must first be forwarded to one of Magnolia's clearinghouses. This can be completed via a direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and Plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important you review this error report daily to identify any claims that were not transmitted to Magnolia. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Magnolia, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Magnolia by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are rejected and sent back on a daily basis to the clearinghouse. The clearinghouse in turn forwards the rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important you review this report daily. The report shows rejected claims and these claims need to be reviewed and

CLAIMS FILING INSTRUCTIONS

corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Magnolia.

- If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor customer service department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

Invalid Electronic Claim Record Rejections/Denials

All claim records sent to Magnolia must first pass the clearinghouse proprietary edits and Plan-specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Magnolia. In these cases, the claim must be corrected and re-submitted within the required filing deadline of 90 calendar days from the date of service. It is important that you review the acceptance or claim status reports received from the clearinghouse in order to identify and re-submit these claims accurately.

Our companion guides to billing electronically are available on our website at www.magnoliahealthplan.com. See the section on electronic claim filing for more details.

CLAIMS FILING INSTRUCTIONS

Exclusions

Certain claims are excluded from electronic billing.

- Excluded Claim Categories – At this time, these claim records must be submitted on paper.

These exclusions apply to inpatient and outpatient claim types.

Excluded Claim Categories
Claim records requiring supportive documentation or attachments. Note: COB claims can be filed electronically, but if they are not, the primary payer EOB must be submitted with the paper claim.
Claim records billing with miscellaneous codes
Claim records for medical, administrative, or claim reconsideration or dispute requests
Claim requiring documentation of the receipt of an informed consent form
Claim for services that are reimbursed based on purchase price (e.g. custom DME, prosthetics). Provider is required to submit the invoice with the claim.
Claim for services requiring clinical review (e.g., complicated or unusual procedure). Provider is required to submit medical records with the claim.
Claim for services needing documentation and requiring Certificate of Medical Necessity- oxygen, motorized wheelchairs

NOTE: Provider identification number validation is not performed at the clearinghouse level. The clearinghouse will reject claims for provider information only if the provider number fields are empty.

CLAIMS FILING INSTRUCTIONS

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you would like to transmit claims electronically...	Contact one of the clearinghouses for Magnolia's payer ID.
If you have a general EDI question...	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
If you have questions about specific claims transmissions or acceptance Claim Status reports...	Contact your clearinghouse technical support area
If you have questions about your Claim Status (if claim has been accepted or rejected by the clearinghouse)...	Contact EDI Support at 1-800-225-2573 Ext. 25525 or via e-mail at EDIBA@centene.com.
If you have questions about claims that are reported on the Remittance Advice...	Contact Provider Services at 1-866-912-6285
If you would like to update provider, payee, UPIN, Tax ID number, or payment address information...	Notify Provider Services in writing at: magnoliapdm@centene.com or Magnolia Health Plan, Inc. 111 East Capitol Street, Suite 500 Jackson, MS 39201
For questions about changing or verifying provider information...	Magnolia Health Plan, Inc. Attn: Provider Services 111 East Capitol Street, Suite 500 Jackson MS 39201 By Telephone: 1-866-912-6285 Or By Fax: 1-877-811-5980

CLAIMS FILING INSTRUCTIONS

Important Steps to a Successful Submission of EDI Claims

1. Select clearinghouse to utilize.
2. Contact the clearinghouse to inform them you wish to submit electronic claims to Magnolia.
3. Inquire with the clearinghouse what data records are required.
4. Verify with Provider Relations at Magnolia that the provider is set up in the Magnolia system before submitting EDI claims.
5. You will receive two (2) reports from the clearinghouse. ALWAYS review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Magnolia and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Magnolia. ALWAYS review the acceptance and claim status reports for rejected claims. If rejections are noted, you must correct and resubmit.
6. MOST importantly, all claims must be submitted with provider's identifying numbers. See the CMS 1500 (8/05) and UB-04 1450 claim form instructions and claim forms for details.

EFT and ERA

Magnolia has partnered with Payformance to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this **free service**, providers can take advantage of EFTs and ERAs to settle claims electronically. For more information, please visit our provider home page on our website at www.magnoliahealthplan.com or, to sign up for this quick and efficient service, you may go directly to www.payformance.com.

CLAIMS FILING INSTRUCTIONS

PROCEDURES FOR ONLINE CLAIM SUBMISSION

For participating providers who have internet access and choose not to submit claims via EDI, Magnolia has made it easy and convenient to submit claims directly to us on our website at www.magnoliahealthplan.com.

You must request access to our secure site by registering for a user name and password and have requested claims access. To obtain an ID, please contact Provider Relations at 1-866-912-6285. Requests are processed within two (2) business days.

Once you have access to the secure portal, you may view web claims, allowing you to re-open and continue working on saved, un-submitted claims. This feature allows you to track the status of claims submitted using the website.

CLAIMS FILING INSTRUCTIONS

CLAIM FORM REQUIREMENTS

Claim Forms

Magnolia only accepts the CMS 1500 (8/05) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (8/05) form and institutional providers complete the CMS 1450 (UB-04) claim form. Magnolia does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms submitted must be completed in black or blue ink. If you have questions regarding what type of form to complete, contact a Magnolia Provider Services Representative at 1-866-912-6285.

Coding of Claims

Magnolia requires claims to be submitted using codes from the current version of ICD-9-CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Claims will be rejected or denied if billed with:

- Missing, invalid, or deleted codes
- Codes inappropriate for the age or sex of the member
- An ICD-9 CM code missing the 4th or 5th digit

For more information regarding billing codes, coding, and code auditing and editing refer to your Magnolia Provider Manual or contact a Magnolia Provider Services Representative at 1-866-912-6285.

Code Auditing and Editing

Magnolia uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), Center for Medicare and Medicaid Services (CMS), public-domain specialty society guidance, and clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario and the State of Mississippi. Claims billed in a manner that does not adhere to these standard coding conventions will be denied.

CLAIMS FILING INSTRUCTIONS

Code editing software contains a comprehensive set of rules and address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- American Medical Association (AMA) – the software utilizes the CPT Manuals, CPT Assistant, CPT Insider’s View, the AMA web site, and other sources.
- Centers for Medicare & Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) which includes column 1/column 2, mutually exclusive and outpatient code editor (OCE0 edits). In addition to using the AMA’s CPT manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.
- Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).
- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario.
- In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

Unbundling of Services – identifies procedures that have been unbundled.

Example: Unbundling lab panels. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Allow

CLAIMS FILING INSTRUCTIONS

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

Code	Description	Status
80053	Comprehensive Metabolic Panel	Disallow
85025	Complete CBC, automated and automated & automated differential WBC count	Disallow
84443	Thyroid Stimulating Hormone	Disallow
80050	General Health Panel	Add

Explanation: 80053, 85025 and 84443 are included in the lab panel code 80050 and therefore are not separately reimbursable. Those claim lines containing the component codes are denied and CPT code 80050 is added to a new service line and recommended for reimbursement.

Bilateral Surgery – bilateral surgeries are identical procedures performed on bilateral anatomical sites during the same operative session.

Example:

Code	Description	Status
69436 DOS=01/01/10	Tympanostomy	Disallow
69436 50 DOS=01/01/10	Tympanostomy billed with modifier 50 (bilateral procedure)	Allow

Explanation: identifies the same code being billed twice, when reimbursement guidelines require the procedure to be billed once with a bilateral modifier. These should be billed on one line along with modifier 50 (bilateral procedure).

Note: Modifiers RT (right), or LT (left) should not be billed for bilateral procedures

CLAIMS FILING INSTRUCTIONS

Duplicate services – submission of the same procedure more than once on the same date for services that cannot be or are normally not performed more than once on the same date.

Example: excluding a duplicate CPT

Code	Description	Status
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Allow
72010	Radiologic exam, spine, entire, survey study, anteroposterior & lateral	Disallow

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services – submission of an evaluation and management (E/M) service either within a global surgery period or on the same date of service of another E/M service.

Global Surgery

Procedures that are assigned a 90-day global surgery period are designated as *major* surgical procedures; those assigned a 10-day or 0-day global surgery period are designated as *minor* surgical procedures.

- Evaluation and management services, submitted with major surgical procedures (90-day) and minor surgical procedures (10-day), are not recommended for separate reporting because they are part of the global service.
- Evaluation and management services, submitted with minor surgical procedures (0-day), are *not* recommended for separate reporting or reimbursement because these services are part of the global service unless the service is a service listed on the Mississippi Medicaid Fee Schedule with an asterisk.

CLAIMS FILING INSTRUCTIONS

Example: global surgery period

Code	Description	Status
27447 DOS=05/20/09	Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).	Allow
99213 DOS=06/02/09	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling & coordination of care w/other providers or agencies are provided consistent w/nature of problem(s) & patient's &/or family's needs. Problem(s) are low/moderate severity. Physicians spend 15 min face-to-face w/patient &/or family.	Disallow

Explanation:

- Procedure code 27447 has a global surgery period of 90 days.
- Procedure code 99213 is submitted with a date of service that is within the 90-day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: evaluation and management service submitted with minor surgical procedures

Code	Description	Status
11000 DOS=01/23/10	Debridement of extensive eczematous or infected skin; up to 10% of body surface.	Allow
99213 DOS=01/23/10	Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent w/nature of problem(s) and patient's and/or family's needs. Problem(s) are low/moderate severity.	Disallow

CLAIMS FILING INSTRUCTIONS

	Physicians spend 15 minutes face-to-face with patient and/or family.	
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Explanation:

- Procedure 11000 (0-day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service - One (1) evaluation and management service is recommended for reporting on a single date of service.

Example: same date of service

Code	Description	Status
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent w/ nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate/high severity. Physicians spend 40 minutes face-to-face with patient and/or family.	Allow
99242	Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling/coordination of care with other providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Physicians spend 30 minutes face-to-face with patient/family.	Disallow

Explanation:

- Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
- Procedure 99242 is used to report an office consultation for a new or established patient.

CLAIMS FILING INSTRUCTIONS

- Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions, provided during an evaluation and management service, typically include the components of an office consultation

NOTE:

Modifier -24 is used to report an unrelated evaluation and management service by the same physician during a post-operative period.

Modifier -25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure.

Modifier -79 is used to report an unrelated procedure or service by the same physician during the post-operative period.

When modifiers -24 and -25 are submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, the evaluation and management service is questioned and a review of additional information is recommended.

When modifier -79 is submitted with an evaluation and management service on the same date of service or during the post-operative period by the same physician, separate reporting of the evaluation and management service is recommended.

Modifiers - Modifiers are added to the main service or procedure code to indicate that the service has been altered in some way by a specific circumstance.

Modifier -26 (professional component)

Definition: Modifier -26 identifies the professional component of a test or study.

- If modifier -26 is not valid for the submitted procedure code, the procedure code is not recommended for separate reporting.
- When a claim line is submitted without the modifier -26 in a facility setting (for example, POS 21, 22, 23, 24), the rule will replace the service line with a new line with the same procedure code and the modifier -26 appended.

Example:

Code	Description	Status
78278 POS=Inpatient	Acute gastrointestinal blood loss imaging	Disallow

CLAIMS FILING INSTRUCTIONS

78278-26 POS=Inpatient	Acute gastrointestinal blood loss imaging	Allow
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Explanation:

- Procedure code 78278 is valid with modifier -26.
- Modifier -26 will be added to procedure code 78278 when submitted without modifier -26.

Modifier -80, -81, -82, and -AS (assistant surgeon)

Definition: This edit identifies claim lines containing procedure codes billed with an assistant surgeon modifier that typically do not require an assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting (if required). This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

Example:

Code	Description	Status
42820-81	Tonsillectomy and adenoidectomy; under age 12	Disallow

Explanation:

- Procedure code 42820 is not recommended for Assistant Surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance this procedure.

CPT® Category II Codes

CPT Category II Codes are supplemental codes developed to assist in the collection and reporting of information regarding performance measurement, including HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service, thus reducing the need for retrospective medical record review.

Use of these codes is optional and are not required for correct coding and may not be used as a substitute for Category I codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

CLAIMS FILING INSTRUCTIONS

Code Editing Assistant

A web-based code auditing reference tool designed to “mirror” how Magnolia code auditing product(s) evaluate code combinations during the auditing of claims is available for participating providers. This allows Magnolia to share with our contracted providers the claim auditing rules and clinical rationale we use to pay claims.

This tool offers many benefits:

- *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services *before* claims are submitted
- *Proactively* determine the appropriate code/code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a ‘what if’ or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.

The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations.

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in a potential denial of the claim and a consequent delay in payment. Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-9 codes. Submit institutional claims with valid Revenue Codes and CPT-4 or HCPCS (when applicable), ICD-9 codes, and DRG codes (when applicable).

Providers will also improve the efficiency of their reimbursement through proper coding of a member’s diagnosis. We require the use of valid ICD-9 diagnosis codes, to the ultimate specificity, for all claims. This means that ICD-9 codes must be carried out to the fourth or fifth digit when indicated by the coding requirements in the ICD-9 manual (Note: not all codes require a fourth or fifth digit). The highest degree of specificity, or detail, can be determined by using the Tabular List (Volume One) of the ICD-9 coding manual in addition to the Alphabetic List (Volume Two) when locating and designating

CLAIMS FILING INSTRUCTIONS

diagnosis codes. The Tabular List gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to the fifth digit, if appropriate. Ancillary providers (e.g., Labs, Radiologists, etc.) and those physicians interpreting diagnostic testing may use V72.6 for Laboratory Exam, V72.5 for Radiological Exam, NEC, and V72.85 for Other Specified Exam as the principal diagnosis on the claim. Please consult your ICD-9 manual for further instruction. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

In addition, written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Magnolia.

Claims Mailing Instructions

Submit claims to Magnolia at the following address:

First Time Claims, Corrected Claims and Requests for Reconsiderations:

Magnolia Health Plan, Inc.
Claim Processing Department
P. O. Box 3090
Farmington, MO 63640-3825

Claim Disputes must be submitted to:

Magnolia Health Plan, Inc.
Attn: Claim Disputes
P. O. Box 3000
Farmington, MO 63640-3800

Please do not use any other post office box that you may have for Magnolia as it may cause a delay in processing. Magnolia encourages all providers to submit claims electronically. Our companion guides to billing electronically are available on our website at www.magnoliahealthplan.com. See section on electronic claim filing for more details. You may also submit claims on-line using our secure website at www.magnoliahealthplan.com.

Claim Form Instructions

Our companion guides to billing are available on our website at www.magnoliahealthplan.com.

CLAIMS FILING INSTRUCTIONS

REJECTIONS VS. DENIALS

All paper claims sent to the Claims Office must first pass specific minimum edits prior to acceptance. Claim records that do not pass these minimum edits are invalid and will be rejected or denied.

A **REJECTION** is defined as an **unclean** claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located on the website at www.magnoliahealthplan.com. A list of common upfront rejections can be found listed below and a more comprehensive list with explanations can be located in Appendix 1.

If all minimum edits pass and the claim is accepted, it will then be entered into the system for processing. A **DENIAL** is defined as a claim that has passed minimum edits and is entered into the system, but has been billed with invalid or inappropriate information causing the claim to deny. An EOP (Explanation of Payment) will be sent that includes the denial reason. A list of common delays and denials can be found listed below and a more comprehensive list with explanations can be located in Appendix 2.

Common Causes of Upfront Rejections

- **Unreadable Information** - Information within the claim form cannot be read. The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), the font is too small, or hand written information is not legible.
- **Member DOB** (date of birth) is missing.
- **Member Name or identification (ID) number** is missing.
- **Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) number** is missing.
- **DOS** - The DOS (date of service) on the claim is not prior to receipt of claim (future date of service).
- **DATES** –A date or dates are missing from required fields. Example: "Statement From" UB-04 & "Service From" CMS 1500 (8/05); "To Date" before "From Date".
- **TOB** - Invalid TOB (Type of Bill) entered.
- **Diagnosis Code** is missing, invalid, or incomplete.
- **Service Line Detail** - No service line detail submitted.
- **DOS** (date of service) entered is prior to the member's effective date.
- **Admission Type** is missing (Inpatient Facility Claims – UB-04, field 14)

CLAIMS FILING INSTRUCTIONS

- **Patient Status** is missing (Inpatient Facility Claims – UB-04, field 17)-
- **Occurrence Code/Date** is missing or invalid.
- **RE Code** (revenue code) is missing or invalid.
- **CPT/Procedure Code** is missing or invalid.
- **Incorrect Form Type** – The form is not a form accepted by Magnolia or not allowed for the provider type.

Common Causes of Claim Processing Delays and Denials

- **Wrong Form Type** - The paper claim form submitted is not on a "Red" dropout OCR form.
- **Diagnosis Code** is missing the 4th or 5th digit.
- **Procedure or Modifier Codes** entered are invalid or missing.
- **DRG** code is missing or invalid.
- **EOB** (Explanation of Benefits) from the Primary insurer is missing or incomplete.
- **Member ID** is invalid.
- **Place of Service Code** is invalid.
- **Provider TIN and NPI** do not match.
- **Revenue Code** is invalid.
- **Dates of Service** span do not match the listed Days/Units.
- **Physician Signature** is missing.
- **Tax Identification Number (TIN)** is invalid.
- **Third Party Liability** (TPL) information is missing or incomplete.

Important Steps to a Successful Submission of Paper Claims

1. Complete all required fields on an original, red CMS 1500 or UB-04 form.
2. Ensure all Diagnosis, Procedure, Modifier, Location (Place of Service), Type of Admission, and Source of Admission Codes are valid for the date of service.
3. Ensure all diagnosis and procedure codes are appropriate for the age and sex of the member.
4. Ensure all diagnosis codes are coded to their highest number of digits available (fourth and fifth digit).

CLAIMS FILING INSTRUCTIONS

5. Ensure member is eligible for services under Magnolia during the time period in which services were provided.
6. Ensure an authorization has been given for services that require prior authorization by Magnolia.
7. Claim forms submitted without “Red” dropout OCR forms may cause unnecessary delays to processing.

Resubmitted Claims

All requests for reconsideration, claim disputes, or corrected claims must be received within 45 calendar days from the date of notification of payment or denial.

Paper claims submitted for review or reconsideration, must be clearly and boldly marked with **“RE-SUBMISSION and/or CORRECTED CLAIM”**, and must include the original claim number, or a copy of the EOP. Failure to do this could allow a claim to deny as a duplicate or deny for non-timely filing.

APPENDIX

- I. Common Rejections for Paper Claims*
- II. Common Causes of Paper Claim Processing Denial*
- III. EOP Denial Codes*
- IV. Instructions for Supplemental Information CMS-1500 (8/05) Form, Shaded Field 24a-G*
- V. HIPAA Compliant EDI Rejection Codes*
- VI. Submitting EPSDT Services*
- VII. Anesthesia Services*
- VIII. Nurse Practitioners & Physician Assistants*

APPENDIX I: COMMON REJECTIONS FOR PAPER CLAIMS

- **Member DOB missing** from the claim.
- **Member Name or Id Number** missing or invalid from the claim.
- **Provider Name, TIN, or NPI Number** missing from claim.
- **Claim data is unreadable** due to either too light (insufficient toner), dot-matrix printers, or too small font to allow for clear electronic imaging of claim.
- **Diagnosis Code** missing or invalid.
- **REV Code** missing or invalid.
- **CPT/Procedure Code** missing or invalid.
- **Dates missing** from required fields. Example: “Statement From” UB-04 & “Service From” 1500 (8/05). “To Date” before “From Date.”
- **DOS on claim** is not prior to receipt of claim (future date of services).
- **DOS prior to effective date** of Health Plan or prior to member eligibility date.
- **Incorrect Form Type** Used (approved form types are CMS 1500 (8/05) for professional medical services or the UB-04 for all facility claims).
- **Invalid TOB** or invalid type of bill.
- **No detail service** line submitted.
- **Admission Type** missing (when Inpatient Facility Claim only).
- **Patient Status** missing (when Inpatient Facility Claim only).

APPENDIX II: COMMON CAUSES OF PAPER CLAIM PROCESSING DELAYS OR DENIALS

- **Billed Charges Missing or Incomplete** – A billed charge amount must be included for each service/procedure/supply on the claim form.
- **Claims not submitted on “Red” dropout OCR forms** – Claim forms submitted without red dropout may cause unnecessary delays to processing.
- **Diagnosis Code Missing 4th or 5th Digit** – Diagnosis should be billed to the highest intensity for proper coding and processing. Review the ICD-9-CM manual for coding to the 4th and 5th digit.
- **DRG Codes Missing or Invalid** – Hospitals contracted for payment based on DRG (Diagnosis Related Grouping) codes should include this information on the claim form for accurate payment. Invalid DRG codes will result in denial.
- **Primary Insurers EOB (Explanation of Benefits) is Missing or Incomplete** – Claims for Members who have OIC (other insurance carrier) must be billed along with a copy of the primary EOB from the OIC (either paid or denied). Include pages with run dates, coding explanations, and messages.
- **Member ID Invalid** – The member ID does not match Name or DOB submitted.
- **Place of Service Code Invalid** – A valid and appropriate two digit numeric code must be included on the claim form. Refer to CMS 1500 coding manuals for a complete list of place of service codes.
- **Procedure or Modifier Codes Invalid or Missing** – Coding from the most current coding manuals (CPT or HCPCS) is required in order to accurately complete processing. All applicable diagnosis, procedure, and modifier fields must be completed.
- **Provider TIN and NPI Do Not Match** – The submitted NPI does not match Provider’s Tax ID number on file.
- **Revenue Codes Missing or Invalid** – Facility claims must include a valid three or four-digit numeric revenue code. Refer to UB-92 coding manual for a complete list of revenue codes.

CLAIMS FILING INSTRUCTIONS

Appendix

- **Date Span Billed does not match Days/Units Billed** – spanned dates of service can only be billed for consecutive days along with matching number of days/units (i.e. Date Span of 01/01 to 01/03 and days/units = 3).
- **Signature Missing** – The signature of the provider of service, or an authorized representative must be present on the claim form
- **Tax Identification Number (TIN) Missing or Invalid**- Provider's Tax ID number must be present and must match the service provider name and payment entity (vendor) on file with Magnolia.

APPENDIX III: EOP DENIAL CODES AND DESCRIPTIONS

DENIAL CODE	DENIAL DESCRIPTION
07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED
18	DENY: DUPLICATE CLAIM/SERVICE
1K	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
1L	DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION
20	DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER
21	DENY: CLAIM THE RESPONSIBILITY OF THE NO-FAULT CARRIER
22	DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER
23	DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB
24	DENY: CHARGES COVERED UNDER CAPITATION
25	DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET
26	DENY: EXPENSES INCURRED PRIOR TO COVERAGE
27	DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT
46	DENY: THIS SERVICE IS NOT COVERED
48	DENY: THIS PROCEDURE IS NOT COVERED
4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT
6L	EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL
86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
99	DENY:MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT
9I	INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED
A1	DENY: AUTHORIZATION NOT ON FILE
BG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
BI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL

CLAIMS FILING INSTRUCTIONS

Appendix

DENIAL CODE	DENIAL DESCRIPTION
C2	CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT
C6	CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT
C8	CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT
CV	DENY: BILL WITH SPECIFIC VACCINE CODE
DD	DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED
DJ	DENY: INAPPROPRIATE CODE BILLED, CORRECT & RESUBMIT
DS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
DT	DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING.
DW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.
DY	DENY: APPEAL DENIED
DZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
EB	DENY: DENIED BY MEDICAL SERVICES
EC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
FP	DENY: CLAIMS DENIED FOR PROVIDER FRAUD.
FQ	DENY: RESUBMIT CLAIM UNDER FQHC/RHC CLINIC MEDICAID NUMBER
GL	SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
GM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K
H1	DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING
HL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH
HP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING
HQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED
HS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING
HT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING
I1	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
I9	DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD9 CODE
IE	CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE
IK	DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 & MED RECORDS, PLEASE RESUBMIT
IL	VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT
IM	DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT
IV	DENY: INVALID/DELETED/MISSING CPT CODE
L0	PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS

CLAIMS FILING INSTRUCTIONS

Appendix

DENIAL CODE	DENIAL DESCRIPTION
L6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.
LO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.
M5	DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE
MA	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT
MG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MH	DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING
MO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.
MQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT
MY	DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS
N5	DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM
ND	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE
NT	DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
NV	DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION
NX	DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT
OX	DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED
PF	DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM
RC	DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING
RD	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.
RX	DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.
TM	TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT.
U1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
U5	DENY:UNLISTED / UNSPECIFIC CODE -RE-BILL MORE SPECIFIC CODE
V3	MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE
V4	MED RECORDS RECEIVED NOT LEGIBLE
V5	MED RECORDS RECEIVED FOR WRONG PATIENT
V6	MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS
V8	MED RECORDS RECEIVED WITHOUT DOS
VC	DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES
VS	DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.
x3	PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE
x4	PROCEDURE CODE/ICD-9 CODE INCONSISTENT WITH MEMBERS GENDER

CLAIMS FILING INSTRUCTIONS

Appendix

<i>DENIAL CODE</i>	<i>DENIAL DESCRIPTION</i>
x5	PROCEDURE CODE CONFLICTS WITH MEMBER'S AGE
x6	ADD-ON CODE REQUIRED WITH PRIMARY CODE FOR QUANTITY GREATER THAN ONE
x7	ADD-ON CODE CANNOT BE BILLED WITHOUT PRIMARY CODE
x8	MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED
x9	PROCEDURE CODE PAIRS INCIDENTAL, MUTUALLY EXCLUSIVE OR UNBUNDLED
xa	CODE IS A COMPONENT OF A MORE COMPREHENSIVE CODE
xb	PROCEDURE CODE NOT ELIGIBLE FOR ANESTHESIA
xc	PROCEDURE/DIAGNOSIS CODE DELETED, INCOMPLETE OR INVALID
xd	PROCEDURE CODE PREVIOUSLY BILLED ON HISTORICAL CLAIM
xe	PROCEDURE CODE INCONSISTENT WITH MEMBER'S AGE
xf	MAXIMUM ALLOWANCE EXCEEDED
xg	SINGLE/UNILATERAL PROCEDURE SUBMITTED MORE THAN ONCE ON THE SAME DOS
xh	SERVICE LINE REPRESENTS DENIAL OF ADDITIONAL UNITS BILLED
ZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY

APPENDIX IV: INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION

CMS-1500 (8/05) Form, Shaded Field 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (8/05) form field 24A-G:

- Anesthesia duration in hours and/or minutes with begin (start) and end times
- Narrative description of unspecified/miscellaneous/unlisted codes
- National Drug Codes (NDC) for drugs
- Vendor Product Number–Health Industry Business Communications Council (HIBCC)
- Product Number Health Care Uniform Code Council–Global Trade Item Number (GTIN), formerly Universal Product Code (UPC) for products
- Contract rate

The following qualifiers are to be used when reporting these services.

7 Anesthesia information

CTR Contract rate

ZZ Narrative description of unspecified/miscellaneous/unlisted codes

N4 National Drug Codes (NDC)

The following qualifiers are to be used when reporting NDC units:

F2 International Unit

GR Gram

ML Milliliter

UN Unit

OZ Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN)

VP Vendor Product Number- Health Industry Business Communications Council (HIBCC) Labeling Standard

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the supplemental

CLAIMS FILING INSTRUCTIONS

Appendix

information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

More than one (1) supplemental item can be reported in a single shaded claim line **IF** the information is related to the un-shaded claim line item it is entered on. When entering more than one (1) supplemental item, enter the first qualifier at the start of 24A followed by the number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code. After the entry of the first supplemental item, enter three (3) blank spaces and then the next qualifier and number, code, or other information. Do not enter a space between the qualifier and the supplemental information. Do not enter hyphens or spaces within the NDC, HIBCC, or GTIN number/code.

Examples:

Anesthesia

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	
From To				PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPSDT	ID.	RENDERING	
MM	DD	YY	MM	DD	YY	SERVICE	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL.	PROVIDER ID. #
											Units	Pen		
7	Begin	13	15	End,	14	45	Time	90	minutes					
													NPI	

Unlisted, Non-specific, or Miscellaneous CPT or HCPC Code

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	
From To				PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPSDT	ID.	RENDERING	
MM	DD	YY	MM	DD	YY	SERVICE	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL.	PROVIDER ID. #
											Units	Pen		
ZZ	Laparoscopic	Ventral	Hernia	Repair	Op	Note	Attached							
													NPI	

NDC

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	
From To				PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPSDT	ID.	RENDERING	
MM	DD	YY	MM	DD	YY	SERVICE	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL.	PROVIDER ID. #
											Units	Pen		
N455513019001	Pegfilgrastim	ML	0.6											
													NPI	

Vendor Product Number- HIBCC

24. A. DATE(S) OF SERVICE				B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.	
From To				PLACE OF	EMG	(Explain Unusual Circumstances)		DIAGNOSIS	\$ CHARGES	DAYS	EPSDT	ID.	RENDERING	
MM	DD	YY	MM	DD	YY	SERVICE	CPT/HCPCS	MODIFIER	POINTER		OR	Family	QUAL.	PROVIDER ID. #
											Units	Pen		
VPA123ABC7D9E1F														
													NPI	

CLAIMS FILING INSTRUCTIONS

Appendix

Product Number Health Care Uniform Code Council – GTIN

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.
From			To			PLACE OF		(Explain Unusual Circumstances)			DIAGNOSIS	\$ CHARGES	DAYS	EPSDT	ID.	RENDERING
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER	POINTER			OR	(Rate)	QUAL	PROVIDER ID. #
OZ01234567891112																NPI

No qualifier - More Than One (1) Supplemental Item

APPENDIX V: HIPAA COMPLIANT EDI REJECTION CODES

These codes are the standard national rejection codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

Please see Magnolia's list of common EDI rejections to determine specific actions you may need to take to correct your claims submission.

- 01 Invalid Mbr DOB**
- 02 Invalid Mbr**
- 06 Invalid Prv**
- 07 Invalid Mbr DOB & Prv**
- 08 Invalid Mbr & Prv**
- 09 Mbr not valid at DOS**
- 10 Invalid Mbr DOB; Mbr not valid at DOS**
- 12 Prv not valid at DOS**
- 13 Invalid Mbr DOB; Prv not valid at DOS**
- 14 Invalid Mbr; Prv not valid at DOS**
- 15 Mbr not valid at DOS; Invalid Prv**
- 16 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv**
- 17 Invalid Diag**
- 18 Invalid Mbr DOB; Invalid Diag**
- 19 Invalid Mbr; Invalid Diag**
- 21 Mbr not valid at DOS; Prv not valid at DOS**
- 22 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS**
- 23 Invalid Prv; Invalid Diag**
- 24 Invalid Mbr DOB; Invalid Prv; Invalid Diag**
- 25 Invalid Mbr; Invalid Prv; Invalid Diag**
- 26 Mbr not valid at DOS; Invalid Diag**
- 27 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag**
- 29 Prv not valid at DOS; Invalid Diag**
- 30 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag**
- 31 Invalid Mbr; Prv not valid at DOS; Invalid Diag**
- 32 Mbr not valid at DOS; Prv not valid; Invalid Diag**
- 33 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag**
- 34 Invalid Proc**
- 35 Invalid Mbr DOB; Invalid Proc**

- 36 Invalid Mbr; Invalid Proc
- 38 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
- 39 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag

- 40 Invalid Prv; Invalid Proc
- 41 Invalid Mbr DOB, Invalid Prv; Invalid Proc
- 42 Invalid Mbr; Invalid Prv; Invalid Proc
- 43 Mbr not valid at DOS; Invalid Proc
- 44 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
- 46 Prv not valid at DOS; Invalid Proc
- 48 Invalid Mbr; Prv not valid at DOS; Invalid Proc
- 49 Mbr not valid at DOS; Invalid Prv; Invalid Proc
- 51 Invalid Diag; Invalid Proc
- 52 Invalid Mbr DOB; Invalid Diag; Invalid Proc
- 53 Invalid Mbr; Invalid Diag; Invalid Proc
- 55 Mbr not valid at DOS; Prv not valid at DOS; Invalid Proc
- 57 Invalid Prv; Invalid Diag; Invalid Proc
- 58 Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
- 59 Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
- 60 Mbr not valid at DOS; Invalid Diag; Invalid Proc
- 61 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
- 63 Prv not valid at DOS; Invalid Diag; Invalid Proc
- 64 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 65 Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 66 Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
- 67 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
- 72 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 73 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 74 Services performed prior to Contract Effective Date
- 75 Invalid units of service
- 76 Original Claim Number Required
- 81 Invalid units of service, Invalid Pvr
- 83 Invalid units of service, Invalid Pvr, Invalid Mbr

APPENDIX VI: SUBMITTING EPSDT SERVICES

Mississippi Cool Kids Program EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services are limited to beneficiaries under age 21.

Modifier EP is required to be billed in box 24d of CMS 1500 claim form

Procedure Codes for Screenings:

Initial:

- 99381 – EP (under the age of 1)
- 99382 – EP (1-4 years of age)
- 99383 – EP (5-11 years of age)
- 99384 – EP (12-17 years of age)
- 99385 – EP (18-21 years of age)

Periodic:

- 99391 – EP (under the age of 1)
- 99392 – EP (1-4 years of age)
- 99393 – EP (5-11 years of age)
- 99394 – EP (12-17 years of age)
- 99395 – EP (18-21 years of age)

Hearing:

- 92551 – EP (3-21 years of age)

Vision:

- 99173 – EP (3-21 years of age)

Adolescent Counseling:

- 99401 – EP (9-21 years of age)

Note: All Mississippi Cool Kids screening CPT codes must be billed with modifier **EP** in box 24d of the CMS 1500 claim form. The vision, hearing, and adolescent counseling CPT codes must also be billed in conjunction with the comprehensive age appropriate screening.

Hemoglobin and/or Hematocrit & Urine Dipstick for Sugar & Protein are included in the screening reimbursement and cannot be billed separately.

APPENDIX VII: ANESTHESIA SERVICES

Anesthesia CPT Codes fall within the range of **00100 – 01999**.

All Anesthesia Providers are required to bill one of the following modifiers to each CPT Anesthesia code:

AA – Anesthesia service performed personally by Anesthesiologist

- AA modifier can only be billed by an Anesthesiologist
- Do not use for Medical direction of CRNA's

GC – This service has been performed in part by a Resident under the direction of a Teaching Physician

- GC can only be used by Anesthesiologist in a teaching facility

QX – CRNA Service: with medical direction by a physician

- QX must be used by both the CRNA and the Anesthesiologist
- Anesthesiologist may not bill for direction of more than four CRNA's at any one time

QZ – CRNA Service: without medical direction by a physician

- QZ can only be used by the CRNA

Mississippi Medicaid defines one (1) anesthesia time unit as one (1) minute.

Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in attendance. That is when the patient may be safely placed under post-operative supervision.

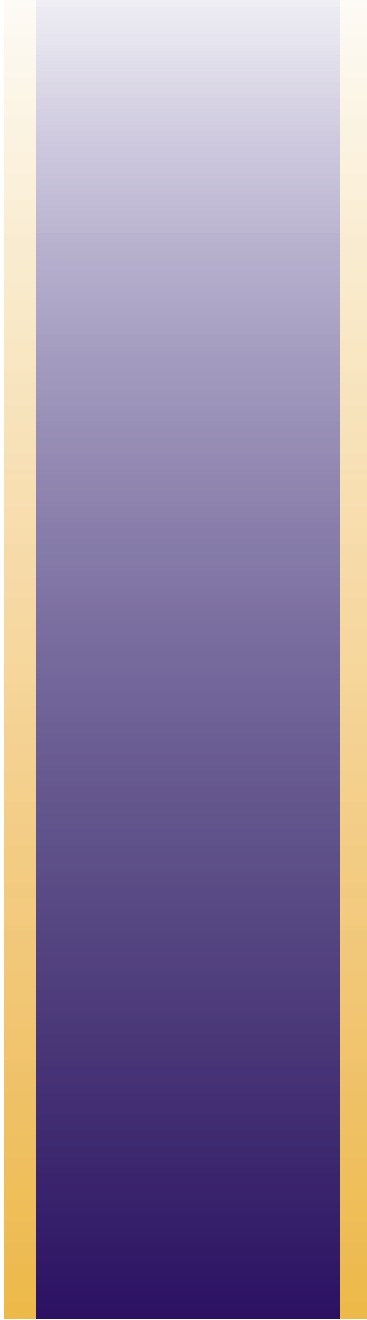
Reimbursement will not be made for additional modifying units for physical status, extreme age, utilization of total body hypothermia, or controlled hypotension, or emergency conditions.

When filing for anesthesia services on the CMS-1500 claim form, apply the following guidelines:

- Enter the correct CPT anesthesia code from the 00100 through 01999 range in box 24d.
- The correct number of anesthesia time units must be entered in box 24g. One minute of anesthesia time will equal one unit.

APPENDIX VIII: NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Nurse practitioners and physician assistants, as licensed by the state of Mississippi, may bill for the covered services within the scope of practice allowed by their respective protocols. All services and procedures provided by nurse practitioners and physician assistants should be billed in the same manner and following the same policy and guidelines as like physician services.



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