Provider Notice

Thank you for participating with Magellan Complete Care of Virginia (MCC of VA) to provide high quality healthcare services to our members. The purpose of this notice is to provide you with information regarding upcoming changes to processes and/or guidelines for claims submission timeframes, claims payment rules and our retrospective review process.

Claims Submission—Timely Filing

In recognition of our implementation work across Virginia for both the Commonwealth Coordinated Care Plus and Medallion 4.0 programs, MCC of VA will be relaxing its claim timely filing timeframes through December 31, 2019.

Effective immediately, our timely filing timeframe will be extended to **365 days from the date of service** through December 31, 2019. The MCC of VA provider handbook section 16 (Claims Submission) will be updated to reflect this change.

Claims Submission and Payment—New Processing Edit

MCC of VA will be implementing changes to its claims processing and payment approach with respect to discarded drug billing. Effective **October 4, 2018**, we will be applying a new claims processing edit that will impact discarded drug payment for claims paid to providers under the Enhanced Ambulatory Patient Grouping (EAPG) system (outpatient hospital). Under the EAPG methodology, line items on UB-04 facility claims are paid based on the procedure billed, regardless of the quantity. Accordingly, for dates of service on or after **October 4, 2018**, our claims processing system will be adjusted to pay $0 on the discarded drug line (JW modifier), as payment of the EAPG rate is made on the main drug line.

Retrospective Review Process

A retrospective review is afforded to inpatient facilities that did not obtain an authorization for an acute behavioral or medical stay and the notification of the admission is received after the member has been discharged from the facility.

Effective **October 4, 2018,** a retrospective review can be submitted up to five (5) calendar days from the date of the discharge. For any request made after the five (5) calendar days from discharge the facility must submit a claim, and once the claim has been denied for no authorization, the review of the stay with supporting medical records can be submitted for an appeal to conduct a medical necessity review. In order to expedite this appeal process, the provider must submit a copy of the claim Explanation of Payment (EOP) and the member's medical records within 60 calendar days of the denied claim stating no authorization. Requests exceeding this timeframe will be denied as untimely. Members are held harmless and have no financial liability for services rendered.

Non-hospital providers are expected to submit a pre-service authorization request to MCC of VA prior to providing the service or care. These requests cannot be accepted as a retrospective review. A claim must be submitted and once the claim has been denied for no authorization, the review of the service or care with supporting medical records can be submitted for an appeal to conduct a medical necessity review within 60 calendar days. The appeal must include the copy of the claim EOP and the member's medical records. Requests exceeding this timeframe will be denied as untimely. Members are held harmless and have no financial liability for services rendered.

Should you have any questions about the changes outlined in this notice, please contact your Regional Network Manger or call 1-800-424-4524 and follow the prompts to be connected with a member of our network management team.