## Housekeeping

<table>
<thead>
<tr>
<th>Feature</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| **Link Participant ID with Audio** | If your Participant ID has not been entered, dial #ParticipantID#.  
EXAMPLE: Participant ID is 16, then enter #16#.                                                                                     |
| **Mute your line**               | **UNMUTED**  
[Mute](#)  
[Start Video](#)  

**MUTED**  
[Unmute](#)  
[Start Video](#)  

**OTHER MUTE OPTIONS**  
[Mute Me](#)  
[Raise Hand](#) |
| **Raise your hand with questions** | CLICK the Raise Hand button. The presenter will be notified that you have a question.                                                          |
Objectives

At the completion of this training, participants will have received an overview on the following:

- Claims Submission and Reimbursement Overview
- Electronic Funds Transfer (EFT)
- Provider Payment Dispute Process
- Provider Portal and Other Support Resources
Claims Submission and Reimbursement
Overview
Verify Member Eligibility and Benefits

It is important that you verify eligibility and benefits for MCC of VA members each time a member presents to your office or practice for care or prior to scheduling a care visit with a member.

The member ID card alone can not be solely relied upon as a guarantee of payment. Service authorizations are also contingent upon eligibility and benefits at the point of service.

Providers can access the following methods to verify eligibility:

**By Phone:** Call our 24-hour eligibility line:
- CCC Plus: 1-800-424-4524
- Medallion 4.0: 1-800-424-4518
  - or-

**Online:** Visit our Provider portal and follow the relevant prompts at [www.MCCofVA.com](http://www.MCCofVA.com)
Check for Authorization Requirements:

- There are some treatments, medications, and services that require approval prior to the service/medication being provided.
- If the service the member needs is covered through Medicare, then a service authorization is not needed from MCC of VA CCC Plus.
- Service authorizations are not required for early intervention services, EPSDT, emergency care, family planning services (including LARC (long acting reversible contraceptives), preventive services, and basic prenatal care.
- MCC of VA utilizes clinical practice guidelines to make determinations for authorization.

Treatments/services that require authorization:

<table>
<thead>
<tr>
<th>Inpatient Hospital – Elective and Non-Elective Procedures</th>
<th>Hospital or Ambulatory Care Center-based Outpatient Surgery</th>
<th>Inpatient Skilled Nursing Facilities and Long Stay Hospital</th>
<th>Rehabilitation Services: Inpatient, Cardiac and Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Evaluation Services</td>
<td>Abortions</td>
<td>Specialty Drugs</td>
<td>IV Infusion or Injectable Medications</td>
</tr>
<tr>
<td>Outpatient Diagnostic Services; High-Tech Radiology; Chiropractic Services; and Acupuncture</td>
<td>Cardiac Testing; Genetic Testing; Experimental or Investigational</td>
<td>Behavioral Health; Inpatient, Mid-level Rehab; ARTS, and Skill Building Services</td>
<td>Transportation Non-urgent ambulance and Non-ambulance</td>
</tr>
<tr>
<td>Dental – refer to DentaQuest; Dental Varnish Vision – refer to VSP Hearing and Hearing Aids</td>
<td>Medical Devices; Durable Medical Equipment; Prosthetics/Orthotics and Replacements</td>
<td>Therapy: Physical, Occupational, Speech, Hyperbaric, Radiation, and Pain Management</td>
<td>Nutritional Supplements and Supplies; Infant Formula; Non-Emergency Referral to Non-contracted Provider</td>
</tr>
<tr>
<td>LTSS: Nursing Facility; Personal Care Skilled/Unskilled; Respite Skilled/Unskilled;</td>
<td>Home Health Care: Occupational, Physical or Speech; PDN; Home Health Aide RN/LCSW</td>
<td>Hospice; Transition Services; Specialized Care; Skilled Private duty nursing;</td>
<td>Adult Day Health Care; Assistive Technology; Environmental Modifications</td>
</tr>
</tbody>
</table>
### Physical Health Services

<table>
<thead>
<tr>
<th>Service Authorization Review Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Services (Standard or Expedited Review Process)</td>
</tr>
<tr>
<td>Outpatient Services (Standard Review Process)</td>
</tr>
<tr>
<td>Outpatient Services (Expedited Review Process)</td>
</tr>
<tr>
<td>Long Term Services and Supports (Standard Review Process)</td>
</tr>
<tr>
<td>• Includes CCC Plus Waiver services</td>
</tr>
<tr>
<td>• EPSDT Personal Care and Private Duty Nursing</td>
</tr>
<tr>
<td>• Nursing Facility</td>
</tr>
<tr>
<td>• Long Stay Hospital</td>
</tr>
<tr>
<td>• Hospice</td>
</tr>
<tr>
<td>Long Term Services and Supports (Expedited Review Process)</td>
</tr>
<tr>
<td>Same as those listed above</td>
</tr>
</tbody>
</table>

### Behavioral Health Services

<table>
<thead>
<tr>
<th>Service Authorization Review Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient (Standard Review Process)</td>
</tr>
<tr>
<td>Inpatient (Standard Review Process)</td>
</tr>
<tr>
<td>Inpatient (Expedited Review Process)</td>
</tr>
<tr>
<td>Other Urgent Services</td>
</tr>
</tbody>
</table>

### Pharmacy Services

<table>
<thead>
<tr>
<th>Service Authorization Review Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy Services</td>
</tr>
</tbody>
</table>
MCC of VA requires the use of these standard code sets (and successor code sets when published, upon their effective dates) on both paper and electronic claim transactions.

**HIPAA specifically identifies the following procedure and diagnostic code sets as standard:**

- ICD-10-CM
- CPT®-4 and modifiers
- HCPCS Level II and modifiers
- Revenue codes
- Place of Service codes
- Type of Bill codes

- Ensure that all claims information submitted to MCC of VA contains the member's Medicaid ID and or MCC of VA ID to ensure proper identification
- Paper and EDI claims must submitted on a fully completed CMS 1500 form for professional services or UB04/CMS1450 form for institutional services
- Use of current standard codes in accordance with HIPAA requirements is required
- Apply for and use a National Provider Identifier (NPI) on all claims submitted to MCC of VA
- Obtain a current copy of MCC of VA’s Universal Services List (USL) for standard codes for most facility and program services

Visit our website for more information about [HIPAA code sets](#) and clean claim requirements.
Use of National Provider Identifier (NPI) and Tax Identification Number

• The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions (also required for billing on paper claim forms)

• There are specific fields on the paper claim forms and electronic file that you should indicate the NPIs for "Rendering and Pay to/Billing provider"

• An NPI does not replace a provider’s TIN; the TIN/SSN continues to be required on all claims – paper and electronic

• The NPI is for identification purposes, while the TIN/SSN is for tax purposes

• For organizations, please bill the organization as the rendering and pay to NPI (this excludes inpatient facilities who bill on UB-04 and requires attending physician)

• For groups, please bill the individual as the rendering NPI and the group as the pay to NPI

**Important:** Claims that do not include a TIN/SSN will be rejected
Tips for Filing a Clean Claim

DO:

 ✓ Give complete information on the member and policy holder
 ✓ Give complete information on you, the provider
 ✓ Include any other carrier's payment information
 ✓ Include the complete, HIPAA-compliant diagnosis
 ✓ Obtain authorization for services
 ✓ Show your entire charge
 ✓ Include appropriate billing modifier (where applicable)
 ✓ Submit your claims electronically and within timely filing guidelines
 ✓ Monitor your EDI transaction reports
 ✓ Include accurate rendering provider and NPI number
 ✓ Attach the primary carrier’s Explanation of Benefits (EOB)

DON’T:

 ✓ Use invalid procedure or diagnosis codes
 ✓ Forget to include the authorization number
 ✓ Omit information on the claim because you have already provided it on the treatment plan
 ✓ Forget the place of service code

Please Note: Incomplete forms will delay processing
Submission Order, Dual-Eligible Members and Coordination of Benefits

• Providers should follow traditional claims submission order in accordance with industry standard coordination of benefit rules.

• Claims for services provided to members who have another primary insurance carrier must be submitted to the primary insurer first in order to obtain an Explanation of Benefits (EOB)
  – The full obligation of the primary insurer must be met before MCC of VA can make a payment

• Claims for dual-eligible members should be submitted to Medicare for reimbursement, for services covered by Medicare
Timely Filing and Payment Timeframes

- MCC of VA commits to the timely processing of claims for covered services provided to our members.

- We have established guidelines and infrastructure that ensures timely processing and payment within both Federal and State guidelines.

- Clean claims for covered services must be received no later than one hundred and eighty (180) days from the date of services to ensure acceptance by MCC of VA.

Submit claims through the provider web portal.
Timely Filing and Payment Timeframes

• Processing and payment for covered services are generally made within 30 days upon receipt of clean claim and any required supporting documentation.

• Processing and payment for clean claims for Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), ARTS and Early Intervention providers are processed within 14 calendar days of receipt.

• Payment is made in accordance with the rate exhibit and terms of your provider agreement.

Corrected claims are subject to a timely filing period equal in length to the initial timely filing period, starting from the first denial or most recent payment.
Electronic Data Interchange (EDI) and Paper Claims Submission Information

- We strongly encourage all providers to submit claims electronically to Magellan. EDI streamlines the submission process, and can expedite receipt and payment for covered services provided to our members.
- Paper submissions and/or claims requiring supporting documentation can also be submitted by US Mail.
- We also offer electronic funds transfer (EFT) option to our Participating Providers who register for EFT via our provider portal.

Electronic claims submission
- EDI Clearing House: Availity, Office Ally, and Trizetto Provider Solutions
- Payer ID: MCCVA

Paper claims submission
- Magellan Complete Care of Virginia Claims Service Center
  1 Cameron Hill Circle, Ste. 52
  Chattanooga, TN 37402

Electronic funds transfer
- Enrollment information via provider portal: [www.mccofva.com](http://www.mccofva.com) or email us at:
  - CCC Plus: VAMLTSSProvider@magellanhealth.com
  - Medallion 4.0: VAM4Provider@magellanhealth.com
Advantages of Electronic (EDI) Claims

**What’s in it for providers?**

**Improved Efficiency**
- No paper claims. No envelopes. No stamps.
- Prompt confirmation of receipt or incomplete claim
- Reduced administrative costs
- Less paper storage

**Improved Quality**
- Up-front electronic review ensures higher percentage of clean claims
- Claims do not need to be re-keyed from paper claim, eliminating human error
- Errors are quickly identified
- Secure process with encryption keys, passwords, etc.

**Faster Reimbursement**
• Upon receipt of a claim, MCC of VA reviews the documentation and makes a payment determination

• As a result of this determination, a remittance advice, known as an Explanation of Payment (EOP) or Explanation of Benefits (EOB) is sent to the provider

• The Remittance Advice (EOP/EOB) includes details of payment or the denial

• It is important that you review all remittance advice promptly

• Check cycles occur once per week for payable claims. Electronic Funds Transfer (EFT) and paper check options are available

• You can review your remittance advice online after registering with our portal for secure access at www.MCCofVA.com Select “Check Claims Status” and select the Remittance Advice Search tab
Electronic Funds Transfer (EFT)
MCC of VA Accepts Electronic Funds Transfer

• Providers can take advantage of Magellan’s online feature -- Electronic Funds Transfer (EFT) -- for claims payments. You can request to have certain claims payments directly deposited to your business bank account.

• EFT is quicker than the standard process of mailing and cashing or depositing a check, leaving you more time to devote to your practice.

• EFT is available to organizations, group practices and individual providers who own the Taxpayer Identification Number (TIN) linked to the submitted claim:
  − Individual providers within an organization or group practice are not able to receive EFT claims payment.
Getting Enrolled for Electronic Funds Transfer (EFT)

Magellan Complete Care of Virginia accepts electronic funds transfer (EFT) enrollment through **CAQH Enrollhub**

**CAQH Enrollhub** offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA

Enrollment information is available on the **CAQH Enrollhub** website at [https://solutions.caqh.org](https://solutions.caqh.org).

*Note:* Vendor and MCC of VA shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.
Using Electronic Funds Transfer (EFT)

• Once you begin to receive EFT payments, you will no longer receive an Explanation of Payment (EOP) or Explanation of Benefits (EOB) by U.S. mail for those benefit plans that allow EFT

• EOP or EOB information can be accessed and printed through the Magellan provider website at www.MCCofVA.com

• You must use Check Claim Status on the www.MCCofVA.com, or review your Electronic Remittance Advice (ERA) online through your clearinghouse, in order to obtain the processing result for EFT paid claims

• Should a claim be denied, no payment will be due and there will be no EFT transaction. You will need to check your EOP or EOB online via the Magellan provider website at www.MCCofVA.com
Provider Payment Dispute
Reconsideration of a Denied Claim

- Claim denials will be sent on the provider paper EOP or the electronic remittance advice, whichever the provider receives.

- Providers who sign up for electronic funds transfer (EFT) will be able to view remittance advice on the MCC of VA website after secure login:
  - Electronic submissions are the preferred method for claims submission, payment and remittance advice.

- In the event a provider has submitted a claim, but it cannot be located in MCC of VA's claims system, it is possible the claim has been rejected in imaging.

- In some cases a rejected claim may be proof of timely filing.

- The provider should submit a corrected claim.
Most Frequent Reasons for Claims Non-Payment

For your reference, the most frequent 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
- Untimely claim submission/filing
- UB-04 claim 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.
Submitting a Corrected Claim

• Corrected claims can be submitted electronically by selecting the appropriate data as shown below.

• Corrected Paper Claims - Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

• Submit a new claim form with the correct data using the CMS-1500 Claim Form as follows:
  
  ➢ Submit a Frequency Code “7” (Replacement of prior claim) or “8” (Void/Cancel of prior claim) in the “Resubmission Code” field of Block 22.
  
  ➢ The claim number originally used by MCC of VA to process the claim should be included in the “Original Ref. No.” field of Block 22.
  
  ➢ Failure to include the appropriate “Resubmission Code” and “Original Ref. No.” in Block 22 may result in a claim rejection or denial.

Need assistance? We can help!

Contact MCC of VA Provider Services at:

CCC Plus: 1-800-424-4524
Medallion 4.0: 1-800-424-4518
## Provider Appeals and Timeframes

There are three types of provider appeals with different filing requirements:

<table>
<thead>
<tr>
<th>Policy Related Disputes</th>
<th>Utilization Management Related Disputes</th>
<th>Claims Related Disputes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filing Process - Oral or Written</td>
<td>Filing Process-Must be filed in writing</td>
<td>Filing Process – Must be filed in writing</td>
</tr>
<tr>
<td>Timeliness – Providers have 60 days from the date the provider becomes aware of the issue generating the complaint</td>
<td>Timeliness – Providers have 60 calendar days from the original utilization management decision</td>
<td>Timeliness - Providers have 60 calendar days from the date of the adverse benefit determination notice / remittance advice</td>
</tr>
<tr>
<td>Forms can be found in the MCC of VA Provider Handbook and under the Forms tab at mccofva.com/For Providers</td>
<td>Forms can be found in the MCC of VA Provider Handbook and under the Forms tab at mccofva.com/For Providers</td>
<td>Complaints filed after that time will be denied for untimely filing.</td>
</tr>
<tr>
<td>Submit written appeal requests to: Attn: Appeals Specialist, Fax: (866) 325-9157 or Address: MCC of VA, 3829 Gaskins Road, Richmond, VA 23233</td>
<td>Submit written appeal requests to: Attn: Appeals Specialist, Fax: (866) 325-9157 or Address: MCC of VA, 3829 Gaskins Road, Richmond, VA 23233</td>
<td>Forms can be found in the MCC of VA Provider Handbook and under the Forms tab at mccofva.com/For Providers</td>
</tr>
<tr>
<td>MCC of VA will make a decision on routine appeals within 30 calendar days from the receipt of the appeal or within 72 hours for expedited review</td>
<td></td>
<td>Submit written appeal requests to: Attn: Appeals Specialist, Fax: (866) 325-9157 or Address: MCC of VA, 3829 Gaskins Road, Richmond, VA 23233</td>
</tr>
</tbody>
</table>
Accessing a Provider Dispute Resolution Form

• The *Provider Dispute Resolution Form* is available in the MCC of VA Provider Handbook and via the mccofva.com website or call our Provider Services Line to initiate a provider appeal at:
  - CCC Plus: 1-800-424-4524
  - Medallion 4.0: 1-800-424-4518

• Indicate one of the following reasons in the addressee line:
  - Retro review (no authorization)
  - Claims appeal
  - Appeals (clinical and administrative)
  - Customer comments (complaints)

• The submission should include:
  - Prior correspondence
  - Supporting documentation
  - Pertinent medical records (if applicable)
  - Detailed explanation providing the basis of the dispute
  - Identify the issues, adjustments, or items the provider is appealing

MCC of VA
Attn: Appeals Specialist
3829 Gaskins Road
Richmond, VA 23233
Required Documentation for Submitting a Dispute

Insufficient Documentation:

- The Provider Appeals form instructs the provider to submit any information necessary to reconsider MCC of VA’s initial claim or utilization decision.

- If additional information is needed, the Provider Appeals Department will notify the provider that we are closing the file pending receipt of the required information.
Provider Appeal Resolution Process

All provider appeals will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying MCC of VA written policies and procedures. At the conclusion of the review, the provider will receive a written decision with an explanation of the decision.

Internal Appeals Process

• For appeals not resolved wholly in favor of the provider, MCC of VA’s written Notice of Internal Appeal Decision will include the description of appeal rights for a DMAS informal appeal, including the address for filing the appeal, the timeframe, and the list of pertinent statutes/regulations governing the appeal process.

External Appeals Process

• Medicaid providers have the right to appeal adverse decisions to the Department. However, the MCC of VA’s internal appeal process must be exhausted prior to a DMAS provider filing an appeal with the DMAS Appeals Division. External review requests must be submitted to DMAS in writing. Written requests to DMAS must be sent at the address below within 30 days of notification of Magellan’s appeal decision. Submit your written request for external review to: DMAS, 600 E. Broad St., Richmond, VA 23219 or Fax: 1-804-786-5799.
Provider Portal and Other Support Resources
Provider Website

The website is continually updated to provide easy access to information and greater convenience and speed in exchanging information with Magellan Complete Care. Visit our website at: www.MCCofVA.com.

Available resources include:

- Provider handbooks
- Claims forms and submission tips
- Compliance information
- Pharmacy directory
- Medication formulary
- Services/medications requiring prior authorization
- Provider network information
- CMS Best Available Evidence policy
- Clinical and administrative forms
- Online provider education resources
- Answers to frequently asked questions (FAQs)
- Access to Interpretive and Translation Services
Secure Provider Portal

Magellan Complete Care of Virginia’s provider portal offers you the opportunity to check and complete various claims functions to include:

- Remittances
- Claims status and claims acknowledgement
- Direct Claims Entry

For authorizations, please fax the request to 1-866-210-1523.

If you have any questions, please reach out to us at:

CCC Plus: 1-800-424-4524; TTY 711
Medallion 4.0: 1-800-424-4518; TTY 711
Go to www.MCCofVA.com for the "Provider Tools" page.

In this section, you will find information and resources on:

- **Important Updates**
  - EFT Registration
  - Availity Sign On Instructions

- **Training**
  - Provider Orientation
  - Claims Education

- **Utilization Management**

- **Forms**
  - Claims
  - Appeals
  - General
Contacting MCC of VA

The Customer Service Center is available 24/7:

CCC Plus: 1-800-424-4524
Medallion 4.0: 1-800-424-4518

MCC of VA website: www.MCCofVA.com

The following are examples of information which can be obtained from accessing the Magellan Complete Care website or contacting the Customer Service Center:

- Eligibility
- Authorization request forms
- Claims
- Benefits
- PCP and provider information
- Interpretation Services
References

MCC of VA Provider Handbook: www.mccofva.com

DMAS Website: http://www.dmas.virginia.gov/

DMAS Program Manuals:
Leading humanity to healthy, vibrant lives
Thanks!
Confidentiality statement

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.

The information contained in this presentation is intended for educational purposes only and is not intended to define a standard of care or exclusive course of treatment, nor be a substitute for treatment.

*If the presentation includes legal information (e.g., an explanation of parity or HIPAA), add this: 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.