CLAIMS AND BILLING

MASS ADVANTAGE
A Medicare Advantage Plan

GENERAL PAYMENT GUIDELINES

An important element in claims filing is the submission of current and accurate codes to reflect the provider's services. HIPAA-AS mandates the following code sets:

- Internal Classification of Disease – 10th Revision – Clinical Modification (ICD-10-CM)
- Provider's Current Procedural Terminology, 4th edition (CPT)
- Healthcare Common Procedure Coding System (HCPCS)

Claims should be submitted in one of three formats:

- Electronic claims submission
- CMS 1500 Form
- UB04 Form

Mass Advantage covers the professional and technical components of global CPT procedures. Therefore, the appropriate professional component modifiers and technical component modifiers should be included on the claim form. Providers are required to use the standard CMS codes for ICD-10, CPT, and HCPCS services, regardless of the type of submission. Claims processing is subject to change based upon newly promulgated guidelines and rules from CMS.

For payment of Medicare claims, Mass Advantage has adopted all guidelines and rules established by CMS. Mass Advantage members may only be billed for their applicable co-payments, co-insurance, non-Medicare covered services, and member cost share.

CLAIMS SUBMISSION

This section provides information about claims submission, processing, and payment. Providers should submit all claims for Mass Advantage members, except for certain services that must be billed to Original Medicare (e.g., certain clinical trial services CMS determines and hospice care). If a provider submits a claim to Mass Advantage but should have sent it to Original Medicare, Mass Advantage will deny the claim to the provider, therefore the provider should submit to their local carrier or fiscal intermediary.

Mass Advantage claims should be submitted using Medicare billing guidelines and format (CMS-1500 or UB-04), and the National Provider Identifier (NPI).

Providers should include the member's complete and accurate Mass Advantage identification number when submitting a claim. The complete Mass Advantage identification number includes the alpha prefix, C, and subsequent numbers as they appear on the member's ID Card. Mass Advantage cannot process claims with incorrect or missing alpha prefixes and member identification numbers. Claims submitted without all required information will be returned (paper submission) or denied (electronic submission).

WHEN TO SUBMIT CLAIMS

Mass Advantage encourages providers to submit all claims as soon as possible after the date of service to facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements.

Exceptions may be made to the timely filing requirements of a claim when situations arise concerning other payer primary liability such as Original Medicare, Medicaid, or third-party insurers, or legal action and/or an error by Mass Advantage.

Mass Advantage must submit encounter data and medical records to certify completeness and truthfulness of information submitted to CMS. In turn, Mass Advantage network providers must submit complete and accurate coded claims and assist Mass Advantage in correcting any identified errors or omissions.

TIMELY SUBMISSION OF CLAIMS

For Mass Advantage network providers, claims should be submitted within the timely filing period established by your contract with Mass Advantage (90 days). Providers should reference their contract with Mass Advantage for the stipulated claims submission guidelines.

For non-network providers, Mass Advantage abides by CMS Prompt Payment Guidelines. Timely submission is subject to statutory changes. Therefore, claims should be submitted within the timely filing period established by regulatory statute (365 days).

Plan members cannot be billed for services denied due to a lack of timely filing. Claims appealed for timely filing should be submitted with proof along with a copy of the Explanation of Benefits (EOB) and the claim.

ELECTRONIC CLAIMS SUBMISSION

Electronic data filing requires billing software through which you can electronically send claims data to a clearinghouse. Since most clearinghouses can exchange data with one another, you can continue to use your existing clearinghouse even when it is not the clearinghouse selected by Mass Advantage. Prior to submitting claims through a clearinghouse exchange, you must check with your existing clearinghouse to make sure they can complete the transition with the Mass Advantage vendor. If you do not have a clearinghouse or have been unsuccessful in submitting claims to your clearinghouse, please contact Provider Relations for assistance.

Filing claims electronically is the most effective way to submit claims for processing and receiving payment.

ELECTRONIC TRANSACTIONS AND CODE SETS

Law requires payers to have the capability to send and receive all applicable HIPAA-compliant transactions and code sets.

One requirement is that the payer must be able to accept a HIPAA-compliant 837 electronic claim transaction, in standard format, using standard code sets and standard transactions. Specifically, claims submitted electronically must comply with the following Provider-focused transactions:

- 270/271 – Health Insurance Eligibility/ Benefit Inquiry & Response
- 276/277 – Health Care Claim Status Request & Response

- 835 – Health Care Claim Payment/ Advice. The X12N-837 claims submission transactions replaces the manual CMS 1500/UB92 forms. All files submitted must be in the ANSI ASC X12N format, version 4010A, as applicable.

COMPLETION OF "PAPER" CLAIMS

In the need to submit, Paper claims should be completed in their entirety. Paper claims can be mailed to:

Mass Advantage
PO Box 830059
Birmingham, AL 35283

If you have any questions regarding paper claim submission, please contact Provider Services.

COMPLIANCE ISSUES RESULTING IN CLAIM DENIALS

Mass Advantage may deny coverage or reject a claim for the following reasons:

- The patient is not eligible for Mass Advantage benefits.
- The provider is not qualified to furnish the Medicare services billed.
- Mass Advantage is the secondary payer to other insurance and the primary plan has not processed the claim.
- Services are excluded by national or local coverage policy because:
  - The service is not covered.
  - A limited benefit is exhausted.
  - Claim/services do not meet technical requirements for payment, e.g., non-compliance with Correct Coding Initiative (CCI) edits (including national and local requirements).

SPECIAL CONSIDERATIONS WHEN SUBMITTING MASS ADVANTAGE CLAIMS

Depending on the specialty of the provider, there are additional, special considerations a biller must be aware of when submitting claims. These considerations include:

- Determining whether claims should be submitted to Medicare.
- Requesting prior authorization for:
  - Services that require authorization (see Prior Authorization Code List)
  - Services that are not normally covered by the plan, if medical necessity may warrant coverage.
- Providing Notice of Exclusions of Medical Benefits (NEMBs)

PROMPT PAYMENT BY MEDICARE ADVANTAGE ORGANIZATION

A submitted claim will be considered a "clean claim" if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The following prompt payment requirements apply:

- Mass Advantage shall either pay or deny clean claims submitted by contracted providers for covered services to Mass Advantage members within thirty (30) days of receipt.
- Mass Advantage will either pay or deny clean claims submitted by non-contracted providers within thirty (30) calendar days of the request. All other claims submitted by non-contracted providers will be paid or denied within sixty (60) calendar days from the date of the request.

Claims with incomplete or inaccurate data elements will be denied. Corrected claims can be submitted within claims submission timelines for corrected claims. Providers should reference their contract with Mass Advantage for the corrected claims submission guidelines.

Medicare Advantage organizations may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a provider or other practitioner who has opted out of the Medicare program by filing with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at www.cms.gov. You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

ONLINE CLAIMS INFORMATION

Mass Advantage encourages participating providers to check the status of their claims on the Mass Advantage Provider Portal. In addition to checking claims status, you can also verify eligibility and benefit information. You will need your login information to access.

If you need assistance with registration or have questions about the portal, please contact Mass Advantage Provider Relations at Provider.Relations@MassAdvantage.com or by calling (774) 701-1414.

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