MASS ADVANTAGE
Plan to love your plan.

CLAIMS AND BILLING

Claims General Information

Mass Advantage maintains billing and claims processing guidelines consistent with industry standards. This section contains billing and claims guidelines for claims filed with Mass Advantage. Providers must follow these guidelines to ensure accurate and timely payments.

Timely Filing

Providers are required to file claims with Mass Advantage within 90 calendar days of the date the services are rendered.

Providers must bill within 365 calendar days from the date of an Explanation of Benefits (EOB) from the primary carrier when Mass Advantage is secondary. An original bill along with a copy of the EOB is required to process the claim. Requests for reviews/corrections of processed claims must be submitted within 180 calendar days from the date of the corresponding remittance advice. All claims submitted after the 180-day period following receipt of the EOB or after the 180-day follow-up period from the date on the remittance will be denied.

Mass Advantage processes the majority of claims within 30 days; however, providers are encouraged to call Mass Advantage's Provider Services Department to inquire on any claim not processed within 60 days.

Electronic Claims Submission

Mass Advantage accepts claims electronically through Change Healthcare and encourages providers to take advantage of the electronic claims processing capabilities. Submitting claims electronically offers the following benefits:

- Faster Claims Submission and Processing
- Reduced Paperwork
- Increased Claims Accuracy

- Time and Cost Savings

For submission of professional or institutional electronic claims for Mass Advantage, the Payer ID is 86220.

HIPAA 5010

The 5010 version of the HIPAA electronic transactions is required to support the transfer of ICD-10 diagnosis code and ICD-10 procedure code data on claims and remittances.

Only version 5010 transactions will be accepted. The billing provider address submitted on claims must be a physical address. Claims submitted via Change Healthcare or will be rejected if a P.O. Box number is submitted as the billing address. To prevent claims from being rejected, please be sure to submit a physical address as the billing address.

Claims Dispute Process

Mass Advantage will review any claim that a provider feels was denied or paid incorrectly if the provider follows the process to dispute a claim. The provider can request a claims review in writing (per instructions below), or by phone call to the Provider Services Department if the inquiry relates to an administrative issue. Hard copies of the information should be mailed to the Claims Review Department along with all of the relevant supporting documentation, i.e., the actual claim, medical records, and notations regarding telephone conversations, in order to expedite the review process. Initial claims that are not received within the timely filing limit will not qualify for review. All review requests must be received within 180 calendar days of the initial remittance advice.

Mass Advantage cannot accept verbal requests to retract claim(s) overpayments. Providers are required to complete and submit a Refund Form or a letter that contains all of the information requested on this form located on the provider section of the massadvantage.com.

The form, together with all supporting materials relevant to the claim(s) reversal request being made including but not limited to EOB from other insurance carriers and your refund check should be mailed to:

Mass Advantage Care, PO Box 830059, Birmingham, AL 35283.

Administrative Claims Review

Claims that need to be reviewed based upon administrative or processing issues are handled by a Provider Services Representative via a phone call to Mass Advantage Plan. Reviews requiring additional documentation are evaluated to determine whether the documentation is sufficient to allow for reconsideration.

Claims that qualify for adjustments will be reprocessed and claim information will appear on subsequent remittance advices. Claims that do not qualify for reconsideration will be forwarded to the Appeals Department for review. All review requests must be received within 180 days of the initial remittance advice.

Please refer to the Appeals and Grievances Section of the manual for information on procedures for Appeals submitted by providers on behalf of a member.

Claims inquiries for administrative reviews should be mailed to:

Mass Advantage, P.O. Box 1285, Maryland Heights, MO 63043.

Coordination of Benefits

Some Mass Advantage members may have other insurance coverage. Mass Advantage follows Medicare coordination of benefits rules. Mass Advantage does not deny or delay approval of otherwise covered treatment or services unless the probable existence of third party liability is identified in Mass Advantage's records for the member at the time the claims are submitted.

To receive payment for services provided to members with other insurance coverage, the provider must first bill the member's primary insurance carrier using the standard procedures required by the carrier. Upon receipt of the primary insurance carrier's Explanation of Benefits, the provider should submit a claim to Mass Advantage. The provider must:

1. Follow all Mass Advantage authorization and billing procedures.
2. File all claims within timely filing limits as required by the primary insurance carrier.
3. Submit a copy of the primary carrier's EOB with the claim to Mass Advantage within 180 days of the date of the primary carrier's EOB.

The amount billed to Mass Advantage must match the amount billed to the primary carrier. Mass Advantage will coordinate benefits; the provider should not attempt to do this prior to submitting claims.

Members seeking care, regardless of primary insurer, are required to contact their primary care provider and use participating providers or obtain appropriate authorization for healthcare professionals outside of the network.

Billing Procedures

A "clean claim" as used in this section means a claim that has no defect, impropriety, lack of any required substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirement for equivalent claims under Medicare.

In addition, a claim shall be considered "clean" if the appropriate authorization has been obtained in compliance with Mass Advantage's Policy and Procedure Manual and the following elements of information are furnished on a standard UB-04 or CMS.

1500 (08-12) Form (or their replacement with CMS designations, as applicable) or an acceptable electronic format through clearinghouse:

1. Patient name;
2. Patient medical plan identifier;
3. Date of service for each covered service;
4. Description of covered services rendered using valid coding and abbreviated description;
5. ICD-10 surgical diagnosis code(s) (as applicable);
6. Name of providers/providers and applicable/required NPI numbers;
7. Provider tax identification number;
8. Valid CMS place of service code(s);
9. Billed charge amount for each covered service;

10. Primary carrier EOB when patient has other insurance;
11. All applicable ICD-10-CM diagnosis codes—inpatient claims include diagnoses at the time of discharge or in the case of emergency room claims, the presenting ICD10-CM diagnosis code;
12. MS-DRG code for inpatient hospital claims.

Mass Advantage processes medical expenses upon receipt of a correctly completed CMS1500 (08-05) Form and hospital expenses upon receipt of a correctly completed UB-04. Sample copies of a UB-04 and a CMS-1500 (08-05) Form can be found in the Forms and Reference Material Section of this manual. A description of each of the required fields for each form is identified later in this section. Paper claim forms must be submitted on original forms printed with red ink.

Mass Advantage requires all providers to submit claims according to the updated National Provider Identification (NPI) submission procedures. These changes went into effect January 1, 2013 as mandated by the Patient Protection and Affordable Care Act (ACA) of 2010. The Final Rule, published in the April 27, 2012 Federal Register, is applicable to all claims submitted to Mass Advantage. Below please find a few highlights of the ACA requirements and Mass Advantage policies and procedures to support these requirements.

- NPIs for billing providers are required to be reported on paper and electronic claims.
- For imaging and clinical laboratory services and items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), as well as home health services, the NPI of the ordering/referring provider is required in addition to the NPI of the billing provider on paper and EDI claims.

Paper and EDI Claims without the required NPI numbers will be rejected and returned to the provider's EDI clearinghouse or returned via US Postal service to the billing address on the claim form and just like rejected EDI claims will not be loaded in Mass Advantage's claims system. Providers will be held to Mass Advantage's timely filing policies regarding submission of the initial and corrected claims.

NOTE: Applicable Paper Claim Fields:

- CMS-1500: The following fields are to be reported as indicated:
  - Field 17b: NPI of Referring Provider (for imaging, clinical laboratory, DMEPOS, and home health)

  - Field 24J (b): NPI of Rendering Provider (if applicable) Field 32a – NPI of Service Facility (if applicable)
  - Field 33a: NPI of Billing Provider (required)
- UB-04: The following fields are to be reported as indicated: Field 56 – NPI of Billing Provider (required)
  - Field 76: NPI of Attending Physician (required)
  - Field 77: NPI of Operating Physician (if applicable)
  - Field 78 & 79: NPI of Other Physician (if applicable)

All claims must have complete and accurate ICD-10-CM diagnosis codes for claims consideration. If the diagnosis code requires but does not include the fourth or fifth digit classification, the claim will be denied.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. By signing a claim for services, the provider certifies that the services shown on the claim were medically indicated and necessary for the health of the patient and were personally furnished by the provider or an employee under the provider's direction. The provider certifies that the information contained in the claim is true, accurate and complete.

Mass Advantage's claim office address is: Mass Advantage, PO Box 830059, Birmingham, AL 35283.

Any questions concerning billing procedures or claim payments can be directed to Mass Advantage's Provider Services Department at:

- HMO: 1-844-918-0114
- PPO: 1-844-915-0234
- TTY: 711