Provider Manual

CLAIMS SECTION

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MBHN is committed to reimbursing Network Providers in a timely manner. To achieve that goal, Network Providers are asked to submit or file claims for services rendered according to specific guidelines. This section delineates the definitions, procedures, and guidelines used for submitting claims.

ELIGIBILITY & REIMBURSEMENT

Whenever referring members to Providers, MBHN makes every effort to verify a member's eligibility. Should a member be determined to be ineligible after clinical services have been rendered, MBHN will notify the Provider. The Provider is then free to bill the member directly. Whenever submitting a claim, clinical Providers should keep in mind that reimbursement is based on two prerequisites:

(1) The **Covered Individual's Eligibility** at the time of service.
(2) The Provider or member has obtained **Pre-authorization** from MBHN for services rendered subject to terms of the member's health plan; exception for psychiatric medical management refer to section 3 c. under Pre-Authorization for Services is Required.

PRE-AUTHORIZATION FOR SERVICES IS REQUIRED

1. *<u>Important Interpretation of Pre-authorization Policy</u>*: If the Provider is presented the insurance card and informed by the member of the member's health benefit plan, and that health benefit plan is included in the Agreement with MBHN, then the Provider has agreed, by contract, to deliver services to that member for covered services and to follow MBHN policies.

   MBHN policy requires pre-certification of treatment in most health benefit plans that it administers, and allows either the member or Provider to obtain pre-certification. It is the Provider's responsibility to insure that pre-authorization has been received. Therefore, the member may not be held financially responsible for any charges beyond the co- payment, co-insurance, and deductible. The Provider is prohibited from billing the member for any covered services due to failure to pre-certify.

   The health plans and MBHN Network consider the date that the insurance information was received by the employer as the date when Provider was informed by the member of the insurance card and coverage, and thus obligation for pre-authorization according to the Plan document. In the event that a member or Provider has significant reasons why they did not have information regarding their insurance, were incapacitated and unable to give information, but did call as soon as information was obtained, this may constitute rationale to reconsider a denial decision.

2. All claims are paid and adjudicated based on the typical requirement that all treatment has been pre-certified by MBHN as handled through the intake and case management processes subject to the terms of the health benefit plans for which MBHN administers benefits or is the “gatekeeper” for benefits.

3. The exceptions to this are: a) if the specific health benefit plan does not require prior authorization for part or all of the health benefit plan covered services; or b) recognition of emergency services that will be retroactively reviewed through the medical management program or c) psychiatric medical management pre-authorization is no longer required for specific mental health plans contracted with MBHN at the time of this printing. Providers have been informed of these specific plans in writing; when in question the Provider should call MBHN to verify if a specific plan requires psychiatric medical management authorization. Any claims for non-emergency treatment services that were provided without a required pre-authorization are subject to denial.

4. New Avenues issues on a regular basis an Insurance Reference Guide to assist Providers with up-to-date information about pre-certification requirements for the health benefit plans that it manages. Referral to this guide assists Providers in placing the call for member eligibility and pre-certification.

CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES

It is in the best interest of Providers to examine the member's insurance card to determine if any co-payments, co-insurance or deductibles exist, and what those amounts are. Providers are responsible for obtaining that portion of the member's charge.

DIRECT BILLING OF MBHN MEMBERS

Providers may bill Members directly for:

1. Co-payments, co-insurance or deductibles;
2. Services rendered if the member has been determined to be ineligible for coverage;
3. Services not covered by the member's health benefit plan in the first place The Provider must demonstrate that the member has been informed about the specific service that is not covered by their health benefit plan and that the Member has given written consent to accept financial responsibility for related charges.

Providers may not bill members for*:*

1. Services delivered which were not properly authorized; (this practice is called balance-billing);
2. Services to be paid for by MBHN;
3. Any amounts that exceed MBHN fee schedule;
4. Any interest on overdue co-payments or deductibles;
5. Any fees for EAP services such as for missed appointments, co-payments, or charges that exceed the EAP rates.

Any Providers who knowingly balance-bills a member will be subject to provider sanctions.

TIMELINESS OF CLAIM SUBMISSION

In order to receive reimbursement payable under the insurance health benefit plan, **all claims must be submitted within 90 days of the date services were rendered**. Claims submitted after the 90 day period may be denied due to late filing. Failure to file claim (proof of loss) within the time frame required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required. Some states have specific timely filing rules that supersede our contracted limits.

CLAIM FORMS:

Claims for professional services must be filed on a CMS-1500 claim form (formerly HFCA-1500). All claims for facility-based services and/or programs should be filed on a UB-92 claim form. Claims received that are not submitted on the standard industry forms shall be returned to the Provider for re-submission. Facility-based services/programs are defined as the following:

- Inpatient hospital care
- Residential treatment
- Partial hospitalization ("Day Treatment")
- Intensive outpatient programs (IOPs)

COMPLETE OR “CLEAN” CLAIMS:

In order to facilitate payment according to contractual expectations and in a timely manner, a “complete” claim, (also referred to as a “clean” claim by many third-party Payors and insurance carriers), must be submitted. A complete claim is defined as a claim which:

a. Has been submitted on either a CMS -1500 or UB92 claim form;
b. Contains all eligibility information available, particularly the patient’s Identification Number, the patient’s Date of Birth and the patient’s Group Number;

c. Has been filled out accurately and completely;
d. Has the insurance carrier correctly identified;
e. Has all required clinical pre-authorizations for services related to the claim in place; and
f. If subject to Coordination of Benefits, MBHN is the primary Payor.

If all required information is not included, the claim form will be returned to the Provider. Subsequently, a delay in reimbursement will occur.

CODING OF CLAIMS

Claims will be paid based on appropriate inclusion of the diagnosis and procedure. Providers in submission of claims using a CMS 1500 or UB 92 form must include diagnosis and procedure codes according to the following references. Diagnostic codes must be from the current International Classification of Diseases (ICD-9) or the Diagnostic Statistical Classification Manual (DSM-IV-TR), AMA Current Procedural Terminology (CPT), Health Care Financing Administrations Common Procedure Coding System (HCPCS) or Revenue Codes.

DENIALS

Situations that may result in a claim denial or reduction in benefit coverage:

1. Claim form is not completed;
2. Claim is not a clean claim;
3. Claim indicates services were delivered outside of the period of authorization;
4. Claims submitted after the 90 day filing period from date of delivery of service.
5. Claims for failed appointments: Failed or missed appointments are non-covered services, and as such, will not be paid for under either MBHN or EAP.
6. Procedures for which claims were filed were not pre-authorized;
7. Services delivered were not a covered benefit or did not meet terms of health plan coverage;
8. Services were delivered by an Out-of-Network Provider;
9. Claims for services with procedural codes or diagnostic codes not covered under behavioral health benefits;
10. Claims for services that are not pre-authorized did not show documentation of life-threatening emergency situations.
11. Other situations that are not compliant with terms of the Payor's Schedule of Benefits or Medical Management Program of MBHN.

In the event the claim does not meet criteria for payment, then the Claims Department shall issue a denial. Claim denials are accompanied by the Explanation of Benefits sheet (EOB) and information giving the member and Provider information about the:

- Reason for denial,
- Information to re-file claim with clarified, complete information;
- Procedures for appealing the decision to include name, address, and toll free number of MBHN and the Payor.

MBHN reserves the right to request the medical record prior to payment or during an appeal to determine if the service met criteria for coverage. A sample of the EOB is available; denial logs and template claim denial letters are maintained in each Payor or Insurer's file.

All denials of claim payment shall be issued to the Provider and member giving reasons for the denial, opportunity and procedures to re-submit additional information or appeal of the decision. The denial letter shall contain the name, address, and toll free number of MBHN or the Payor health benefit plan according and in compliance with each Payor's appeal and grievance processes.

Note: Health benefit plans handle appeals for claim denials in different ways.

- The HMO health benefit plans that handle appeals will defer appeals for claim denials based on contractual issues back to the Network.
- The HMO retains authority over handling all appeal and grievances. A member or person acting on behalf of a member may appeal a decision. However, the HMO health benefit plans that handle appeals will defer appeals for claim denials based on contractual issues back to the Network.
- Carve-out health benefit plans that require pre-certification usually uphold the denial.
- Non-HMO health benefit plans with out-of-Network benefit may allow payment of the claim (without pre-cert) at the lower level of benefit.

In all cases, it is very important for the Provider to refer to the New Avenues Insurance Health benefit plan Reference Guide to follow pre-certification Requirements.

COORDINATION OF BENEFITS

Network Providers are asked to cooperate with MBHN in providing any information reasonably requested in connection with claims and in obtaining necessary information relating to coordination of benefits, subrogation, verification of coverage, and health status. Such cooperation would also include the Provider:

1. Making its best efforts to determine if members have insurance or other health care coverage other than through a particular Payor and informing MBHN if any duplicate coverage may exist;

2. Notifying the member's Payor promptly in the event any services are provided which relate to work-related injuries, motor vehicle accidents, or other occurrences that may involve third-party liability.
3. Notify New Avenues/MBHN for preauthorization even if New Avenues/MBHN is secondary.

MBHN will coordinate benefits with a member's primary health insurance carrier. In order to facilitate the reimbursement process, the service Provider must include a copy of the primary carrier's EOB when submitting a claim. If such information does not accompany the claim, the claim will be pended until the information is received.

When coordinating benefits, the assessment and referral procedures of MBHN must be followed in order to obtain the maximum reimbursement possible. The Network Provider has 60 days from the time the primary carrier's EOB is received to submit a claim to MBHN.

ASSIGNMENT OF BENEFITS:

MBHN will pay service Providers directly if the following conditions have been fulfilled:

1. The patient is an MBHN Member;
2. All services were properly authorized and covered under the health benefit plan benefits; and
3. After the claim form (CMS-1500) has been completed, it is important that line 13 (appropriate signature) be signed and line 27 (accept assignment) is marked “Yes”.

EAP AND MBHN RATES:

The EAP and MBHN rate structure for MBHN facility and professional fees shall be reviewed each year, and shall be considered the allowable amount for the reimbursement of Provider claims, unless an exception is documented by a letter of agreement with the Provider. The Professional and Facility rate structure is given to Providers for their specialty or facility at the time of credentialing and contract execution. The Master Fee Schedule is considered proprietary information and shall only be given out by permission of the Executive Director.

PROVIDER FEEDBACK

Periodically, MBHN will solicit feedback regarding its claims payment guidelines. This solicitation will occur formally via its Provider Satisfaction Survey. It also will occur informally through contacts with clinical Providers by MBHN Care Managers and Administrative staff.

Changes in MBHN guidelines will occur as part of the annual policy and procedure review.

PROVIDER DISPUTE RESOLUTION PROCESS:

In the event a provider is dissatisfied with a claim payment reimbursement, NEW AVENUES/MBHN has an established claim dispute process. This process allows providers the opportunity to express their disagreement regarding medical, or administrative complaints against NEW AVENUES/MBHN. Every effort will be made to resolve problems and disputes in a rapid and equitable manner.

If NEW AVENUES/MBHN is unable to resolve the payment dispute, the provider should follow the appeals process for specific coverage.

EAP CLAIMS: Appeals should be made to New Avenues within 180 days from the date of the initial adverse decision.

GATEKEEPING CLAIMS: Issues not resolved with MBHN should be directed to the appropriate TPA, making the payment.

ALL OTHERS: Contact MBHN for information on particular contracts.

INSTRUCTIONS FOR COMPLETING FORM CMS-1500 FOR CLAIMS SUBMISSION

New Avenues uses the industry standard Form CMS-1500 (formerly CMS 1500) for claims submission. This is the claim form used by the Centers for Medicare and Medicaid Services (CMS) formerly know as the Health Care Finance Administration (CMS). To obtain a blank copy of Form CMS-1500 (pdf format) go to our website at www.NewAvenuesOnline.com click on Provider's Desk, Provider Forms or to www.cms.gov complete a search under Form CMS-1500.

In the table below are general instructions for completing Form CMS-1500. You may find more detailed instructions at www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf

Item Number	Item Description	Data Type	Instructions
Items 1 – 11 – Patient and Insured Information			
1	Type of health insurance	Required	Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
1A	Insured's ID number	Required	Enter the insured's ID number that appears on the insurance ID card.
2	Patient's name	Required	Enter the patient's last name, first name, and middle initial, if any.
3	Patients date-of-birth	Required	Enter the patient's 8 digit birth date (MM/DD/CCYY) and patient's gender.
4	Insured's name	Required	Enter insured's name.
5	Patient's mailing address, telephone	Required	Enter the patient's mailing address (street address, city, state, ZIP code) and telephone number.
6	Patient's relationship to the insured	Required	Check the appropriate box for patient's relationship to the insured when item 4 is completed.
7	Insured's mailing address, telephone	Required	Enter the insured's mailing address (street address, city state, ZIP code) and telephone number.
8	Patient status	Required	Enter the patient's marital status and whether employed or a student.
9	Other insured's name (other health insurance coverage)	Conditional	Required if Item 11d is marked "yes" or if the patient is covered by other insurance involved in the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.
9a	Other insured's policy or group number	Conditional	Required if Item 11d is marked "yes" or if the patient is covered by other insurance involved in the reimbursement of this claim. Enter the policy or group number for the other insurance.
9b	Other insured's date-of-birth	Conditional	Required if Item 11d is marked "yes" or if the patient is covered by other insurance involved in the reimbursement of this claim. Enter the other insured's date-of-birth (MM/DD/CCYY) and gender.
9c	Other insured's employer's name or school name	Conditional	Required if Item 11d is marked "yes" or if the patient is covered by other insurance involved in the reimbursement of this claim. Enter the other insured's employer's name or

			school name.
Item Number	**Item Description**	**Data Type**	**Instructions**
9d	Other insured's insurance health benefit plan name or program name	Conditional	Required if Item 11d is marked "yes" or if the patient is covered by other insurance involved in the reimbursement of this claim. Enter the name of the other insurance health benefit plan or program.
10	Is the patient's condition related to:	Required	Check "yes" or "no" if condition is related to: 10a employment, 10b auto accident, 10c other accident.
10d	Reserved for local use	Not required	Not required.
11	Insured's policy or FECA number	Required	Enter the insured's insurance policy or group number.
11a	Insured's date-of-birth	Required	Enter the insured's date-of-birth (MM/DD/CCYY) and gender.
11b	Insured's employer name or school name	Required	Enter the insured's employer's name or school name.
11c	Insurance health benefit plan name or program name	Required	Enter the insured's insurance health benefit plan name or program name.
11d	Is there another health benefit health benefit plan?	Required	Check the appropriate box if the patient is covered by other insurance involved in the reimbursement of this claim. If yes, complete Items 9 a-d.
12	Patient's or authorized person's signature	Required	The patient or authorized person must sign and date the claim if authorizing the release of medical information. Or if "signature on file" is indicated, the Provider must maintain a signed release form or signed Form CMS-1500 on file, or computer generated signature. Enter date signed (MM/DD/CCYY).
13	Patient's or authorized person's signature.	Conditional	The patient or authorized person may sign authorizing payment of medical benefits to the undersigned physician or supplier for services described below. "Signature on file" or computer generated signature may be used.
Items 14 – 33 - Provider of Service or Supplier Information			
14	Date of current illness, injury or pregnancy	Not required	Enter the date (MM/DD/CCYY) of onset of illness or symptoms for the condition you are treating.
15	If patient has had same or similar illness, give first date	Not required	Not required
16	Dates patient unable to work in current occupation	Conditional	Enter the dates (MM/DD/CCYY).
17	Name of referring physician or other source	Conditional	Enter the name of the referring physician or other source, if applicable.
17a	Enter the ID number of referring physician	Conditional	Enter the employee identification number of the referring physician indicated in item 17.
18	Hospitalization dates related to current services	Conditional	If patient is hospitalized, enter the admission and discharged dates (MM/DD/CCYY).
19	Reserved for local use	Not	Please leave blank.

		required	
20	Outside lab	Conditional	Complete if billing for lab services.
21	Diagnosis or nature of illness or injury	Required	Enter the patient's diagnosis or condition using an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). Relate items 1, 2, 3, or 4 to item 24e by line.
Item Number	**Item Description**	**Data Type**	**Instructions**
22	Medicaid resubmission code	Not required	Not required.
23	Prior authorization number	Conditional	Enter the Preauthorization or Care Authorization number assigned – if applicable.
24a	Date(s) of service	Required	Enter the "from" and "to" date(s) (MM/DD/CCYY) for each procedure, service, or supply.
24b	Place of service	Required	Enter the appropriate place of service code(s) from the list provided following this table.
24c	Type of service	Not required	Not required.
24d	Procedures, services or supplies code (CPT/HCPCS)	Required	Enter the procedures, services, or supplies using the CPT (Current Procedural Terminology) or CMS Healthcare Common Procedure Coding System (HCPCS) code.
24e	Diagnosis code	Required	Enter the diagnosis code reference number (1, 2 ,3 ,4)as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. *Do not enter the ICD-9-CM code here.*
24f	Charge for each listed service	Required	Enter the Provider's billed charge for each listed service.
24g	Number of days or units	Required	Enter the number of days or units corresponding to the date entered in item 24a.
24h	EPSDT family health benefit plan	Not required	Not required.
24i	EMG	Not required	Not required.
24J	COB	Conditional	Enter a "Y" if another payer has already paid on this service; otherwise, leave blank .
24k	Reserved for local use	Not required	Not required.
25	Federal Tax ID Number	Required	Enter the Provider of service or supplied Federal Tax ID [Employer Identification Number (EIN)] or Social Security Number (SSN). A 9 digit number. Check the "SSN" or "EIN" box.
26	Patient's account number	Optional	Enter the patient's account number assigned by the Provider's of service or supplier's accounting system.
27	Accept assignment?	Required	Check the appropriate box, "yes" or "no".
28	Total charge	Required	Enter the total charges for this claim for the services listed [total of item(s) lines 1 – 6] in Item 24f.
29	Amount paid	Conditional	Enter the total amount the patient or other service paid on the covered services only.
30	Balance due	Conditional	Enter the total balance due for the services less any amount entered in item 29.
31	Signature of physician or supplier including	Required	Enter the signature of Provider of service or supplier including degree(s) or credentials and the signature date

	degree(s) or credentials		(MM/DD/CCYY).
32	Name and address of facility where services were rendered	Required	Enter the name, address and ZIP code of the facility if the services were furnished in a hospital, physician's office, clinic, laboratory, or facility other than the patient's home.
33	Physician's, supplier's name and billing address	Required	Enter the Provider of service or supplier's billing name, address, ZIP code and telephone number. Enter the Provider's PIN number and Group number (MBHN does not supply a Provider PIN or Group number).

Place of Service Codes used by New Avenues, Inc. for Item 24b

Code	Description
10	New Avenues EAP sessions
11	MBHN outpatient sessions
13	New Avenues EAP Gatekeeping sessions
50	Inpatient psychiatric facility – sub acute
51	Inpatient psychiatric facility – acute care
52	Psychiatric facility – partial hospitalization
57	23 hour hold
58	Partial psychiatric physician visit
59	Inpatient psychiatric physician visit
62	Intensive outpatient session

Form UB-92

The Form UB-92 (Universal Billing Form, or UB92 - formerly HCFA-1450) claim forms are used by institutional Providers (hospitals, skilled nursing facilities, home health, hospital-based clinics, etc.) to bill third-party insurers as well as government programs such as Medicare and Medicaid. The design of the UB-92 form is approved by the National Uniform Billing Committee (NUBC). The UB-92 is neither a government printed form nor distributed by the Centers for Medicare and Medicaid Services (CMS). To obtain a blank copy of the UB-92 (pdf format) go to our website at www.NewAvenuesOnline.com click on Provider's Desk, Provider Forms.