Policy Information			
Policy Title	Billing and Claims Administration	**Current Version Publish Date**	10/2025
Policy Manual	Reimbursement Manual	**Original Effective Date**	10/2025
Policy Number	1	**Next Review Date**	Annual

Policy Applicability (LOB)			
☒Medicare Inc	☒Commercial IA	☒Commercial IL	☒Health Choices
☒Medicare WI	☒Commercial WI	☒CPPHP (Kansas)	

Policy Statement and Purpose

This policy applies to all healthcare professionals and institutional providers and sets forth the procedures that **Medical Associates Health Plans** (MAHP) utilizes to process reimbursement requests for services rendered to our members. The policy also offers information to providers on the billing procedures that would provide for accurate reimbursements in a timely manner. If the processes outlined in this policy are not followed, payments may be delayed, denied or only partially paid.

All requests for reimbursement and payment are subject to the benefit plan that the member was enrolled in at the date the services were rendered. We recommend that the you verify a member's eligibility for services you wish to perform or the supplies and drugs you wish to administer. Verifying eligibility, however, does not guarantee payment. The actual reimbursement received is dependent a number of factors including compliance with our reimbursement policies, adherence to our billing protocols, whether the medical records that we request are provided to us and if those records support the billed charges.

This policy is expressly incorporated into and made a part of all reimbursement agreements and will provide context and clarity to the extent there is ambiguity in payment terms and notwithstanding contrary claims with regard to industry standards or practices.

Policy Definitions

Clean Claim: A claim for Covered Services that is filed on the appropriate industry standard form, that includes all relevant member and provider information, that applies industry standard code sets including but not limited to applicable CPT, HCPCS, NDC, where all charges on the claim reconcile with the itemized bill and all requested documentation that would allow for a determination of the accuracy and propriety of a charge. MAHP's written request to the provider will be deemed the determinant for the records that are necessary to determine the accuracy and propriety of a charge.

Corrected claim: A claim submitted by a provider to amend a claim that was already processed but contains errors or inaccuracies that prevented payment for some charges.

Covered Services: Those health care services and supplies that qualify for payment according to the applicable Health Plan and Subscriber Agreement.

Current Procedural Terminology (CPT) Codes: A set of standardized medical codes used by healthcare providers, including physicians, hospitals, and laboratories, to describe medical, surgical, and diagnostic services and procedures.

CMS: Centers for Medicare and Medicaid Services

CPT: Current Procedural Terminology. A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

ICD-10-CM (the International Classification of Diseases, Tenth Revision, Clinical Modification): A standardized system used to code diseases and medical conditions (morbidity) data.

HCPCS: Healthcare Common Procedure Coding System.

Healthcare Common Procedure Coding System (HCPCS): A standardized coding system used in the United States to report medical procedures, services, supplies, and products for billing and insurance claim processing.

Health Plan: The group or individual contract, employee benefit plan or government program offered by Medical Associates Health Plan, Inc., or The Medical Associates Clinic Health Plan of Wisconsin, identified as the MAHP Products in Exhibit A to this Agreement.

HIPAA: Health Insurance Portability and Accountability Act.

Interim Billing: Claims where services and/or supplies are billed before the member has been discharged and are an extension of the dates of services on a previously billed or paid claim.

Itemized Bill (IB): A statement of all charges billed by a provider for the services rendered for a specific episode of care.

National Correct Coding Initiative (NCCI): The Centers for Medicare & Medicaid Services (CMS) developed these edits to promote consistent, correct coding and appropriate payment. These coding edits are developed based on the AMA CPT code set and the HCPCS code set, as well as analysis of standard medical and surgical practice and input from various groups, including specialty societies, other national health care organizations, Medicare contractors, providers, and consultants.

National Uniform Billing Committee (NUBC): Committee responsible for revenue code definitions and requirements.

National Drug Code (NDC): A unique 10-digit or 11-digit, 3-segment number, and a universal product identifier for human drugs in the United States. Each medication is assigned a number under Section 510 of the U.S. Federal Food, Drug and Cosmetic Act. It identifies the manufacturer, product and package size.

Overcharge: Occurs when a healthcare provider charges more than is supported in the medical records or in excess of the contractual rate.

Overpayment: Occurs when a healthcare provider receives more money than the amount due for a service rendered or the supply/medication administered.

PPHAC: Provider Preventable Healthcare Acquired Conditions

Pre-authorization: A process where a healthcare provider must obtain approval from a member's insurance plan before delivering a specific medical service, procedure, or prescribing a medication. This is also known as prior authorization, prior approval, or precertification.

Provider: Physicians and health care practitioners, corporation, LLC. Partnership or other legal entity duly licensed or authorized to practice in the state, that are employed by, affiliated with or contracted with the legal entity.

Rebilled claim: A claim that is submitted by a provider when we have denied the claim prior to processing due to incorrect or missing information rendering the claim unclean.

Recoupment: The recovery of funds by a payor that were overpaid to a provider due to errors in billing or incorrect coverage information.

Refunds: The return of money initiated by a provider to a payor due to billing errors.

Resubmitted claim: A claim that was submitted for payment but was rejected due to errors or missing information but before it was formally denied. These are usually caused by data entry errors, invalid codes on the claim form or formatting issues that prevent the claim from processing. These claims are automatically rejected by the claims system.

Split Billing: Claims where services and/or supplies are billed after the member has discharged and are an extension of the dates of services on a previously paid claim.

Revenue Code: A three or four digit numeric code used to categorize the location or department for a type of service, procedure, or item provided to a patient within a healthcare facility.

Undercharge: Occurs when a healthcare provider charges less than is supported in the medical records or less than the contractual rate.

Underpayments: Partial payments made by a payor on a claim reimbursement request by a provider.

Unlisted codes: Codes used to identify services or procedures not described by other HCPCS/CPT codes.

Policy Provisions and Required Procedures

The Centers for Medicare and Medicaid Services (CMS) has announced, *"Each year in the U.S. health care insurers process over 5 billion claims for payment. Standardized coding systems are essential so Medicare and other health insurance programs can process claims in an orderly and consistent manner"*[1]. CMS imposes strict regulations in response to *"the high volume of improper payments identified through CMS audits, which include overpayments, underpayments, or payments made without sufficient documentation. Common causes of these improper payments include insufficient documentation, errors in establishing medical necessity, and incorrect coding, all of which can result in substantial financial losses … . To combat these issues, CMS emphasizes the importance of thorough documentation, accurate coding practices, and adherence to medical necessity criteria…*[2]

Medical Associates Health Plans conforms to CMS coding and billing guidelines. Our payment protocols explained herein, describe how we implement CMS billing guidelines.

Claims Submission Requirements

Who can submit a claim?

Only providers licensed in the state where the services were rendered may submit a claim. You must bill in compliance with our agreement with you and under the person/entity/institution so named.

Who is not permitted to submit a claim?

Licensees who are not licensed in the state where the services were rendered, or who did not perform the service, or who performed services on behalf of another licensed provider may not submit a claim.

When must claims be submitted?
In order to receive payment for your services, a claim must be submitted within the timeframe defined in your agreement with us. If a timeline is not specifically identified in our agreement or unless otherwise stipulated by federal or state requirements, claims must be submitted within the timely filing limitation in your provider contract.

What happens if the claim is not timely filed?
Claims that are not timely filed will be denied. There are no exceptions. Denied claims cannot be billed to or collected from our member.

What happens if a claim was filed but MAHP has no record of it in their claims system?
If you filed a claim but our claims system does not show a filing, you must provide evidence of timely filing.

How should claims be submitted?
Claims may be submitted either electronically or via paper claim forms. We require that CMS guidelines for claim submission be followed regardless of the mode of submission. For details of those requirements, please refer to the links below.

- **Electronic claims**
  - Electronic Billing for Facility Claims
  - Electronic Billing for Professional Claims

  Exchange healthcare information using 837 standard format. MAHP's Payor ID is MAHC1

- **Paper claims**
  - Facility Billing with a Paper Claim
  - Professional Billing with a Paper Claim

Send completed paper claims to: Medical Associates Health Plan
PO Box 211094
Eagan, MN 55121

What documentation must be sent with the claim?
Medical records should not be sent at the time you submit your claim. Any support that we require to process your claim will be requested at that time. If we do require records, we will send you a letter detailing the records we require you to send and the timeframe for submission.

Claim Coding Requirements
Medical Associates Health Plans conforms to CMS coding guidelines. These include the following industry standard codes and code sets: NUBC Revenue Codes, Internal Classification of Disease 10th revision, Clinical Modification (ICD-10-CM) diagnosis code, active Current Procedural Terminology (CPT), Healthcare Common Procedure Coding Systems (HCPCS), and National Drug Codes (NDC).

Are all claims required to include coding?
Reimbursement requests are not eligible for processing if such requests lack coding. This applies to all services and supplies including medications for all healthcare professionals and institutional providers.

If a provider's system is unable to generate the correct billing codes, can reimbursement be allowed?
The coding billed must be valid for the date the services were rendered or the supplies/drugs were administered. Services/ supplies including drugs will not be reimbursed if such services/supplies are incorrectly coded. Incorrect

coding includes invalid codes, inactive codes, deleted codes, deprecated codes or provider proprietary codes. This applies to all healthcare professionals and institutional providers.

Unlisted Codes

What are unlisted codes?

CMS defines unlisted codes as those codes used to identify services or procedures not described by other HCPCS/CPT codes. These codes are generally identified as XXX99 or XXXX9 and are located at the end of each section or subsection for a code classification.[3]

Unlisted codes can be termed as follows:

- Not Otherwise Specified (NOS)
- Not Elsewhere Classified (NEC)
- Not Otherwise Classified
- Not Listed
- Not Elsewhere Specified
- Unlisted
- Unclassified
- Unspecified

Are unlisted codes eligible for reimbursement?

Unlisted codes are eligible for reimbursement only when no other code is available that describes the service rendered or supply/drug administered. The medical record must identify with specificity the service rendered and the medical necessity. This is also required for supplies and pharmaceutical products for which no code is available at the time of administration and an unlisted code is used to bill the charge.

Is prior authorization required for services/supplies/drugs billed with unlisted codes?

Pre-authorization is not required but it is advisable to obtain prior authorization for any charge related to an unlisted code. Claims for unlisted codes must be accompanied with an itemization of the description of the service such as operative report or invoice.

Will appending a modifier to a charge billed with an unlisted code process the charge more efficiently?

Do not append a modifier to an unlisted code. This will not expedite processing or bypass claim system edits. In fact, payment may be delayed or denied if a modifier is appended to an unlisted code.

Why are the requirements for unlisted codes so strict?

Our claims' processing system does not designate fee allowances or relative value units (RVU) for services/supplies that are billed with unlisted codes. These codes must be reviewed manually by our staff prior to payment.

Processing the Claim

When can payment for a claim be expected?

Compliance with our billing guidelines is crucial to obtaining timely payment for your services. You can expect payment of a **clean** claim within thirty (30) days from the date a CLEAN claim is accepted in our claims system unless otherwise stipulated in our agreement with you.

My claim was not paid for one or more issues found during processing. How can I obtain payment?

Obtaining payment for claims that were not reimbursed according to your expectations would depend on the defect that caused the claim to be initially rejected, denied, or only partially paid. This would have been explained

in the letter we sent you notifying you why the claim wasn't paid or only partially paid. The letter would also inform how to address the defect we found in the claim.

In general, there are three ways that a rejected claim, denied claim, or partially paid claim can become eligible for reimbursement.

1. **Resubmitting a claim**

   A resubmitted claim is one that was submitted for payment but was rejected due to errors or missing information but before it was formally denied. These are usually caused by data entry errors, invalid codes on the claim form or formatting **issues that prevent the claim from processing**. These claims are automatically rejected by the claims system.

   > **Example:** An inpatient claim was submitted with an incorrect EDI format. The claims system cannot read the claim and it is rejected. The provider would resubmit the claim using the correct EDI format.

   You may resubmit a claim once the defect that initially rejected the claim has been corrected. Resubmitted claims must be filed within in the timely filing limitation defined in your provider contract.

2. **Rebilling a claim**

   A rebilled claim is submitted by a provider when we have **denied the claim prior to processing** due to incorrect or missing information rendering the claim unclean. Only CLEAN CLAIMS can be processed.

   > **Example:** An inpatient claim was submitted with no revenue codes listed on the UB-04 and/or the itemized bill. This claim does not have all the necessary information for our system and reviewers to process it. This claim will be denied as unclean. The provider would submit a rebilled claim listing the appropriate revenue codes on the UB-04 and itemized bill for the services rendered.

   You many submit a rebilled claim with all the necessary information to correct the defects/issues that caused the denial of the unclean claim. Rebilled claims must be submitted within the timely filing limitation defined in your provider contract.

3. **Correcting a claim**

   A corrected claim is submitted by a provider to **amend a claim that was already processed** but contains errors or inaccuracies that prevented payment for some charges. These claims are often only partially paid.

   > **Example:** The NDC codes for some drug charges were omitted on the itemized bill for the billed claim. The claim would be paid less those charges where an NDC was not provided. The provider would submit a corrected claim with the appropriate NDC codes to obtain payment for the denied charges.

   You may submit a corrected claim to correct errors for charges we denied due to incomplete information or an error we found on the claim during processing. **The appropriate frequency code must be used on the corrected claim**. Claims without the appropriate frequency code will be denied as a duplicate claim. Corrected claims must be submitted within the timely filing limitation as defined in your provider contract.

Are accident/injury claims processed differently?

MAHP processes the claim and pursue subrogation post payment. MAHP utilizes PHIA Group to process subrogation. If a claims is flagged to be a possibly the responsibility of a third party – PHIA may contact you for a refund. Once we become aware that a claim is related to an accident or injury, the processing is suspended. Our member is sent a letter requesting additional information. If the member has not responded within thirty (30)

days from the date of the letter or if the member does not submit requested documentation, the claim is closed and charges for services are deemed member responsibility.

How are Interim Bills processed?

Interim bills are claims where services and/or supplies are billed **before the member has been discharged** and are an extension of the dates of services on a previously billed or paid claim. The initial claims is processed according to the contract, when subsequent billings are received claims are reviewed together and additional payment is made on the current claim according to the contract payment limitations.

How are Split Bills processed?

Split bills are claims where services and/or supplies are billed after the member has discharged and are an extension of the dates of services on a **previously paid claim**. MAHP does not accept split billings. Submission of split bills will result in a denial of the claim and recoupment of the paid portion of the claim. Denied claims cannot be billed to or collected from our members.

Claim Reviews

In an effort to ensure our members' care is consistent with their benefit plans and MAHP's quality requirements, and claim payments are compliant with MAHP's reimbursement policies, we reserve the right to review a claim prior to payment or after payment if a claim was not reviewed prior to reimbursement. Once a reviewed claim has been deemed eligible for payment, MAHP will pay according to the PAYMENT PROCEDURES stipulated in our agreement with you.

What type of claim reviews can be expected?

Our reviews may include medical necessity evaluations when a prior authorization was not obtained, line by line reviews to ensure compliance with MAHP reimbursement policies or CMS guidelines, assessments related to correct coding, place of service, and DRG assignment.

If we become aware of quality concerns brought to us by our members or their families or caregivers or we become aware of provider preventable healthcare acquired conditions, MAHP reserves the right to conduct reviews sufficient to satisfy any concerns we may have regarding the care our members are receiving.

Please cooperate with our reviews. They are in the best interest of our members, and the best interest of our members is of utmost importance to all
our providers also.

Do all claims undergo review?

All claims will be screened using industry standard CMS National Correct Coding Initiative (NCCI) edits. If a charge on a claim triggers an edit, that charge will automatically be denied by our claims processing system.(For more information on NCCI edits, please refer to CMS' Website.) Edits can be applied to any claim type including institutional, physician and non-physician billings.

In addition to NCCI edits and depending on the claim, other reviews may be applied to a claim prior to payment as indicated in the section above. These reviews can be performed via our automated review systems or manually by our RNs, Certified Coders, Pharmacy Technicians or Claim Analysts.

How are OVERCHARGES found on a PRE-PAYMENT CLAIM REVIEW handled?

Any charge that is more than allowed either by our agreement, or by duplication, or by unbundling we will deny the charge. Any overcharges we find during the claim adjudication or review process that result in a denial will be identified in a letter to you. Any denials related to overcharges are eligible for appeal or reconsideration. You may also submit a Corrected Claim, if applicable.

How are UNDERCHARGES found on a PRE-PAYMENT CLAIM REVIEW handled?

Unless stipulated on our agreement, we will pay the lessor of the billed charges or the negotiated rate.

If our review of the claim finds that an item was not charged at all or charged less than the units administered, we will identify this in a letter to you and provide an opportunity to bill a Corrected Claim. As with overcharges, our reviews do not guarantee that undercharges will always be identified.

How are OVERPAYMENTS found on a POST-PAYMENT CLAIM REVIEW handled?

If we perform a post-payment review and find that we overpaid the claim and if the overpayment isn't returned to us within thirty (30) days of our letter to you informing of the overpayment, we will either recoup the funds or on subsequent claim payments depending on our agreement and any applicable state laws. Any recoupments related to overpayments are eligible for appeal or reconsideration.

How are UNDERPAYMENTS found on a POST-PAYMENT CLAIM REVIEW handled?

Unless stipulated on our agreement, we will pay the lessor of the billed charges or the negotiated rate.

If our review of the claim finds that an item was not charged at all or charged less than the units administered, we will identify this in a letter to you and provide an opportunity to bill a Corrected Claim. As with overpayments, our reviews do not guarantee that underpayments will always be identified.

Medical Records

Our claim reviews may require us to request records from you. Please cooperate with these requests. The information below will assist you in understanding the need for records and how to submit your records in a timely manner.

Why are records required to pay my claim?

MAHP requests records that we deem necessary to ensure a complete and accurate review of a reimbursement request for services/supplies rendered during an episode of care so we can pay the claim correctly.

What type of records will be requested?

The type of records that we may request will be determined by the charges on the claim. This may include medical records and/or administrative/financial records such as an itemized bill or implant invoices.

Does HIPAA allow MAHP access to patient records?

Our request for records is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR § 164.506) which authorizes the submission of medical records and other information related to patient care, to a member's health plan without the express written consent of the member.

Requirements for Records Submission

When should records be submitted to MAHP?

Our written request for specific records is deemed the determinant that records are necessary to determine the accuracy and propriety of a charge and/or claim.

How much time does a provider have to submit records?

Our letter to you requesting records will identify the timeline to send records. The timeline for an initial request is thirty (30) days from the date of the letter. If we are required to send a follow up letter, the timeline is fifteen (15) days from the date of the notice we send to you.

How should records be submitted?

Records can be transmitted in any of the following modes.

MAILING ADDRESS: Medical Associates Health Plan
Attn: Payment Integrity
1605 Associates Drive Ste 101
Dubuque, IA 52002

SECURE FAX: 563-556-5134

PROVIDER PORTAL: The link to access the provider portal can be found on this page https://www.mahealthplans.com/hp/for-businesses/providers/

FileCloud can be utilized for secure electronic submission upon request. Please email for details.

Please do not submit records via DVD or CD.

Requirements for Requested Documentation

The documentation that that we request that you provide to us may be handwritten or electronic. Regardless of the format you provide the documentation, the submission must be complete, legible, and consistently organized.

Below are the guidelines that will help you ensure that the documentation is acceptable for review.

- Each page must contain the member's name and/or member's ID.
- The documentation was created by the person who rendered the service or administered the supply/medication for the member identified in the record.
- The record provided is the original record without unauthorized alterations. Correcting a medical record should be done with a strike through of the original content with a signature appended to the amended content.
- The itemized bill must be consistent with the claim in both number of units and amounts charged.

Disregarding a Record Request

Our claim was denied for REQUESTED RECORDS NOT RECEIVED. How can we obtain payment?

Once all of the requested records are received, MAHP will begin the claim review and adjudication process. Claims denied for a provider's failure to heed an MAHP's records' request are not eligible for reconsideration or appeal.

All the records we have for the member was sent to MAHP but our claim was denied for INCOMPLETE MEDICAL RECORDS. How can we obtain payment?

MAHP's request for documentation is predicated on the coding that you submitted on the claim for the services rendered. If a code was billed, the expectation is that the records exist to support the charge.

A claim with **insufficient documentation is not a CLEAN claim**. The manner in which such a claim is handled would depend on the records that were omitted in your original transmittal to us. At the very least the claim may experience a delay in payment and then only be partially paid; but the claim may be denied altogether until the requested records are sent.

Claims denied for lack of records or insufficient documentation are not eligible for appeal or reconsideration.

Record Fees

Unless otherwise stipulated in our agreement with you, MAHP will not pay a provider or third-party vendor to assist with the acquisition or transmission of records to us. There are no exceptions.

Preservation of Records

Unless otherwise stipulated in our agreement or mandated by federal and/or state law, records of any type that would support the medical necessity of a claim and/or verify compliance with CMS guidelines and/or our reimbursement policies should be maintained for ten (10) years

Related Policies	
Related Training/ Job Aids	
NCQA Standard	
References	[1] Healthcare Common Procedure System [2] NIH National Library of Medicine [3] CMS General Correct Coding Policies
Exhibits	

Policy Owners / Reviewers			
Department Owner	Lisa Kuhls, Provider Relations Manager	**Date Reviewed**	10/1/2025
Department Reviewer	Network Strategy Committee	**Date Reviewed**	
Approving Committee if applicable	☐Compliance ☒UMC ☐QIC ☐Board of Directors ☐Other: _____	**Date Approved**	

History	
Date of revision	*Summary of changes* Prior Reviews: