Provider Notice

From: Magellan Healthcare
Subject: Prepayment review process and medical record submission requirements

Overview

Magellan Healthcare, as the administrator of the Idaho Behavioral Health Plan (IBHP), conducts systemic prepayment reviews for "unclean claims" as part of quality assurance efforts. These reviews help ensure that services billed are supported by documentation and meet applicable Medicaid, Centers for Medicare & Medicaid Services, and industry standards.

"Unclean Claim" means a claim submission that is incomplete, inaccurate, inconsistent, or otherwise deficient such that the claim cannot be properly evaluated, adjudicated, validated, or processed for payment. Examples of unclean claims include, but are not limited to, claims that contain missing required information, conflicting data, insufficient supporting documentation, billing or coding discrepancies, eligibility issues, or any other defect that prevents a determination of coverage, liability, medical necessity, or payment.

When a claim is determined to be unclean, Magellan reserves the right to suspend review and deny or pend the claim pending receipt of additional information, documentation, or clarification necessary to complete its evaluation. Such a denial or pend status shall not constitute a final determination on the merits of the claim or entitlement to payment. The claim will not be considered for payment until all requested information has been received and the claim has been determined to be clean and otherwise payable under applicable policy provisions, contractual requirements, and governing laws and regulations.

Provider action required

Providers should regularly review their Electronic Remittance Advice (ERA) or Explanation of Payment (EOP) for denials related to prepayment review activities.

Medical record submission requirements

If a claim is denied with a request for medical records:

- Submit the requested documentation via email to PIURecordsReview@magellanhealth.com
- Records must be submitted within 30 days from the date of denial

Review process

- Upon receipt of medical records, Magellan's certified professional coders will review the documentation to determine if:
    - The services billed are supported by the documentation in the clinical record
    - The documentation meets applicable regulatory and industry standards
- This review does not assess the medical necessity or quality of care provided
- A determination is typically issued within 30 days of receipt of the requested records

Review outcomes

- Claims will be approved if documentation supports the billed service and complies with applicable requirements
- Claims may be fully or partially denied if:
    - Documentation does not support the service(s) billed, or
    - Documentation does not meet required guidelines
- Denials may apply to all or only some of the codes billed on a claim, based on review findings

Provider options

- Providers may submit an appeal through the standard claims appeal process if they disagree with the determination
- If an incorrect code was billed, providers should submit a corrected claim following standard billing procedures

Important reminder

Timely submission of complete and accurate medical records is critical to avoid claim denials and ensure compliance with IBHP requirements.

Questions?

Please contact Magellan at IdahoProvider@MagellanHealth.com.