Magellan payment is payment in full

Magellan payment determinations are considered payment in full for a covered service. It is not acceptable to bill the member or their family for any remaining balance over and above what Magellan has paid for the service. "Balance billing" or billing the difference between the provider's charge and the Magellan contracted reimbursement fee for a service is not permitted by Nebraska Medicaid.

Magellan, as the Nebraska Medicaid managed care vendor, is the payer of last resort. When a Magellan member has primary insurance coverage through another carrier (i.e., Medicare or commercial insurance) the primary insurance must be billed first and those coverage resources exhausted before Magellan considers payment.

> For dual eligible Medicare/Medicaid members, Magellan will reimburse copays, coinsurance, and deductibles up to the Medicare allowable amount. However, the total amount paid by Magellan will not exceed the Magellan contracted rate. Reimbursement above the Medicare allowable amount cannot be collected by the provider.
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> When a commercial payer or other third party payer is primary, Magellan will reimburse copays, coinsurance, and deductibles up to the Medicaid allowable amount as the secondary payer. The Medicaid allowable amount is defined as the lesser of the Magellan contracted rate, or the amount allowed by the third party primary payer.

If for any reason Magellan denies a claim for payment for a covered service, the provider **cannot** bill the member for the denied service. In addition, providers **cannot** bill members for cancelations and/or missed appointments.

In order to promote efficiency it is recommended that providers incorporate the following steps into their billing management workflow:

1. Establish financial responsibility and any required copay at intake by checking the Medicaid eligibility system.
2. Re-check the Medicaid eligibility system monthly, at a minimum, to verify eligibility and copays.
3. Treatment vouchers through a third party (i.e. a Nebraska Region or Probation) should not be utilized when the member has Magellan coverage, and the service is a medically necessary covered service. Regardless of a voucher, providers may not bill the member for any balance for a service that is covered by the Magellan plan.

4. Claims must be submitted within 180 days of rendering a service.
5. Ensure submitted claims are accurate, with correct coding and practice information.
6. In cases for which there is other primary insurance coverage, an EOB or denial letter must accompany the claim to be considered for payment by Magellan.

For more detailed information on Provider Reimbursement, please review the Nebraska Provider Handbook Supplement.