SummaCare

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Policy Number: CSCL0024
Manual Name: SMSO Policy Manual
Policy Name: Claim Payment to Non-contracted Providers for Medicare
Approved By: Stephen Adamson
Last Revised: 07/10/2019

SMSO Policy Manual
CLAIM PAYMENT TO NON-CONTRACTED PROVIDERS FOR MEDICARE

Executive Sponsor:	Stephen Adamson, Chief Operations Officer
Issuing Department:	Claims
Gate Keeper:	Melissa Rusk, Director Claims

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Health Management Company
- ☒ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☐ Commercial Groups
- ☐ Medicare Supplemental
- ☐ Off-Exchange
- ☒ Medicare
- ☐ On-Exchange
- ☐ Self-Funded

Purpose:

1.1 The plan must adhere to CMS requirements regarding claims processing for claims submitted by non-contracted providers.

2.0 Policy:

2.1 To outline the process for handling claims submitted by non-contracted providers.

3.0 Procedure:

3.1 Claims payment to non-contracted providers for Medicare needs to adhere to Center for Medicare and Medicaid Services (CMS) guidelines. This training document explains the CMS guidelines regarding non-contracted provider claim submissions, adjustments, processing, and application of interest to claims received for Medicare members.

3.2 Claim Filing Timeframe

3.2.1 Services furnished on or after January 1, 2010 must be filed within one calendar year after the date of service.

3.3 Claim Adjustment Timeframe

3.3.1 Medicare claim adjustment requests follow the same timeframe as initial submissions. Each claim adjustment request must be submitted with the following information:

3.3.1.1 Claim number

3.3.1.2 Member identification number

3.3.1.3 Member name

3.3.1.4 Date of service

3.3.1.5 Name of rendering provider

3.3.1.6 Description of claim adjustment request

3.4 Claim Processing Timeframe

3.4.1 CMS guidelines require 95% of clean claims submitted by non-contracted providers must be finalized within 30 days of receipt

3.4.2 CMS guidelines require unclean claims to be paid or denied within 60 days of receipt

3.4.3 Interest is applied to the net payment amount after all applicable deductions are determined (i.e. deductible, co-payment) for claims not paid within the established timeframe

3.5 Melissa Rusk, Director, Claims & BPO Operations has the authority and responsibility for the activities in this policy or procedure.

3.6 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.6.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 Internal Standard

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 Part C Medicare Claim Denials

4.3.2 Interest Payments – Medicare Plans

4.3.3 Provider Claim Submission and Adjustment Filing Medicare Plans

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 None

6.0 Key Words or Aliases (Optional):

6.1 Medicare, non contracted provider

ORIGINAL *EFFECTIVE DATE*: 4/1/2007
REVIEWED: 8/18/2009; 8/12/2011; 5/24/2013; 7/17/2013
REVISED: 7/17/2013; 7/10/2019 (format)