SummaCare

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Manual Name: SMSO Policy Manual
Policy Name: Medicare Member Claim Reimbursement
Approved By: Stephen Adamson
Last Revised: 07/01/2019

SMSO Policy Manual
MEDICARE MEMBER CLAIM REIMBURSEMENT

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

1.0 Purpose:

1.1 To develop guidelines for processing claims which are submitted directly by the Medicare member; requesting member reimbursement. These instructions do not apply to foreign claims or DME claims. Submission of those types of claims will be processed according to their respective claims policy.

2.0 Policy:

2.1 The plan will process claims submitted by Medicare Members for services that are covered by Medicare when the member submits a complete claim, including all necessary supporting documentation.

3.0 Procedure:

3.1 Process Medicare member submitted claims for services that are not covered by Medicare (e.g. cosmetic surgery) in accordance with normal processing procedures;

3.2 Process Medicare member submitted claims for services that are covered by Medicare when the member has submitted a complete claim (Form CMS-1490S is preferred) and all supporting documentation associated with the claim, including an itemized bill with the following information

3.2.1 Date of Service

3.2.2 Place of Service

3.2.3 Description of illness or injury

3.2.4 Description of each surgical or medical service or supply furnished

3.2.5 Charge for each service

3.2.6 The doctor's or supplier's name and address

3.2.7 The doctor's or supplier's National Provider Identifier (NPI) and Tax Identification Number (TIN)

NOTE: Claims submitted without the provider's NPI number will not be considered incomplete. The plan will utilize the NPI registry to locate the provider or supplier's NPI.

3.3 If an incomplete claim or a claim containing invalid information is received, the plan will manually return the claim to the Medicare member as incomplete. The return will include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return Form CMS-1490S for processing.

3.3.1 If the Medicare member submits a claim on Form CMS-1500, the plan will return the Form CMS-1500 claim to the member, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return Form CMS-1490S for processing.

3.3.2 A copy of the Medicare member submitted claim and supporting documentation will be kept in the member's Document Management System file for the purposes of timely filing rules in the event that the member resubmits the claim.

3.3.3 The letter attached to the returned claim will inform the Medicare member that the provider or supplier is required by law to submit a claim on behalf of the member (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, the plan will encourage the member to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. If the provider refuses to submit a claim on the member's behalf and/or refused to enroll in Medicare, then the member should:

3.3.3.1 Notify the plan in writing that the provider or supplier refused to submit a claim to Medicare and/or refused to enroll in Medicare

3.3.3.2 Submit a complete Form CMS-1490S with all supporting documentation

3.3.4 The Plan will process and pay the Medicare member's claim if it is for a service that would be payable by Medicare. Claims will be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status.

3.3.4.1 If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary minus any applicable member cost share, if appropriate.

3.3.4.2 If for a non-covered service/excluded service, the claim shall be processed and denied with the appropriate denial reason. An explanation will be included on the beneficiary's Explanation of Benefits which outlines specifically why the service is non-covered or excluded. This is to include claims submitted for sanctioned/excluded and opt-out providers.

3.3.5 Due to the ability of providers to opt-out of participation in Medicare, all Medicare member submitted claims will need to be reviewed via the website https://data.cms.gov/Medicare-Enrollment/Opt-Out-Affidavits/7yuw-754z

3.3.5.1 If the provider is on the Medicare Opt Out list, Claims will notify Provider Configuration to have the provider updated in the claims system with the opt out indicator.

3.3.5.1.1 If the provider does have a contract with the member, the claim will be denied with EX code WZ (DENY OPT OUT OF MEDICARE

PHYSICIANS AND PRACTITIONERS). A letter will be sent to the member outlining specifically why the service was denied.

3.3.5.1.2 If there is not a contract between the provider and member, and the claim is for urgent or emergent services, the claim will be processed and paid in accordance with normal processing guidelines, with reimbursement sent to the member.

3.3.5.2 If the provider is not on the Medicare Opt Out list, the claim will be paid in accordance with normal processing guidelines, with reimbursement sent to the member.

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

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

4.0 References:

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

4.1.1 MMCM

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

4.2.1 DMS Member Return Letter

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

4.3.1 None

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, DMR, Member, Reimbursement

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