

SMSO Policy Manual

PROMPT PAYMENT OF CLAIMS – MEDICARE

Executive Sponsor: Stephen Adamson, Chief Operations Officer

Issuing Department: Claims

Gate Keeper: Melissa Rusk, Claim Director

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 ☐ Apex
☐ Summa Health Management Company ☒ Summa Insurance Company

Line of Business:

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

1.0 Purpose:

- 1.1 To ensure mechanisms are in place to comply with CMS prompt pay regulations.

2.0 Policy:

- 2.1 All claims are processed within CMS regulatory prompt pay requirements. CMS requires MA plans to process 95% of clean non-contracted provider claims within 30 days of receipt, and all other claims (clean or unclean) within 60 days of receipt. Clean claims paid after more than 30 days will accrue interest.

3.0 Procedure:**3.1 Compliance with Prompt Pay**

- 3.1.1 Compliance with prompt pay is monitored weekly and monthly. Reports are provided to compliance. Compliance may issue corrective action plans to areas who are not handling the processing of claims within the regulatory requirements.

3.2 Tracking of Prompt Pay – Claim Adjustments

- 3.2.1 To ensure time service is accurately reported, the clean date must be populated correctly on each service line of the claim. The clean date for external notification of an issue will be the date of the notification. The clean date for internal identification of an issue will be the date of identification.
- 3.2.2 It is the responsibility of the requestor to supply the clean date information to the Claims Area at the time a request for a claim adjustment is made. Requests for adjustments without this information will be returned to the requestor.
- 3.2.3 Time service goals for processing claims
 - 3.2.3.1 Claims must be processed within 30 days of receipt of the required information or within 30 days of the identification of the issue.

3.3 Interest

- 3.3.1 Interest calculation is performed programmatically on all applicable services prior to the payable run. The process uses the number of days late times the interest rate. Interest is paid at the time the services are paid.
- 3.3.2 The government-established interest rate is released twice a year (1/1 and 7/1) and can be found at <https://www.fiscal.treasury.gov/prompt-payment/>
 - 3.3.2.1 Configuration Management is responsible for obtaining and updating the interest rate for automated interest calculation within the claims processing system.

3.3.2.2 Interest rate updates must be made prior to the first payable run after the interest rate changes to ensure interest is paid at the correct rate.

3.3.3 The Claims Area will monitor the interest rate table to ensure updates are made in conjunction with the updates from CMS.

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.

3.5.1 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 42 C.F.R. § 422.500; § 422.520(a)(1), MMCM, Chapter 11, Sec. 100.2

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 None

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 A "Complete" Claim

5.1.1 A claim containing an itemized billing and all such supplemental or medical administrative information that is reasonably required by SummaCare to determine the eligibility of the service or diagnosis for the reimbursement under a beneficiary's Health Plan contract.

6.0 Key Words or Aliases (Optional):

6.1 Clean claim, interest, prompt pay, Medicare

ORIGINAL EFFECTIVE DATE: 09/30/2011

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