

SMSO Policy Manual

PROVIDER CLAIMS SUBMISSION AND ADJUSTMENT FILING FOR MEDICARE PLANS

Executive Sponsor: Steve 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 | ☐ Apex |
| ☐ Summa Health Management Company | ☒ Summa Insurance Company |

Line of Business:

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

Purpose:

- 1.1 To outline the process for compliance with CMS regulations for beneficiary materials.

2.0 Policy:

- 2.1 SummaCare includes all CMS requirements in beneficiary materials.

3.0 Procedure:

- 3.1 The Centers for Medicare and Medicaid Services (CMS) establishes regulations that payers need to follow. SummaCare ensures compliance with these regulations. One regulation mandates that Medicare beneficiaries must receive a detailed notification when an adverse determination is made on a claim. Another regulation mandates beneficiary notification if a claim has been pending for review longer than 60 days.
- 3.2 Services from contracted providers cannot be denied as a beneficiary liability.
- 3.3 Notice of Pending Review CG Letters
 - 3.3.1 A daily report is generated that lists claims pended longer than 60 days
 - 3.3.1.1 The following Explanation (EX) codes are excluded:
 - 3.3.1.1.1 IE (service being considered on separate claim)
 - 3.3.1.1.2 WM (previously processed on incorrect patient. Do not bill patient)
 - 3.3.1.1.3 WP (previously processed under incorrect provider do not bill patient)
 - 3.3.1.1.4 WQ (provider billing error – do not bill patient)
 - 3.3.2 The letters for these claims print in the Claims area and are prepared for mailing
 - 3.3.3 Appeal language must be printed and attached to each letter being sent
- 3.4 Notice of Denial Letters
 - 3.4.1 Services with beneficiary-responsible denials fall into the Medicare CG Letter Review Queue
 - 3.4.2 Claims are reviewed to determine if the service should be allowed or denied
 - 3.4.2.1 If the service should be denied, the claim is readjudicated to release the denial
 - 3.4.2.1.1 Pend EX codes
 - 3.4.2.1.1.1 GS (service is not a covered benefit, bill patient)

3.4.2.1.1.2 GT (services have exceeded benefit limits of plan)

3.4.2.1.2 Denial EX codes:

3.4.2.1.2.1 FR (services provided are not considered medically necessary)

3.4.2.1.2.2 FS (service is not a covered benefit, bill patient)

3.4.2.1.2.3 FT (services have exceeded benefit limits of plan)

3.4.2.1.3 Services which systematically deny:

3.4.2.1.3.1 WZ (deny opt out of Medicare Physicians and Practitioners)

3.4.3 Appeal language must be printed and attached to each letter being sent

3.5 Request for Information Letters

3.5.1 Services where additional information is needed from the beneficiary are stopped for review and drop into a document management system queue

3.5.1.1 An example: EX code 3Y(other coverage primary submit EOB or proof of termination)

3.5.2 Appeal language must be printed and attached to each letter being sent

3.6 Handling of the Explanation (EX) codes

3.6.1 Benefit Limits Exceeded / EX code GT

3.6.1.1 Override with PA if:

3.6.1.1.1 It is verified that the beneficiary did *not* have services exceeding benefit limits within the established timeframe

3.6.1.1.2 The technical fee could have been billed with a different Date of Service (DOS) than the professional fee, causing the count to be higher. If so, deny the professional fee claim as a billing error

3.6.1.2 Deny with EX FT if:

3.6.1.2.1 None of the above apply

3.6.2 Medical Necessity Not Met

- 3.6.2.1 Override with PA if:
 - 3.6.2.1.1 Services were authorized as an exception
- 3.6.2.2 Deny with FR if:
 - 3.6.2.2.1 All other scenarios
- 3.7 The member beneficiary liability explanation is included on the Explanation of Benefits (EOB)
- 3.8 General Processing Guidelines
 - 3.8.1 Locations
 - 3.8.1.1 Physical therapy in a nursing home, billed on a UB04 form, maps to location 31. Check the type of bill, provider, and where services were rendered to determine the correct location
 - 3.8.1.1.1 Location 31 is for inpatient Skilled Nursing Facility (SNF) services
 - 3.8.1.1.2 Location 32 is for outpatient SNF services
 - 3.8.1.1.3 Location 33 is for custodial care facility
 - 3.8.1.1.3.1 Custodial services such as feeding, bathing, etc. are not covered
 - 3.8.1.1.3.2 Medical physician services are payable if appropriate
 - 3.8.2 Urgent care
 - 3.8.2.1 For claims not billed on a HCFA, use the urgent care location code 20
 - 3.8.2.2 For claims billed on a HCFA, the location billed cannot be changed
 - 3.8.3 Speech Therapy
 - 3.8.3.1 For non-contracting providers, speech therapy requires pre-certification at location 31 but not at location 32
 - 3.8.4 Other Denials
 - 3.8.4.1 Some denial EX codes are beneficiary-liable denial codes and do not generate beneficiary liability language. In that case, change the EX code as indicated below.
 - 3.8.4.1.1 EX BA (service is not a covered benefit, bill patient) – use EX FS

3.8.4.1.2 EX SE (refer to plan documents, specific plan exclusion. Bill patient) – use EX FS

3.8.4.2 Watch patient liability on other denial EX codes. A service line should not have conflicting EX codes (i.e. one EX code puts beneficiary liable and one doesn't)

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

3.10 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 Chapter 13

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 Medicare Plan Directed Care Policy

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 Contracted Providers

5.1.1 A physician or facility that participates in the SummaCare network

5.2 Non-Contracted Provider

5.2.1 A physician or facility that does not participate in the SummaCare network

6.0 Key Words or Aliases (Optional):

6.1 None

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