SummaCare

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Policy Number: CSCL0002
Manual Name: SMSO Policy Manual
Policy Name: Payment for plan directed care
Approved By: Melissa Rusk
Last Revised: 10/09/2024

SMSO Policy Manual
PAYMENT FOR PLAN DIRECTED CARE

Executive Sponsor:	Melissa Rusk, Vice President Operations
Issuing Department:	Claims
Gate Keeper:	Terry Snyder, 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 outline processes in place to ensure claims are handled in accordance with regulations.

2.0 Policy:

2.1 Medicare Advantage enrollees are not financially responsible for plan-directed care.

3.0 Procedure:

3.1 General Rules

3.1.1 If a contracted provider furnishes a service or refers an enrollee for a service that an enrollee reasonably believes is a plan-covered service, the enrollee cannot be financially liable for more than the applicable in-network cost-sharing for that service.

3.1.1.1 If a contracted provider believes an item or service may not be covered for an enrollee, or could be covered only under specific conditions, the appropriate process is for the enrollee or provider to request a pre-service organization determination from the plan.

3.1.1.2 If a contracted provider fails to obtain a pre-service organization determination, the contracted provider may be held liable for the cost of the service.

3.1.2 If a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan upon referral or with prior authorization, the enrollee is financially liable only for the applicable in-network cost-sharing for that service. The member is not held responsible for the contracted provider's failure to follow plan rules regarding referrals or prior authorization.

3.1.2.1 This is true of all plan types, including HMO, HMOPOS and PPO.

3.1.3 However, if a service is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the enrollee is clear that the service or item is never covered, the plan is not required to hold the enrollee harmless from the full cost of the service or item (i.e., the enrollee may be billed by the provider).

3.1.3.1 Example 1: Acupuncture is an exclusion in the EOC, so the enrollee would be responsible for the cost whether provided by a contracted or a non-contracted provider.

3.1.3.2 Example 2: The EOC provides coverage for Ambulance services. Transportation by means other than ambulance is not covered, and therefore is the enrollee's financial responsibility.

3.2 Members are not responsible for prior authorization. If a contracted provider orders or refers a member for services that normally require prior authorization, the services should still be covered at the in-network benefit level as plan-directed care. This is true even if the service provided is determined not to be reasonable and necessary.

3.3 Claims will be developed as indicated below:

3.3.1 Use EX YU (PROVIDER: PLEASE SUBMIT FULL NAME AND NPI FOR REFERRING PHYSICIAN) for the following types of claims:

3.3.1.1 Durable Medicare Equipment / X-ray / Outpatient independent lab

3.3.1.1.1 With no auth on file, and

3.3.1.1.2 No referring provider listed in box 17 or

3.3.1.1.3 Provider in box 17 is service provider

3.3.1.2 Services rendered which would require authorization or order, such as OT, PT or Home Health Services, etc

3.3.1.2.1 With no auth on file, and

3.3.1.2.2 No referring provider listed in box 17 or

3.3.1.2.3 Provider in box 17 is service provider

3.3.2 Providers responding to claims denied YU are not required to submit a corrected claim. The update must be documented by Provider Services on a contact service form and forwarded to Claims via Macess. A priority of 1 may be used to expedite claim re-processing.

3.3.2.1 When the information is received, the guidelines outlined above should be applied based on the submitted information.

3.4 The Director, Claims 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 The Compliance Department will conduct periodic audits to ensure compliance with this policy.

4.0 References:

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

4.1.1 Medicare Managed Care Manual, Chapter 4, Section 170.1

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

4.2.1 Departmental Policy: Medicare Correspondence Generated (CG) Letters

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 Company

5.1.1 SummaCare, Inc. and its related companies including Summa Insurance Company, Inc. and Apex Benefits Services, LLC. dba Apex Health Solutions.

5.2 Contracted Provider

5.2.1 A physician or facility that has a contract with the plan to provide covered services to enrollees.

5.3 Non-Contracted Provider

5.3.1 A physician or facility that does not participate in the plan's network

5.4 Plan Directed Care

5.4.1 Services that are provided by or authorized by either the plan or a contracted provider, even if the contracted provider fails to obtain plan approval.

6.0 Key Words or Aliases (Optional):

6.1 None

ORIGINAL *EFFECTIVE DATE*: 6/25/2014
REVIEWED:
REVISED: 6/25/2014; 7/24/2014; 1/29/2015; 2/13/2015; 3/26/2015; 8/18/2015; 9/18/2015; 7/9/2019 (format): 10/9/2024