Billing Members

Collecting Payment

Providers should bill Harvard Pilgrim and collect member cost sharing payment as follows.

Deductible and Copayment

Members are not required to make payment for any portion of the deductible or coinsurance at the time services are rendered. For services that are subject to a deductible and/or coinsurance, providers should:

- Bill Harvard Pilgrim within one year from the date of service.
- Upon receipt of your Harvard Pilgrim Explanation of Payment (EOP) report, determine the amount the member is responsible for, as indicated by the EOP.

Harvard Pilgrim will send an Explanation of Benefits (EOB) to the member showing the services provided by the provider and any amount the member owes to the provider; however, the EOB is not a bill.

Copayment

In most cases, copayment is payable, whether or not the deductible has been met, until the annual out-of-pocket maximum has been reached. Hospitals should wait until they receive their EOP to determine whether a deductible or a copayment applies to an emergency room visit. For services that require a copayment, providers should:

- Collect the copayment listed on the member's ID card at the time of service.
- Bill Harvard Pilgrim within one year from the date of service.

Harvard Pilgrim's reimbursement will be the allowed amount minus the copayment.

Qualified Medicare Beneficiary (QMB) Members

Federal law bars Medicare providers and suppliers, including pharmacies, from billing an individual enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Part A and Part B cost-sharing under any circumstances. (See Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act.) The QMB program is a State Medicaid benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B premiums and cost-sharing, including deductibles, coinsurance, and copays.

Providers and suppliers, including pharmacies, may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States may limit Medicare cost-sharing payments, under certain circumstances. Persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing.

Prohibition of Billing Members/Balance Billing

As a participating provider you have entered into a contractual agreement to accept payment directly from Harvard Pilgrim. Payment from the Plan constitutes payment in full, except for applicable copayments, and/or co-insurance as listed on the EOB/EOP.

You may not balance bill members for the difference between actual billed charges and your contracted reimbursement rate. A member cannot be "balance billed" for covered services. Failure to notify the Plan of a service that requires prior authorization will result in payment denial. In this scenario, Plan members may not be balance billed and are responsible only for their applicable cost-sharing.

A member cannot be billed for a service that is not medically necessary, i.e., a non-covered service, unless the member's informed written consent is obtained prior to rendering a non-covered service. This consent must include the specific charge to the member for the specified non-covered service.

Please note that the process of submitting an Advance Beneficiary Notice of Non-coverage (ABN) is applicable for Original Medicare only, and is not considered a valid form of denial notice for a Medicare Advantage member. Prior to performing any non-covered service for a Stride[SM] (HMO)/(HMO-POS) Medicare Advantage member — regardless of whether or not the service requires prior authorization — providers are required to request an organization determination (sometimes referred to as a request for prior authorization) from the Plan and receive a denial notice from the Plan before the provider may bill the member.

The appropriate course of action before prescribing a non-covered prescription drug for a Stride member is to submit a coverage determination to the Plan, which can be done by phone, fax, or online via PromptPA at https://point32health.promptpa.com. If the Plan denies coverage, the provider must obtain the member's informed consent before prescribing the drug.

When the Patient is Not Entitled to Medicare Benefits

Providers are expected to determine a patient's Medicare Advantage Stride[SM] (HMO) eligibility before providing services in order to help prevent a claim denial or claim rejection because the patient is not entitled to Medicare coverage. Providers can determine eligibility by getting a copy of the member's health insurance card during the first visit or facility admission, and by confirming eligibility to receive benefits for the services to be provided. Providers can also verify patients' Stride[SM] (HMO) eligibility via Harvard Pilgrim's Medicare Advantage Provider Portal or by calling Harvard Pilgrim's Medicare Advantage Provider Service Center at 888-609-0692.

Referral for Non-Covered Services – Provider Responsibility

- Sometimes you and your patient may decide that a service or treatment is the best course of care, even though it isn't covered by Original Medicare or Harvard Pilgrim Stride[SM] (HMO)(HMO-POS) Medicare Advantage. Contracted providers should request an organization for:
  - Services that require authorization (see Medicare Advantage Provider Manual)
  - Services that are not normally covered by the plan, if medical necessity may warrant coverage (As noted in the Prohibition of Billing Members section above, submitting an Advance Beneficiary Notice of Non-coverage [ABN] is not appropriate for Medicare Advantage members, as this process only applies for Original Medicare.)
- The provider and member will be notified of the decision
- If an organization determination is unfavorable, the decision may be appealed by the member or provider
- There are claim adjustment and appeal processes available
- Contracted providers may not balance bill Medicare Advantage members
- To determine if a service is covered, providers can contact the Medicare Advantage Provider Call Center at 888-609-0692

Harvard Pilgrim will take appropriate action if you fail to obtain these written notifications.

When the Provider is Not Qualified to Furnish the Services Billed

A provider's billing office must be aware of the status of not only its billing provider number, but also whether all participating providers and clinicians furnishing and billing for Medicare-covered services through the provider number are legally permitted to participate in the Medicare Program. Harvard Pilgrim may not pay for services furnished by excluded providers. In addition, Harvard Pilgrim may prohibit facilities from submitting claims in some situations for services they furnished if an excluded employee was indirectly involved in the care of a Medicare Advantage member (e.g., an excluded medical director). Providers need to ensure that they do not bill Harvard Pilgrim for services furnished by individuals excluded from Medicare participation.

Maximum Out-of-Pocket Expenses (MOOP)

The term Maximum Out-of-Pocket (MOOP) refers to the limit on how much a Medicare Advantage Plan enrollee must pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. Copayments and coinsurance comprise member expenses for purposes of MOOP. MOOP is not applicable to the member's Medicare Part B Premium.

All our health plans have a MOOP. If a member reaches a point where they have paid the MOOP during a calendar year (coverage period), the member will not have to pay any out-of- pocket costs for the remainder of the year for covered Medicare Part A and Part B services. If a member reaches this level, the Plan will no longer deduct any applicable member expenses from the provider's reimbursement.

The MOOP can vary by Plan and may change from year to year. Please refer to the summary of benefits available online at our website www.harvardpilgrim.org. You may confirm that a member has reached their MOOP by contacting the Stride[SM] (HMO) Medicare Advantage Provider Services at 888-609-0692.

PUBLICATION HISTORY

10/15/13	original documentation
12/15/14	reviewed; no changes
07/15/17	updated "referral for non-covered services - provider responsibility" section
08/01/18	added Qualified Medicare Beneficiary (QMB) program information
05/01/19	reviewed; updated the Qualified Medicare Beneficiary (QMB) program information; added additional information on how to verify patient's eligibility
01/01/22	updated document format
01/01/23	reviewed; administrative edits
04/01/23	reviewed; clarified information for collecting payment and billing for non-covered services