Billing Members

Collect Copayments or Coinsurance at Time of Service

Providers should collect the applicable cost-sharing from the member at the time of the service when possible. Cost-sharing may refer to a fixed-dollar copayment and percentage coinsurance. You can only collect the appropriate Medicare cost-sharing amounts from the member. After collecting these amounts, please submit your clean claims to Harvard Pilgrim for payment.

Harvard Pilgrim requires providers to only charge a member their applicable cost share. If you collect more from a member than the applicable cost-sharing, you must refund the difference. Charges that can be billed and collected from the member will be indicated on the Explanation of Benefits (EOB) notice from the Plan. The provider gets an Explanation of Payment (EOP).

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

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, with the exception of 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 denied for lack of information. 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 copayments, and/or coinsurance.

A member cannot be billed for a covered service that is not medically necessary, unless the member‘s informed written consent is obtained prior to rendering a non-covered service. This consent must include information regarding their financial responsibility for the specific services received.

When the Patient is Not Entitled to Medicare Benefits

Providers are expected to determine a patient’s Medicare Advantage Stride℠ (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℠ (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 Medicare or our plan. Contracted providers should request an organization determination (sometimes referred to as a request for prior authorization) 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
- 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 PIN 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.

Balance Billing is Not Allowed

Harvard Pilgrim does not allow balance billing. You may only collect applicable cost-sharing from our members for covered services and may not otherwise charge or bill them.

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 has to 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 of 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℠ (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