Reimbursement Methodology

Provider Reimbursement

Harvard Pilgrim reimburses network providers at the reimbursement level stated in the provider's Medicare Advantage HMO Agreement minus any member required cost sharing, for all medically necessary services covered by Medicare, granted authorization rules are followed.

When billing for services rendered to Harvard Pilgrim Stride℠ (HMO) members, providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 professional and CMS-1450 facility health insurance claim forms. Medical/clinical codes including modifiers should be reported in accordance with the governing coding organization. Please refer to your Harvard Pilgrim Medicare Advantage contract for reimbursement specifics.

Final reimbursement determinations are based on several factors, including but not limited to, member eligibility on the date of service, medical appropriateness, code edits, applicable member co-payments, coinsurance, coverage determinations, benefits plan exclusions/limitations and medical policy. The maximum allowable subject to final reimbursement determinations represents payment in full to provider. Payment in full means there will be no additional payments via periodic interim payment or cost report settlement processes.

If there is a conflict between the following information and information published by CMS, the information published by CMS will prevail.

Details regarding Medicare reimbursement methodologies can be found on the CMS Web site, www.cms.gov. Links to the CMS Web site for specific Provider types are located in the following grid. In the event CMS changes one or more of the links, refer to CMS Web site, *www.cms.gov*.
Each provider contract, amendment or payment exhibit describes specific details regarding contracted payment amounts.

CMS applies a risk-adjusted payment methodology based on diagnostic and demographic information. Harvard Pilgrim conducts ICD-10 coding validation reviews of all claims submitted by network providers. These reviews help Harvard Pilgrim comply with CMS regulations and assist network providers in achieving maximum reimbursement.

As a Medicare Contractor, Harvard Pilgrim must ensure that it pays only for those services that comply with Medicare coverage and coding rules, including only reasonable and medically necessary services. For medically necessary services, Harvard Pilgrim, as a Medicare contractor, must ensure that services are rendered in the most cost-effective manner (i.e., consideration is given to the location of service and the complexity and level of care provided).

To ensure that payment is made only according to Medicare rules, Harvard Pilgrim performs data analysis to identify potentially aberrant patterns of care and to apply the Medical Review process.

How Does Medical Review (MR) Apply to Reimbursement Methodology

Medicare Contractors conduct the MR process in accordance with both national and local policies that are the foundation of the review process. The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Contractors apply Medicare policies from regulations, National Coverage Decisions (NCDs), coverage provisions in interpretive manuals and local coverage determinations (LCDs) to comply with the Social Security Act.

National Coverage Determinations (NCDs)

CMS developed NCDs to describe the circumstances for Medicare coverage for a specific medical service, procedure or device. NCDs generally stipulate conditions under which a service is covered (or not covered) under Title XVIII, Section 1862(a) (1) of the Social Security Act or its applicable provisions. CMS typically

issues these policies as CMS program instructions. Once published in a CMS program instruction, an NCD is binding on all Medicare Contractors and providers. NCDs that CMS made under Title XVIII, Section 1862(a)(1) of the Social Security Act are also binding for Administrative Law Judges (ALJs) during the claim appeal process.

Current NCD Information

A list of the most current NCDs is available at *www.cms.hhs.gov/center/coverage.asp* on the CMS Web site. The Medicare National Coverage Determinations Manual is available at *www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS Web site. Search for *publication #100-03*.

Coverage Provisions in Interpretive Manuals

Coverage provisions in interpretive manuals include instructions CMS publishes that are not NCDs. CMS uses these instructions to further define when Medicare may cover or not cover services. Once published, the coverage provision in an interpretive manual is binding for all Medicare Contractors and providers.

Local Coverage Determinations (LCDs)

Section 522 of the Benefits Improvement and Protection Act (BIPA) created the LCD. An LCD is a decision by a Medicare Contractor to cover a particular service on a contractor-wide basis in accordance with Title XVIII, Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). CMS published the Final Rule establishing LCDs on November 11, 2003.

Local Medical Review Policy (LMRP) to LCD Conversion

Effective December 7, 2003, Medicare Contractors began issuing LCDs instead of LMRPs. Fiscal Intermediaries (FIs) and Carriers retired or converted all existing LMRPs into LCDs by December 2005.

LCDs include codes that describe services Medicare does and does not cover, for example: (a) lists of Healthcare Common Procedure Coding System (HCPCS) codes that identify services to which a LCD applies; (b) lists of International Classification of Disease, 9th Revision, Clinical Modification (ICD-10-CM) codes for Medicare-covered services; and (c) lists of ICD-10-CM codes for services Medicare considers not reasonable and necessary. As a Medicare Contractor, Harvard Pilgrim considers these coding descriptions only if they are integral to determination of medical necessity. LCDs specify under what clinical circumstances a service is reasonable and necessary, and serve as administrative and educational tools to assist providers with correctly submitting claims.

CMS publishes LCDs to provide local guidance to the public and medical community within their jurisdiction. Harvard Pilgrim develops LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments and comments from the provider community. Harvard Pilgrim may develop LCDs individually or collaboratively with other contractors. Harvard Pilgrim ensures that all LCDs are consistent with all statutes, rulings, regulations and national coverage, payment and coding policies.

LCDs do not provide guidance to address fraud. For example, the following sentence would be inappropriate in an LCD: “If, on post pay review, we find that the provider billed XYZ procedure to Medicare after the effective date of this LCD, we will consider that billing fraudulent.” This sentence would be an acceptable LCD if the Contractor replaced the word “fraudulent” with the phrase “not reasonable and necessary.”

Harvard Pilgrim will continually review medical payment policies to determine how local practices align with national coding and billing guidelines by the American Medical Association’s (AMA’s) Current Procedural Terminology (CPT), the Centers for Medicare and Medicaid Services (CMS) and specialty societies. Harvard Pilgrim follows National Coverage Decisions (NCDs) to determine the conditions under which a service is or is not covered.

What Documentation Do Providers Need to Submit With Medical Review (MR)

Providers should document and maintain legible and comprehensive medical records. The medical record chronologically documents the patient’s medical history in sufficient detail, and substantiates services as medically necessary.

Providers should document in the patient's medical record precise descriptions of all aspects of patient care, including information regarding the need for and results of services provided. Dictated and transcribed descriptions and other related medical information must be legible and accurate. While initial descriptions of services provided may not be altered, providers may submit documentation in addition to that initially submitted to support a claim.

Network providers are responsible for voluntary disclosure of information that was omitted or incorrect in the initial claim submission. If submission of incorrect claim information results in an overpayment, the provider agrees to promptly return the overpaid amount to Harvard Pilgrim.

Harvard Pilgrim requests documentation through the Additional Documentation Request (ADR) letter. Examples of MR documentation Harvard Pilgrim needs may include, but are not limited to:

- Medical records, including progress notes, a current history and physical, and a treatment plan
- Documentation of the identity and professional status of the clinician
- Laboratory and radiology reports
- A comprehensive problem list
- A current list of prescribed medications
- Progress notes for each visit that demonstrate the patient's response to prescribed treatment
- Documentation supporting the time spent with the patient when using time-based codes
- Any required referrals or prescriptions (for many non-physician services/supplies)
- Any required contractor certifications

The information provided on the next page is intended to summarize the reimbursement methodologies for Harvard Pilgrim Medicare Advantage Program. Payment methodologies are reviewed by the Centers for Medicare & Medicaid Services (CMS) for accuracy. Payment rates will not be less than under Original Medicare (Medicare fee-for-service) in accordance with 42 CFR 422.114.

Payment by Provider Type for Harvard Pilgrim Medicare Advantage Covered Services

Provider Type	CMS Link for Detailed Information
Ambulance Services	http://www.cms.gov/AmbulanceFeeSchedule/
Ambulatory Surgical Center (ASC)	http://www.cms.gov/HospitalOutpatientPPS
Clinical Laboratory	http://www.cms.gov/ClinicalLabFeeSched/
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	http://www.cms.gov/DMEPOSFeeSched/
End Stage Renal Disease (ESRD) Center	http://www.cms.gov/center/esrd.asp
Federally Qualified Health Centers (FQHC)	http://www.cms.gov/center/fqhc.asp
Home Health	http://www.cms.gov/HomeHealthPPS/
Hospice	http://www.cms.gov/center/hospice.asp http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Acute Inpatient Service	http://www.cms.gov/AcuteInpatientPPS/
Critical Access Hospitals	http://www.cms.gov/center/cah.asp

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