

Anthem BlueCross

## Member Submitted Claims

Anthem BlueCross (Anthem) has seen an increase in the number of claims submitted by our members that should be submitted by their provider. When seeing a patient with our Medicare Advantage plan it is expected that the Provider bill on behalf of the member to receive reimbursement according to the Medicare guidelines. The following are the only charges that we would expect to see from a member:

- Part B Drugs not billed by pharmacy (compound)
- Covered Part B Immunizations (influenza and pneumonia)
- Optional Supplemental Benefits
  - Acupuncture
  - Chiropractic
  - Vision
  - Dental
- Some DME purchased from a private source (Ex. WalMart where a member is expected to pay at the time of service.)
- Glasses/Lens after cataract surgery
- Opt-out providers – Urgent/Emergent Care Only
- Foreign or Cruise Ships – Urgent/Emergent Care Only
- Transplant lodging and transportation costs
- Non covered services that Medical Review has authorized
- Any exception authorized from Grievance and Appeal
- Medicare is the secondary payer which requires the other payer's EOB
- Medicare Non-covered services to obtain EOB for another coverage

Anthem has also seen an increase in members being balance billed for claims they have submitted to us. By agreeing to see a Medicare Advantage plan member, Medicare guidelines must be followed which includes adherence to balance billing guidelines and not billing the member above the Medicare allowed amount.

When either of these situations is received a letter will be sent regarding the claim to both the provider and the member. If it is a member submitted claim for services that should be billed by the provider we will be requesting future claims to come directly from the provider. If the claim is related to a member being balance billed and the provider continues to balance bill our Medicare Advantage members they will be referred to CMS for investigation.

Here are the categories that a provider could fall into and how Anthem will handle the payments:

**Anthem Contracted** - There is no balance billing paid by either the MA plan or the member. Paid @ contracted rate less any member cost share amount

**Anthem Non-contracted/Medicare Participating (accepts assignment)**- There is no balance billing paid by either the MA plan or the member. Paid @ original Medicare rate less any member cost share amount

**Anthem Non-contracted/Medicare Non-Participating (does not accept assignment)**- The MA plan owes the non-contracting, non-participating provider the difference between the member's cost-share amount and the Original Medicare limiting charge which is the maximum amount that Original Medicare requires an MA plan to reimburse a provider. The member pays only plan-allowed cost-share.

**Medicare Opt-Out provider** – The MA plan will reimburse the member only for emergent/urgent care claims until the member is stabilized. These claims will be paid at the Original Medicare limiting charge amount. The member pays only the plan-allowed cost-share. For all other claims, the provider should have a signed private contract with member stating the member assumes responsibility for full payment.

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