Reimbursement Policy
Plan Directed Care: Professional and Facility Reimbursement
Committee Approval Date: **12/2/2021**
These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by the Member's plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record. Unless otherwise noted within the policy, our policies apply to both participating and non-participating Providers and facilities. If appropriate coding/billing guidelines or current reimbursement policies are not followed, MHHP may reject/deny claim, recover/recoup payment or adjust the reimbursement to reflect the appropriate services and/or procedures performed. These policies may be superseded by mandates in Provider contracts, or state, federal or CMS requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, MHHP strives to minimize these variations.
References: MCM Chapter 4 (cms.gov)
Medicare Managed Care Manual (cms.gov)

Policy Statement

CMS defines "plan-directed care" as the Health Plan and/or its contracting network Providers who are responsible for ensuring that ordered or referred care are services covered by the Member's plan. If a Member believes either he or she was instructed to obtain or authorized to receive services by a health plan representative (Provider), the Provider needs to ensure that the service is covered.

Referral Management

Medicare Advantage Members are required to select a primary care physician (PCP). The PCP will coordinate the care and oversee all services including referral of medically necessary specialty care. Out of network referrals require Health Plan prior authorization. Providers may be held financially responsible for any services received by a Member at the direction of his or her PCP, if prior authorization guidelines are not followed, or the services are not covered under the Member's benefit plan. As indicated in the CMS manual, Chapter 4, Section 160

Beneficiary Protections Related to Plan-Directed Care, CMS prohibits holding the Member financially responsible in these situations.

CMS considers plan-directed care to be the financial responsibility of the Health Plan and contracted network Providers, not the responsibility of the MA Member. Therefore, network Providers need to obtain authorization from the Health Plan prior to referring a Member to an out of network Provider. If referring network Provider does not follow our Health Plan prior authorization guidelines, the Health Plan may deny payment of claim, holding Provider financially responsible for services rendered to the Member.

Contracted Providers for MA Members are responsible for the following:

- Providing and ordering services that are covered by Medicare
- Obtaining prior authorization for referrals to out of network Providers
- Ensure the Provider you are referring to understands he or she is accepting the Member per plan-directed care, and he or she must also provide and order covered services in accordance with Health Plan requirements.

Memorial Hermann *Advantage* HMO is provided by Memorial Hermann Health Plan, Inc., a Medicare Advantage organization with a Medicare contract. Enrollment in this plan depends on contract renewal.

Memorial Hermann *Advantage* complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

If you have any questions, please contact Customer Service at 855.645.8448 (TTY 711).