Subject Advance Notice of Non-coverage for Medicare Members	Attachments ☐ Yes ☒ No
Key words notice of non-coverage, Medicare non-coverage, advance notice of non-coverage for Medicare members	**Number** **AAOO5**
Category Business Practices (BP)	**Effective Date** **3/1/2015**
Manual HPI Administrative Manual	**Last Review Date** **1/15/2015**
Issued By Quality and Utilization Improvement	**Next Review Date**
Applicable • All Primary Care Clinics and Providers • All Specialty Care Clinics and Providers • All Facilities and Providers	**Origination Date** **3/1/2015** **Retired Date**
Review Responsibility	**Contact** Bev Vacinek

Products
☐ Fully Insured ☐Self-Insured ☒ Medicare Cost ☐ Medicaid ☒ MSHO

I. PURPOSE

The Centers for Medicare and Medicaid (CMS) requires notification of non-coverage to members prior to any service(s) being rendered. Per CMS regulations, providers contracted with HealthPartners are responsible for determining whether services are covered for Medicare enrollees, including members enrolled in HealthPartners Freedom (Cost) and Minnesota Senior Health Options (MSHO) plans. Providers are required to follow the process outlined below for determining coverage prior to rendering a service or referring to a non-contracted provider.

II. POLICY

Provider Responsibility:

1. Prior to rendering an item or service or referring to a non-contracted provider, providers must determine whether or not the item or service is covered by the member's HealthPartners plan. The following resources cited in the member's Evidence of Coverage (EOC) or Member Handbook should be used to determine coverage:
   - HealthPartners Member Services
   - HealthPartners Medicare coverage policies
   - National Coverage Determinations (NCDs)
   - Local Coverage Determinations (LCDs)
   - Other CMS published guidance

2. When the item or service **is** covered by HealthPartners and doesn't require prior authorization:
   - No additional steps are necessary and the service can be provided.

3. When the item or service **is never** covered by HealthPartners and Medicare and is listed as an exclusion in the member's health plan documents (ex. Evidence of Coverage, or EOC), providers:
   - Must obtain the member's written consent prior to rendering any non-covered service or item.

Written consent must include the date of service, the procedure or item, the estimated cost, and the signature of the member.

- A P*re-service Organization Determination* is not required in order to bill the member when the service is never covered and written consent has been obtained. The claim would not be submitted to HealthPartners.

  Note: CMS prohibits providers from issuing the *Advance Beneficiary Notice of Non-coverage* (ABN) or an ABN-like form to health plan Medicare enrollees.

4. After using the coverage resources referenced in #1 above and it is still unclear whether or not an item or service being provided or referred for is covered by HealthPartners, providers:
   - Must request a *Pre-service Organization Determination* from HealthPartners. HealthPartners must issue a determination before the service may be provided.
   - To request a pre-service organization determination, follow the process outlined in the *Prior Authorization for Medicare Products* policy found in the HPI Administrative Manual, click here to review: Prior Authorization Review Process for Medicare and Medicaid

5. If HealthPartners determines the service or item is not covered, the Notice of Denial of Medical Coverage, or Integrated Denial Notice, will be sent to the provider and the member. The Notice of Denial of Medical Coverage informs members that the service or item is not covered and includes their appeal rights. Providers must make sure the member has received the Denial Notice and obtain written member consent before rendering the non-covered service or item.

6. Providers will receive administrative claim denials for non-compliance with this policy.

7. Providers held financially liable for failure to obtain written member consent may not charge members for the cost of non-covered services or items.

HealthPartners Responsibilities:

1. HealthPartners reviews the information submitted and requests additional information if necessary. The member's eligibility status and contracts are reviewed and additional research is done if the request is for use of new technology.

2. Coverage decisions will be made by the Utilization Review (UR) staff for contract exclusions, benefit limitations and lack of information. HealthPartners Medical Directors make determinations for non-administrative reviews that do not meet HealthPartners coverage criteria. The following timelines are followed for prior authorization reviews:

   a) Non-urgent pre-service care:
      i. Decision: as soon as possible after receipt of request, but not longer than 14 calendar days after the receipt of the request or additional information.
      ii. Notification: Attending Health Care Professional, member and /or Provider notified of decision by fax or phone within one day of the decision followed by written notification, if applicable. Written notification within 14 business days of the receipt of the request.

   b) Urgent pre-service care:
      i. Decision: Within 72 hours of receipt of request.
      ii. Notification: For urgent pre-service requests, the Attending Health Care Professional, members and/or providers are notified of decision by fax or phone within 72 hours of the request. Written notification is sent within 3 calendar days of oral notification. For denials, the provider and member are informed on how to initiate an expedited appeal.

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3. For members or providers requesting an extension of timeframe:
   a) Pre-service non-urgent and post-service extension of timeframe:
      i. Decision: Extend decision period up to an additional 14 calendar days if the member or provider requests the extension. Decision and notification no later than 28 calendar days from the receipt of the request.
      ii. Notification: Attending Health Care Professional, members and/or Provider notified by fax or phone within one working day of making decision followed by written notification, if applicable.

4. If HealthPartners determines the service or item is not covered, the Notice of Denial of Medical Coverage, or Integrated Denial Notice, will be sent to the provider and the member. The Denial Notice informs members that the service or item is not covered and includes their appeal rights.

5. Other information regarding notifications:
   a) When a request for coverage is denied, HealthPartners notifies physicians regarding how to contact a Medical Director or appropriate health plan reviewer to discuss the case.
   b) The HealthPartners Member Rights and Benefits area will manage the appeals/complaints and expedited appeals for denied coverage.

6. In the following situations, services will not be covered even if written authorization of coverage was obtained:
   a) The enrollee was not eligible on the date of service;
   b) Services provided differ from those approved;
   c) The member has not satisfied an applicable deductible per contract;
   d) Fraud on the part of the member or provider; and
   e) Payment of services is not required by coordination of benefits rules.

III. PROCEDURE(S) N/A

IV. DEFINITIONS

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS None

VII. OTHER RESOURCES

Medicare Managed Care Manual Chapter 4
Final Rule CMS 4069-F

VIII. APPROVAL(S

Martin Michael, Sr. Director
Professional Services Network Management

Charles Abrahamson, Vice President
Network Management and Provider Relations

IX. ENDORSEMENT