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FDRs can have their own internal processes in place for reporting Fraud Waste & Abuse OR non-compliance, however, instances which impact MCA business should be reported back to us by using one of the methods below:

You can report compliance concerns free from retaliation to your MCA Compliance Team. Or you can call the ALERTLINE anonymously toll-free at 1-888-891-8910 (24/7).

Ban of Advanced Beneficiary Notices (ABN) for Medicare Advantage (MA)

Provider organizations should be aware that an Advanced Beneficiary Notice of Non-Coverage (ABN) is not a valid form of denial notification for an MA member. ABNs, sometimes referred to as “waivers,” are used in the original Medicare program. However, you can’t use them for patients enrolled in Mercy Care Advantage (MCA) as CMS prohibits use of ABNs.

As a provider who has elected to participate in the Medicare program, you need to understand which services are covered by original Medicare and which are not. Medicare Advantage plans are required to cover everything that original Medicare covers, and in some instances may provide coverage that is more generous or otherwise goes beyond what is covered under original Medicare. As a MCA contracted provider, if you have questions about MCA covered benefits, please contact the plan. CMS mandates that providers who are contracted with a Medicare Advantage plan, such as MCA, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member’s Medicare Advantage plan unless that member has received a pre-service Organization Determination (OD) notice of denial from MCA before such services are rendered. If the member does not have a pre-service organization determination notice of denial from MCA on file, you must hold the member harmless for the non-covered services and cannot

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charge the member any amount beyond the normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles).

However, where a service is never covered under original Medicare or is listed as a clear exclusion in the member’s Evidence of Coverage (EOC) or other similar plan document, a pre-service organization determination is not required in order for you to hold the member financially liable for such non-covered Services. Please note, services or supplies that are not medically necessary or are otherwise determined to be not covered based on clinical criteria do not constitute “clear exclusions” under the member’s plan, as the member is not likely to be able to ascertain on the face of the EOC that such services will not be covered.

ODs can be initiated by you as the provider or the member in order to determine if the requested/ordered service is covered prior to a member receiving it or prior to scheduling a service such as a lab test diagnostic test or procedure.

Questions and Answers

Below are answers to some of the frequently asked questions on the topic of ABNs.

Q: All my patients sign an ABN stating they will be financially responsible for anything their insurance does not cover. Can I still use this process?

A: No, ABNs are for original Medicare and are not permitted for use with MCA members. An ABN does not allow you to hold a member financially responsible for services that their MCA plan won’t cover. To hold a member financially responsible for a service, the member must be notified through MCA’s OD process that the item or service will not be covered by MCA. This OD must be completed prior to providing the item or service.

Q: An item or service is sometimes covered based on medical necessity. I’m not sure if my patient qualifies, what should I do?

A: If you aren’t absolutely sure the service is covered, you or the member should request an OD from MCA. This OD should be completed prior to the service being provided. MCA will make a decision after reviewing the request and any relevant medical records. ODs can be standard (14 days or less) or an OD can be

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expedited (72 hours or less) if the physician believes that delay would place the member’s life, health or ability to regain maximum functioning in serious jeopardy.

Remember, unless the service or supply is never covered under original Medicare, you will not be able to hold the MA member financially responsible for the non-covered service unless the member has a pre-service OD denial from MCA and receives the services.

Q: What should I do if an item or service is excluded from coverage and is explicitly listed as an exclusion in the Evidence of Coverage (EOC)?

A: If the EOC clearly indicates that the service is not covered under any circumstance, members and providers do not need to go through the OD process. Providers can hold the MA member financially liable for these services. However, you should educate the member that the service is NOT covered by Medicare or MCA and they will be held responsible.

Q: Can a member be held financially responsible for a non-covered service if he or she was advised to request an OD but did not?

A: It depends. If the service is never covered by original Medicare or is listed as a clear exclusion in the member’s EOC, then the member can be held financially responsible without an OD. However, if this exception does not apply, and the member was advised to obtain an OD but does not, then you will not be able to bill the member for the non-covered service. It is for this reason that many providers choose to initiate the OD process on behalf of their members.

Q: Do I need to get the member’s permission before requesting an OD on the member’s behalf?

A: No permission or proof is needed for a provider to request an OD on behalf of a patient. Providers can, and often do, request ODs on behalf of their patients.

Get more information

Information about the OD process and the probation of ABNs can be found in Chapter 4, section 170, of the Medicare Managed Care Manual or the Code of Federal Regulations in section 42 CFR §§ 422.568 and 422.572. You can also reference the HPMS memo titled “Improper Use of Advance Notices of Non-coverage” issued on May 5, 2014.