Payment Policy and Procedure

Policy Number: GAODN1

Policy Title: Acknowledgement and Financial Responsibility

Applies To: Generations Advantage

PURPOSE

This policy defines the limitations on billing a Martins Point Healthcare Generations Advantage member and the process a provider must follow order to bill the beneficiary for Medicare Part C Non-Covered Services.

POLICY

Patients covered on Medicare Advantage plans—like Martin's Point Generations Advantage—must be held harmless for any additional charges above deductibles and other plan-determined cost shares (copayments/coinsurance) for **covered** services. Beyond these member responsibilities, providers will look solely to the Generations Advantage plan for payment for such covered services.

In 2014, CMS outlined requirements for providers with Medicare Advantage patients who are considering receiving services that **may not be covered**. In this situation, if there is any doubt of coverage based on the benefits outlined in the Generations Advantage *Evidence of Coverage* document (including where coverage is contingent on proof of medical necessity) the provider must follow the Organization Determination process. Members cannot be expected to know when a service is medically necessary and when it is not.

Providers must do the following in order to be able to assign financial liability to patients in the case of non-coverage:

> The provider or patient must request that Generations Advantage make a preservice **Organization Determination**—a formal notification from the plan as to whether we will authorize coverage for the service.

- If the plan authorizes coverage, the member pays any plan-determined deductibles/cost shares and is held harmless for any additional charges.

- If the plan denies authorization for coverage, the plan issues an **Integrated Denial Notice (IDN)**, informing the plan member and their provider of the specific reason for the denial as well as the member's appeal rights under the Medicare Advantage program. **If the member chooses to proceed with treatment with the full knowledge that it is not covered (as confirmed by the IDN), the**

provider may then hold the member financially liable for the cost of services.

IMPORTANT NOTE: *This process IS NOT the same as the ABN (Advance Beneficiary Notice) process used with patients covered by Original Medicare. CMS does not permit the use of ABNs for Medicare Advantage plan members.*

For services that are clearly **never covered**, as indicated in the "exclusions" section (found at the end of the Medical Benefits chart in the Generations Advantage *Evidence of Coverage* document), providers must do the following in order to be able to assign financial liability to the patient:

- The provider must notify the patient (preservice) of lack of coverage as indicated in the "exclusion" section of the plan's *Evidence of Coverage* document; and of the patient's financial liability must they proceed with treatment.

- Document this conversation in the patient's record. **If the patient chooses to proceed with treatment with the full knowledge that it is not covered (as documented in the patient record). Documentation must additionally include the date of service, procedure code, and dollar amount to be billed to the patient. Once documented the provider may then hold the member financially liable for the cost of services.**

Where to Find the *Evidence of Coverage* for All Generations Advantage Plans
Please go to: https://medicare.martinspoint.org/Member-Toolkit/Plan-Documents.

How to Request an Organization Determination
Providers (the member's PCP or the servicing provider/facility) may request a preservice Organization Determination using our Authorization Request Form
(Available online **at https://ForProviders.MartinsPoint.org/Tools/Preauthorizations)** or, by calling **1-888-339-7982,** 8 am–4:30 pm, Monday through Friday.

How to Bill a Patient for Non-covered Services
If you have received an **IDN** from the plan, or you have documented the member's acknowledgement that they were advised the service is not covered under the plan, the member may be financially responsible for charges. Contracted providers must submit a claim with the GY modifier appended to applicable non-covered line items. If a Member elects to purchase an item above the basic covered item, providers must submit a claim with the basic code on line one and the deluxe features on subsequent lines with a GY modifier.