December 28, 2015

Frequently Asked Questions regarding Advanced Notices of Non-Coverage

On May 5, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a memo addressing the "Improper Use of Advanced Notices of Non-coverage." This clarified that:

1) Medicare Advantage organizations must provide the member with a standard written denial notice (form CMS-10003- Notice of Denial of Medical Coverage, also known as the Integrated Denial Notice) when a pre-service organizational determination is made. This notice includes the specific reason for the denial and informs the member of his or her appeal rights.
2) A pre-service organizational determination and the appropriate notice must be obtained in order for a provider to hold a Medicare Advantage patient financially responsible.
3) Advance Beneficiary Notices (ABN's) are not intended for use with individuals enrolled in Medicare Advantage plans. Their use is limited to Original Medicare only.

As a result, UCare published a Provider Bulletin on January 26, 2015, instructing providers to discontinue use of the ABN. Providers hold *UCare for Seniors* and *EssentiaCare* members financial liable for non-covered services, including services that were provided under a previously-executed ABN/waiver, unless that member has received a pre-service determination (PSD) from UCare. If services are supplied before UCare issues a PSD and the member receives a written denial notification, the provider may only be allowed to bill the member for the applicable cost-sharing amounts (i.e., copayments, coinsurance, and/or deductible).

UCare received several questions from providers regarding the January 26, 2015 bulletin, including when the GA and GY modifiers would be applicable. On January 1, 2016, UCare will implement several changes to consistently process Medicare claims billed with the GA and GY modifiers.

Effective for claims received on or after January 1, 2016, UCare will fully implement revised definitions of the GA and GY modifiers for *UCare for Seniors* and *EssentiaCare* claims as noted in the chart below.

Modifier	Medicare definition	UCare definition for Medicare benefits
GY	If the service provided is statutorily excluded from the Medicare program, the claim will deny whether or not the modifier is on the claim.	The item, service or procedure is not covered according to the member EOC. Pre-service determination is not required. Deny patient responsibility.
GA	The provider or supplier has provided an ABN to the patient. Service denies under a "medical necessity" denial.	A pre-service determination of "not covered" was obtained from UCare. Service, item or procedure will deny patient responsibility.

As a Medicare Advantage plan, UCare can and does cover some statutorily excluded services, so it's important to consult the member's EOC. These documents are available for all UCare plans at www.ucare.org.

Below are answers to frequently asked questions regarding UCare's implementation of the ABN guidance and the use of GA and GY modifiers.

Q: **Under what circumstances am I required to obtain a pre-service determination (PSD)?**

A: A pre-service determination (PSD) is needed in order to hold a *UCare for Senior* or *EssentiaCare* member financially liable for non-covered services that are not clearly excluded in the member's Evidence of Coverage (EOC). Providers must obtain a pre-service determination (PSD) **BEFORE** rendering a service, item or procedure that may not be covered. The non-covered service should not be rendered until UCare issues a determination.

Q: **When am I not required to get a PSD?**

A: The following scenarios do not require a PSD:

- When there is no reason to believe a service item or procedure would not be covered and there is no intention at any time to bill the member for costs beyond their applicable cost-sharing.
- When the service, item or procedure is clearly documented as not covered or excluded from benefits in the member's EOC. (Note: As a Medicare Advantage plan, UCare can and does cover some statutorily excluded services, so it's important to consult the member's EOC. These documents are available for all UCare plans at www.ucare.org.)

A service, item or procedure may not be covered if any of the following apply:

- UCare has provided general notice, including medical and payment policies, that we will not cover a particular service or a particular service will be covered only under certain circumstances.
- CMS has published guidance through National Coverage Determinations, Local Coverage Determinations or other CMS guidance to indicate the service may not be covered in certain circumstances. Providers are required to review the available guidance in the Medicare Coverage Center at https://www.cms.gov/Center/Special-Topic/Medicare-Coverage-Center.html.

Please see below for when to use the GY modifier for a non-covered service.

Q: **How do I request a PSD from UCare?**

A: To get a PSD for most medical services, submit a PSD request to UCare Clinical Services by completing the Clinical Services authorization form (found on UCare's Eligibility & Authorization page) and faxing it to 612-884-2499 or 1-866-610-7215 BEFORE rendering services.

If a PSD is needed for a physical, occupational or speech therapy service, please submit a prior authorization request to Magellan Healthcare (previously known as Health Services Management, Inc. – HSM). More information is available here: https://www.hsminc.com/ucare/home/

Q: **How and when will the patient and I know if a PSD has been denied or approved?**

A: If a PSD request results in a "not covered" determination the member will receive a Notice of Denial of Medical Coverage letter in the mail indicating the denial reason, their financial liability and appeal rights. The provider will receive a copy of this denial notice via fax.

If a PSD request results in a "covered" determination the member will receive a letter indicating services have been approved for coverage. The provider will receive a copy of this approval notice via fax.

Standard PSD requests can take up to 14 days. Urgent requests are completed up to 72 hours. Urgent requests are reserved for life-threatening services only.

Q: **When should I bill a service, item or procedure with the GA and GY modifiers?**

A: Below is a description of what to expect when using the GA and GY modifiers on services, items and procedures billed for *UCare for Seniors* and *EssentiaCare* members.

GA modifier: This modifier should only be used to indicate a PSD of "not covered" was obtained from UCare for the service, item or procedure. The patient and provider received a Notice of Denial of Medical Coverage from UCare for a rendered service, item or procedure. Services billed with a GA modifier will deny and become the patient's liability.

If the provider bills the GA modifier for a service, item or procedure that did not have PSD or the PSD resulted in a "covered" status, the claim line will deny to provider liability due to inappropriate use of the modifier. If a PSD request results in a "covered" determination, the service should be billed as a covered benefit (i.e. without GA/GY modifiers).

GY modifier: This modifier indicates that the item, service or procedure is not covered according to the member's Evidence of Coverage (EOC). The service, item or procedure does not require a PSD to be obtained for the service to be denied as not covered. Services billed using the GY modifier will deny to patient responsibility.

Q: When is it acceptable for me to bill a *UCare for Seniors* or *EssentiaCare* patient for services that are never covered?

A: It is not necessary for provider to obtain a PSD from UCare to bill members for services that are clearly indicated as not covered in the member's EOC. This typically includes statutorily excluded Medicare services; however, as a Medicare Advantage plan, UCare can and does cover some statutorily excluded services. It's important to consult the member's EOC. These documents are available for all UCare plans at www.ucare.org.

Providers may collect payment from Medicare patients for never covered services when patient responsibility (PR) is assigned on the remittance advice for the service, item or procedure.

Q: What if I expect the PSD to be denied or "not covered" but the request is approved or determined to be covered?

A: Only services included in a denied or not covered PSD can be billed to *UCare for Seniors*/*EssentiaCare* patients. If services are approved through the PSD process, the patient may not be billed and claims should be submitted to UCare without the GA/GY modifiers for payment.

Q: Can a member request a PSD?

A: Yes. If a member wants to request a PSD, they should contact Customer Service at the phone number on the back of the member ID card.

Q: How are UCare members aware of the process for non-covered services?

A: Below are the chapters in the *UCare for Seniors* Evidence of Coverage (EOC) that address non-covered services.

- Chapter 3: Using the plan's coverage for your medical services
  - Section 4.2 - If services are not covered by our plan, you must pay the full cost
- Chapter 4: Medical Benefits Chart (what is covered and what you pay)
  - Section 1.33 - Our plan does not allow providers to "balance bill" you
- Chapter 7: Asking us to pay our share of a bill you have receive for covered medical services or drugs
- Chapter 8: Your rights and responsibilities

Questions? If you have further questions, please call UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.