ATRIO™
HEALTH PLANS

Notice of Non-Covered/Covered Medical Services

This notice applies to services on the ATRIO Medicare Advantage plans.

Under Medicare Advantage (Part C) rules, plans are to provide appropriate notice of non-coverage/coverage to the members and educate providers on 1) coverage & exclusions of medical services, 2) limits of plan coverage, and 3) how to correctly advise members prior to providing services of such limitations or service exclusion under Medicare. To ensure that you understand what your role and responsibility is concerning covered and non-covered medical services we are providing you this notice as a guide.

Providing Notice of (Non) Coverage

The first method ATRIO utilizes to educate members of non-covered services is provided upon enrollment through the Evidence of Coverage (EOC) booklet Chapter 4, Section 3: “What services are not covered by the plan?” The second method is provided through the “Notice of Denial (or Partial denial) of Medical Coverage” issued through the pre-service determination (also known as “prior authorization”, coverage determination, organization determination) process. Lastly, for every service that is billed to ATRIO for payment, the member receives Explanation of Benefits (EOB) that provides an explanation of the charges and what if any the member is financially responsible for paying to the provider. When an EOB is issued to the member, as a provider you will receive a Remittance Advice, which provides more detail of the services, charges, and payment codes and explanations.

Unsure if Covered

For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining member financial liability. In such instances, the appropriate process is for the member, or the provider acting on behalf of the member, to request a pre-service determination.

Never Covered

However, if a service is <u>never</u> covered by the plan (statutorily excluded from coverage per Medicare rules) and the plan’s Evidence of Coverage (EOC) provided to the member is clear that the service or item is never covered, ATRIO is not required to hold the member harmless from the full cost of the service or item.

Appeal Rights

For any payment or coverage request for service that ATRIO receives that is denied, a standardized denial notice as stated above is provided with appeal rights. The member or you as their treating provider have the right to appeal any denial of a service or item.

Member liability

When the provider, or the plan acting on behalf of the provider, can show that a member was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that:

a) the item or service is not covered by the plan; or
b) that coverage is available only if the member is referred for the service by a contracted provider

And nonetheless, the member receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require that plans to hold the member harmless from the full cost of the service or item charged by the provider.

Medicare Advantage billing rules are different

This page explains how and when to bill a member for non-covered services.

As a contracted provider with ATRIO Health Plans you must always submit a claim for payment of services to ATRIO prior to billing our members, even if you have received a pre-service determination denial. The Remittance Advice will always provide an indication of when a service is non-covered and what if any financially responsibility for payment of a service belongs to the member.

Billing for Non-covered Services

GY - No pre-service determination was made

Use this modifier to tell us that you informed/explained to the member that in his/her ATRIO Health Plan EOC there was a "clear" exclusion and the service was not covered.

GA - Pre-service notice of non-coverage was provided by the plan

Use this modifier to tell us that:

- A pre-service determination was requested and the “Notice of Denial (or Partial denial) of Medical Coverage” was issued; or
- The member either refused your offer of obtaining a pre-service determination or wanted to proceed with the service.

Note: When using this modifier please also provide the pre-service determination number in field #23 of the CMS1500 form.

When claims are billed with these modifiers they are processed with the appropriate codes for member financial liability and you may bill the member.

However, if you bill us for **non-covered** services **without** using the GA or GY modifier, ATRIO Health Plans will deny your claim as provider responsibility. If you bill us for **Covered** services **with** the GY or GA modifier, ATRIO Health Plans will deny your claim for incorrect use of modifier.

Part of your responsibility as a contracted provider is to inform your patients when a service is not covered (or statutorily excluded) by ATRIO Health Plans. In order for ATRIO Health Plans Medicare Advantage to know if you have given proper notice of non-coverage to our members, you must follow our billing rules and use the modifiers as stated above. Following our billing rules and appropriate use of the modifiers ensures that you understand when to provide proper notice of non-coverage of medical services to our Medicare Advantage plan members in advance and limits the confusion of coverage and financial responsibility between the members and ATRIO Health Plans.

IMPORTANT REMINDER: Improper Use of Advance Notices of Non-Coverage (ABN)

On May 5, 2014 CMS released a memo titled “Improper Use of Advance Notices of Non-coverage”, directing all Medicare Advantage Organizations (MAO) and their contracted providers to cease with using ABN notices and ABN-like notices as they are not compliant with the MA organization determination requirements. Per CMS, an ABN does not apply in or under the Medicare Advantage context because a MAO member has the right under these statutes and regulations to a pre-service determination prior to receiving services.

CY 2016 Clarification of Covered Preventive Services

On 01/01/2016, we discontinued providing coverage for preventive services that are not listed in ATRIO Health Plans EOC. All ATRIO Health Plans EOCs specify coverage for “Medicare Covered Preventive Services”. This is not a change in benefit language from prior years, so an Annual Notice of Change (ANOC) was not necessary for this benefit. Preventive services identified in range 99381 through 99397 are not covered by Original Medicare. ATRIO Health Plan MA is not able to cover this service as a supplement benefit for 2016 benefit year as we did not enter in a Bid for Medicare approval. Medicare covered preventive services include a “Welcome to Medicare” preventive visit, Annual Wellness Visit (not to be confused with Physical Examination), and limited preventive screenings/examinations. Medicare does not provide coverage for routine physical exams. See attached link to view Medicare Preventive Service chart (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS-QuickReferenceChart-1TextOnly.pdf).