MEDICARE ADVANTAGE - MEDICAL NECESSITY CLAIM DENIALS

BACKGROUND/OVERVIEW
At times, providers may encounter situations in which a claim for services provided to a Medicare Advantage member is denied because medical necessity criteria were not met. New guidelines have been developed to identify when a member with coverage under FreedomBlue PPO can be billed for services rendered in such situations.

A participating, preferred or network provider cannot bill the member for the denied service unless all of the following are true:

- The provider has given advance written notice, informing the member that the specific service to be provided may be deemed not medically necessary; and
- The written notice includes an estimate of the cost; and
- The member must agree in writing to assume financial responsibility, in advance of receiving the service; and
- The signed agreement is maintained in the provider’s records.

Purpose of the Written Notice
The purpose of a signed agreement is to document that a) the provider has had a conversation with the member regarding lack of coverage for the specific service to be performed and the estimated out-of-pocket expense the member will incur, and b) the member agrees in writing to be financially responsible for the cost of the service. This conversation must occur before the service is provided and the claim is submitted.

New Forms for Members With Coverage Under FreedomBlue PPO
Following guidelines established for Traditional Medicare by the Centers for Medicare & Medicaid Services (CMS), Highmark will provide Pre-Service Denial Notice forms that must be used in these instances for FreedomBlue PPO members. The Pre-Service Denial Notice forms were modeled after the Advance Beneficiary Notice of Noncoverage (ABN) Form commonly used for Traditional Medicare. A sample of the form is included in this bulletin. Providers can also access and download these forms from the Blue Cross of Northeastern Pennsylvania® (BCNEPA) Provider Center via BCNEPA sponsored Navinet or corporate website at www.bcnepa.com.

Please note that the Pre-Service Denial form is specific to the service to be provided and may not be used to secure a routine or “blanket” acceptance of financial responsibility by the FreedomBlue PPO member.

If the FreedomBlue PPO member has questions about the form or about his or her appeal rights, the member can be directed to contact the appropriate Member Service department, at the telephone number listed on his or her ID card.

New EOB/Remittance Remark Code
Effective January 2009, when a claim is denied for medical necessity reasons, the denied amount is reported on the Remittance Advice and Explanation of Benefits as Provider Penalty. In addition, the member’s Explanation of Benefits will indicate that the amount owed the provider is $0.00. This is the case because if the member has not signed a waiver agreeing to be financially responsible for the services rendered, the provider cannot in fact bill the member for the service deemed not medically necessary. However, the member’s Explanation of Benefits will also display the following remark.code message, clearly stating that the member can be billed for the service if he or she has signed a waiver: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.

This information will also be delivered via ANSI Group and Reason Code CO 50 and Remark Code N492 in the provider’s HIPAA 835 Transaction/Electronic Remittance Advice.
IMPACT/ACTION
Highmark’s payment to providers constitutes reimbursement for services rendered according to the facility’s highest standard of care. The availability of the waiver option as described above does not give providers the ability to charge Highmark members outside of the normal claim process for services or items provided in the course of a covered inpatient stay or outpatient visit.

Providers are asked to develop internal procedures to ensure that Highmark members receive the appropriate written notification, according to the specifications above, in all situations in which a service will be denied for medical necessity reasons. The signed agreement is to be maintained in the provider’s records and must be available as needed for audit.

As always, providers are expected to comply with all applicable regulations governing retention of records.

Important Reminder:
Highmark’s medical policy already allows a provider to bill a Medicare Advantage member for services that are deemed to be experimental or investigational. In such cases, Highmark asks providers to ensure that the member understands that he or she is personally liable for the cost of services that are considered to be experimental or investigational.

ASSISTANCE
Questions about the Pre-Service Denial Notice form should be directed to the FreedomBlue PPO Facility Provider Service Unit, at 1-866-588-6967 or 1-866-803-3708, option #3. Other questions regarding this bulletin may be directed to your BCNEPA Provider Relations Consultant.

Inquiries About Eligibility, Benefits, Claim Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark encourages providers to use the electronic resources available to them – NaviNet and the applicable HIPAA transactions – prior to placing a telephone call to the Provider Service Center.
<table>
<thead>
<tr>
<th>Pre-Service Denial Notice</th>
<th>Provider Name</th>
<th>Provider Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member's Name</td>
<td>Member's ID Number</td>
<td></td>
</tr>
<tr>
<td>Item/Service Denied</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Estimated Cost:

There are certain items and services that are not paid for by Original Medicare or FreedomBlue PPO, even some care that you or your health care provider have good reason to think you need. We expect that FreedomBlue PPO may not pay for the Item/Service listed above.

WHAT YOU NEED TO DO NOW.
- Read this notice, so you can make an informed decision about your care.
- Ask any questions that you may have after you finish reading.
- Choose an option below about whether to receive the item/service listed above.

OPTIONS: Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the Item/Service listed above. You may ask to be paid now, but I also want FreedomBlue PPO billed for an official decision on payment, which is sent to me on an explanation of benefits (EOB). I understand that if FreedomBlue PPO doesn’t pay, I am responsible for payment, but I can appeal to FreedomBlue PPO by following the directions I receive from FreedomBlue PPO.

- **OPTION 2.** I want the Item/Service listed above, but do not bill FreedomBlue PPO. You may ask to be paid now as I am responsible for the payment. I cannot appeal if FreedomBlue PPO is not billed.

- **Option 3.** I don’t want the Item/Service listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if FreedomBlue PPO would pay.