Reimbursement Policy

Plan-Directed Care

REIMBURSEMENT POLICY NUMBER: RP35

Effective Date: 10/1/2023

Last Review Date: 9/2023

Next Annual Review: 9/2024

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do no not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☒ Facilities

Plan Product:

☐ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

Note: For the purposes of this policy, the terms "contracted providers," "in-network providers," and "plan providers" are used interchangeably.

I. **In-network (contracted)** providers are obligated to obtain prior authorization from the

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

Company before making referrals to (when appropriate or required under the Member Benefit Plan) or ordering services from out-of-network (non-contracted) providers.

II. **In-network (contracted)** providers must order, provide, or supply only services and items which are considered covered by Medicare. Services or items which are not covered by Medicare are denied as provider financial responsibility unless an organization determination was submitted and a Company (Plan) determination made prior to services being rendered.

III. In the absence of a prior authorization, members may be held financially liable for items and services that are clear and direct benefit exclusions of the member Evidence of Coverage (EOC).

POLICY GUIDELINES

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Plan-Directed Care

Medicare Advantage Organizations (MAOs) and their contracted providers must ensure services rendered, ordered or referred for Medicare Advantage members are covered (including being considered medically reasonable and necessary) by Medicare and/or the MAO plan. Since Medicare considers a contracted provider to be an "agent of the MAO," if an in-network provider refers or orders a service from an out-of-network provider, this is considered "plan-directed care" and Medicare prohibits holding the member financially responsible when plan rules are not followed.[1]

According to Medicare, "Contracted providers are expected to coordinate care or work with plans prior to referring an enrollee to a non-contracted provider to ensure, to the extent possible, that enrollees are receiving medically necessary services covered by their plan."[1] Therefore, if a **contracted** provider provides or supplies a service or item which is not covered by Medicare or does not meet medical necessity criteria for coverage, the service will deny as **provider liability**.

Contracted providers are expected to be knowledgeable of Medicare coverage rules, as well as coverage rules found in Company medical policies. In accordance with Medicare requirements and the provisions of in-network provider agreements, providers must assure that all services are Medicare eligible – including meeting medically reasonable and necessary requirements – before those services are rendered. The following resources provide coverage criteria, as well as specific documentation requirements (this list of resources may not be all-inclusive):

- Medicare Internet-Only manuals (IOM) can be found on the CMS IOM website.
- national and local coverage determinations (NCDs and LCDs) are found on the Medicare Coverage Database.
- The Company's portfolio of current policies can be found online and accessed here.

In addition, **in-network** providers are contractually obligated to obtain prior authorization from the Company prior to referring a Medicare Advantage member to a **noncontracted** provider.

Exceptions

There are some exceptions to the plan-directed care rule, which include the following:

- Services or items which are a clear and direct exclusion of the member's Evidence of Coverage (EOC). These services or items will deny as member liability.
- Services or items for which the member has received prior written notification of the Company's non-coverage position (i.e., denied prior authorization requests are not subject to plan-directed care provisions because the member is receiving the appropriate non-coverage notice by the Company, as required under Medicare regulation).
- Services or items which are provided or furnished by a contracted provider but deemed to be not medically necessary. These will be denied as provider liability in accordance with the provider contract.

Advanced Beneficiary Notices (ABN)

While Original Medicare uses the Advance Beneficiary Notice of Non-Coverage (ABN) form, CMS prohibits Medicare Advantage (MA) plans from using the ABN form for MA members.[2] Instead, MA plan members have the right to obtain a coverage decision prior to obtaining an item or service. This request for a pre-service coverage review is also known as a request for a pre-service organization determination.[1] This means providers are unable to use the ABN form for services provided to MA plan members as an alternative to any plan-directed care provision requirement (such as the organization determination process).

Pre-Service Organization Determinations

A pre-service (advance) organization determination can be requested for any item or service believed to be covered by the MA Plan **and/or** when a contracted provider refers a member to a noncontracted provider. These must be submitted ***prior to*** services being received. Either the member, the provider acting on behalf of the member, or another authorized representative of the member (known as appointment of representative, or AOR) may request a pre-service organization determination. If the Company denies the request, a written denial notice with appeal rights will be issued.

It should be noted that a non-coverage determination does not constitute medical advice, nor does it attempt to govern a provider's practice of medicine. It only reflects the Company's reimbursement and coverage position in accordance with Medicare rules and regulations. Physicians and members must exercise clinical discretion and personal judgment in determining medical care and services ultimately received. This pre-service organization determination process allows the individual MA plan member the opportunity to make informed decisions about receiving potentially non-covered care and any financial responsibilities around those services, as well as offer the member the opportunity to appeal any non-coverage decision, if they choose.

SUMMARY

Contracted providers are responsible for ensuring they are providing, suppling, and ordering services that are covered by Medicare and the Medicare Advantage plan. This means any service that is not covered by Medicare or is not a clear exclusion of the member's EOC must not be provided without obtaining an advance (pre-service) organization determination by the Company.

Contracted providers must obtain a prior authorization from the Company before referring a Medicare Advantage member to a **noncontracted** provider.

If non-covered services are provided by a **contracted** provider without an organization determination from the Company, claims for these services may be denied as **provider** responsibility.

The above does not apply to items or services that are clear exclusions of the member EOC documents, for which the member may be held financially liable without a written pre-service determination. Likewise, if an unfavorable pre-service organization determination is made by the Company prior to the services being rendered and the member still wishes to proceed with the service or item, then the claim will deny as the financial responsibility of the member.

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 160 – Beneficiary Protections Related to Plan-Directed Care; Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf [Cited 8/12/2022]
2. Medicare *Improper Use of Advance Notices of Non-coverage* Letter to MA Plans: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/improper%20abn%20use%2005%2005%2014_1.pdf

POLICY REVISION HISTORY

Date	Revision Summary
12/2022	New reimbursement policy (converted to new format 2/2023
10/2023	Annual review, no changes