DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE

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TO: Medicare Advantage Organizations, Medicare Health Care Prepayment Plans, and Medicare Cost Plans

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SUBJECT: Improper Use of Advance Notices of Non-coverage

The Medicare Enrollment & Appeals Group (MEAG) and Medicare Drug & Health Plan Contract Administration Group (MCAG) have received reports of Medicare Advantage organizations (MAOs) issuing notices to enrollees that advise of non-coverage for an item or service that do not comply with the requirements for such notices set forth under the organization determination process at 42 CFR Part 422, Subpart M. The notices being used by MAOs appear to be based on, and similar in purpose and content to, the advanced beneficiary notice of non-coverage (ABN) used in the Original Medicare program. Such notices are not applicable to the Medicare Advantage program, and are not appropriate for use by an MAO with respect to its enrollees. MAOs sending such notices should immediately cease this practice and instead follow the process for issuing a notice of a denial of coverage in accordance with 42 CFR §§ 422.568 and 422.572.

Original Medicare ABN notices were established in order to allow a Medicare beneficiary to find out whether a service is covered by Medicare without having to receive services, and then submit a claim for reimbursement for the costs of such services. By their own terms, the ABN requirements in the statute and regulations do not apply in the Medicare Advantage context. This is because a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services. Specifically, section 1852(g)(1)(A) requires MA organizations to "have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization. . .is entitled to receive a health care service under this section." The regulations at 42 CFR §§ 422.568 and 422.572 set forth rules that apply to this determination procedure. These rules must be followed when an MAO is making a determination of coverage, including the requirements applicable to the notice required upon making such a determination. Because these regulations are incorporated by reference for cost plans and HCPPs, the foregoing analysis applies to such plans as well.

Under the procedures at issue, when an MAO or cost plan or HCPP wishes to inform an enrollee that a service is not covered or that payment is denied, in whole or in part, the decision is an organization determination under 42 CFR § 422.566(b) and the appropriate notice must be used. *See* http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html (notice for denials of payment and coverage). This is reflected in the self-referral provision, at 42 CFR § 422.105(a), which states that when an enrollee receives an item or service of the plan that is covered upon referral or pre-authorization by a contracted provider, the enrollee cannot be financially responsible for more than the normal cost-sharing if the enrollee correctly identified himself or herself as an enrollee of the plan to the contracted provider prior to receiving the item or service. This limitation on liability under § 422.105(a) applies unless the contracted provider can show that the enrollee received prior notice that the item or service would only be covered if further action was taken by the enrollee. Such prior notice is the issuance of an organization determination. The enrollee's request for services from a contracted provider, whether such services are from that provider or from another provider in connection with a referral, is a request for an organization determination being made to an MAO representative. If the requested item or service is furnished to the enrollee, the furnishing of the item or service is a favorable organization determination made on behalf of the MAO. If the provider does not furnish the item or service (or does not make a referral) because the provider believes the item or service may not be covered, the contracted provider must advise the enrollee to request a pre-service organization determination from the MAO or the provider can request the organization determination on the enrollee's behalf.

This long-standing CMS policy is reflected in Chapter 4, section 170, of the *Medicare Managed Care Manual*. Section 170 of Chapter 4 states, in part, that services and referrals a contracted provider gives are considered plan-approved unless "notice is provided to the enrollee that the services will not be covered." MAOs appear to be misinterpreting this statement to mean that providing an advance notice to an enrollee that an item or service is non-covered (i.e., providing a notice outside of the organization determination process) is a permissible means of holding the enrollee financially responsible for the cost of an item or service provided by a contracted provider or a non-contracted provider on the basis of a referral from a contracted provider. However, these ABN-like notices are not compliant with the MA organization determination requirements.

Our Manual guidance in Chapter 4, section 170 means the notice provided as part of the organization determination processes set forth at 42 CFR §§ 422.566 – 422.576 is necessary for an MAO to deny coverage or payment. With respect to properly notifying enrollees regarding matters of non-coverage, MAOs are prohibited from circumventing the organization determination process. The use of non-compliant advance notices of non-coverage by MAOs diminishes the enrollee protections that are part of the organization determination process. In circumstances where there is a question whether or not the plan will cover an item or service, the enrollee has the right to request an organization determination. If coverage is denied, the plan must provide the enrollee with a standardized written denial notice (form CMS-10003) that states the specific reasons for the denial and informs the enrollee of his or her appeal rights. Unless a plan notifies an enrollee that an item or service will not be covered by issuing standardized denial notice CMS-10003, the MAO has not complied with the applicable regulations in 42 CFR Part 422, subpart M; the failure to provide a compliant denial to the enrollee means that the

enrollee is not liable for services provided by a contracted provider or upon referral from a contracted provider. To enhance understanding of and compliance with these requirements, CMS plans to issue clarifications to Chapter 4 of the *Medicare Managed Care Manual*, consistent with this memorandum.

Any concerns an MAO may have with the provision or referral of services should be addressed under its contractual arrangements with its network providers, not by going outside of the organization determination process and related notice requirements that protect beneficiaries.

As noted above, MAOs that are currently issuing advance notices of non-coverage outside of the organization determination process are to immediately cease from doing so. Continuation of this practice may result in compliance action. Plans that have questions regarding this memorandum should contact their account manager.