Posted on 01-23-2015

TODAY'S MESSAGE

CMS UPDATE ON PRE-SERVICE ORGANIZATION DETERMINATIONS FOR MEDICARE ADVANTAGE MEMBERS

DIRECTION REGARDING EVIDENCE OF COVERAGE (EOC) EXCLUSIONS

Earlier this year, the Centers for Medicare and Medicaid Services (CMS) issued clarification regarding how Medicare Advantage members should be notified when requested or recommended services may not be covered. In response Highmark published specific directions in **May, 2014** addressing how and when members or providers on the member's behalf must request pre-service organization determinations (decision about coverage of a service or an item) prior to the receipt of non-covered services. At that time, providers were also instructed to discontinue use of Pre-Service Denial Notice forms as this practice was against CMS regulation.

In November, CMS reinforced its stance on this policy, stating that when a provider believes that an item or service may not be covered for a member, the member or provider must request a pre-service organization determination from the health plan. However, CMS did provide for a new exception to this policy regarding requirements related to organization determinations for services or items that are never covered by Medicare or the members' Medicare Advantage plan. Therefore, effective immediately, pre-service organization determinations **are not required** for members receiving the following services listed as a clear exclusion in Highmark's Evidence of Coverage (EOC) and issued to all Medicare Advantage members:

1) Private duty nurses
2) Personal items in member's room at a hospital or a skilled nursing facility, such as a telephone or a television
3) Full-time nursing care in the member's home
4) Custodial care provided in a nursing home, hospice, or other facility setting when the member does not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps the member with activities of daily living, such as bathing or dressing
5) Homemaker services including basic household assistance, including light housekeeping or light meal preparation
6) Fees charged by member's immediate relatives or members of the member's household
7) Meals delivered to the member's home
8) Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids
9) Reversal of sterilization procedures, sex change operations, and non-prescription contraception supplies
10) Acupuncture
11) Naturopath services (uses natural or alternative therapies)
12) Services provided to veterans in Veterans Affairs (VA) facilities
13) Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines
14) Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease

The services listed above are not eligible for payment, and can be billed to the members.

HIGHMARK®

CONCLUSION

The following summary outlines the important facts regarding pre-service organization determinations for Medicare Advantage members:

- Providers are still required to direct members to obtain or request a pre-service organization determination prior to the receipt of all non-covered services other than those listed above. Provider manuals will be updated to reflect this information.
- Existing timeframes previously communicated for organization determinations remain in force. **May, 2014**
- Discontinue use of Highmark Pre Service Denial Notice Forms. These forms have been removed from the Provider Resource Center.

HIGHMARK®