Fulcrum Health, Inc.

Policy Title:	**Non-Covered Services**		
Policy Number:	NM007	**Effective Date:**	10/01/2010
		Last Revision Date:	3/31/19
		Last Approval Date:	3/31/19
Responsible Area/Individual:	Network Management		
Purpose:	To establish guidelines for billing patients for non-covered services.		
Regulation Reference:	HIPAA 164.522 (a)(1)(vi)(B), 42 CFR §§ 422.566 – 422.576, Medicare Managed Care Manual, Chapter 4, section 160 MHCP Provider Manual DHS 2019 Contract – State of Minnesota DHS 3640 form Minnesota Rules 9505 Minnesota Statutes 256B.0625, subd. 55 Payment for noncovered services		

POLICY:
It is the policy of Fulcrum Health, Inc. that contracted network providers comply with all administrative requirements for billing members for non-covered services, as follows.

Never-Covered Services:

- Notify patients and obtain proper patient acknowledgement of member liability prior to delivering non-covered services for which the member will be billed.

Services that may not be covered, e.g. spinal manipulation believed to be in a maintenance or wellness phase of care:

Medicare Patients:

- Obtain required pre-service organizational determinations of coverage.
- Notify patients and obtain proper patient acknowledgement of member liability prior to delivering non-covered services for which the member will be billed.

Medicaid Patients:

- Obtain required pre-service organizational determinations of coverage.
- Notify patients and obtain proper patient acknowledgement of member liability prior to delivering non-covered services for which the member will be billed.

- If the service is denied and the patient chooses to receive the denied service, submit claim to Fulcrum and receive claim denial before billing the patient.

Commercial Patients:

- Notify patient and obtain proper patient acknowledgement of member liability prior to delivering non-covered services for which the member will be billed.
- Pre-service organizational determinations of coverage are not required for commercial members but are recommended.

Failure to follow administrative procedures noted above and further defined below will annul the patient's liability for any non-covered service provided.

BACKGROUND:

Network providers are expected to understand general benefit limitations associated with each line of business that Fulcrum Health, Inc. administers, e.g. Commercial, Medicare, Medicaid, etc. Further, Fulcrum Health, Inc. requires its contracted network providers to obtain required pre-service organizational determinations of coverage, notify patients of non-coverage and the related financial liability prior to the delivery of any such service, and submit required claims for elective services before billing the patient. Related processes must comply with all state and federal requirements in order to support patient billing.

PROCEDURE:

Never-Covered Services (All Patients)

- **When the service is never payable when rendered by a chiropractor based on the patient's coverage, e.g. exam, modality, procedure, etc.:**

1. Prior to rendering the service, provider must obtain and retain the patient's written consent to receive and accept financial liability for the non-covered service(s).

If this step is not completed prior to delivery of the service, all patient financial liability related to the non-covered service will be annulled.

Services that May or May Not be Covered:

Medicare Patients:

- **When the service being delivered may, or may not be covered, e.g. spinal manipulation believed to be in a maintenance or wellness phase of care:**

1. CMS requires that a pre-service organization determination (authorization request) be submitted to confirm coverage or lack thereof. Patients will be notified of an approval or denial through distribution of the standard

member communication, i.e. Notice of Denial of Medical Coverage, or Integrated Denial Notice, prompted by the organization determination. This communication will also provide the member with any applicable appeal rights.

Organizational determinations of denial for typically covered services, i.e. spinal manipulations found to not be medically necessary, are eligible for patient billing provided the following step is completed.

2. If the service is denied and the patient chooses to receive the denied service, providers must obtain and retain the patient's written consent to receive, and accept financial liability for the non-covered service, prior to the service being rendered.

If either of these steps is not completed prior to delivery of the service, all patient financial liability related to the non-covered service will be annulled.

Medicaid Patients:

- **When the service being delivered may, or may not be covered, e.g. spinal manipulation believed to be in a maintenance or wellness phase of care:**

1. DHS requires that a pre-service organization determination (authorization request) be submitted to confirm coverage or lack thereof. Patients will be notified of an approval or denial through distribution of the standard member communication, i.e. Notice of Denial of Medical Coverage, or Integrated Denial Notice, prompted by the organization determination. This communication will also provide the member with any applicable appeal rights.

   Organizational determinations of denial for typically covered services, i.e. spinal manipulations found to not be medically necessary, are eligible for patient billing provided the following additional steps are completed.

If the service is denied and the patient chooses to receive the denied service, providers must:

2. Obtain and retain the patient's written consent to receive, and accept financial liability for the non-covered service, prior to the service being rendered.

3. After the service is rendered, submit a claim to Fulcrum and receive a claim denial for patient liability before billing the patient.

If any of these steps are not completed prior to delivery of the service, all patient financial liability related to the non-covered service will be annulled.

MSHO members

Minnesota Senior Health Options (MSHO) is a product that includes coverage through both Medicare and the Minnesota Medical Assistance (Medicaid) program. When treating MSHO members, Medicaid rules must be followed.

- **Commercial Patients When the service being delivered may, or may not be covered, e.g. spinal manipulation believed to be in a maintenance or wellness phase of care:**

1. Fulcrum requires that network providers obtain and retain the patient's written consent to receive, and accept financial liability for the non-covered service, prior to the service being rendered.

   If this step is not completed prior to delivery of the service, all patient financial liability related to the non-covered service will be annulled.

2. To reduce risk to the network provider, Fulcrum recommends that a pre-service organization determination (authorization request) be submitted to confirm coverage or lack thereof prior to obtaining the patient's consent to accept financial liability.

Note: *Revisions to the HIPAA Privacy Rules now requires a provider to grant an individual's request* ***not*** *to disclose PHI to a health plan for a health care item or service where the individual has agreed to pay out of pocket.*

Obtaining Patient Consent – Medicaid and Commercial

To reduce risk to the network provider, Fulcrum Health, Inc. strongly recommends use of the Fulcrum Health, Inc. Non-Covered Services Financial Disclosure Form to clearly communicate chiropractic benefit limitations and document the patient's agreement to financial liability related to non-covered services. To ensure the patient's clear understanding, the form should be filled out in its entirety. Forms that do not contain the required elements listed below will be determined to be invalid, annulling the patient's financial liability.

Should the provider elect to use their own form to document proper member notification and patient agreement to financial liability, it must include the following elements:

1. Provider name.
2. Provider address.
3. Detailed list of non-covered services for which the member may be billed **and** the cost associated with each.

4. Signature of the provider or health care representative who explained the Financial Disclosure Form and discussed available options to the patient.
5. A clearly written statement indicating the patient's understanding that the identified services are not covered by insurance and patient agrees to pay for them in full.
6. Patient name.
7. Patient signature.
8. Date of patient signature (note: the signature must be obtained prior to the service being rendered and updated when benefits change or a maximum period of 12 weeks has lapsed).

Provider may not bill the patient, or the payor, for the applicable non-covered services if they fail to obtain appropriate documentation as described above. Further, failure by the provider to obtain and/or produce acceptable forms upon request could lead to corrective actions or change in network participation status.

Obtaining Patient Consent – Medicare

To support patient billing related to non-covered services rendered to Medicare members, Fulcrum Health, Inc. has developed a Medicare Member Consent for Non-Covered Services Form. Use of this form serves as documentation of the patient's written consent to receive and accept financial liability for the listed non-covered service(s). While it is recommended that providers utilize this form, providers may elect to use another version of a consent form however, it must include the following elements:

1. Provider name.
2. Provider address.
3. Detailed list of non-covered services for which the member will be billed, **and** the cost associated with each.
   Note: for spinal manipulations, the listed services must align with the organization determination (authorization) denial for both care volume and timeframe, e.g. 6 visits over 4 weeks. Spinal manipulations that have not been denied through the organization determination process can not be billed to the patient.
4. Signature of the provider or health care representative who explained the Consent Form and discussed available options to the patient.
5. Patient name.
6. Patient signature (note: The signature must be obtained prior to the service being rendered and updated when benefits change or a maximum period of 12 weeks has lapsed).
7. Date of patient signature (note: the signature must be obtained prior to the service being rendered and updated when benefits change or a maximum period of 12 weeks has lapsed).

Per the guidelines from Centers for Medicaid and Medicare Services (CMS), Managed Care Organizations, e.g. health plans (and their delegates) may not use the CMS Advanced Beneficiary Notice (ABN) Form to hold the patient financially responsible for any rendered service.

REFERENCES/ATTACHMENTS:

Fulcrum Health, Inc. Non-Covered Services Financial Disclosure Form
CLINUM120 Request for Organizational Determination of Maximum Therapeutic Benefit
Non-Covered Services Financial Disclosure Form – Frequently Asked Questions
Billing Medicare Members– Frequently Asked Questions

Document History:

Date	**Update**
10/10/2010	Policy effective date
06/16/2015	Policy updated
9/22/16	Yearly review and committee approval
9/21/17	Yearly review
06/27/2018	Moved from Credentialing to Network Management
3/31/19	Update to reflect 2019 DHS contract requirements for Medicaid members