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Claims System Update Addresses Medicare Advantage Liability that Does Not Fall on the Patient

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) plans to clearly delineate the specific services and items covered and not covered for plan enrollees.

CMS considers in-network providers to be agents of the Medicare Advantage organization who must follow the plan's internal procedures. This includes obtaining pre-authorizations required for certain services and items. Failing to do so means the item or service is not covered, and no liability falls to the patient.

In its preamble to the final rule, CMS states, "If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization), then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

For example, if a certain service is limited to four visits and a provider orders more than four, without following the below process Medicare will cover only four. Billing the patient for the extra visits may not be allowed.

If the MA beneficiary wants the service, the network physician needs to submit a pre-service Organization Determination to Florida Blue, obtain the denial, and submit the claim using a -GA modifier (indicating an Organization Determination was issued to the member and the provider in advance, as required by plan guidelines). The -GA modifier may only be billed if both an adverse Organization Determination was received, and the member's signature is on file in the provider's record. This record would indicate the member was advised in advance of the service, clearly understands it is not covered and has agreed to be responsible for the cost of the service. If the provider did not obtain the organizational determination in advance of providing a non-covered service, then the member may not be billed for that service.

For more information regarding billing for non-covered services, refer to the Medicare Products section of the Florida Blue Provider Manual.

To help prevent this type of billing to Florida Blue MA members, we have implemented some changes in our claims processing to automatically identify and deny claims that incorrectly place liability on the patient. This system update, which also helps create awareness of provider and patient responsibilities under our MA plan, became effective October 1, 2022.

This CMS rule can be found in the Managed Care Manual Chapter 4 Section 160 - Beneficiary Protections Related to Plan-Directed Care on the CMS.gov website.

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