Reasons for Non-coverage

- Experimental and investigational
- Not safe and effective
- Limited coverage based on certain criteria
- Obsolete tests
- Number of services exceed the norm and no medical necessity demonstrated for the extra number of services.

Examples of Medicare Program Exclusions are

- Personal comfort items
- Self-administered drugs and biologicals (i.e., pills and other medications not administered by injections)
- Cosmetic surgery (unless required for prompt repair of accidental injury or for improvement of a malformed body member)
- Eye exams for the purpose of prescribing, fitting or changing eyeglasses or contact lenses in the absence of disease or injury to the eye
- Routine immunizations (except influenza vaccine, pneumococcal vaccine, and Hepatitis B vaccine)
- Physicals, laboratory tests and X-rays performed for screening purposes (except screening mammograms, screening Pap smears, and various other mandated screening services)
- X-rays and physical therapy provided by chiropractors
- Hearing aids and hearing examinations
- Routine dental services (i.e., care, treatment, filling, removal or replacement of teeth)
- Supportive devices for the feet
- Routine foot care (i.e., cutting or trimming corns or calluses, unless inflamed or infected; routine hygiene or palliative care of trimming of nails)
- Custodial care
- Services furnished or paid by government institutions
- Services resulting from acts of war.

Coding and OSA Responsibilities:

1. The following procedures must be completed (the forms are available in English and Spanish):
    a. Identify the appropriate form to be used:
        i. ABN (Form No. CMS-R-131-G) – used for services and fees not covered by Medicare or commercial insurance *(not to be used for Medicare patients with non-covered laboratory tests)*
        ii. ABN (Form No. CMS-R-131-L) – used for Laboratory Tests not covered by Medicare
        iii. Medicaid ABN Form - used for services or fees not covered by Medicaid due to diagnosis limitations
        iv. Private Pay Agreement Form - used for patient requested services that are not a benefit of their payer (including Medicaid) or in situations where the patient is enrolled with a non-contracted payer (including MK HMO's) but wants to be seen at UTMB
2. The OSA should complete the appropriate ABN thoroughly and accurately with all relevant information based on case comments.
    *a. Failure to complete this form **completely** could result in serious compliance issues; therefore, it is critical to this process that all information be reviewed at the time the patient signs the form for accuracy.*

3. Review the form with the patient/guardian before having patient/guardian sign and date.
4. Provide the patient with a signed copy of the ABN/PPA.
5. When a patient has indicated "*Yes*" that a non-covered service should be performed and has signed an ABN/PPA, the ABN/PPA form will then be attached to the SECD and sent to the coding staff. The coding staff should ensure that the service contains a '**GA**' modifier *(indicates that an ABN is on file and does not have to be submitted, but must be made available upon request)*. The coder should then forward the ABN/PPA to the Faculty Group Practice billing office where it will be stored in the electronic patient file.
    a. If the patient refuses to sign the ABN and still demands the service, the provider should have a second person witness that the ABN was delivered, and the patient's refusal to sign. Both the provider and the witness should sign an annotation on the ABN attesting to having witnessed both the delivery and the refusal to sign. The service can then be filed with the '**GA**' modifier and the patient held liable for the payment.
6. If a patient indicates "*No*" on the ABN/PPA indicating that they choose not to have the service, the completed ABN should be sent to Health Information Management to be filed in the medical record.
7. If an ABN/PPA was not obtained prior to the service being provided, the coding staff will place a '**GZ**' modifier *(indicates that an ABN was not signed by the beneficiary)* on the charge.
    a. NOTE - The patient has to agree to pay to be liable. If the patient refuses to sign the waiver and demands the services, the provider must know that the patient cannot be billed. The claim would be filed with a **'GZ'** modifier.
    b. 100% of all cases that get 'GZ' modifiers should be reviewed by the clinic's Practice Manager in order to identify potential training issues and/or opportunities to collect payment by using the appropriate forms/processes.
8. Payment in full will be collected prior to the service being rendered only when the services are not a benefit of the payer or the payer is not contracted with UTMB and the Private Pay Form is completed accurately.
9. INVISION
    a. ABN's
        i. Any service(s) indicated as a potential non-covered benefit will remain '**Y**' verified.
    b. PPA's
        i. Any patient requested service indicated as not a benefit or for a patient that is enrolled with a non-contracted payer will have a patient flag of '**N**' and the financial class '**S**' will be loaded.
    c. ABN's/PPA
        i. Case comments will be notated as non-covered/non-contracted and collect in full with dollar amount.
        ii. This information must be communicated to the patient *prior* to arrival in the clinic and the patient expectation must be set that all fees will be due *prior* to service(s) being rendered and an additional bill(s) may be received from ancillary services. This communication will be documented in the case comments.
        iii. Case comments will be notated to obtain ABN/PPA at arrival.
        iv. Payment in full will be collected prior to the service being rendered only when the services are not a benefit of the payer or the payer is not contracted with UTMB and the Private Pay Form is completed accurately.
10. At disposition, the patient will be presented to an Outpatient Services Associate (OSA) for any additional collections.