Reimbursement Policy

Plan-Directed Care

REIMBURSEMENT POLICY NUMBER: RP35

Effective Date: 10/1/2025

Last Review Date: 9/2025

Next Annual Review: 9/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do no not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☒ Facilities

Plan Product:

☐ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

Note: For the purposes of this policy, the terms "contracted providers," "in-network providers," and

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

"plan providers" are used interchangeably.

I. **In-network (contracted)** providers are obligated to obtain prior authorization from the Company before making referrals to (when appropriate or required under the Member Benefit Plan) or ordering services from out-of-network (non-contracted) providers.

II. **In-network (contracted)** providers must order, provide, or supply only services and items which are considered covered by Medicare. Services or items which are not covered by Medicare are denied as provider financial responsibility unless an organization determination was submitted and a Company (Plan) determination made prior to services being rendered.

III. In the absence of a prior authorization, members may be held financially liable for items and services that are clear and direct benefit exclusions of the member Evidence of Coverage (EOC).

POLICY GUIDELINES

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Plan-Directed Care

Medicare Advantage Organizations (MAOs) and their contracted providers must ensure services rendered, ordered or referred for Medicare Advantage members are covered (including being considered medically reasonable and necessary) by Medicare and/or the MAO plan. Since Medicare considers a contracted provider to be an "agent of the MAO," if an in-network provider refers or orders a service from an out-of-network provider, this is considered "plan-directed care" and Medicare prohibits holding the member financially responsible when plan rules are not followed.[1]

According to Medicare, "Contracted providers are expected to coordinate care or work with plans prior to referring an enrollee to a non-contracted provider to ensure, to the extent possible, that enrollees are receiving medically necessary services covered by their plan."[1] Therefore, if a **contracted** provider provides or supplies a service or item which is not covered by Medicare or does not meet medical necessity criteria for coverage, the service will deny as **provider liability**.

Contracted providers are expected to be knowledgeable of Medicare coverage rules, as well as coverage rules found in Company medical policies. In accordance with Medicare requirements and the provisions of in-network provider agreements, providers must assure that all services are Medicare eligible – including meeting medically reasonable and necessary requirements – before those services are rendered. The following resources provide coverage criteria, as well as specific documentation requirements (this list of resources may not be all-inclusive):

- Medicare Internet-Only manuals (IOM) can be found on the CMS IOM website.
- national and local coverage determinations (NCDs and LCDs) are found on the Medicare Coverage Database.
- The Company's portfolio of current policies can be found online and accessed here.

In addition, **in-network** providers are contractually obligated to obtain prior authorization from the Company prior to referring a Medicare Advantage member to a **noncontracted** provider.

Exceptions

There are some exceptions to the plan-directed care rule, which include the following:

- Services or items which are a clear and direct exclusion of the member's Evidence of Coverage (EOC). These services or items will deny as member liability.
- Services or items for which the member has received prior written notification of the Company's non-coverage position (i.e., denied prior authorization requests are not subject to plan-directed care provisions because the member is receiving the appropriate non-coverage notice by the Company, as required under Medicare regulation).
- Services or items which are provided or furnished by a contracted provider but deemed to be not medically necessary. These will be denied as provider liability in accordance with the provider contract.

Advanced Beneficiary Notices (ABN)

While Original Medicare uses the Advance Beneficiary Notice of Non-Coverage (ABN) form, CMS prohibits Medicare Advantage (MA) plans from using the ABN form for MA members.[2,3] Instead, MA plan members have the right to obtain a coverage decision prior to obtaining an item or service. This request for a pre-service coverage review is also known as a request for a pre-service organization determination.[1] This means providers are unable to use the ABN form for services provided to MA plan members as an alternative to any plan-directed care provision requirement (such as the organization determination process).

Pre-Service Organization Determinations

A pre-service (advance) organization determination can be requested for any item or service believed to be covered by the MA Plan **and/or** when a contracted provider refers a member to a noncontracted provider. These must be submitted ***prior to*** services being received. Either the member, the provider acting on behalf of the member, or another authorized representative of the member (known as appointment of representative, or AOR) may request a pre-service organization determination. If the Company denies the request, a written denial notice with appeal rights will be issued.

It should be noted that a non-coverage determination does not constitute medical advice, nor does it attempt to govern a provider's practice of medicine. It only reflects the Company's reimbursement and coverage position in accordance with Medicare rules and regulations. Physicians and members must exercise clinical discretion and personal judgment in determining medical care and services ultimately received. This pre-service organization determination process allows the individual MA plan member the opportunity to make informed decisions about receiving potentially non-covered care and any financial responsibilities around those services, as well as offer the member the opportunity to appeal any non-coverage decision, if they choose.

SUMMARY

Contracted providers are responsible for ensuring they are providing, suppling, and ordering services that are covered by Medicare and the Medicare Advantage plan. This means any service that is not covered by Medicare or is not a clear exclusion of the member's EOC must not be provided without obtaining an advance (pre-service) organization determination by the Company.

Contracted providers must obtain a prior authorization from the Company before referring a Medicare Advantage member to a **noncontracted** provider.

If non-covered services are provided by a **contracted** provider without an organization determination from the Company, claims for these services may be denied as **provider** responsibility.

The above does not apply to items or services that are clear exclusions of the member EOC documents, for which the member may be held financially liable without a written pre-service determination. Likewise, if an unfavorable pre-service organization determination is made by the Company prior to the services being rendered and the member still wishes to proceed with the service or item, then the claim will deny as the financial responsibility of the member.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 7/25/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which Medicare Advantage regulatory guidance regarding plan-directed care (PDC):

- Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §160 – Beneficiary Protections Related to Plan-Directed Care
- CMS 2014 Letter to MAOs (See Appendix I)

In addition, the Noridian website for *Advance Beneficiary Notice of Noncoverage (ABN)* states ABN forms are "not used for items or services provided under the Medicare Advantage (MA) Program."[3]

The above policy statement, and policy guidelines are consistent with the CMS guidance for PDC and Medicare Advantage plans.

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §160 – Beneficiary Protections Related to Plan-Directed Care. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf. Accessed 7/23/2025.
2. Medicare *Improper Use of Advance Notices of Non-coverage* Letter to MA Plans. Dated 5/5/2014. See Appendix I.
3. Noridian Healthcare Solutions Inc. (Noridian) Jurisdiction D (J-D). Advance Beneficiary Notice of Noncoverage (ABN). Updated 2/27/2024. https://med.noridianmedicare.com/web/jddme/topics/abn. Accessed 7/23/2025.

POLICY REVISION HISTORY

Date	Revision Summary
12/2022	New reimbursement policy (converted to new format 2/2023
10/2023	Annual review, no changes
10/2024	Annual review, no changes
10/2025	Annual review, no changes

APPENDICES

Appendix I: Below is a copy of the CMS 2014 letter to Medicare Advantage Organizations (MAOs) regarding *Improper Use of Advance Notices of Non-coverage*.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: May 5, 2014

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

FROM: Arrah Tabe-Bedward
Director, Medicare Enrollment & Appeals Group

Danielle R. Moon, J.D., M.P.A
Director, Medicare Drug & Health Plan Contract Administration Group

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.