Starting 2/1/25, MPG will follow UHC's ABN (Advance Beneficiary Notice) process for their Commercial & MA (Medicare Advantage) members.

UHC ABN Reference Guide

Rules & Requirements

We may only collect payment from UHC Commercial & MA members for services not covered under their benefit plan if we first get the member's written consent (ABN). The member must sign/date the consent before the service is provided & a copy of this consent must be kept in the member's medical record.

If we know or have reason to suspect the patient's benefits do not cover a service(s), the consent must include:

- An estimate of the charges for the specific service(s).
- A statement of reason for our belief the service(s) may not be covered.
- When it was determined the planned service(s) is/are not covered.
- A statement that UHC has determined the service(s) is/are not covered, that the member knows this determination & agrees to be responsible for any charges.

****Generic written notices, blanket written notices or signed blank written notices are NOT acceptable.**

For **MA members**, in addition to obtaining the member's written consent before the service(s) is/are rendered, we must:

- Request a pre-service determination from UHC prior to rendering service(s) if we know or have reason to believe that said service(s) we are providing or referring may not be covered.
    - A pre-service determination is not required to collect payment from an MA member where the Evidence of Coverage (EOC), or other related materials issued to the MA member, is clear that a service(s) is/are not covered.
- Make sure the member has received an Integrated Denial Notice (IDN) prior to rendering or referring for non-covered service(s) to collect payment.
    - If UHC determines the service(s) is/are not covered, they issue an IDN to both the member & provider. The IDN gives the member their cost for the non-covered service(s) & appeal rights.
        - Per CMS requirements, for providers to hold an MA member financially liable for non-covered service(s), the member must first have an IDN, unless the EOC or other related materials clearly exclude the service(s).

- Review the Medicare Coverage Center.
  - https://www.cms.gov/medicare/coverage/center
    - CMS has published information to help you determine whether the service(s) is/are covered.

****If we do not follow these protocols, we cannot bill the UHC member.**

Pre-service Determination - Validation of CPT Codes

- To submit an advance notification request via the UHC Provider Portal, go to **UHCprovider.com** > Sign In > Prior Authorizations & Notifications.
- Choose **Check by Member** & fill in all information accordingly.

Modifiers

- **GA Modifier**
  - If we followed protocol by requesting a pre-service determination & an IDN was issued before the non-covered service(s) was/were rendered, we must include the GA modifier to the non-covered service(s).
- **GZ Modifier**
  - If we know or have reason to believe that a service(s) we are providing or referring will be denied as *not reasonable and necessary* & we did not provide an ABN to the member, we must include the GZ modifier to the non-covered service(s).
- **GY Modifier**
  - If we know the service(s) we are providing or referring is/are *statutorily excluded from Medicare coverage* & the service(s) is/are explicitly excluded in the member's EOC, we must include GY modifier to the non-covered service(s).