Payment Policy | Coverage of Complications Following a Non-Covered Service

EFFECTIVE DATE: 04|01|2014
POLICY LAST UPDATED: 02|06|2018

OVERVIEW
This policy documents the intent for reimbursement of services supplied for the treatment of medical complications occurring after a non-covered medical service.

MEDICAL CRITERIA
None

PRIOR AUTHORIZATION
None

POLICY STATEMENT
BlueCHiP for Medicare and Commercial Products
Coverage is subject to terms, conditions, and limitation of the member's contract. The treatment of medical and surgical complications is considered medically necessary and, therefore, covered when, without immediate intervention, the complication would lead to loss of life or limb. Medical and surgical complications include, but are not limited to, complications resulting from cosmetic or other non-covered procedures.

Outcomes following non-covered or cosmetic procedures that have unsatisfactory cosmetic results are not considered medical or surgical complications and are, therefore, not covered.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate section of the Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable non-covered conditions if approved, then coverage will be based on the applicable benefit.

BACKGROUND
A complication is an adverse event that occurs in the course of another condition or during its treatment. Complications may be of either medical or surgical origin, may modify the course of the original condition, and may require revisions to the treatment plan.

Medical and/or surgical therapy for untoward events may be necessary to correct functional impairment of a body part or system. Additionally, medical and/or surgical therapy for untoward events may be therapeutic for purposes that coincidentally also serve a cosmetic purpose (e.g., treatment of severe burns following accidental trauma). Typically, cosmetic services are those provided to improve an individual's physical appearance, from which no significant improvement in physiologic function can be expected. Emotional and/or psychological improvement does not constitute improvement in physiologic function.

Non-covered services include surgery considered experimental/investigational or cosmetic in nature, procedures performed at an inappropriate facility and a surgery performed by an unlicensed or uncredentialed provider. The subscriber agreement does not cover services that may otherwise be considered covered when provided with a non-covered service, or as part of a non-covered regimen of care.

Regimen of care is a regulated course, such as diet, exercise, or manner of living, intended to preserve or restore health or to attain some result.

Covered healthcare services means any service, treatment, procedure, facility, equipment, drug, device, or supply that we have reviewed and determined is eligible for reimbursement under the members' Subscriber Agreement.

BlueCHIP for Medicare
The Advanced Beneficiary Notice (ABN) is not used for items or services provided under the BlueCHiP for Medicare program. If a provider believes a service will not be covered by the plan, the provider is expected to request a pre-service organization determination from the plan. If the provider does not request a pre-service organization determination prior to rendering the services, the provider will be liable for the cost of the services. BlueCHiP for Medicare members will be held harmless.

This determination on behalf of BlueCHiP for Medicare members may be obtained by contacting Blue Cross & Blue Shield of Rhode Island (BCBSRI) or our vendor for the applicable services. See the Prior Authorization section for details.

Commercial Products:
The Advance Notice of Non-coverage (ANN), also known as an Advance Beneficiary Notice (ABN), is a written notice given to a commercial member to indicate that the service will not be covered by the member's insurance. Providers who must issue an ANN include physicians, laboratories, hospice providers, inpatient/outpatient hospitals, durable medical equipment (DME) providers, skilled nursing facilities (SNF), hospice providers, and home health providers.

An ANN should be given to members prior to having services tha**t** are non-covered or not medically necessary. Claims for these health service codes that are filed with the GA, GU, and GX modifiers will deny as member liability.

Providers should complete an ANN to notify commercial members in advance of:

- **Initiation of services**: the beginning of a new patient encounter, start of a plan of care, or beginning of treatment; OR
- **Reduction of services:** a decrease in the frequency or duration of a component of care. For example, a patient is receiving physical therapy five days a week and wishes to continue this frequency; however the treating provider believes that the patient's therapy goals can be met with only three days of therapy weekly; OR
- **Termination of services**: discontinuation of items/services. For example, a patient receives speech therapy and the treating provider determines that the therapy is no longer reasonable and necessary; however the patient wishes to continue to receive speech therapy which the provider believes to be non-covered items or services.

Note: An ANN is not to be given if a service is covered but not separately reimbursed, or is considered bundled in another service as members may not be held liable for these services.

CODING
None

RELATED POLICIES
Coding and Payment Guidelines
Cosmetic Services/Procedures
Advanced Notice of Noncoverage
Preauthorization Via Web Based Tool for Procedures

PUBLISHED

Provider Update, March 2018
Provider Update, April 2017
Provider Update, June 2016
Provider Update, May 2015
Provider Update, August 2014

REFERENCES

1. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Items_and_Services_Not_Covered_Under_Medicare_BookletICN906765.pdf

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS