UCare

Member Liability &Waiver Reference Sheet

Did you know?

A waiver is a form that is issued by the provider to a patient when it is expected that the health plan may deny payment for services. The waiver serves as protection for the provider and allows the provider to bill the patient for services the patient received after signing an acceptable waiver. Typically a financial waiver does not meet the definition of an acceptable waiver.

What specific information must an acceptable waiver contain?

An acceptable waiver must include the following fields:

- Name of the entity providing service, treatment, or equipment.
- Anticipated reason for health plan payment denial.
- Full description of the service, treatment or equipment.
- HCPCS codes for DME and medical supply providers.
- Date of service.
- Total cost of the service, treatment or equipment.
- Indication of patient acceptance or rejection of service, treatment, or equipment.
- Patient name, signature, and date of signature.

A sample waiver can be viewed at the conclusion of this FAQ and in the UCare Provider Manual in the billing chapter at www.ucare.org You may use the sample waiver form however you must remove the word "SAMPLE."

The waiver guidelines apply to all UCare products. UCare products are either State or Federal programs and are mandated to have special member and provider protections in place.

Filing a Claim:

Once an acceptable waiver is on file a claim can be submitted to UCare for the service, treatment, or equipment. The line items on the claim for services, treatment or equipment, that may not be payable by the health plan, should include the GA modifier.

Billing a Patient:

Contracted UCare providers should not bill UCare members until a remittance advice is received from UCare showing no payment or member responsibility.

"Balance billing" occurs when a provider requests that a patient pay the difference between the amount the provider billed and the amount UCare paid. This includes covered and non-covered services. This does not include coinsurance amounts or co-payments by the enrollee under some benefit packages.

Minnesota Health Care Programs (MHCP)

A health plan participating provider may bill a member for services if:

1. The service is not covered under the member's Certificate of Coverage (COC),
2. The provider notified the member in writing prior to providing the service that the member is responsible for the bill. The Department of Human Services (DHS) Minnesota Health Care Programs Provider Manual Chapter 4 – Billing Policy states, the provider should institute procedures to prevent misunderstandings concerning whether a member has been properly informed about the non-covered status of a health service.

References

MN Rules, Part 9505.0225, Subpart 3.

www.ucare.org/providers

Medicare Advantage

Section 1876(c)(4)(B) of the Social Security Act requires that Medicare Advantage health plans assume financial responsibility for all care that Medicare would cover.

In all cases, the enrollee's financial liability is for co-payments or coinsurance amounts imposed by the *UCare for Seniors* CMS-approved benefit package. Out-of-network physicians are paid based on the following guidelines.

1. UCare pays Medicare participating physicians the Medicare rate and contractually agree not to seek any additional payment.
2. Non-participating physicians (with Medicare) who accept Medicare Assignment are paid 95% of the Medicare rate as determined by the Federal Government.
3. Medicare non-participating physicians who do not accept Medicare Assignment are limited to charging UCare Minnesota 115% of the non-participating Medicare rate as determined by the Federal Government.

SAMPLE WAIVER

Clinic, Facility, Provider Entity ____

Name of Person Completing Form ____

Date Form Completed ____

The service, treatment, or equipment you are receiving probably will not be covered by your health plan because it is;

❒Not medically necessary ❒Investigational ❒Excluded from coverage

The service, treatment or equipment is:
The date the service, treatment, or equipment or will be received is:
The total cost of the service, treatment, or equipment is:

TO BE COMPLETED BY PATIENT.

❒ **Yes I want to receive the service, treatment, or equipment.** **By checking this box, I understand that I will be responsible for paying for the service, equipment or treatment described above.**
❒ **No, I have decided not to receive the service, treatment or equipment.**

____

Patient Name Patient Signature Date of Patient Signature

Please provide patient with a completed copy and retain original.