Organization Determinations: An enrollee, or a provider acting on behalf of the enrollee, always has the right to request a pre-service organization determination if there is a question as to whether an item or service will be covered by the plan. If the plan denies an enrollee's (or his/her treating provider's) request for coverage as part of the organization determination process, the plan must provide the enrollee (and provider, as appropriate) with the standardized denial notice (Notice of Denial of Medical Coverage (or Payment)/CMS-10003). For the requirements related to organization determinations and issuance of the standardized denial notice (CMS-10003), see chapter 13 of the MMCM located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c13.pdf.

Limitations on Enrollee Liability: CMS considers a contracted provider an agent of the MAO offering the plan. As stated in the preamble to the January 28, 2005 final rule (CMS-4069-F):

"MA organizations have a responsibility to ensure that contracting physicians and providers know whether specific items and services are covered in the MA plan in which their patients are enrolled. If a network physician furnishes a service or directs an MA beneficiary to another provider to receive a plan-covered service without following the plan's internal procedures (such as obtaining the appropriate plan pre-authorization),

then the beneficiary should not be penalized to the extent the physician did not follow plan rules."

Consequently, when a contracted provider furnishes a service or refers an enrollee for a service that an enrollee reasonably believes is a plan-covered service, the enrollee cannot be financially liable for more than the applicable cost-sharing for that service. If a contracted provider believes an item or service may not be covered for an enrollee, or could be covered only under specific conditions, the appropriate process is for the enrollee or provider to request a pre-service organization determination from the plan.

If a contracted provider refers an enrollee to a non-contracted provider for a service that is covered by the plan upon referral, the enrollee is financially liable only for the applicable cost-sharing for that service. 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. Furthermore, plans are expected to work with their contracted providers to ensure that clear processes are in place and providers are educated about those processes, including appropriate documentation, to substantiate that a referral has been made.

If a service is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the enrollee is clear that the service or item is never covered, the plan is not required to hold the enrollee harmless from the full cost of the service or item. For a service or item that is typically not covered, but could be covered under specific conditions (e.g., dental care that is necessary to treat an illness or injury), the EOC, in and of itself, is not adequate notice of non-coverage for purposes of determining enrollee liability. In such instances, the appropriate process is for the enrollee, or the provider acting on behalf of the enrollee, to request a pre-service organization determination. If the plan denies the service, the plan must issue the standardized denial notice with appeal rights. The enrollee has the right to appeal any denial of a service or item. Plans also must educate their contracted providers about the limits of plan coverage and the need to correctly advise enrollees when providing referrals for covered services. This will prevent confusion related to plan coverage and enrollee financial liability as well as ensure coordination of the care furnished.

When the provider, or the plan acting on behalf of the provider, can show that an enrollee was notified (via a clear exclusion in the EOC or the standardized denial notice) prior to receipt of the item or service that the item or service is not covered by the plan or that coverage is available only if the enrollee is referred for the service by a contracted provider but the enrollee nonetheless receives that item or service in the absence of a referral, the regulation at §422.105(a) does not require the MA plan to hold the enrollee harmless from the full cost of the service or item charged by the provider.