Organization Determinations: Charging Medicare Advantage Patients for Non--Covered Services
This information applies to any dental office that sees a Medicare Advantage patient.

An organization determination is pre--service determination of coverage by the Medicare Advantage health plan required to bill the patient for a service. We are providing you with a summary of the Centers for Medicare and Medicaid Services (CMS) guidance addressing what you must do in order before charging a patient on a Medicare Advantage plan for services that are not covered by the patient's plan benefits.

In accordance with the CMS guidelines, you must inform a patient when a service or item is not covered before the service or item is delivered. This means you must refrain from charging any Medicare Advantage patient for any non-covered services, unless a pre--service organization determination is completed.

It is your responsibility to know whether specific items and services are covered in the Medicare Advantage plan in which your patients are enrolled. If you believe an item or service may not be covered for a patient, or could be covered only under specific conditions, either you or the patient should request a pre--service organization determination from Delta Dental of Minnesota. You may verify coverage of services and items in advance of treatment in the following ways:

Providers:

- View the Dental Office Toolkit
- Call Delta Dental of Minnesota customer service
    - Sanford Health Plans at 1.866.502.9753
- Submit pre--treatment estimate electronically
- Mail: Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120

Patients:

- Call Delta Dental of Minnesota customer service
    - Sanford Health Plans at 1.866.502.9753
- Mail: Delta Dental of Minnesota PO Box 9120 Farmington Hills, MI 48333-9120

If you intend to charge the patient for non--covered service, obtain the patient's written consent prior to rendering service.

An organization determination is not needed if a service or item is never covered by the plan and the plan's Evidence of Coverage (EOC) provided to the patient is clear that the service or item is never covered. In this case, 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 patient liability. In these cases, a pre--service organization determination is required.

You cannot hold patients with Medicare Advantage plans responsible for payment of non--covered services unless the patient has been fully informed in advance of Delta Dental's determination and given his or her appeal rights. Once an organization determination has occurred, the appeals process is available if a patient believes Delta Dental's decision is unfavorable.

If you supply non--covered services to a patient who has not received a Notice of Denial of Medical Coverage, you must hold the patient harmless for the non--covered services, and you are prohibited from charging the patient any amount beyond the normal cost--sharing amounts.