

Section 6 Waivers

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Section 6

Benefit Exclusions and Clinical Non-coverage Waivers

As stated in the CDPHP participating provider agreement, members shall not be held responsible for payment of charges above the payment obligation set forth in their benefit contract, unless the services in question were not covered by their benefit package, they were informed of this in advance, and agreed to pay for the services by signing a specific waiver that indicates their understanding of non-coverage of the specific service.

Services that CDPHP does not cover fall into two main categories: benefit exclusions and clinical non-coverage.

Benefit exclusions are not covered as stated in the member's benefit contract, such as hearing aids or orthotic shoe inserts. When we receive a request for such services, our determination letter states that the member is responsible and may be billed.

Clinical non-coverage decisions are based on an evaluation of the clinical indication for the service in light of our medical policies and clinical guidelines. Typical reasons for denial would include the service being cosmetic, experimental, or medically unnecessary.

A waiver is a statement that the member signs agreeing that he or she will be responsible for payment. Many offices use a generic waiver stating that the member is responsible for any charge that the insurance does not pay. This form may not be adequate, however, particularly for services that fall into the clinical non-coverage category as defined above.

It is expected that the provider must explain, and the member must sign, a waiver that explicitly states that the insurance is not expected to pay for the service and the member still wishes to have it performed even if he or she must pay for it. Ideally, the waiver will state the reason that CDPHP is not expected to pay, such as that the procedure may be considered cosmetic.

The provider of care, who is familiar with the clinical guidelines and policies and understands the clinical circumstances, must be certain before providing a service that the member understands that it may not be covered. For this reason, when such services are provided, our determination states that the member may not be billed **unless a specific waiver has been signed**.

Please note that the signing of the waiver does not eliminate the need to submit a request for prior authorization, if the member wishes it to be submitted, or the right for the member to appeal the CDPHP decision. All member rights regarding appeals still apply even if a waiver is signed, and the provider is expected to provide the appropriate documentation, if requested.

PCP, OB/GYN Waiver Form

CDPHP members are required to select a primary care physician (PCP) and women age 18 and older may also select an OB/GYN to see without being referred. However, sometimes this may not be accomplished on a timely basis and a member may seek services prior to selecting his or her PCP or OB/GYN.

It is very important to verify the current member identification number for all CDPHP members. It is also important to include your "Patient's Account Number" in field 26 of the CMS 1500 form, to assist you in applying reimbursements.

In order to facilitate claims payment and reduce appeals, CDPHP has developed a PCP/OB/GYN waiver form that allows you to bill the member for services rendered if you receive a denied claim from CDPHP that states the member has not selected you as his or her PCP or OB/GYN physician. **Select Plan and Family Health Plus members are required to select a PCP, and they are encouraged, but not required, to select an OB/GYN provider.**

The physician's office procedure is as follows:

1. Verify the member eligibility information by accessing the secure area of www.cdphp.com or by calling provider services. For new enrollees, you may accept a copy of their enrollment form as a form of verification.
2. Verify that the member's product coverage requires them to select a PCP or OB/GYN of record.
3. If the PCP designation is required and you are not indicated as the member's PCP, have the member sign the PCP/OB/GYN waiver form on the day of the visit.
4. Submit a claim as usual to CDPHP for payment.
5. If the claim is paid by CDPHP, no further action is necessary.
6. If the claim is denied by CDPHP stating the member has not selected you as the member's PCP/OB/GYN physician, you may bill the member for all services associated with that visit provided that you have requested and received a signed patient treatment waiver that notifies the member of his/her payment responsibilities.

This procedure does not apply to existing patients.

The member has been instructed through the *CDPHP Member Handbook* to select and notify CDPHP of his or her new PCP or OB/GYN prior to seeking services or **within five business days** of the service, or the member will be responsible for payment.

The goal of this procedure is to promote member accountability, continuity of care, and timeliness in choosing a primary care physician.

Triplicate form #3008, two copies for the physician and one copy for the member, can be ordered directly from CDPHP, at no cost to your office by calling (518) 641-3500.



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Primary Care Physician (PCP)/Obstetrics & Gynecology (OB/GYN)

PATIENT TREATMENT WAIVER

I, _____, _____ am a CDPHP member
(Member Name) (Member ID #)

who is requesting treatment from _____,
(Provider Name)

without contacting Capital District Physicians' Health Plan, Inc. (CDPHP) prior to this visit to designate the provider as my PCP and/or OB/GYN of record. As a result, I agree that I shall be responsible for payment in full for any charges related to services provided to me or my dependent at this office if I fail to notify CDPHP to change my PCP and/or OB/GYN provider to the provider listed above within **five (5) business days**.

Signed: _____

Date: _____

Witnessed: _____

This waiver is being used to ensure that all CDPHP members select a PCP and/or OB/GYN physician and notify CDPHP of that selection in a timely manner. Select Plan and Family Health Plus members are required to select a PCP, and they are encouraged, but not required, to select an OB/GYN provider.

Form # 3008-0103

MEMBER COPY

