	Regulatory Compliance Policy	No. COMP-RCC 5.00
	Title:	Page: 1 of 7
	MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Effective Date: 09-27-11
		Retires Policy Dated: 10-13-10
		Previous Versions Dated:

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%, and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility and which provide inpatient care to Medicare beneficiaries (each, a “Tenet Hospital”) (collectively, “Tenet”).

II. PURPOSE:


The purpose of this policy is to establish a standardized process for medical necessity screening of all outpatient tests or services when Medicare is the primary or secondary payer for purposes of providing an Advance Beneficiary Notice to the patient when necessary.¹

III. DEFINITIONS:

- A. In the context of this policy, “**Physician**” means a medical doctor or any licensed independent practitioner legally accountable for establishing the patient’s diagnosis.
- B. “**Medical necessity**” for ordering and providing services means that the tests, drugs, items or services are:
 1. ordered by a Physician, who has assessed the patient and determined that the test or service is necessary;
 2. Provided by a qualified health care provider; and
 3. Supported by documentation in the medical record that the test or service was provided in the care or management of the patient’s condition.
- C. “**Medical Necessity for Medicare Billing and Reimbursement (MNMBR)**” means that the diagnostic information provided by the Physician and coded by the coder for the service matches the covered code listed in a Medicare coverage determination, which determinations include National Coverage Decisions and Local Coverage Determinations.²

¹ An Advance Beneficiary Notice may not be used for services provided under Medicare Advantage Plans (Medicare Part C) or under the Medicare Prescription Drug Program (Medicare Part D).

² The fact that an item or service is not supported by a code listed in an applicable Medicare coverage determination does not necessarily mean that the item or service was not reasonable and necessary for the diagnosis or treatment of the patient, but does indicate that Medicare does not consider the services to be covered in most instances, and that—absent an appeal—the services are likely to be denied by the Medicare contractor.

	Regulatory Compliance Policy	No. COMP-RCC 5.00	
	Title: MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Page:	2 of 7
		Effective Date:	09-27-11
		Retires Policy Dated:	10-13-10
		Previous Versions Dated:	

- D. “**Advance Beneficiary Notice of Non-coverage (ABN)**” means the form health care providers are required to give Medicare patients to explain patient rights and protections related to patient financial obligations for certain tests or services. (Currently form CMS-R-131 (03/08).)³

IV. POLICY:

Prior to furnishing tests, drugs or services ordered by a Physician for a Medicare fee-for-service (traditional Medicare) beneficiary, Tenet Hospitals must screen for MNMBR, using the Tenet approved screening tool. When a test or service does not meet MNMBR, the Medicare beneficiary shall be given an ABN before receiving the service.⁴

V. PROCEDURE:

A. Hospital Implementation


1. All orders for outpatient services, drugs or diagnostic tests, shall be accompanied and supported by a physician-documented diagnosis, in narrative or ICD-9 code form, prior to the services being furnished.
2. Tenet Hospital personnel shall screen all outpatient tests or services (that are hard coded where the chargecode contains the CPT or HCPCS code) ordered for Medicare patients using the Tenet-approved medical necessity screening software prior to providing the tests, drugs or services.
3. When a test, drug or service does not meet MNMBR, the Tenet Hospital shall give the standard form ABN to the Medicare beneficiary (or the beneficiary’s representative) prior to providing the item or service⁵ according to the instructions provided in the Order Checker Users Guide.
 - a. For purposes of this policy “prior to providing the test or service” means prior to any of the following “triggering events:”⁶

³This CMS form is currently available in English and Spanish and may be reproduced for use by Tenet Hospital.

⁴ Provision of an ABN is not required for services that are categorically excluded from Medicare coverage under the Medicare statute (“never covered” services), such as personal comfort items; routine physicals; routine eye care; dental care; and routine foot care, or services that fails to meet the definition of a covered Medicare benefit; however, ABNs may be issued regarding such services to avoid potential patient confusion.

⁵ABNs should be given in person whenever possible. When personal delivery is not possible delivery can be made by mail, Fax, or email, subject to HIPAA privacy and security rule requirements and documentation of the alternative method of delivery and receipt of a returned signed copy of the ABN.

⁶An ABN can remain effective up to one year, particularly in cases involving repetitive or continuous course of treatment.


	Regulatory Compliance Policy	No. COMP-RCC 5.00	
	Title: MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Page:	3 of 7
		Effective Date:	09-27-11
		Retires Policy Dated:	10-13-10
		Previous Versions Dated:	

- (1) Initiation of a new patient encounter, starting a plan of care, changing a plan of care or beginning treatment, whichever is applicable to the service in question. In the case of procedures, the ABN must be given before the patient is prepped for the procedure.
 - (2) Reduction of services (*e.g.*, a patient who has been receiving a service five days a week, wishes to continue the service five days a week, but whose physician has reduced the order to three days weekly based on medical necessity considerations).
 - (3) Termination of a course of treatment that the beneficiary wishes to continue, when the physician has determined the services are no longer reasonable and necessary.⁷
- b. The ABN form shall not be modified or customized except as permitted by subject to the requirements of [Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, § 50.6.2](#). Contact the Director Revenue Analysis if you have questions regarding customization of ABN forms for particular circumstances.
- (1) Blank G (Options) and Blank I (Signature) of the ABN must be completed by the beneficiary or representative after the ABN is issued and must not be (i) pre-filled by or on behalf of the Tenet Hospital or (ii) completed by the beneficiary prior to the completion of all other sections of the ABN.⁸
 - (2) Blank D must list the specific items or services that Tenet Hospital believes are likely to be noncovered, including if applicable the frequencies and durations of service. General descriptions of grouped items are sufficient (*e.g.*, “wound care supplies”) and it is not generally necessary to include an itemized list.⁹

⁷This includes situations following normal recovery or any extended recovery periods authorized by medical staff policy following outpatient procedures.

⁸Blank J (Date) should also be completed by the beneficiary, but may be completed by Tenet Hospital personnel if the patient requests, but shall not be completed prior to Blank I.

⁹If the beneficiary wishes to receive some, but not all, of the identified items and services it may be necessary to prepare separate ABNs to allow the beneficiary to select appropriate options in Blank G.

	Regulatory Compliance Policy	No. COMP-RCC 5.00	
	Title: MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Page:	4 of 7
		Effective Date:	09-27-11
		Retires Policy Dated:	10-13-10
		Previous Versions Dated:	

- (3) Blank E must explain in understandable language why Tenet Hospital believes the listed items and/or services may not be covered by Medicare. A reason must be given for each listed item or service.¹⁰
 - (4) Blank F must reflect a good faith estimate of the cost to the patient of each item and/or service identified on the ABN. Items and services that are routinely provided together may be bundled for purposes of this estimate.¹¹
 - (5) Blank H is optional, but may be used to provide additional information to the beneficiary.¹²
- c. The ABN shall be given sufficiently in advance of provision of the potentially noncovered services to allow reasonable time for the beneficiary to consider available options.
- (1) Tenet Hospital must also explain the information in the ABN and answer any related questions from the beneficiary accurately and completely to the best of Tenet Hospital's ability.
 - (2) Tenet Hospital shall direct the beneficiary to 1-800-MEDICARE if the beneficiary has questions about the ABN that Tenet Hospital cannot answer.


¹⁰ Common reasons for noncoverage subject to the ABN procedures include:

- “Medicare does not pay for this test for your condition.”
- “Medicare does not pay for this test as often as this (denied as too frequent).”
- “Medicare does not pay for experimental or research use tests.”

¹¹ CMS considers estimates to be reasonable when they are within the greater of \$100 or 25% of the actual cost. See [Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, § 50.6.3B](#).

¹² Blank H is frequently used to provide information such as:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage, such as Medi-gap, if applicable;
- An additional dated witness signature; or
- Other necessary annotations, with date if different from the rest of the ABN.

	Regulatory Compliance Policy	No. COMP-RCC 5.00
	Title: MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Page: 5 of 7
		Effective Date: 09-27-11
		Retires Policy Dated: 10-13-10
		Previous Versions Dated:

d. An ABN shall not be given when a beneficiary is in a medical emergency or under duress, or otherwise could not be expected to make a reasonably informed consumer decision regarding the services and resulting financial responsibility.¹³

4. Tenet Facilities shall not provide ABNs unless there is a reasonable expectation the test, service or drug will be provided and that the Medicare program will not cover the item or service.
5. Tenet Hospitals shall scan all ABNs into VIWeb. If VIWeb is not available, the Tenet Hospital shall retain ABNs for the period required by [Administrative Policy AD 1.11 Records Management](#). Whenever possible the Tenet Hospital should retain the original of the ABN and provide a copy to the beneficiary or representative.
6. If a patient refuses to sign an ABN that has been presented pursuant to this policy or refuses to select a option on the ABN, Tenet Hospital personnel shall:
 - a. Annotate both the original and beneficiary copies of the ABN indicating that the patient refused to sign or select an option.¹⁴
 - b. File the annotated original ABN in the patient’s Medical Record and return the annotated beneficiary copy to the beneficiary.
 - c. In the event the patient refused to sign the ABN or select an option but still wants to receive the service, a witnessed refusal where two hospital personnel sign as an attestation the patient receives notice will serve as a valid ABN and services maybe provided.


B. Auditing and Monitoring

The Hospital Compliance Committee is responsible for auditing and monitoring compliance with this policy, including such activities as:

1. Verification that ABNs are completed correctly;

¹³ [Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, §§ 50.6.5C, 40.3.6.4](#). This prohibition is commonly called the routine notice prohibition, while that terminology is frequently confusing, it does not prohibit the issuance of ABNs on a routine basis when services appropriate, such as for items and services that are always denied as not reasonable and necessary, services exceeding frequency limitations, experimental items and services.

¹⁴The refusal and annotation should, when possible, be witnessed by two Tenet Hospital employees, who shall also sign the annotation.

	Regulatory Compliance Policy	No. COMP-RCC 5.00
	Title: MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Page: 6 of 7
		Effective Date: 09-27-11
		Retires Policy Dated: 10-13-10
		Previous Versions Dated:

2. Analysis of medical necessity write-offs when ABNS were not issued (*e.g.*, -- GZ modifier situations); and
3. Investigation of trends related to specific services or departments that raise questions.

An action plan must be developed for any issues discovered during the monitoring process. The Hospital Compliance Committee may delegate responsibility to another committee, such as the Tenet Hospital’s Laboratory Compliance Committee or Utilization Management Committee, provided that the Hospital Compliance Committee reviews reports and action plans resulting from the delegate committee’s actions at least quarterly.

C. Responsible Person


Patient Access Directors, Outpatient Services Directors and Clinical Department Directors are responsible for ensuring that all personnel adhere to the requirements of this policy. Directors shall immediately report instances of non-adherence to the Hospital Compliance Officer.

D. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- [Order Checker Users Guide](#)
- [Administrative Policy AD 1.11 Records Management](#)
- [Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, § 50 *et seq.* and § 40.3 *et seq.*](#)

	Regulatory Compliance Policy	No. COMP-RCC 5.00
	Title: MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)	Page: 7 of 7
		Effective Date: 09-27-11
		Retires Policy Dated: 10-13-10
		Previous Versions Dated:

VII. ATTACHMENTS:

- ABN form