CORPORATE POLICY

Manual/Library Name: Tenet Healthcare – Compliance Revenue Cycle	**No**: EAC.05.00
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	Effective Date: 08/13/26
Policy Title: Medical Necessity and Advance Beneficiary Notice of Non-Coverage of Outpatient Services [COMP-RCC 5.00]	**Previous Versions**: 08/30/19, 05/12/16, 09/27/11, 10/13/10
	Approved By: Executive Leadership Team
	Approval Date: 08/11/26

I. Scope

This policy applies to Tenet Healthcare Corporation and its subsidiaries and affiliates other than Conifer Holdings Inc. and its direct and indirect subsidiaries (each, an "Affiliate"), any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of greater than 50%, and any entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

II. Purpose

To establish a standardized process for Medical Necessity screening of all outpatient tests or services in the facility outpatient department or provider-based entity setting when Medicare is the primary or secondary payer for purposes of providing an Advance Beneficiary Notice (ABN) to the patient when necessary.

III. Definitions

Advance Beneficiary Notice of Non-Coverage (ABN): The form health care providers are required to give Medicare patients to convey that Medicare is not likely to provide coverage in a specific case (tests or services).

Licensed Independent Practitioner (LIP): In the context of this policy, a medical doctor or any practitioner who is authorized by state law to order tests or services and/or legally accountable for establishing the patient's diagnosis.

Medical Necessity: In the context of this policy, for ordering and providing services, the tests, drugs, items, or services are:

1. Ordered by a LIP, who has assessed the patient and determined whether the test or service is necessary;
2. Provided by a qualified health care provider;
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; and
4. Service matches the covered code listed in a Medicare coverage determination, which determinations include National Coverage Decisions and Local Coverage Determinations.

IV. Policy

Prior to furnishing tests, drugs or services ordered by a LIP for a Medicare fee-for-service (traditional Medicare) beneficiary, facilities must screen for Medical Necessity, using a corporate approved screening

tool. When a test or service does not meet Medical Necessity, the facility must give the Medicare beneficiary an ABN before providing the service.

V. Procedure

A. Facility Implementation

1. All orders for outpatient services, drugs or diagnostic tests, must be accompanied and supported by a LIP documented diagnosis prior to the services being furnished.
2. Facility personnel must screen all outpatient tests or services ordered for Medicare patients using the company approved Medical Necessity screening software prior to providing the tests, drugs, or services.
3. When the screening software suggests that a test, drug or service does not meet Medical Necessity, the facility must give the standard form ABN to the Medicare beneficiary (or the beneficiary's representative) prior to providing the item or service according to the instructions provided in the Medical Necessity screening software.
4. Facility must scan all completed ABNs into a company approved imaging system or patient's medical record. This requirement applies even when an ABN is issued solely to inform a beneficiary of financial liability for services that are never covered.

VI. 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.

VII. References

AD 1.11 Records Management

Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, § 50 et seq. and § 40.3 et seq.

Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, §§ 40.3.6.4, 40.3.7

Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, § 50.6.2