| | Regulatory Compliance Policy | No. COMP-RCC 5.00 |
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| | **MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE OF OUTPATIENT SERVICES (ABN)** | **Effective Date:** 08-30-19 |
| | | **Previous Versions Dated:** 05-12-16; 09-27-11; 10-13-10 |
| | | **Corporate Review Dated:** 08-16-19 |

## 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 Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (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 in the hospital outpatient department or provider-based entity setting 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. "Licensed Independent Practitioner" means, 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.

B. "**Medical Necessity**" for ordering and providing services means that the tests, drugs, items or services are:

1. Ordered by a Licensed Independent Practitioner, 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**" or "**Medical Necessity**" means that the diagnostic information provided by the Licensed Independent Practitioner 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]

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[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.

D. "**Advance Beneficiary Notice of Non-coverage**" **or "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.[3]

## IV. POLICY:

Prior to furnishing tests, drugs or services ordered by a Licensed Independent Practitioner for a Medicare fee-for-service (traditional Medicare) beneficiary, Tenet Entities must screen for Medical Necessity, using the Tenet approved screening tool. When a test or service does not meet Medical Necessity, the Tenet Entity must give the Medicare beneficiary an ABN before providing the service.[4]

## V. PROCEDURE:

A. Tenet Entity Implementation

1. All orders for outpatient services, drugs or diagnostic tests, must be accompanied and supported by a Licensed Independent Practitioner documented diagnosis, in narrative or ICD-10 code form, prior to the services being furnished.

2. Tenet Entity personnel must screen all outpatient tests or services (that are hard coded where the charge code 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 Medical Necessity, the Tenet Entity must give the standard form ABN to the Medicare beneficiary (or the beneficiary's representative) prior to providing the item or service[5] according to the instructions provided in the medical necessity screening software.

   a. For purposes of this policy "prior to providing the test or service" means

[3] This CMS form is currently available in English and Spanish and may be reproduced for use by Tenet Entities.
[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.
[5] ABNs 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.

prior to any of the following "triggering events:" [6]

(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 Licensed Independent Practitioner 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 Licensed Independent Practitioner has determined the services are no longer reasonable and necessary.[7]

b. The ABN form must 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 Tenet Entity Director of Revenue Analysis, or equivalent title, with 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 Entity 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 the Tenet Entity believes are likely to be non-covered, 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]

(3) Blank E must explain in understandable language why the Tenet

[6]An ABN can remain effective up to one year, particularly in cases involving repetitive or continuous course of treatment.
[7]This includes situations following normal recovery or any extended recovery periods authorized by medical staff policy following outpatient procedures.
[8]Blank J (Date) should also be completed by the beneficiary, but may be completed by Tenet Entity personnel if the patient requests, but shall not be completed prior to Blank I.
[9] If 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.

Entity 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 non-covered services to allow reasonable time for the beneficiary to consider available options.

(1) The Tenet Entity must also explain the information in the ABN and answer any related questions from the beneficiary accurately and completely to the best of the Tenet Entity's ability.

(2) The Tenet Entity must direct the beneficiary to 1-800-MEDICARE if the beneficiary has questions about the ABN that Tenet Entity cannot answer.

d. An ABN must 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]

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[10] Common reasons for non-coverage 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* Form Instructions Advance Beneficiary Notice of Non-coverage (ABN).

[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.

[13] Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 30, §§ 40.3.6.4, 40.3.7. This prohibition is commonly called the routine notice prohibition, while that terminology is frequently confusing, it does not prohibit

4. Tenet Entities must 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 Entities must scan all ABNs into VIWeb. If VIWeb is not available, the Tenet Entities must retain ABNs for the period required by Administrative policy AD 1.11 Records Management and its Record Retention Schedule. Whenever possible the Tenet Entity should retain the original of the signed 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 an option on the ABN, Tenet Entity 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 Tenet Entity personnel sign as an attestation the patient receives notice will serve as a valid ABN and services maybe provided.

B. Auditing and Monitoring

The Tenet Entity's Compliance Committee is responsible for auditing and monitoring compliance with this policy, including such activities as:

1. Verification that ABNs are completed correctly;

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.

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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.

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

An action plan must be developed for any issues discovered during the monitoring process. The Compliance Committee may delegate responsibility to another committee, such as the Utilization Management Committee, provided that the 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 must immediately report instances of non-adherence to the 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:

- Administrative policy AD 1.11 Records Management and its Record Retention Schedule

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