**DIGNITY HEALTH**
**ADMINISTRATIVE POLICY AND PROCEDURE**

**FROM:** Dignity Health Compliance Oversight Committee

**SUBJECT:** Advance Beneficiary Notice – Outpatient Services

**EFFECTIVE DATE:** April 22, 2012

**REVISED:** April 22, 2012, April 22, 2011; July 1, 2009; March 1, 2005; November 1, 2004

**ORIGINAL EFFECTIVE DATE:** November 1, 2004

**REPLACES:**

**APPLIES TO:**

| | |
|---|---|
| System Offices: | X |
| Acute Care Entities: | X |
| Non-acute Care Entities: | X |

## I. POLICY

It is the policy of Dignity Health to bill Medicare Fee for Service (FFS) beneficiaries for medical necessity denials, only when an Advanced Beneficiary Notice of Non-Coverage (ABN) was executed prior to the service being performed. Medicare Advantage Plans may have similar requirements and specific forms to utilize that are not addressed in this policy.

When an ABN was not obtained, , the billing entity will not bill the guarantor for those non-covered services and will need to properly adjust the account.

## II. PURPOSE

The purpose of this policy is to establish responsibility and accountability for the completion of the medical necessity screening process to determine if an ABN is required and to outline the use of the ABN for outpatient services.

The purpose of the Medicare Advance Beneficiary Notice (ABN) is to provide written notice to a Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for by Medicare, that Medicare certainly or probably will not pay for the item(s) or service(s) on that particular encounter. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed.

Medicare requires that a provider issue an ABN each time it makes the assessment that Medicare payment will likely not be made. Medicare requires that this notice be timely and effective and must meet specific Medicare standards. It serves as proof that the beneficiary was informed and had knowledge prior to receiving services

## III. PRINCIPALLY AFFECTED DEPARTMENTS:

The following entities are principally affected by the policy elements and shall receive the required training, as provided in Administrative policy 70.1.003, Compliance Policy Dissemination and Implementation Process:

- Hospitals
- Clinics / Physician Practices
- Patient Care Facilities (Nursing & Non-Nursing / Ancillary Services) that bill Medicare for Outpatient Services.
- Central Business Offices (CBOs) / Billing Offices

Specifically, the following departments:

- Admitting / Registration
- Ancillary Outpatient Departments
- Emergency Department
- HIM / Medical Records
- Laboratory
- Patient Financial Services / Billing Offices
- Research Accountable Executives

A Dignity Health entity may, in the exercise of its reasonable judgment, determine that other departments are affected by this policy and provide necessary training to the workforce in those departments.

## IV. GUIDELINES:

<u>ABN Generation:</u>

Individuals involved in the ordering of services and/or registering of Medicare beneficiaries receiving outpatient services must review the patient's diagnosis(ses), sign(s), symptom(s), disease(s) or ICD-9-CM code(s) and perform a medical necessity verification against Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). This verification screening shall be done utilizing DHLTH approved ABN screening software or in the case where the software is not available, by manual review of LCD and/or NCD.

An ABN must be obtained when one or more of the following circumstances exists:

- The test/service does not meet Medicare medical necessity guidelines according to LCD or NCD
- The test/service have frequency limitations defined within the LCD/NCD or CMS directive.
- The test/service is for investigative, experimental or research use only.
- No diagnosis, sign, symptom or ICD-9-CM code is provided, or is illegible, and cannot be obtained prior to rendering the service or performing the test.
- Obsolete test

**If one of the conditions above is met and an ABN was not obtained prior to rendering the service, the facility is prohibited from billing the beneficiary the denied service.**

The physician ordering the test(s)/service(s) must include sufficient information on the requisition/order to perform a verification screening of medical necessity. Required information includes the ICD-9-CM code(s) or a narrative description of the diagnosis and the test/service to be rendered. If the requisition or order for the outpatient test(s)/services(s) received from the physician does not contain sufficient information to perform a medical necessity verification, the physician will be contacted to obtain the required information. ICD-9-CM codes can only be assigned or changed based upon provider documentation within the medical record. It would be inappropriate to amend the medical record or test requisition to ensure payment if it did not reflect the clinical condition of the patient. If the information cannot be obtained prior to rendering the service(s) an ABN will be obtained.

ABNs must be obtained **prior to** rendering services.

Dignity Health facilities must use the CMS-approved ABN form CMS-R-131 (which replaces CMS-R-131-G and CMS-R-131-L and CMS-20007 NEMB, implemented as of March 2011 and mandated as of January 2012). The signed ABN form should be distributed to the patient, the facility's business office, and a copy retained at the originator's office (registration). The ABN must list each item or service(s) that is determined not to be medically necessary or otherwise not covered and state the specific reason to believe that Medicare will not cover the service. The estimated cost or charge to the beneficiary for the item(s)/services(s) must be noted on the ABN form. Skilled Nursing Facilities (SNFs) must use the revised ABN form for items/services expected to be denied under Medicare Part B only.

Routine use of ABNs, providing generic ABNs, blanket or blank ABNs is strictly prohibited. There must be a specific reason to believe that Medicare will not cover the test/service in order to request a beneficiary sign an ABN.

A single ABN covering an extended course of treatment may be obtained provided the ABN identifies all items and services that may not be covered and does not extend more than one year. Examples of extended courses of treatment include physical therapy and repeat laboratory tests. If additional services are added to the extended course of treatment that are not medically necessary, or outside the frequency limitations, an additional ABN must be obtained. When a service has a technical component and a professional component, one ABN may be obtained provided the description of the service clearly indicates both components and associated costs. For example, if the hospital bills on behalf of a radiologist for radiology interpretations performed at the hospital, one ABN may be obtained from the beneficiary that includes both the performance of the radiology procedure (technical component) and the radiologist's interpretation and report (professional component).

When a hospital laboratory receives a specimen only and the test to be performed does not meet medical necessity guidelines, the laboratory must obtain an ABN prior to performing the test and/or attempt to contact physician office to see if an ABN has been executed at the office. If the integrity of the specimen is at risk and the test has been determined not medically necessary by the ABN software, laboratory personnel may perform the test(s). However, if an ABN is not obtained prior to performing the test(s), neither Medicare nor the beneficiary may be billed for the test(s).

An ABN is not required for items or services that are statutorily excluded form coverage by the Medicare Program but can be utilized on a voluntary basis if the facility/entity elects to do so. Such items and services include:

- Custodial care
- Hearing aids and hearing exams
- Most screening tests
- Most vaccines/routine immunizations
- Personal convenience items
- Routine dental services
- Self-administered drugs and biologicals
- Services related to a routine physical

It is not appropriate to obtain an ABN when the beneficiary is unable to comprehend the ABN (for example, if the patient is comatose, confused or legally incompetent, he/she is unable to understand the implications of signing the ABN) and his/her authorized representative is not available.

An ABN must never be obtained from a beneficiary under great duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies, until a medical screening examination has been completed and the patient has been stabilized.

A patient who is illiterate and/or unable to read the ABN, must have the ABN read to them in order for notification to be valid. The identity of the person reading the ABN to the patient should be noted on the form or within the medical record/billing record accordingly.

A person who does not speak or understand the language in which the ABN is written must have the ABN translated (orally or in writing) into the patient's spoken language in order for the notification to be valid. If the ABN is translated orally, the name of the person doing the translation should be noted on the ABN.

If the beneficiary refuses to sign the ABN and accept financial responsibility in the event Medicare denies payment, the ordering physician should be contacted to determine if non-performance of the services will compromise patient care.

If the beneficiary refuses to sign the ABN and accept financial responsibility in the event Medicare denies payment and demands that the services be performed, two facility staff members will indicate the circumstances and persons involved and will witness the refusal. In this case, Medicare considers the patient "notified" that their services may not be covered and the claim will be filed as if an ABN was obtained. In the case of a denial by Medicare, the beneficiary will be held liable for payment per Section 1879(c) of the Social Security Act.

Once the ABN is signed it may not be altered in any way. If additional services will be provided for which an ABN will be necessary, a new ABN must be obtained. If new diagnoses or orders are received, those changes must be communicated to Health Information Management ("HIM") to ensure coding compliance and appropriate Patient Financial Services ("PFS") billing.

A copy of the ABN should be provided to the beneficiary. The facility must maintain copies of signed ABNs with the patient's financial records and retain in accordance with policy 70.2.020 *Record Retention*.

<u>Medicare Administrative Contractor (MAC):</u>

Claims submitted for services outlined in a LCD/NCD will include the appropriate ABN modifier:

- GA: ABN executed
- GZ: ABN was not obtained and the provider is expecting a denial
- GX: Voluntary ABN obtained
- GY: Statutorily excluded item

The Medicare Administrative Contractor (MAC) will make a determination whether or not Medicare will pay for the services rendered. If the MAC determines that the services are not medically necessary, the facility may bill the beneficiary for the services for which an ABN was obtained. If the MAC pays for the services then the beneficiary must not be billed for the services for which the ABN was obtained.

All charges, covered or non-covered, with or without an ABN, will be billed to Medicare. The only exception would be if the patient selected on the CMS-R-131 form 'Option #2'- accepting financial responsibility for the non-covered service and requesting that Medicare not be billed. These charges will be removed from the Medicare bill and separately billed to the guarantor.

Patient Billing:

Following claim adjudication, PFS staff will review Medicare remittances as part of their follow-up process. Services determined as non-covered with an ABN on file (line items with a -GA modifier), must be billed to the guarantor for those charges. Facilities will follow the *Uninsured Patient Discount Policy* (60.4.005) for guidance on the discounting any non-covered services.

## V. STATUTORY/REGULATORY AUTHORITIES:

- CMS Pub. 60AB, Transmittal No. A-02-114, July 31, 2002 ABNs and DMEPOS Refund Requirements
- CMS Pub. 60AB, Transmittal No. A-02-117, November 1, 2002
- Medicare Claims Processing Manual (Pub 100-4), Chapter 30 – Financial Liability Protections, Sections 40 – 50.7.8, Rev. 1, 10/1/03.
- Medicare Claims Processing Manual (Pub 100-4), Chapter 1, Section 60
- Medicare Program Integrity Manual (Pub 100-8), Chapter 13, Sections 1.1 and 1.3
- www.cms.gov/BNI/02 ABN.asp