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SCOPE: All Company-affiliated hospitals performing and/or billing hospital outpatient and emergency services. Specifically, the following departments:

Business Office	Emergency Department
Outpatient Services	Nursing
Admitting/Registration	Health Information Management
Medical Staff	Physician Office Staff
Medical Directors	Physician Advisors
Central Scheduling	Ancillary Departments
Revenue Integrity	Case Management
Reimbursement	Non-physician Practitioners
Parallon Shared Services Centers Administration	Patient Access

PURPOSE: To outline the use of the mandatory Advance Beneficiary Notice of Noncoverage (ABN) for outpatient hospital services not covered by Medicare fee-for-service.

POLICY:

Prior to rendering an outpatient service, hospitals should issue ABNs to Medicare fee-for-service outpatients if they plan to hold the patient financially liable and:

1. The item/service provided does not meet medical necessity guidelines. For example, the service does not meet the requirements of a National Coverage Determination (NCD)/Local Coverage Determination (LCD).
2. The item/service may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
3. The item/service is for experimental or research use only.

Prior to issuing an ABN, hospitals may contact the ordering physician for additional information regarding the patient's case.

If there is ambiguity as to whether the requirements of an NCD/LCD have been met, hospitals should proceed with obtaining an ABN in order to allow the Medicare Contractor to adjudicate the claim.

ABNs must not be issued to patients who are unable to comprehend the ABN, under duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies. However, **for cases where EMTALA applies**, if after completion of the medical screening examination and necessary stabilization, if required, the patient will be receiving further services that are not medically necessary according to NCD/LCD; the hospital may choose to obtain an ABN for these non-medically necessary services. This applies to treatment in any hospital outpatient department that is located on or off the campus of the hospital.

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ABNs may be obtained for an extended course of treatment provided it identifies all items and services that may not be covered and does not extend more than one year.

Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage: ABNs may be issued to beneficiaries with QMB coverage (*i.e.*, Medicaid coverage of Medicare premiums and cost sharing) and/or Medicaid coverage. If the provider has any indication that the beneficiary is a QMB and/or has Medicaid coverage, special guidelines outlined in the Procedure section of this policy must be followed.

Services for which ABNs are issued must be billed in accordance with the requirements within this policy.

If a proper ABN is not obtained for an outpatient service determined not to be reasonable and necessary, the patient cannot be held financially liable.

The use of the ABN for statutorily excluded services (*e.g.*, self-administered drugs, cosmetic surgery) is not required by CMS. The guidance in this policy does not apply to situations where a voluntary ABN may be issued.

PROCEDURE:

USE OF THE ABN FORM

1. If the service to be provided is governed by an NCD or LCD, the pertinent information, including CPT/HCPCS codes and diagnosis codes if applicable, must be reviewed to determine if the service meets the requirements specified in the NCD and/or LCD and to determine if an ABN is necessary.

2. An ABN may be obtained for a service that would normally be packaged but that does not meet medical necessity per a particular National or Local Coverage Determination and is thus noncovered. For example, an ABN may be obtained for a laboratory test when medical necessity criteria are not met even if payment for the lab test is expected to be packaged.

3. If the decision to issue an ABN is made, the ABN must **not** be provided:
   a. after services have been rendered.
   b. when an item or service is expected to be covered by Medicare.
   c. without genuine reason to believe that Medicare may deny the item/service.
   d. when the beneficiary is unable to comprehend the ABN (*e.g.*, 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.

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4. 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 if the hospital intends to bill the beneficiary in the event Medicare denies payment. If the integrity of the specimen is at risk and the test is not medically necessary, 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 held financially liable for the test(s).

COMPLETION OF THE ABN FORM

1. HCA hospitals must use the CMS-approved form (CMS-R-131), which is also available from the Company-approved medical necessity vendors, and may not be altered (see Attachment A). All fields on the ABN form must be completed in sufficient detail to specify the potentially non-covered service. All entries must be in Arial or Arial Narrow font in the size range of 10 – 12 point font or legibly handwritten. When Spanish-language ABNs are used, the insertions on the form must also be in Spanish.

2. 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 needed, a new ABN must be obtained. The signed ABN form should be distributed as follows: retain the original copy at the notifier's office (if other than the hospital), give one copy to the patient, and retain one copy in the patient's financial record.

3. The hospital must include its name, address and telephone number in "Notifier(s)" section. Hospitals may also include their logo.

4. The first and last name of the patient must be entered in the "Patient Name" section.

5. The "Identification Number" section is optional; however, if completed, this section should include an identification number that ties the notice to the specific claim for which the ABN applies. Hospitals may enter the patient account number in this section. Medicare numbers or Social Security numbers must not appear on the notice.

6. The "Items and Services" section must include a general description of the items and services for which the ABN is being obtained in a language that is easy for the beneficiary to understand. It is not appropriate to only include a CPT/HCPCS code as a description. If a CPT/HCPCS is used then additional language must be provided describing the service. Whenever possible the general description of the service to be provided should be used. For example, use "CT Scan of the Head" as the description instead of "CT Scan of the Head without contrast."

7. The ABN form section titled Reason Medicare May Not Pay can be prepopulated with the following four options:
   a. "Medicare does not pay for the items(s) or service(s) for your condition."

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b. "Medicare does not pay for the item(s) or service(s) more often than_____."
c. "Medicare does not pay for experimental or research use items or services."
d. "Other reason: _____."

When completing the ABN form one of the four options must be utilized to indicate the reason why Medicare may not pay. If the "Other" option is used a reason must also be entered as to why the hospital believes Medicare may not pay for the item or service.

8. The Estimated Cost section of the ABN **must** be completed for any items or services listed as not being covered by Medicare. If multiple items or services are listed the estimated cost may reflect the total cost of all the potentially non-covered items and services. The ABN will **not** be considered valid if a good faith estimated cost is not included.

   In general, the estimate should be within $100.00 or 25% of the actual cost, whichever is greater. For example, a service that costs $250.00, the estimate could be listed as:
   a. Any dollar estimate equal to or greater than $150.00
   b. "Between $150.00 - $300.00"
   c. "No more than $500.00"

9. The beneficiary must select one of the three options listed in the Options section on the ABN form. Only one of the three options may be selected. If an option is not marked or more than one option is marked then the ABN will **not** be valid. The beneficiary may choose:
   a. **Option 1** where they receive the item or service and Medicare is billed;
   b. **Option 2** where they receive the item or service and are responsible for payment; or
   c. **Option 3** where they refuse the item or service.

   Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage:
   When the beneficiary signs the ABN, he/she must be instructed to check **Option 1** on the ABN in order for a claim to be submitted for Medicare adjudication. **This is the only instance where the provider may indicate what option the beneficiary should choose**. Even though the ABN indicates the beneficiary may be asked to pay now and is responsible for the payment if Medicare doesn't pay, the provider cannot bill the dual eligible beneficiary when the ABN is furnished.

   If the beneficiary chooses Option 1, Occurrence Code 32 and the date the ABN was obtained must be entered into the Meditech Admissions Module. The exact items or services for which the ABN was obtained must be described within the system notes.

   If the beneficiary chooses Option 2 or 3, Occurrence Code 32 should not be entered into the Meditech Admissions module, since Medicare will not be billed in either scenario.

10. The Additional Information section may be used to insert additional clarification that will be of use to beneficiaries.

11. The beneficiary or his/her representative must sign and date the ABN form. If the ABN form is not signed and dated it will not be considered valid.

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

13. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment and demands that the services be performed, a second person should witness the provision of the ABN and the beneficiary's refusal to sign. The witness should sign an annotation on the ABN stating that he/she witnessed the provision of the ABN and the beneficiary's refusal to sign. 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 per Section 1879(c) of the Social Security Act.

BILLING FOR SERVICES FOR WHICH AN ABN WAS OBTAINED

1. If the services are not medically necessary and the beneficiary chose **Option 1** on the ABN:
   a. Occurrence code 32 must be reported to indicate the date that the ABN was provided to the beneficiary.
   b. The services must be reported in Total Charges on the UB.
   c. The GA modifier must be appended to the CPT/HCPCS code representing the service(s) for which an ABN was obtained.

   The Medicare Contractor will make a determination whether or not the services will be paid by Medicare.
   a. If the Medicare Contractor determines that the services are non-covered, the hospital must bill the beneficiary for the services for which an ABN was obtained.
   b. If the Medicare Contractor pays for the services then the beneficiary must not be billed for the services for which an ABN was obtained.

Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage:
   a. If Medicare denies a claim as not medically reasonable and necessary and a Remittance Advice (RA) is received, the claim may be crossed over to Medicaid for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue an RA based on this determination.

b. If both Medicare and Medicaid deny coverage the beneficiary may be billed, subject to any state laws that limit beneficiary liability.
c. Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the beneficiary in the following circumstances:
   - If Medicare denies the claim as not reasonable and medically necessary and the beneficiary has QMB coverage without full Medicaid coverage, the ABN would allow the provider to shift liability to the beneficiary per Medicare policy.
   - If Medicare denies the claim as not reasonable and medically necessary for a beneficiary with full Medicaid coverage, and subsequently, Medicaid denies coverage (or will not pay because the provider does not participate in Medicaid,) the ABN would allow the provider to shift liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

2. If the services are not medically necessary and the patient chose **Option 2** on the ABN, the services must not be billed to Medicare and Occurrence Code 32 must not be reported on the UB. The Medicare Service Center must be informed of this decision by following established procedures for providing special instructions to the Medicare billers.

3. If the services are not medically necessary and the patient chose **Option 3** on the ABN, the beneficiary is choosing not to receive the items/services and no services will be billed to Medicare.

4. If the services have frequency limits:
   a. The services should be reported in Total Charges on the UB.
   b. The GA modifier must be appended to the CPT/HCPCS code representing the frequency limited service(s) if an ABN was obtained.
   c. Occurrence code 32 and the corresponding date must be reported when an ABN was obtained.
   d. The beneficiary must not be billed for the services if the Medicare Contractor pays for the services.
   e. The hospital must bill the beneficiary for the services for which an ABN was obtained if the Medicare Contractor determines that the services have exceeded the frequency limits.
   f. The hospital must not bill the beneficiary if the Medicare Contractor determines that the services have exceeded the frequency limits and an ABN was not obtained.

5. If the services are outside the scope of the LCD and/or NCD the services should be reported as covered in Total Charges on the UB.

6. If multiple ABNs are obtained for services included on one claim, occurrence code 32 and the date the ABN was provided must be reported for each ABN, even if the date is the same for each ABN.

7. If the services are not medically necessary and an ABN was not obtained prior to rendering the non-covered services, the services must be reported as non-covered with the GZ modifier on the UB. The charges should be written off as non-covered/non-allowable and must **not** be claimed as Medicare Bad Debt Expense.

EDUCATION

Ancillary Department, Service Center and Business Office personnel must educate all staff associates and medical staff members responsible for ordering, referring, registering, performing, charging, coding and billing ancillary services regarding the contents of this policy. **Note**: The Company offers a web based course, Advance Beneficiary Notice of Noncoverage, available through HealthStream, which includes detailed information regarding the ABN and meets the education requirement of this policy.

MONITORING

1. On a quarterly basis, Service Center personnel must provide a report to each hospital for which they bill that includes all write-offs performed during the past quarter due to lack of an ABN. This data must include a summary as well as patient detailed information that specifies patient type, write-off amount, ordering physician, service type, and HCPCS code.

2. Each hospital must review the data provided by their Service Center in #1 above and discuss the findings of the review within the FECC. The FECC must review the write-offs and determine if the volume and amount is reasonable. The FECC must also investigate any trends that relate to specific services or departments that do not appear to be appropriate. This review should be documented in the FECC minutes.

3. Hospital and Service Center personnel must randomly review 15 ABNs per hospital obtained during the past quarter to validate the ABNs were completed in accordance with CMS rules. (Refer to the Completion of the ABN FORM section above.)

4. A hospital found to have no errors for two consecutive quarters may reduce their review of ABNs to a total of 5 per quarter. If during any quarter any errors are found in the sample of 5 ABNs, the population must be expanded to 15 ABNs. The review sample will remain at 15 until such time that there are two consecutive quarters with no errors.

4. Quarterly monitoring must be completed no later than 60 days after the end of each quarter.

5. An action plan must be developed for any issues discovered during the monitoring process.

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The FECC is responsible for the implementation of this policy within the hospital.

REFERENCES:

1. Medicare - National and Local Coverage Determinations Policy, REGS.GEN.011
2. Medicare Contractor Local Coverage Determinations
3. CMS National Coverage Determinations
4. CMS Pub. 60AB, Transmittal No. AB-02-114, July 31, 2002 – ABNs and DMEPOS Refund Requirements
5. CMS Pub. 60AB, Transmittal No. A-02-117, November 1, 2002
6. Medicare Claims Processing Manual (Pub 100-4), Chapter 30 – Financial Liability Protections, Sections 40 – 50
7. Medicare Claims Processing Manual (Pub 100-4), Chapter 1, Section 60
8. Medicare Program Integrity Manual (Pub 100-8), Chapter 13, Sections 1.1 and 1.3
9. CMS Form Instructions for Advance Beneficiary Notice of Noncoverage (ABN), OMB Approval Number: 0938-0566
10. Social Security Act Section 1862
11. CMS Frequently Asked Questions - Outpatient Therapy Services and Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, August 2018
12. CMS Frequently Asked Questions - Qualified Medicare Beneficiary Program – FAQ on Billing Requirements, July 2018

Sample

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

If Medicare will not pay for a service, does that mean I do not need the service?

No. Your doctor bases decisions on a wide range of factors including your personal medical history, any medications you might be taking, and generally accepted medical practices. Even if your doctor believes a particular item/service is “good medicine,” and useful information to have in order to provide the best care for you, it is possible Medicare may not consider the service to be medically necessary for patients with your diagnosis.

What if I have questions?

If you have questions, you should discuss them with your physician and/or healthcare provider at the time of service.

For additional Information contact your Medicare Representative

Important Information for Medicare Patients Concerning Non-covered Services

What is “Medical Necessity”?

Medicare covers only those services which are reasonable and necessary for your treatment. Medicare requires providers to report information regarding the patient’s diagnosis when seeking payment so that they can determine whether the services ordered were medically necessary.

What is an ABN?

An ABN is an Advance Beneficiary Notice of Noncoverage. The purpose of the ABN is to give you advance notice that Medicare may not pay for your services. The ABN tells you which item(s)/service(s) may not be reasonable and necessary and informs you that you will be financially responsible for the services should Medicare deny payment. When it is required, you will be asked to sign the ABN before services are performed.

What options do I have?

You have three options when an ABN form is presented to you. You may 1) receive the services and request that Medicare be billed for a determination. You agree to be responsible for payment of the services if Medicare does not consider them reasonable and necessary; 2) receive the

services and Medicare not be billed. You will be responsible for the payment; or 3) refuse to be responsible for payment of services that Medicare will not cover and, therefore, not receive the items or services.

What are my rights as a patient?

As a Medicare beneficiary, you have certain guaranteed rights. These rights protect you when you receive health care; assure you access to needed health care services; and protect you against unethical practices. Your rights include, but are not limited to:

- The right to information about what services are covered and how much you will have to pay
- The right to information about all treatment options available to you The right to appeal decisions to deny or limit payment for medical care

How does the billing process work?

Generally, your doctor will bill Medicare when you receive a service at his/her office. However, when your doctor orders items or services from a hospital or outside of his or her office, the hospital performs the items/services which were requested and the hospital, not your doctor, bills Medicare directly for the services being performed for you. The hospital provides Medicare with your Medicare number, the services performed, and your diagnosis provided by your doctor