



## ESSENT HEALTHCARE, INC.

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<b>Section: Corporate Compliance</b>	<b>Effective Date:</b>	<b>12/01/04</b>
<b>Subject: Advance Beneficiary Notices</b>	<b>Revision Date:</b>	<b>09/01/05</b>
<b>Policy #: CC-9</b>	<b>Review Date:</b>	<b>11/18/09</b>
<b>Approved By: Corporate Compliance Officer</b>	<b>Revision #:</b>	<b>1</b>

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**Scope:**

This policy applies to all Essent facilities.

**Purpose:**

The purpose of this policy is to provide guidance regarding Advance Beneficiary Notices (ABN) for Medicare patients.

**Policy:**

ABNs must be obtained in accordance with Medicare requirements. Hospitals must bill Medicare for all medically necessary services and obtain an ABN for services that do not meet medical necessity criteria according to Local Medical Review Policy (LMRP), Local Coverage Determinations (LCD) and/or National Coverage Determinations (NCD).

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**Procedure:**

- 1) Individuals involved in the ordering and/or delivery of outpatient services must review the patient's diagnosis, sign, symptom, disease or ICD-9-CM code for medical necessity to determine if an ABN is necessary.
  - a) If the physician or practitioner expects Medicare to make payment, an ABN should not be given.
  - b) If the physician or practitioner "never knows whether or not Medicare will pay" an ABN should not be given.
  - c) If the physician or practitioner expects Medicare to deny payment on the basis of not reasonable and/or necessary, an ABN should be given.
- 2) An ABN must be obtained **before** items or services are furnished when the physician or practitioner has reason to believe that Medicare will not make payment because the item or service does not meet medical necessity requirements (Local Medical Review Policies, Local Coverage Determinations, and National Coverage Determinations).
- 3) ABNs are designed for use with Medicare beneficiaries only, including those who are dually-eligible for Medicare/Medicaid. ABNs are not for use with patients who are not Medicare beneficiaries.
- 4) The purpose of the ABN is to inform a Medicare beneficiary that Medicare will probably not pay for a particular item or service in under the current circumstances.



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- 5) The ABN must be issued each time, and as soon as, the physician or practitioner makes the assessment that Medicare payment probably or certainly will be denied.
- 6) To be acceptable, the ABN must
  - a) Be on the approved form CMS-R-131 (see attached).
  - b) Be only one page in length.
  - c) Clearly identify the item or service expected to be denied.
  - d) State that the physician or practitioner believes that Medicare is likely (or certain) to deny payment for the item or service.
  - e) Give the physician or practitioner's reason for their belief that Medicare is likely to deny payment for the item or service.
    - Simply stating "medically unnecessary" is not an acceptable reason; insofar as it does not explain why the physician or practitioner believes the item or service will be denied as not reasonable and necessary.
- 7) The ABN should not be used unless and until the physician or practitioner has some genuine doubt regarding the likelihood of Medicare payment. Giving ABNs for all items or services is not an acceptable practice **nor** is the practice of issuing blank ABNs to be filled in at a future time as needed.
- 8) Delivery of the ABN occurs when the beneficiary (or authorized representative) both has received the notice and can comprehend its contents.
- 9) Patients must be given notice far enough in advance of receiving a medical service so that they can make rational, informed consumer decisions without undue pressure. As a general rule, ABN delivery should take place before a procedure is initiated and before physical preparation of the patient has begun.
- 10) **Exception for Repetitive Services** – A single ABN covering an extended course of treatment is acceptable provided the ABN identifies all of the items and services for which the physician or practitioner believes Medicare will not pay.
- 11) **Exception for Emergency Services** – ABNs should not be given to patients in a medical emergency or otherwise under great duress since that individual cannot be expected to make a rational, informed decision.
  - a) A hospital would violate the EMTALA statute if it delayed a medical screening examination or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature.
- 12) **Exception for Statutorily Excluded Services** – ABNs are not required in the case of statutorily excluded items and services. Examples of statutorily excluded items or services include:
  - a) Personal comfort items
  - b) Routine physicals and most screening services
  - c) Most outpatient prescription drugs



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- d) Cosmetic Surgery
  - e) Dental care
  - f) Other items and services that are **never** covered by Medicare
- 13) The approved Notice of Exclusion from Medicare Benefit (NEMB) form should be used in lieu of the ABN for the excluded services outlined in item number 12 above (see attached)

### References:

AIS Compliance Guide  
HCCA Compliance Manual  
CMS Transmittal AB-02-168, 10/22/02  
CMS Beneficiary Notices Initiative (BNI) web site  
CMS R-193; "Important Message from Medicare"