 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	<i>Policy Number</i> FIN118
	<i>Subject</i>	<i>Effective Date</i> 05-15-09
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		<i>Supersedes</i> 07-15-08

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).

Purpose

This policy is intended to assist the three Hospital entities in their efforts to comply with Medicare requirements associated with the use of Advance Beneficiary Notices (ABN) by providing uniform guidelines on when to use these forms and how they are to be completed.

General Conditions


Medicare will only pay for tests or services that meet the Center for Medicare and Medicaid Services' definition of medical necessity. In order to preserve its right to bill the patient for non-covered services, Medicare requires that the provider inform the Medicare patient that the test or service ordered by his or her physician is not expected to be covered. Such notice must be in writing and is referred to as an Advance Beneficiary Notice (ABN). The ABN process must be completed prior to providing the test or service. The fundamental purpose of the ABN is to allow Medicare beneficiaries the option of accepting financial responsibility for services in the event that Medicare does not cover them, or decline receiving the services altogether.

It is the policy of JHHS Hospitals to issue ABNs to Medicare beneficiaries in those instances where it is anticipated that the Medicare program will not cover the test or service that has been ordered.*

Note: Medicare Advantage plans and prescription drug programs are not subject to an ABN.

The guidelines listed below must be followed in accordance with Medicare requirements:

- a.) an ABN must be in writing (see Exhibit A)
- b.) a complete ABN must be obtained before the test or service is performed. It is not necessary for the patient to sign the ABN in all instances however, in those cases where it is not a witness must sign.
- c.) the ABN must include the following:
 - a description of the test or service which may be denied (together with the associated CPT/HCPCS code, including the professional as well as technical components of the test or service at JHH and JHBMC)
 - reason why the test/service may be denied
 - estimated cost for test or service (professional and technical at JHH and JHBMC)
 - patient's name, Medicare number (HIC#), (date of birth and treating physician)
 - patient or patient representative's signature and date or a witness signature and date
 - 3 Options regarding the item or service that may be non-covered:
 - Option 1- notice that the patient may both obtain the test(s)/service and agree to accept

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the responsibility for payment. Requests that Medicare is billed for an official decision from Medicare. Patient Appeal rights are retained.

Option 2- notice that the patient may agree to obtain the test(s)/service and agree to accept financial responsibility however; does not want Medicare billed. Patient Appeal rights are forfeited under this option.

Option 3- the patient may refuse test(s)/service and will not be financially responsible.

- d.) if multiple services are to be performed a separate ABN must be obtained for each service.
- e.) if non-covered services are repetitive or continuous, a single ABN may be issued. The duration of services must be described and may not exceed 1 year.

*ABNs are not required when the test or service in question is statutorily not covered by Medicare (e.g. routine physicals, hearing aids, etc.)


PROCEDURES

To help maximize compliance with Medicare requirements, an ABN must be obtained by the ordering provider when non-covered tests or services ordered meet one or more of the following criteria:

- the test is for routine testing or screening purposes
- the test is for investigative or research purposes (except where such tests are paid by the research grant)
- the diagnosis does not meet the medical necessity requirements
- there was no diagnosis provided by the physician
- there is a frequency limit for the test (e.g. mammograms or PAP smears) and performing the test would exceed that limit and therefore not be reimbursed


The diagnosis on the requisition form must be reviewed by designated ordering departmental personnel when processing the outpatient Medicare order.

1. Personnel in the ordering department responsible for processing the requisition must determine whether or not the CPT code for the test/service that has been ordered is covered for the assigned diagnosis based on Medicare's medical review policies. If the ordered test/service is identified as being non-covered, personnel check whether the patient has been given an ABN by the ordering physician. If the patient does not have an ABN and the diagnosis provided does not meet the medical necessity guidelines, then the responsible staff must complete an ABN.
2. Explain the purpose of the ABN to the patient and request that he or she sign either an (1) agreement to pay for the test(s)/service, bill Medicare for official decision on payment (2) agreement to pay for the test(s)/service but do not want Medicare billed, or (3) deny responsibility and not obtain the test(s)/service.
3. For patients that select Option 1- Collection of the estimated cost or services should be obtained from the patient.
4. For patients that select Option 2- Collection of the estimated cost for the service should be

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obtained from the patient. Medicare should be deleted from the account to ensure MC is not billed. The account should be made self pay. Patient needs to be advised that secondary insurances will not process or pay claims without Medicare explanation of benefits. If patient has no other insurance, the account should be made self-pay.

5. For patients that select Option 3- If no other test(s)/services are performed and no charges are generated the account should be cancelled.
6. If the patient demands the test(s) and refused to sign the ABN form, the "refusal to sign" section of the ABN must be signed and dated by an employee as a witness.
7. The signed ABN form must be distributed as follows:
 - JHH- original copy scanned into Document Imaging
 - JHBMC- original copy scanned into EMR
 - HCGH- original copy scanned onto a shared drive with JHPFS
 - a copy is given to the patient or sent to the patient via mail.
 - a copy is kept in the patient's departmental medical records
8. On the JHH campus, charge entry staff may indicate an ABN was obtained by setting the ABN flag in Keane during charge capture.
9. On the JHBMC campus, registration and or clinic staff document ABN collection through setting ABN waiver flag to Y. The field is located under the occurrence code tab in outpatient Pre-reg and Registration screen. Patient Financial Services staff can see that the ABN flag has been completed by pulling up the EDIT CDS screen in Meditech BAR and viewing the ABN waiver flag response under the second tab labeled occurrence codes.
10. On the HCGH campus, clinicians/medical office staff takes the physician requisition/order form and input tests ordered through ABN medical necessity module in Meditech system. Please note this is only for services entered in Order Entry (OR). If tests edit with a failed status, clinician/medical office staff collect an ABN and collection is documented via the system when entering the choice that the patient made once presented with the ABN. Patient Financial Services staff are able to view medical necessity status assigned (Pass/Fail) to each test by accessing screens 50 & 51 in the Meditech system.
 There are also "manual" ABN's issued which are not processed through the ABN software. (Ex. Rehab patient's that have maximized their goals but wish to continue care or specific diagnosis within cardiac rehab). In this case, the registration and/or clinic staff document ABN collection through setting ABN waiver flag to Y. The field is located under the occurrence code tab in outpatient Pre-reg and Registration screen. Patient Financial Services staff can see that the ABN flag has been completed by pulling up the EDIT CDS screen in Meditech BAR and viewing the ABN waiver flag response under the second tab labeled occurrence codes.
11. Patient Financial Services personnel must annotate the patient's billing record that an ABN is on file by placing a GA modifier in field 44 of the UB92 after the CPT or HCPC that has been identified as not medically necessary. Occurrence code 32 with the ABN collection date must also be reported on the UB92 claim under UB92 field locations 32-35.

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TRAINING OF OUTPATIENT PERSONNEL

Personnel involved in the delivery of Hospital outpatient services, including ancillary department personnel, shall attend an educational session in the correct usage of Advance Beneficiary Notices and medical necessity guidelines (to be provided by the Ambulatory Services Management at each hospital and/or the JHHS Corporate Compliance Department).

RESOURCES

Department personnel may review information about Local Medical Review Policies to determine if an ABN is needed by going to the following website:

http://www.medicare.gov/coverage/search/LMRPNCDInterim.asp?cov_id=90&state_id=MD

SPONSOR

Senior Director, Patient Finance (JHH, JHBMC, HCGH)
 Deputy Chief Compliance Officer & Director of Billing Compliance (JHHS)

REVIEW CYCLE

Three (3) years

APPROVAL


 Vice President of Finance/CFO and Treasurer, JHHS

5-15-09
 Date

(A) Notifier(s):

(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:
<p>_____</p>		

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.
<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p>

(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:
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