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On the topic:

The ABN: Protecting Your Reimbursement
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The ABN
Protecting Your Reimbursement

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The Advanced Beneficiary Notice

The Advanced Beneficiary Notice (ABN) is:

- A notice that a provider should give a patient before she/he receives a service if, based on insurance coverage rules, your provider has reason to believe the carrier will not pay for the service.
- Also known as a waiver of liability, or notice of non-coverage.
- Required by Medicare, as well as Medicare Advantage Plans and other commercial carriers.
- Used to allow the beneficiary to make an informed decision on whether to get the care in question and to accept financial responsibility for the service (pay for the service out-of-pocket).
The History of the ABN

• The need to “notify” was born under the Social Security Act provision to limit beneficiary liability for services or items may not be paid for under Medicare Part A and B insurance.

• Let’s explore:
  – How the ABN came into existence
  – The Medicare ABN
  – The Medicare Advantage Plan ABN
  – The Commercial Carrier ABN

ABN History - Protection for Beneficiaries


• 50.2 – General Statutory Authority - Financial Liability Protection Provisions (FLP) of Title XVIII (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

• The Financial Liability Protection Provisions (FLP) of the Social Security Act (the Act) protect beneficiaries, health care providers and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay.
Things we know to be TRUE:

Whatever CMS/Medicare does, other carriers will do also!

Let’s begin our journey into the ABN world.

THE MEDICARE ABN
Applicability to Limitation On Liability

• 50.2.1 - Applicability to Limitation On Liability (LOL)  
  (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)
  
  – The Limitation On Liability (LOL) protections of the Act apply only when a provider believes that a Medicare covered item or service may be denied in a particular instance because:
    • it is not reasonable and necessary under §1862(a)(1) of the Act or;
    • because the item or service constitutes custodial care under §1862(a)(9) of the Act.

Applicability to Limitation On Liability

– The Act also requires a provider to notify a beneficiary in advance when s/he believes that items or services will likely be denied either as:
  • not reasonable and necessary or;
  • as constituting custodial care.
Applicability to Limitation On Liability

– If such notice (in the form of an ABN or as otherwise noted in §40.2) is not given, providers may not shift financial liability to beneficiaries for these items or services if Medicare denies the claim.

• Beneficiaries are afforded LOL protection when items or services are denied for reasons listed in §50.3.1.

Financial Liability Protection

• The FLP provisions include:
  – Limitation On Liability (LOL) under §1879(a)-(g) of the Act;
  – Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l) of the Act; and
  – Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act.
Limitation on Liability

- The LOL provisions of §1879 apply to this new subparagraph; thus,
  - providers must issue an ABN prior to providing a preventative service that is usually covered by Medicare but will not be covered in this instance because frequency limitations have been exceeded.
  - In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) when a noncontract supplier furnishes an item included in the Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) Competitive Bidding Program (CBP) for a Competitive Bidding Area (CBA).
  - Although all other denial reasons triggering mandatory use of the ABN are found in §1879 of the Act, in this situation, §1847(b)(5)(D) of the Act permits use of the ABN with respect to these items and services.

The Approved Notice

- The ABN is an Office of Management and Budget (OMB)-approved written notice.
  - Issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and certain care provided under Part A (hospice and religious non-medical healthcare institutes only).
The Medicare ABN

• The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program.

• It is not used for:
  – items or services provided under the Medicare Advantage (MA) Program
  – prescription drugs provided under the Medicare Prescription Drug Program (Part D)
  – items or services provided by commercial carriers.

Medicare Claims Processing Manual

• Section 50 of the Medicare Claims Processing Manual:
  – establishes the standards for use by providers and suppliers (including laboratories) in implementing the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131.

• This section provides instructions regarding the notice issued by providers to beneficiaries in advance of providing what they believe to be noncovered items or services.

• The ABN must meet all of the standards found in Chapter 30.
Who is a Notifier?

• Section 50.4.1(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13) gives this definition:
  – Entities who issue ABNs are collectively known as “notifiers”. These entities can include physicians, practitioners, providers (including laboratories), and suppliers, and/or utilization review committees for the care provider.
  – In 2013, HHAs (Home Health Agencies) are added as ABN issuers.

Who is a Notifier?

• Expanded mandatory ABN use in 2011 The Patient Protection and Affordable Care Act, P.L. 111-148, §4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1) of the Act. Per §1862(a)(1)(P),
  • Medicare covered personalized prevention plan services (as defined in section 1861(hhh)(1)) that are performed more frequently than indicated per coverage guidelines are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
Notifiers

• Notifiers may direct an employee or a subcontractor to deliver an ABN.

• The billing entity will always be held responsible for effective delivery regardless of who gives the notice.

• When multiple entities are involved in rendering care, it is not necessary to give separate ABNs.

• Either party involved in the delivery of care can be the notifier when:
  – There are separate “ordering” and “rendering” providers (e.g. a physician orders a lab test and an independent laboratory delivers the ordered tests);
  – One provider delivers the “technical” and the other the “professional” component of the same service (e.g. a radiological test that an independent diagnostic testing facility renders and a physician interprets); or
  – The entity that obtains the signature on the ABN is different from the entity that bills for services (e.g. when one laboratory refers a specimen to another laboratory which then bills Medicare for the test).
  – When the notifier is not the billing entity, the notifier must know how to direct the beneficiary who received the ABN to the billing entity for questions and should annotate the “Additional Information section of the ABN” with this information. It is permissible to enter the names of more than one entity in the header of the notice.
Who is a Recipient?

- Section 50.4.2.-Recipients of the ABN (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12) gives this definition:
  - A FFS Medicare beneficiary or his/her representative.
  - Recipients of ABNs include beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible).

Key Points

- A notifier’s inability to give notice to a beneficiary or his/her representative does not allow the notifier to shift financial liability to the beneficiary.
- Note: See §§40.3.4.6 and 50.6.5.B for information on beneficiary refusals.
Who is a Representative of a Beneficiary?

- Section 50.4.3 - Representatives of Beneficiaries (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13) defines a representative as an individual who may make health care and financial decisions on a beneficiary’s behalf (e.g. the beneficiary’s legal guardian or someone appointed according to a properly executed “durable medical power of attorney”) is an authorized representative.

- If the beneficiary has a known, legally authorized representative, the ABN must be issued to the existing representative.

- When a representative is signing the ABN on behalf of a beneficiary, the ABN should be annotated to identify that the signature was penned by the “rep” or “representative”. If the representative’s signature is not clearly legible, the representative’s name should be printed on the ABN.

Who is a Representative of a Beneficiary?

- If a beneficiary does not have a representative and one is necessary, a representative may be appointed for purposes of receiving notice following CMS guidelines and as permitted by State and Local law. See §40.3.5 of this chapter for more detailed guidance on representatives.

- Notifiers are responsible for determining who may act as a beneficiary’s authorized representative for the purposes of ABN issuance under applicable State or other law.
### Triggering Events

50.5 - ABN Triggering Events (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

*Triggering Events dictate when Notifiers are required to issue ABNs.*

- This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as “triggering events”.
- It happens when an item or service is expected to be denied based on one of the provisions in §50.3.1.

### Triggers: Initiation

*An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment.*

- If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, *an ABN must be issued prior to the beneficiary receiving the non-covered care.*
Example of an Initiation Trigger

- Example:
  - Mrs. S. asks her physician for an EKG because her sister was recently diagnosed with atrial fibrillation. Mrs. S. has no diagnosis that warrants medical necessity of an EKG but insists on having an EKG even if she has to pay out of pocket for it.
  - The physician’s office personnel issues an ABN to Mrs. S. before the EKG is done.

Triggers: Reduction

A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.).

- The ABN is not issued every time an item or service is reduced.
- But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.
Example of a Reduction Trigger

• Example:
  – Mr. T, is receiving outpatient physical therapy five days a week, and after meeting several goals, therapy is reduced to three days per week. Mr. T wants to achieve a higher level of proficiency in performing goal related activities and wants to continue with therapy 5 days a week. He is willing to take financial responsibility for the costs of the 2 days of therapy per week that are no longer medically reasonable and necessary.
  – An ABN would be issued prior to providing the additional days of therapy weekly.

Trigger: Termination

A termination is the discontinuation of certain items or services.

• The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.
Example of Termination Trigger

• Example:
  – Ms. X has been receiving covered outpatient speech therapy services, has met her treatment goals, and has been given speech exercises to do at home that do not require therapist intervention. Ms. X wants her speech therapist to continue to work with her even though continued therapy is not medically reasonable or necessary.
  – Ms. X is issued an ABN prior to her speech therapist resuming therapy that is no longer considered medically reasonable and necessary.

Mandatory ABN Uses

50.3.1 - Mandatory ABN Uses (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

• The following provisions necessitate delivery of the ABN:
  – §1862(a)(1) of the Act (not reasonable and necessary);
  – §1834(a)(17)(B) of the Act (violation of the prohibition on unsolicited telephone contacts);
  – §1834(j)(1) of the Act (medical equipment and supplies supplier number requirements not met);
  – §1834(a)(15) of the Act (medical equipment and/or supplies denied in advance);
  – §1862(a)(9) of the Act (custodial care);
  – §1879(g)(2) of the Act (hospice patient who is not terminally ill); or
Mandatory ABN Uses

Continued:

– §1879(g)(1) of the Act (home health services requirements are not met – not confined to the home or no need for intermittent skilled nursing care).

– §1833(g)(5) of the Act (when outpatient therapy services are in excess of therapy cap amounts and don’t qualify for a therapy cap exception – effective January 1, 2013).

• When Medicare considers an item or service experimental (e.g., a “Research Use Only” or “Investigational Use Only” laboratory test), payment for the experimental item or service is denied under §1862(a)(1) of the Act as not reasonable and necessary.

In circumstances such as this, the beneficiary must be given an ABN.

Voluntary Uses of the ABN

• The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation.

• When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice.
Voluntary Uses of the ABN

• The provider or supplier, when using the ABN for voluntary notification, is not required to adhere to the issuance guidelines for the mandatory notice (as set forth below).

• **NOTE:** Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.

50.3.2 - Voluntary ABN Uses (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

• **ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification).**

• **However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:**
  
  – Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the Social Security Act;
Voluntary Uses of the ABN

Continued:

- Care that is explicitly excluded from coverage under §1862 of the Social Security Act.
  - Examples include:
    - Services for which there is no legal obligation to pay;
    - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual eligibles);
    - Services required as a result of war;
    - Personal comfort items;
    - Routine eye care;
    - Dental care; and
    - Routine foot care.

ABN Standards

Section 50.6 - ABN Standards (Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09) 50.6.1 - Proper Notice Documents (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

- The ABN, Form CMS-R-131, is the Office of Management and Budget (OMB) approved standard notice.
- Failure to use this notice as mandated could result in the notice being invalidated and/or the notifier being held liable for the items or services in question.
ABN Standards

• The online replicable copies of the OMB approved ABN (CMS-R-131) and instructions for notice completion are available on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
  – Language Choice
    • The ABN is available in English and Spanish under a dedicated link on the web page given above.
    • Notifiers should choose the appropriate version of the ABN based on the language the beneficiary best understands.
    • Insertions must be in English when the English language ABN is used.

ABN Standards

Language choice continued:

• Similarly, when a Spanish language ABN is used, the notifier should make insertions on the notice in Spanish, if applicable.
• In addition, verbal assistance in other languages may be provided to assist beneficiaries in understanding the document.
• However, the printed document is limited to the OMB-approved English and Spanish versions.
• Notifiers should document any types of translation assistance that are used in the “Additional Information” section of the notice.
ABN Effective Version Standards

• Effective Versions ABNs are effective as of the OMB approval date given at the bottom of each notice.
  – The routine approval is for 3-year use.
  – Notifiers are expected to exclusively use the current version of the ABN.

Effective versions continued:

  – CMS will allow a transition period for providers and suppliers to switch from using expiring notices to newly approved notices.
  – The date of mandatory use of newly approved notices will be announced on the CMS website with the notice’s release.
ABN Standards: Notice of Preparation

Under Section 50.6.2 - General Notice Preparation Requirements (Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

- The following are the general instructions that notifiers must follow in preparing an ABN for mandatory use:
  - Number of Copies: A minimum of two copies, including the original, must be made so the beneficiary and notifier each have one. The notifier should retain the original whenever possible.
  - Reproduction: Notifiers may reproduce the ABN by using self-carbonizing paper, photocopying, digitized technology, or another appropriate method.
    - All reproductions must conform to applicable form and manual instructions.

- Length and Size of Page:
  - The ABN form must not exceed one page in length; however, attachments are permitted for listing additional items and services.
  - If attachments are used, they must allow for clear matching of the items or services in question with the reason and cost estimate information.
  - The ABN is designed as a letter sized form.
  - If necessary, it may be expanded to a legal-sized page.
ABN Standards: Notice of Preparation

- Contrast of Paper and Print:
  - A visually high-contrast combination of dark ink on a pale background must be used.
  - Do not use reversed print (i.e. white print on black paper), or block-shaded (highlighted) text.

- Font:
  - To the extent practicable, the fonts as they appear in the ABN downloaded from the CMS web site should be used.
  - Any changes in the font type must be based solely on limitations of the notifier’s software and/or hardware.
  - In such cases, notifiers should use alternative fonts that are easily readable, such as Arial, Arial Narrow, Times New Roman, and Courier. Font style and formatting must be maintained regardless of font type used.

Font continued:

- Any other changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the ABN more difficult to read.
- The font size generally should be 12 point.
- Titles should be 14-16 point, but insertions in blanks of the ABN can be as small as 10 point if needed.
- Information inserted by notifiers in the blank spaces on the ABN may be typed or legibly hand-written.
ABN Standards: Notice of Preparation

– Customization:

- Notifiers are permitted to do some customization of ABNs, such as pre-printing information in certain blanks to promote efficiency and to ensure clarity for beneficiaries.
- Notifiers may develop multiple versions of the ABN specialized to common treatment scenarios, using the required language and general formatting of the ABN.

ABN Standards: Notice of Preparation

• Form completion instructions can be downloaded at:

50.6.3 - Completing the ABN
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

- Step by step instructions for notice completion are posted along with the notice on the CMS website and can be downloaded via this link:

- Notifiers must follow guidance provided in this section and the instructions posted on the CMS website to construct a valid notice.
ABN Preparation Guidelines

• Header Blanks A-C:
  – The header of the notice must be completed by the notifier prior to delivering the ABN.
  – Blank (A) Notifier(s):
    ▪ Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice.
    ▪ This information may be incorporated into a notifier’s logo at the top of the notice by typing, hand-writing, preprinting, using a label or other means.
    ▪ If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header
      – as long as it is specified in the Additional Information (H) section who should be contacted for billing questions.

ABN Preparation Guidelines

– Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary’s Medicare (HICN) card.
  ▪ The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.
ABN Preparation Guidelines

– Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim.
  ▪ The absence of an identification number does not invalidate the ABN.
  ▪ An internal filing number created by the notifier, such as a medical record number, may be used.
  ▪ Medicare numbers (HICNs) or Social Security numbers must not appear on the notice.

• BLANK “D”:
  – “Note: If Medicare doesn't pay for (D)”:  
    ▪ The notifier must list the specific names of the items or services believed to be noncovered in the column directly under the header of Blank (D).
  – “We expect Medicare not to pay for the (D) below”:  
    ▪ The notifier must list the specific names of the items or services believed to be noncovered in the column directly under the header of Blank (D).
  – In the case of partial denials:
    ▪ Notifiers must list the excess component(s) of the item or service for which denial is expected in the table, under the column listed Blank (D).
  – For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service.
ABN Preparation Guidelines

– General descriptions of specifically grouped supplies are permitted in this column.
  ▪ For example, “wound care supplies” would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required. When a reduction in service occurs, notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction.
  ▪ For example, entering “wound care supplies decreased from weekly to monthly” would be appropriate to describe a decrease in frequency for this category of supplies; just writing “wound care supplies decreased” is insufficient.

ABN Preparation Guidelines

– Body Blank (D)(continued): The following descriptors may be used in the Blank (D) fields:
  ▪ Please note that there are a total of 7 Blank (D) fields that the notifier must complete on the ABN.
  ▪ Notifiers are encouraged to populate all of the Blank (D) fields in advance when a general descriptor such as “Item(s)/Service(s)” is used.

  – All Blank (D) fields must be completed on the ABN in order for the notice to be considered valid.
  – See § 50.7.1 (b) of the MCPM, Chapter 30 for additional information.
ABN Preparation Guidelines

• Blank (E) Reason Medicare May Not Pay:
  ▪ In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare.
  ▪ Three commonly used reasons for noncoverage are:
    – "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."
  ▪ To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D).
  ▪ The same reason for noncoverage may be applied to multiple items in Blank (D) when appropriate.

• Blank (F) Estimated Cost:
  – Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.
  – Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D).
  – In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.
ABN Preparation Guidelines

Blank (F) Estimated Cost (continued):
– Thus, examples of acceptable estimates would include, but not be limited to, the following:
   ▪ For a service that costs $250:
     Any dollar estimate equal to or greater than $150
     – “Between $150-300”
     – “No more than $500”
   ▪ For a service that costs $500:
     Any dollar estimate equal to or greater than $375
     – “Between $400-600”
     – “No more than $700”
– Multiple items or services that are routinely grouped can be bundled into a single cost estimate.
– For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections.

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ABN Preparation Guidelines

Blank (F) Estimated Cost (continued):
– As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service.
– If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may;
  ▪ enter the initial cost estimate and indicate the possibility of further testing

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ABN Preparation Guidelines

Blank (F) Estimated Cost (continued):

- Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may;
  - indicate in the cost estimate area that no cost estimate is available.
  - We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

- CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general.
- In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

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ABN Preparation Guidelines

• Options Blank (G) Options: Blank (G) contains the following three options:

  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.

  - This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare.

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Options Blank (G) Options (continued):

- This will result in a payment decision that can be appealed. See Ch. 30, §50.15.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare.

- Suppliers and providers who don't accept Medicare assignment may make modifications to Option 1 only as specified below under “D.”

- Additional Information.” Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

ABN Preparation Guidelines

Options Blank (G) Options (continued):

- 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.

- This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket.

- No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.
ABN Preparation Guidelines

Options Blank (G) Options (continued):

- 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.

- This option means the beneficiary does not want the care in question.
- By checking this box, the beneficiary understands that no additional care will be provided; thus, there are no appeal rights associated with this option.

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ABN Preparation Guidelines

Options Blank (G) Options (continued):

- The beneficiary or his or her representative must choose only one of the three options listed in Blank (G).
- Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select.
- Pre-selection of an option by the notifier invalidates the notice.
- However, at the beneficiary’s request, notifiers may enter the beneficiary’s selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.
- If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN.
- The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.
- If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: “beneficiary refused to choose an option.”

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ABN Preparation Guidelines

• Additional Information Blank (H) Additional Information:
  – Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries.
    ▪ For example, notifiers may use this space to include:
      – 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 for beneficiaries, such as a Medigap policy, if applicable;
      – An additional dated witness signature;
      – Or other necessary annotations.

• Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature.

• If annotations are made on different dates, those dates should be part of the annotations.
ABN Preparation Guidelines

• Blank (I) Signature:
  – The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print.

• Signature Box:
  – Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative).
  – This box cannot be completed in advance of the rest of the notice.

• Blank (J) Date:
  – The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.
  – Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document.
ABN Preparation Guidelines

• Special guidance ONLY for non-participating suppliers and providers (those who don’t accept Medicare assignment):
  – Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: If Medicare does pay, you will refund any payments I made to you, less copays or deductibles.
  – This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished.
• Alternatively, the line can be hand-penned on an already printed ABN.
• The sentence must be stricken and can’t be entirely concealed or deleted.

ABN Preparation Guidelines

Continued:

• There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.
• When this sentence is stricken, the supplier shall include the following CMS-approved unassigned claim statement in the (H) Additional Information section:
ABN Preparation Guidelines

“**This supplier doesn’t accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier’s charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier’s charge.**”

- This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.
- An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice.

Continued:

- Similarly, when the unassigned claim statement is included in the “Additional Information” section, the last sentence in Option 1 should be stricken.
- Blanks (G)-(I) must be completed by the beneficiary or his/her representative when the ABN is issued and may never be pre-filled.
- Lettering of the blanks (A-J) should be removed prior to issuance of an ABN.
ABN Preparation Guidelines

• If pre-printed information is used to describe items/services and/or common reasons for noncoverage, the notifier must clearly indicate on the ABN which portions of the preprinted information are applicable to the beneficiary.
  – For example, pre-printed items or services that are inapplicable may be crossed out, or applicable items/services may be checked off.
  – Providers who pre-print a menu of items or services may wish to list a cost estimate alongside each item or service.
    • For example, notifiers may merge the items/service section (Blank D) with the estimated cost section (Blank F) as long as the beneficiary can clearly identify the services and related costs that may not be covered by Medicare.

ABN Preparation Guidelines

• Modification: The ABN may not be modified except as specifically allowed by these instructions.
• Notifiers must exercise caution before adding any customizations beyond these guidelines, since changing ABNs too much could result in invalid notice and provider liability for noncovered charges.
• Validity judgments are generally made by Medicare contractors, usually when reviewing ABN-related claims; however, any complaints received may be investigated by contractors and/or CMS central or regional offices.
ABN Preparation Guidelines

• An example of an approved customization of the ABN which can be used by providers of laboratory services (Sample Lab ABN) is available for download http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

50.6.4 – Retention Requirements
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

• The ABN must be prepared with an original and at least one copy.
  – The beneficiary is given his/her copy of the signed and dated ABN immediately, and
  – The notifier should retain the original ABN in the beneficiary’s record.
• In certain situations, such as delivery by fax, the notifier may not have access to the original document upon signing.
• Retention of a copy of the signed document would be acceptable in specific cases such as this:
  – In a case where the notifier that gives an ABN is not the entity that ultimately bills Medicare for the item or service (e.g. when a physician issues an ABN, draws a test specimen, and sends it to a laboratory for testing), the notifier must give a copy of the signed ABN to the billing entity.
  – The copy provided must be legible and may be a carbon, fax, electronically scanned, or photo reproduction copy.
50.6.4 – Retention Requirements
(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

• Applicable retention periods for the ABN are discussed in Chapter 1 of the manual, §110.
  – In general, it is 5 years from discharge/completion of delivery of care when there are no other applicable requirements under State law.
  – Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice.
  – Electronic retention of the signed paper document is acceptable.
  – Notifiers may scan the signed paper or “wet” version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

50.6.5 - Other Considerations During ABN Completion (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Changes His/Her Mind:
  – If after completing and signing the ABN, a beneficiary changes his/her mind, the notifier should present the previously completed ABN to the beneficiary and request that the beneficiary annotate the original ABN.
  – The annotation must include a clear indication of his/her new option selection along with the beneficiary's signature and date of annotation.
  – In situations where the notifier is unable to present the ABN to the beneficiary in person, the notifier may annotate the form to reflect the beneficiary’s new choice and immediately forward a copy of the annotated notice to the beneficiary to sign, date, and return.
  – In both situations, a copy of the annotated ABN must be provided to the beneficiary as soon as possible.
  – If a related claim has been filed, it should be revised or cancelled if necessary to reflect the beneficiary’s new choice.
50.6.5 - Other Considerations During ABN Completion
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13,
Implementation: 12-09-13)

B. Beneficiary Refuses to Complete or Sign the Notice:
   - If the beneficiary refuses to choose an option and/or refuses to
     sign the ABN when required, the notifier should annotate the
     original copy of the ABN indicating the refusal to sign or choose
     an option and may list witness(es) to the refusal on the notice
     although this is not required.
   - If a beneficiary refuses to sign a properly delivered ABN, the
     notifier should consider not furnishing the item/service, unless;
     ▪ the consequences (health and safety of the patient, or civil liability in
       case of harm) are such that this is not an option.
   - In any case, the notifier must provide a copy of the annotated
     ABN to the beneficiary, and keep the original version of the
     annotated notice in the patient’s file.

50.7 - ABN Delivery Requirements
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.7.1 - Effective Delivery (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13,
Implementation: 12-09-13)

• Delivery Requirements ABN delivery is considered to be effective when
  the notice is:
  1. Delivered by a suitable notifier to a capable recipient and comprehended by that
     recipient.
  2. Provided using the correct OMB approved notice with all required blanks
     completed. Failure to use the correct notice may lead to the notifier being found
     liable since the burden of proof is on the notifier to show that knowledge was
     conveyed to the beneficiary according to CMS instructions.
  3. Delivered to the beneficiary in person if possible.
  4. Provided far enough in advance of delivering potentially noncovered items or
     services to allow sufficient time for the beneficiary to consider all available
     options.
  5. Explained in its entirety, and all of the beneficiary’s related questions are
     answered timely, accurately, and completely to the best of the notifier’s ability.
     The notifier should direct the beneficiary to call 1-800-MEDICARE if the
     beneficiary has questions s/he cannot answer. If a Medicare contractor finds that
     the notifier refused to answer a beneficiary’s inquiries or direct them to 1-800-
     MEDICARE, the notice delivery will be considered defective, and the notifier will
     be held financially liable for noncovered care.
  6. Signed by the beneficiary or his/her representative.
50.7 - ABN Delivery Requirements
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.7.1 - Effective Delivery (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

• Period of Effectiveness:
  – An ABN can remain effective for up to one year.

• Repetitive Care:
  – Notifiers may give a beneficiary a single ABN describing an extended or repetitive course of noncovered treatment provided that the ABN lists all items and services that the notifier believes Medicare will not cover.
  – If applicable, the ABN must also specify the duration of the period of treatment. If there is any change in care from what is described on the ABN within the 1-year period, a new ABN must be given.
  – If during the course of treatment additional noncovered items or services are needed, the notifier must give the beneficiary another ABN.
  – There is a one year limit for using a single ABN for an extended course of treatment.

• Continuous Noncovered Care:
  – If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided,
    ▪ the ABN may be issued at any time during the course of treatment.
    ▪ However, if the ABN is issued after repetitive treatment has been initiated,
      – the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance.
      – In cases such as this, care that was provided before ABN delivery would be the financial responsibility of the supplier/provider.
50.7 - ABN Delivery Requirements
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.7.1 - Effective Delivery (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

• Incomplete ABNs Allegations of improper or incomplete notices will be investigated by Medicare contractors:
  – If the notifier is found to have given improper or incomplete written notice, the applicable Medicare contractor will not hold the beneficiary liable in the individual case.

• Electronic Issuance of the ABN:
  – Electronic issuance of ABNs is not prohibited. If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers.
  – Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records.

50.7.2 - Options for Delivery Other than In-Person (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

• ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be noncovered.

• In circumstances when in-person delivery is not possible, notifiers may deliver an ABN through one of the following means:
  – Direct telephone contact;
  – Mail;
  – Secure fax machine; or
  – Internet e-mail

• All methods of delivery require adherence to all statutory privacy requirements under HIPAA.

• The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery.

• When delivery is not in-person, the notifier must verify that contact was made in his/her records.
50.7 - ABN Delivery Requirements
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)
50.7.2 - Options for Delivery Other than In-Person (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

• In order to be considered effective, the beneficiary should not dispute such contact.
• Telephone contacts must be followed immediately by either a hand-delivered, mailed, emailed, or faxed notice.
• The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the notifier for retention in the patient’s record.
• The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice.
• If the beneficiary does not return a signed copy, the notifier must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

50.7 - ABN Delivery Requirements
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)
50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication (Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability:
- A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable.
- The charge may be the supplier/provider’s usual and customary fee for that item or service and is not limited to the Medicare fee schedule.
- If the beneficiary does not receive proper notice when required, s/he is relieved from liability.
- Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments.
- In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.
50.7 - ABN Delivery Requirements
(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

B. Provider Liability:
– A notifier will likely have financial liability for items or services if s/he knew or should have known that Medicare would not pay and fails to issue an ABN when required, or issues a defective ABN.
– In these cases, the notifier is precluded from collecting funds from the beneficiary and is required to make prompt refunds if funds were previously collected.
– Failure to issue a timely refund to the beneficiary may result in sanctions.
– A notifier may be protected from financial liability when an ABN is required if s/he is able to demonstrate that s/he did not know or could not reasonably have been expected to know that Medicare would not make payment.
– However, issuance of a defective notice establishes the notifier’s knowledge of potential noncoverage, and will not afford the notifier financial protection under the LOL or refund provisions.

50.13 - Collection of Funds and Refunds
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Collection of Funds:
– A beneficiary’s agreement to be responsible for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare that the beneficiary may have.
– The notifier may bill and collect funds from the beneficiary for noncovered items or services immediately after an ABN is signed, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law.
– Regardless of whether they accept assignment or not, providers and suppliers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts. If Medicare ultimately denies payment of the related claim, the notifier retains the funds collected from the beneficiary unless the claim decision finds the provider/supplier liable.
– When Medicare finds the provider/supplier liable or if Medicare or a secondary insurer subsequently pays all or part of the claim for items or services previously paid by the beneficiary to the notifier, the notifier must refund the beneficiary the proper amount in a timely manner.
B. Refund Requirements Requiring Liability Notice

– Under the Refund Requirements in §§1842(l) and 1879(h) of the Act,

– A beneficiary must receive a properly executed ABN so that he or she is “on notice” of liability.

– By signing the ABN, the beneficiary acknowledges that s/he understands the potential for liability and agrees to pay for the item or service described.

– The refund requirements requiring ABNs are:

  1. Supplier claims under §1879(h) of the Act, citing three specific requirements when assignment is accepted:

     a. §1834(j)(1), when supplier number requirements for medical equipment and supplies are not met;

     b. §1834(a)(15), when medical equipment and/or supplies are denied in advance; or

     c. §1834(a)(17)(B), when there is a violation of the prohibition on unsolicited telephone contacts for medical equipment and supplies.

  2. Physician claims under §1842(l) from non-participating physicians when assignment is not accepted for individual items and services that are denied on the basis of §1862(a)(1):

     – Physicians must make prompt refunds unless they could not have been expected to know that Medicare would not provide coverage or they notified the beneficiary in advance by issuing the ABN.

     – Refunds are considered prompt when made within 30 days of notice of denial from Medicare or within 15 days after a determination on an appeal if an appeal is made.
50.13 - Collection of Funds and Refunds
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

50.13.1 - Physicians’ Services Refund Requirements (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

• The physicians’ services refund requirement provision, found in §1842(l) of the Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1986, requires timely refunds for certain services.
• When a reduction in payment, not a full denial, occurs, the physician must refund to the beneficiary amounts collected which exceed the Medicare payment for the less extensive item or service.
• These refund requirements apply to both participating and non-participating physicians.
• When the beneficiary signs an ABN agreeing to accept responsibility for payment before services are delivered, the collected funds can be retained.
• A refund is not required if the physician did not know and could not reasonably have been expected to know that Medicare would not pay for the services because they were not reasonable and necessary.
• The Medicare contractor must notify the beneficiary in any case in which the physician requests review of the denial or reduction in payment or asserts that a refund is not required.

50.13.3 - Time Limits and Penalties for Physicians and Suppliers in Making Refunds (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

• A required refund must be made within specified time limits:
  – The refund must be made to the beneficiary within 30 days after the date the physician/supplier receives the remittance advice (RA) if the physician/supplier does not request review of an initial full or partial denial; or
  – The refund must be made to the beneficiary within 15 days after the date the physician/supplier receives the notice of the review determination if the physician/supplier requests review within 30 days of receipt of the notice of the initial determination.
• Physicians/suppliers who knowingly and willfully fail to make a refund where required within these time limits may be subject to civil money penalties and/or exclusion from the Medicare program.
• The beneficiary should contact the contractor or CMS when a physician/supplier fails to make a timely refund. If the contractor determines that a physician/supplier failed to make a refund, it will contact the physician/supplier in person or by telephone to discuss the facts of the case.
50.13 - Collection of Funds and Refunds
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13
50.13.3 - Time Limits and Penalties for Physicians and Suppliers in Making Refunds (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Continued:
• The contractor will attempt to determine why the required refund has not been made and will explain the legal requirements.
• The contractor will determine whether referral to the Office of Inspector General (OIG) or CMS is appropriate and will make appropriate referrals OIG if necessary.
• The OIG or CMS may impose civil money penalties, assessments, and sanctions if he or she fails to make the required refund. The contractor will retain a detailed written report of contact.

Claim Reporting Modifiers Associated with the ABN

<table>
<thead>
<tr>
<th>Modifier</th>
<th>When to Use the Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case Report when you issue a mandatory ABN for a service as required and it is on file. You do not need to submit a copy of the ABN, but you must have it available on request.</td>
</tr>
<tr>
<td>GX</td>
<td>Notice of Liability Issued, Voluntary Under Payer Policy Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY</td>
</tr>
<tr>
<td>GY</td>
<td>Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit Report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or Service Expected to Be Denied as Not Reasonable and Necessary Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.</td>
</tr>
</tbody>
</table>
Medicare Advantage Plans and the Medicare ABN

- In 2014 CMS issued a notice: Improper Use of Advance Notices of Non-coverage.
  - The Medicare Enrollment & Appeals Group (MEAG) and Medicare Drug & Health Plan Contract Administration Group (MCAG) received reports of Medicare Advantage organizations (MAOs) issuing notices to enrollees that advise of non-coverage for an item or service that do not comply with the requirements for such notices set forth under the organization determination process at 42 CFR Part 422, Subpart M.
  - The notices being used by MAOs were based on, similar in purpose and content to the advanced beneficiary notice of noncoverage (ABN) used in the Original Medicare program.
  - Such notices are not applicable to the Medicare Advantage program, and are not appropriate for use by an MAO with respect to its enrollees.
Medicare Advantage Plans and the Medicare ABN

Medicare Advantage Organizations were advised to immediately cease this practice and instead follow the process for issuing a notice of a denial of coverage in accordance with 42 CFR §§ 422.568 and 422.572.

The reasoning behind this is simple:

- Original Medicare ABN notices were established in order to allow a Medicare beneficiary to find out whether a service is covered by Medicare without having to receive services, and then submit a claim for reimbursement for the costs of such services.
- By their own terms, the ABN requirements in the statute and regulations do not apply in the Medicare Advantage context.
- This is because a Medicare Advantage enrollee has always had the right under the statute and regulations to an advance determination of whether services are covered prior to receiving such services. Specifically, section 1852(g)(1)(A) requires MA organizations to “have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization...is entitled to receive a health care service under this section.”

Medicare Advantage Plans and the Medicare ABN

- Medicare Advantage Organizations under the regulations at 42 CFR §§ 422.568 and 422.572 set forth rules that apply to this determination procedure.
- These rules must be followed when an MAO is making a determination of coverage, including the requirements applicable to the notice required upon making such a determination.
- Because these regulations are incorporated by reference for cost plans and HCPPs, the foregoing analysis applies to such plans as well.
- Under the procedures at issue, when an MAO or cost plan or HCPP wishes to inform an enrollee that a service is not covered or that payment is denied, in whole or in part, the decision is an organization determination under 42 CFR § 422.566(b) and the appropriate notice must be used.

United Healthcare Advantage Plans

• Discontinuation of Advance Notice of Non-Coverage Form and Changes to the Charging Customers for Non-Covered Services Protocol
  – This notice was published by United Healthcare following the notice from CMS of “Discontinuation of Advance Notice of Non-Coverage Form”.
  – The Advance Notice of Non-Coverage (ANN) Form and process was discontinued on May 15, 2014, due to instructions from the Centers for Medicare & Medicaid Services (CMS).
  – The notice from CMS, Advance Notices of Non-Coverage - Improper Use, is posted on UnitedHealthcareOnline.com.
  – Effective for dates of service on or after Dec 1, 2014, the following protocol must be followed to bill a Medicare Advantage member for non-covered services.

United Healthcare Advantage Plans

Continued:
  – Pre-Service Organization Determination: Care providers must use the following process to hold Medicare Advantage members financially liable for non-covered services not clearly excluded in the member’s Evidence of Coverage (EOC) or other related materials:
    ▪ Care providers must continue to obtain the members’ written consent before rendering services in order to seek and collect payment from members for non-covered services.
    ▪ Unless the service is clearly excluded in a member’s EOC or other related materials, care providers must request a pre-service organization determination if they know or have reason to know that a service they are rendering or referring may not be covered. The non-covered service should not be rendered or referred until United Healthcare issues its determination.
      − Care providers do not need to request a pre-service organization determination if the service is clearly excluded in the member’s EOC or other related materials.
      − The –GY modifier no longer needs to be included on claims for non-covered services.
United Healthcare Advantage Plans

Continued:

- Please know that a service may not be covered if any of the following apply:
  - UnitedHealthcare has provided general notice — through a newsletter or bulletin, or information posted on UnitedHealthcareOnline.com including clinical protocols, medical and drug policies — that either we will not cover a particular service or a particular service will be covered only under certain circumstances.
  - UnitedHealthcare has determined that the planned services are not covered services and has communicated that determination to the care provider on this or a previous occasion.
  - CMS has published guidance through National Coverage Determinations, Local Coverage Determinations or other CMS guidance to indicate the service may not be covered in certain circumstances.
  - Care providers are required to review the available guidance in the Medicare Coverage Center at cms.gov/Center/Special-Topic/Medicare-Coverage-Center.html

- After care providers request a pre-service organization determination, UnitedHealthcare will issue its determination.
- If the service is not covered, we will send an Integrated Denial Notice (IDN) to the care provider and member. The IDN informs members of their financial liability and appeal rights.
- CMS requires that members be provided an IDN in order for them to be liable for the non-covered service. Before rendering or referring for the non-covered service, care providers must make sure members received the IDN.
- Before rendering or referring for the non-covered service, care providers must make sure members received the IDN.
United Healthcare Advantage Plans

Continued:

– The –GA modifier must be attached to the claim line for the non-covered service to indicate that the protocol set forth above has been followed.

– Including the –GA modifier on the claim will help ensure the claim for the non-covered service is appropriately adjudicated as member liability.

United Healthcare Advantage Plans

– Requesting a Pre-Service Organization Determination:
  
  ▪ Care providers may continue to request a pre-service organization determination by submitting an advance notification request on
  
    UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notifications/Prior Authorization Submission. (web addresses are subject to change)
  
  ▪ Care providers may also continue to request pre-service organization determinations by phone or fax using the numbers on the back of the member’s identification card.
  
  ▪ Determination letters including the IDN with appeal rights are mailed to both the care provider and the member.
United Healthcare Advantage Plans

- Turnaround times for review of pre-service organization determinations:
  - Standard turnaround time is 14 calendar days from receipt of request.
  - Urgent or expedited requests have a turnaround time of 72 hours from receipt of request.
  - In accordance with CMS, a request is considered expedited if the care provider indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

Blue Cross Blue Shield Advantage Plans

- Advance Beneficiary Notices Disallowed in Billing Noncovered Services for Blue Medicare
  - This notice was published by BC/BS as a result of CMS issuing the memo of Improper Use of Advance Notices of Non-coverage.
  - CMS issued guidance regarding the Medicare Advantage program that affects Blue Cross and Blue Shield Medicare provider agreements
  - CMS’s guidance addresses what a provider must do in order to charge a member on a Medicare Advantage health plan for services that are not covered by the member’s benefits coverage policy.
Blue Cross Blue Shield Advantage Plans

– Prior to this clarification, Medicare Advantage members were often billed for noncovered services when a provider of noncovered services obtained a detailed waiver or an Advance Beneficiary Notice-like document from the member before the noncovered services were provided.

– However, CMS has now stated that providers may not use this waiver process with members of Medicare Advantage plans;

– Instead, they must ensure that the beneficiary has received a pre-service organization determination regarding coverage before the provider can bill the beneficiary for noncovered services.

– As a result, providers must refrain from charging any member on a Blue Cross Medicare Advantage plan for any noncovered services, including services that were provided under a previously-executed waiver, unless that member has received a pre-service organization determination from Blue Cross.

– If services are supplied before Blue Cross issues an organization determination, a provider can only charge a member for any applicable cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles).
Blue Cross Blue Shield Advantage Plans

– Failure to Obtain a Pre-Service Organization Determination:

▪ If a provider supplies noncovered services to a member who has not received a Notice of Denial of Medical Coverage, the provider must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost-sharing amounts. If a provider fails to follow the new CMS-mandated process before supplying noncovered services, the provider will not be entitled to reimbursement from Blue Cross or the member for those services.

▪ Information about the pre-service organization requests process will be included in the revised, January 2015 version of the Blue Cross Blue BookSM Provider Manual, Blue Medicare HMO3rd and Blue Medicare PPOSM Supplemental Guide.

▪ Participating providers in the Blue Cross Medicare Advantage networks will also be notified by U.S. mail of this CMS-mandated change.


Blue Cross Blue Shield Advantage Plans

▪ In compliance with CMS guidance, Blue Cross will no longer accept Advance Beneficiary Notices or similar waivers from providers seeking to charge Blue Cross and/or Blue Medicare members for noncovered services.

▪ Providers participating in Blue Cross Medicare Advantage networks are asked for their cooperation with this federal mandate and to immediately discontinue use of Advance Beneficiary Notices or similar waivers with members of Blue Cross Medicare Advantage plans.

▪ Instead, providers should follow the CMS-mandated process and request a pre-service organization determination from Blue Cross prior to providing any potentially noncovered service for a Blue Cross Blue Medicare member if that member is choosing to self-pay for the service if it’s determined to be noncovered.
Key Point

- Failure to timely notify BCBSTX and obtain pre-approval for listed procedures:
  - may result in denial of the claim(s) for care services.
  - which cannot be billed to the member pursuant to your provider agreement with BCBSTX.
Are ABNs for Medicare only?

The answer is No.

- Private insurance carriers may actually require a waiver/ABN to bill patients for non-covered services – check your contract to be sure.
- Even without a contractual requirement it’s still a great opportunity to talk about non-covered services.
- By having a policy and procedure for ABN’s across the board your practice will benefit because helps the patient to understand that if their insurance doesn’t cover the service specified, the patient will have to pay for it.
BCBS and Advanced Beneficiary Notice

• The same principles apply with BCBS as with Medicare regarding when an ABN should be issued. Providers should complete an ABN (ANN) to notify members in advance of:
  – **initiation of services**: the beginning of a new patient encounter, start of a plan of care, or beginning of treatment; OR
  – **reduction of services**: a decrease in the frequency or duration of a component of care. For example, a patient is receiving physical therapy five days a week and wishes to continue this frequency; however, the treating provider believes that the patient's therapy goals can be met with only three days of therapy weekly; OR
  – **termination of services**: discontinuation of items/services.
  – For example, a patient receives speech therapy and the treating provider determines that the therapy is no longer reasonable and necessary; however, the patient wishes to continue to receive speech therapy.

• The items or services that would be potentially be non-covered must be specifically listed on the ANN and an estimate of the cost must be included.
  – A reasonable estimate for all the items or services should be within $100 or 25% (whichever is greater) of the actual costs.
  – However, an estimate that exceeds the actual cost is acceptable as the member would not be harmed if the actual costs were less than predicted;
  – **AND** the ABN (ANN) must be verbally reviewed with the member or his/her representative and any questions must be answered prior to signing;
  – **AND** the ABN (ANN) must be delivered far enough in advance for the member to consider the options and make an informed decision;
  – **AND** a copy of the signed ANN is given to the member and the issuer must retain the original in the member's file.
BCBS and Advanced Beneficiary Notice

- If a service/item requires utilization review and a denial is issued, if the member elects to go forward despite the denial then an advanced member notice is not required as the denial notice serves as notification to the member that the service/item is not covered.

- COVERAGE BlueCHiP for Medicare/Commercial/Benefits may vary between groups and contracts. Please refer to the appropriate Evidence of Coverage or Subscriber Agreement for “Hospital Services” benefits.

Key Points

NOTE:

- If a written advance notice is not given to the member, the provider is financially liable for the service/item provided to the member.

- This notice is not to be given if a service is covered but not separately reimbursed, or is considered bundled in another service.

- Members may not be held liable for services that are not separately reimbursed or bundled.
BCBS and Advanced Beneficiary Notice

• Billing for Non-Covered Services
  – In the event that BCBSTX determines in advance that a proposed service is not a covered service, a Physician or other Professional Provider may inform the Member/Subscriber in writing in advance of the service rendered.
    ▪ The Member/Subscriber must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the Member/Subscriber.
  – As a provider, you contact BCBSTX and find out that a proposed service is not a covered service - you have the responsibility to pass this along to your patient (our Member/Subscriber).

Continued:

– This disclosure protects both you and the Member/Subscriber.
– If the Member/Subscriber decides for the proposed non-covered service to be rendered, then the Member/Subscriber is responsible for payment to you of the non-covered service.
Key Points

• **Services that are denied by BCBSTX due to bundling or other claim edits may not be billed to Member/Subscriber:**
  – Even if the Member/Subscriber has agreed in writing to be responsible for such services.
• **These services are considered Covered Services but are not payable services according to BCBSTX claim edits.**

BCBS and Advanced Beneficiary Notice

• **Modifier use in coding claims:**
  – GA Waiver of liability statement issued as required by payer policy, individual case
  – GU Waiver of liability statement issued as required by payer policy, routine notice
  – GX Notice of liability issues, voluntary under payer policy HCPCS modifier
  – GA should only be used to report a required ANN issuance. Required notice is for items or services that are not reasonable and necessary, e.g., a member requests a full body MRI when no medical necessity for the scan exists. The -GA should not be reported in association with any other liability-related modifier and should be submitted with noncovered charges only.
BCBS and Advanced Beneficiary Notice

- HCPCS modifiers -GU or -GX should be used to report a voluntary ABN (ANN) issuance.
- Voluntary notice is for care that is typically excluded from coverage, e.g., cosmetic surgery.
- GU or -GX can be used to provide notice of liability to the member and the claim will process as member liability.

Questions?

- Thank you for your attendance!
- Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp