



ADVANCE BENEFICIARY NOTICE

Administrative Consultant Service, LLC

CMS Guidelines for Advance Beneficiary Notices (ABNs)



Advance Beneficiary Notice
AB-02-168

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Two new Advance Beneficiary Notices went into effect on October 1, 2002. One for general use and one for Laboratory use. These two ABN's have also been published in Spanish.

When a procedure is requested and Medicare may consider the service not medically necessary or reasonable, or diagnosis/sign/symptom is not listed on a LMRP or NCD then an Advance Beneficiary Notice (ABN) must be signed to protect the provider's right to collect payment from the patient when claims are not reasonable and necessary.

Routine, Generic and Blanket notices are prohibited by Medicare. By routine we mean giving ABNs to beneficiaries where there is no specific, identifiable reason to believe Medicare will not pay. Physicians and suppliers should not give ABNs to beneficiaries unless the physician or supplier has some genuine evidence by their stated reasons for ordering the test. A physician or supplier is prohibited from ob-

taining beneficiaries signatures on blank ABNs and then completing the ABNs later. An ABN, to be effective must be completed before delivery to the beneficiary. Medicare will hold any ABN that was blank when it was signed to be a defective notice that will not protect the physician or supplier from liability.

Whether an ABN should be given in a particular instance depends on the physician's or supplier's expectation of Medicare payment or denial.

- A. If the physician or supplier expects Medicare to pay, an ABN should **not** be given.
- B. If the physician or supplier "never knows whether or not Medicare will pay," an ABN should **not** be given.
- C. If the physician or supplier expects Medicare to deny payment, the next question is: "On what basis is

denial expected?"

The physician, supplier or provider must always submit a claim, billing as covered, for an initial determination when it gave an ABN on the basis of the likelihood of denial of payment. On such a claim, the physician, supplier or provider must enter occurrence code 32 on the UB-92 in one of the fields numbered 32 through 35. This code indicates the date the physician, supplier or provider gave the ABN to the beneficiary. It is the occurrence code 32, and not any condition code that indicates to the fiscal intermediary that an ABN has been issued. Occurrence code 32 is mandatory; it must be used anytime a signed ABN was obtained.

See Program Memorandum AB-02-168, Nov. 22, 2002.

ABN Guidelines (PM A-02-168)

1. If the patient refuses to sign an ABN, the provider may be held liable for any refunds due, if the service is provided anyway and the claim is submitted with -GZ modifier (item/service expected to be denied as not reasonable and necessary). The new CMS program memorandum clarifies that the physician or hospital would be liable. If the patient paid for the services

when he shouldn't have, failure to refund the patient could mean stiff penalties, including exclusion and civil monetary fines.

2. A patient must be notified far enough in advance of receiving a medical service so that the patient can make a rational, informed decision without undue pressure. The purpose of this timely delivery rule is to avoid putting the beneficiary into a position in which she/he

is already committed to receiving the item or service before receiving notice of the likelihood of denial of payment by Medicare.

3. As a general rule, ABN delivery should take place before a physical preparation of the patient (e.g., disrobing, placement in or attachment of diagnostic or treatment equipment) begins. This criterion does not constitute a blanket prohibition on giving an ABN to a beneficiary after she/he has entered an examination room, a draw station, a DMEPOS sales room, etc., and is ready to receive services or items. We recognize, for example, that situations may arise during an encounter when a physician (or supplier) sees a need for a previously unforeseen service, expects that Medicare will not pay for it, and wishes to give an ABN.

This is permissible, provided that the beneficiary is capable of receiving notice in accordance with section 2 above, and has a meaningful opportunity to act on it (e.g., the beneficiary is not under general anesthesia). Where it is foreseeable that the need for service for which Medicare likely would not pay may arise during the course of an encounter, and the beneficiary is either certain or likely not to be capable of receiving notice during the initial service (e.g., the beneficiary will be under anesthesia), it is permissible to give an ABN before any service is initiated; such an

ABN would not violate the general prohibition of routine ABNs in Section I.1.A.2. Also in a case where a physician draws a test specimen and sends it to a laboratory for testing, and did not give the beneficiary an ABN, the laboratory may contact the beneficiary and give him/her an ABN without violating this timely delivery rule, so long as testing of the specimen has not begun.

4. You can no longer bill a claim with both condition code 20 (beneficiary requested billing) and occurrence code 32 (date beneficiary notified of intent to bill for procedure).

5. Do not consider a telephone notice to a beneficiary, or authorized representative, to be sufficient evidence of proper notice for limiting any potential liability, unless the content of the telephone contact can be verified and is not disputed by the beneficiary. If a telephone notice was followed up immediately with a mailed notice or a personal visit at which written notice was delivered in person and the beneficiary signed the written notice accepting responsibility for payment, accept the time of the telephone notice as the time of ABN delivery.

6. Failure to meet the ABN standards and procedures will expose the risk of potential financial liability for denied items or services in cases where, in the absence of a proper ABN, the beneficiary would be held not to have known, nor to reasonably have been expected to have known, that his/her claims for the denied items and services he/she received were likely to be denied by Medicare. A physician or supplier held liable for such denied charges will be precluded from collecting from the beneficiary and may be required to make refunds to the beneficiary, or face possible sanctions for failure to do so.



*ABNs are designed
for use with
Medicare
beneficiaries only*

Medical Necessity and ABN's

Medicare intermediaries and carriers, along with CMS, have created national and local medical necessity payment edits that can deny coverage based on diagnoses, procedures, and frequency limitations. Medicare requires that patients be told in advance if a service will not be covered, and a signed ABN form allows providers to bill patients for these services. If no ABN is signed, the provider must write off the

charges or resubmit the claim with additional information. Many health-care providers lose tens or hundreds of thousands of dollars every year in medical necessity denials. And even when payment can eventually be secured by submitting corrections, staff time is wasted and paperwork is increased. It is becoming a necessity for hospital's to purchase ABN Software that allows them to minimize denials by getting a signed ABN

form or by clarifying physician orders before the service has been provided. Front-end checking of medical necessity policies is the only way that provider's can be in compliance with the ABN requirements and protect facility's reimbursement. Filing a claim that a provider "knows or should know" isn't covered due to a medical necessity policy that has been published, could be submitting false claims.

Filling Out the ABN

Completing the Form

A properly completed ABN does the following:

- √ Identifies the time or service provided
- √ States the reason the supplier believes Medicare is likely to deny payment
- √ Estimates cost of upgrade or portion of item/service not covered by Medicare
- √ Includes patient selection of either Option 1 or Option 2 is signed and dated by patient.

The ABN must be in writing and signed by the beneficiary prior to the service(s) being rendered. The ABN must cite the specific service(s) for which the provider expects payment to be denied, and the reason why that service(s) is expected to be denied. The date of service must appear on the ABN.

GZ Modifier

If the item or services are furnished despite the beneficiary's refusal to pay. The physician or supplier should file the claim using the **GZ Modifier**. (As not having obtained a signed ABN) since it was not completed properly by the beneficiary.

GA Modifier

The **-GA modifier** must be appended to the service(s) for which the ABN was issued. GA Modifier- Waiver of liability statement on file

Exhibit 1

Advance Beneficiary Notice (CMS-R-131-G) For General Use

Patient's Name: _____

Medicare# (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)**NOTE: You need to make a choice about receiving these health care items or services.**

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact the Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for —**

Items or Services: _____

Because: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimate Cost: \$** _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

_____ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I had to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

_____ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date_____

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Exhibit 1

Advanced Beneficiary Notice (CMS-R-131-L) For Laboratory Test

Patient's Name: _____

Medicare# (HICN): _____

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for the laboratory test(s) indicated below for the following reason:

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as to frequent)	Medicare does not pay for experimental or research use tests

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself.

Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimate Cost: \$**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.

_____ **Option 1. YES. I want to receive these laboratory tests.** I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I had to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

_____ **Option 2. NO. I have decided not to receive these laboratory tests.** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.



ADMINISTRATIVE CONSULTANT SERVICE, LLC

"Providing consultation to improve clinical and financial outcomes of health care."



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