CMS Guidelines for Advance Beneficiary Notice (ABN)

On Monday, March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN) (CMS-R-131). This form replaces the General Use ABN and the Lab ABN for physician-ordered laboratory tests. The form (English and Spanish versions) and notice instructions are now posted on the Beneficiary Notice Initiative web page (www.cms.gov/bni).

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 Local Coverage Decision (LCD) or National Coverage Decision (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 obtaining beneficiaries signatures on blank ABNs and then completing the ABNs later. An ABN, to be effective must be completed before treatment 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 claim 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 FI or MAC that an ABN has been issued. Occurrence code 32 is mandatory; it must be used anytime a signed ABN was obtained.
Compliance with Limitation On Liability Provisions

A healthcare provider (herein referred to as a “notifier”) who fails to comply with the ABN instructions risks financial liability and/or sanctions. LOL provisions shall apply as required by law, regulations, rulings and program instructions. Additionally, when authorized by law and regulations, sanctions under the Conditions of Participation (COPs) may be imposed.

The Medicare contractor will hold any provider who either failed to give notice when required or gave defective notice financially liable. A notifier who can demonstrate that he or she did not know and could not reasonably have been expected to know that Medicare would not make payment will not be held financially liable for failing to give notice. However, a notifier who gave defective notice may not claim that he or she did not know or could not reasonably have been expected to know that Medicare would not make payment as the issuance of defective notice is clear evidence of knowledge. The beneficiary is not protected from liability if there is clear evidence that he or she knew that Medicare would not make payment. See § 50.12 for Refund Requirements.

ABN Scope

The revised ABN is the new CMS-approved written notice that is issued by providers, practitioners, suppliers, and laboratories for items and services provided under Medicare Part A (hospice and regional non-medical healthcare institutes only) and Part B and given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. The revised ABN may not be used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The revised ABN will now be used to fulfill both mandatory and voluntary notice functions.

The revised ABN replaces the following notices:

- ABN-G (CMS-R-131-G)
- ABN-L (CMS-R-131-L)
- NEMB (CMS-20007)

Mandatory ABN Uses

The following are statutory provisions requiring 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).

ABN Triggering Events

Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three points during a course of treatment which are initiation, reduction, and termination, also known as “triggering events”.

Initiations

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 noncovered care.

Reductions

A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). For example, a beneficiary is receiving outpatient physical therapy five days a week and wishes to continue therapy five days; however, the notifier believes that the beneficiary’s therapy goals can be met with only three days of therapy weekly. This reduction in treatment would trigger the requirement for an ABN.
Medical Necessity and ABN’s

Medicare contractors 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 submit and appeal with additional information. Many healthcare providers lose hundreds of thousands of dollars every year in medical necessity denials. And even when payment can eventually be secured by submitting corrections and appeals, staff time is wasted and paperwork is increased. It is becoming a necessity for hospital’s to purchase Medical Necessity 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 provider 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.

Some key features of the new form are that it:

- Has a new official title, the “Advance Beneficiary Notice of Noncoverage (ABN)”, in order to more clearly convey the purpose of the notice;
- Replaces the ABN-G and ABN-L;
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB) (CMS Form 20007);
- Has a mandatory field for cost estimates of the items/services at issue; and
- Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

Please be advised that the ABN-G and ABN-L will no longer be valid beginning March 1, 2009.

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
Revised ABN Guidelines Cont.

Terminations
Termination is the discontinuation of certain items or services. An example would be when a physical therapist no longer considers outpatient speech therapy described in a plan of care reasonable and necessary. An ABN would have to be issued prior to the termination of the speech therapy. If the beneficiary wishes to continue receiving noncovered speech therapy treatments upon receiving the ABN, he or she must select Option 1 or 2 on the ABN stating that he or she wants to receive the services and agrees to be financially responsible if Medicare does not pay.

Proper Notice Documents
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.

Modification
The ABN may not be modified except as specifically allowed by the instructions in the Medicare Claims Processing Manual, Chapter 30, and approved by the appropriate CMS Regional Office.

Retention
The ABN must be prepared with an original and at least one copy. The beneficiary is given his or 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.

Applicable retention periods for the ABN are discussed in Chapter 1 of the Medicare Claims Processing 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.

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 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.

Repetitive or Continuous Noncovered 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 during the course of treatment additional noncovered items or services are needed, the notifier must give the beneficiary another ABN. The limit for use of a single ABN for an extended course of treatment is one year. A new ABN is required when the specified treatment extends beyond one year.

See these other important topics in the Claims Processing Manual—Chapter 30
- ABN Delivery Requirements
- Incomplete ABNs
- Options for Delivery Other than In-Person
- Collection of Funds and Refunds
- Refund Requirements Requiring Liability Notice
- Time Limits and Penalties for Physicians and Suppliers in Making Refunds

Emergencies or Urgent Situations
In general, a notifier, may not issue an ABN to a beneficiary who has a medical emergency or is under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the ER may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.
(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.

<table>
<thead>
<tr>
<th>(D)</th>
<th>(E) Reason Medicare May Not Pay</th>
<th>(F) Estimated Cost</th>
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WHAT YOU NEED TO DO NOW:
Read this notice, so you can make an informed decision about your care. 
Ask us any questions that you may have after you finish reading. 
Choose an option below about whether to receive the (D)__________listed above.

Note: If you choose Option 1 or 2, we may help you to use any other 
insurance that you might have, but Medicare cannot require us to do this.

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

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

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

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

(H) Additional Information:
This notice gives our opinion, not an official Medicare decision. If you have other questions 
on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature_________________________________________________ (J) Date_______________________

Form CMS-R-131 (03/08)
Administrative Consultant Service, LLC

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

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