Advance Beneficiary Notice of Noncoverage (ABN)

Presented by: Part B
Provider Outreach and Education Department
May 2017
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<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>ABN</td>
<td>Advance Beneficiary Notice of Noncoverage</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicaid and Medicare Services</td>
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<td>CR</td>
<td>Change Request</td>
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<td>FFS</td>
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<td>Line Item Date of Service</td>
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<td>OMB</td>
<td>Office of Management and Budget</td>
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<td>UOS</td>
<td>Units of Service</td>
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Agenda

• What is an ABN
  – Mandatory Use
  – Voluntary Use
• ABN Completion
• ABN Tips
  – Special Applications
• ABN Resources
Objective

To provide a better understanding of how and when to appropriately apply an Advance Beneficiary Notice of Noncoverage (ABN) Form to your patients.
Advance Beneficiary Notice of Noncoverage (ABN)
New ABN Form

- Effective June 21, 2017
- Includes language informing beneficiaries of rights to CMS nondiscrimination practices and how to request alternative format
- Form available on CMS website: https://www.cms.gov/medicare/medicare-general-information/bni/abn.html
Who Should Receive the ABN

- ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program
- Not 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)
- ABN used to fulfill both mandatory and voluntary notice functions
ABN

• Its purpose is to inform the beneficiary that the services you wish to provide may not meet the criteria for coverage

• Issued before rendering otherwise covered/noncovered Part B services that are physician ordered

• Transfers financial liability to the beneficiary
Medical Necessity

Medical necessity is defined as services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and are not excluded under another provision of the Medicare Program.
**ABN - Quick Glance Guide**

**Notice Name:** Advance Beneficiary Notice of Noncoverage (ABN)
**Notice Number:** Form CMS-R-131
**Issued by:** Providers and suppliers of Medicare Part B items and services; Hospice and Religious Non-medical HealthCare Institute (RNHCI) providing Medicare Part A items and services; and home health agencies (HHAs) for Part A and Part B items and services

**Recipient:** Original Medicare (fee for service) beneficiary

**Additional Information:** The ABN, Form CMS-R-131 replaces the following notices:
- ABN-G
- ABN-L
- Notice of Exclusion of Medicare Benefits (NEMB)
- Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296, Option Box 1 (effective 2013)

<table>
<thead>
<tr>
<th>Type of notice:</th>
<th>Must be issued:</th>
<th>Timing of notice:</th>
<th>Optional/Voluntary use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial liability notice</td>
<td>Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice, HHA, and RNHCI providers only) but may not be paid for in this particular case because it is not considered medically reasonable and necessary</td>
<td>Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.</td>
<td>Yes. Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit).</td>
</tr>
</tbody>
</table>
Mandatory Use

• Mandatory ABN Uses
  – Not reasonable and necessary items
  – Violation of the prohibition on unsolicited telephone contacts
  – Medical equipment and supplies supplier number requirements not met
  – Medical equipment and/or supplies denied in advance
  – Custodial care
Mandatory Use 2

- Hospice patient who is not terminally ill
- Home Health services requirements are not met
- Outpatient therapy services are in excess of therapy cap amounts and don’t qualify for the therapy cap exception
- Services that exceed frequency such as preventive and screening
- Chiropractic maintenance
ABN

• ABN Triggering Events:
  – Initiation
    • Beginning of a new patient encounter, start of a plan of care or beginning of treatment
  – Reduction
    • Decrease in a component of care (frequency or duration)
  – Termination
    • Discontinuation of certain items of services
Local Coverage Determinations (LCD)

- Contractor developed
- Outline coverage criteria
Policies

Local Coverage Determination (LCD)

A Local Coverage Determination (LCD) is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide, basis. Codes describing what is covered and what is not covered can be part of the LCD. This includes, for example, lists of HCPCS codes that spell out which services the LCD applies to, lists of ICD-10-CM codes for which the service is covered and even lists of ICD-10 codes for which the service is not considered reasonable and necessary. Coding descriptions are included if they are integral to the discussion of medical necessity. View locally published Active LCDs on our website and access others located within the CMS Medicare Coverage Database (MCD). How to Use The Medicare Coverage Database

- LCDs: Active - Draft - Future - Potential - Retired

New LCD Request

Noridian receives inquiries for new LCDs which include supporting evidence. Noridian will consider all new LCD requests from beneficiaries residing or receiving care in Jurisdiction F and any other interested party doing business Jurisdiction F. Noridian will only accept requests for new LCDs. If a new LCD would conflict with an NCD, the request would not be valid. View New LCD Request Process

LCD Timelines

CMS has determined and published applicable timelines, which may be viewed in the CMS Internet Only Manual (IOM), Medicare Program Integrity Manual, Publication 100-08, Chapter 13.
Voluntary ABN

• Voluntary ABN Uses
  – Care that fails to meet definition of a Medicare benefit as defined in section 1861 of Social Security Act
  – Care that is explicitly excluded from coverage under section 1862 of Social Security Act
Voluntary ABN

- Examples
  - Services for which there is no legal obligation to pay
  - Services paid for by a government entity other than Medicare
  - Routine Physicals (less the IPPE and AWV)
  - Personal Comfort Items
  - Services considered to be experimental or for research use (unless specified in a trial)
  - Excluded service(s) from the program
Delivery Requirements

• ABN delivery is considered effective when the notice is:
  – Delivered by a suitable notifier to a capable recipient
  – Provided using the correct approved notice with all required blanks completed
  – Delivered to beneficiary in person if possible
  – Provided far enough in advance of delivering potentially non-covered services to allow sufficient time for the beneficiary to consider all options
  – Explained in its entirety
  – Signed by the beneficiary or representative
Options for Delivery

• When in-person delivery is not possible, notifiers may deliver ABN by:
  – Direct telephone contact
  – Mail
  – Secure fax machine
  – Email
Continuous Non-covered Care

• An ABN can remain effective for up to one year
  – Notifiers may give a beneficiary a single ABN describing an extended course of non-covered treatment provided
  – If there is ANY change in care from the description on the ABN within the one year period, a new ABN must be given
Electronic Issuance of ABN

- Providers may elect to issue an ABN electronically
  - The beneficiary must be given the option of requesting a paper issuance if that’s what they prefer
  - Signature can be captured digitally or paper
  - Beneficiary must be given a paper copy of the signed ABN for their records
ABN Completion
CMS-R-131 (3/2020)

- Available in English and Spanish
- Translate if necessary
ABN Requirements

- Use Form CMS-R-131
- Issue ABN each time
- Before item/service rendered

- Identify item/service
- Denial expected
- State reason for denial
# ABN Information

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn’t pay for the 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>
</tr>
</thead>
<tbody>
<tr>
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</table>

**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.
User Customizable Sections

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>
</tr>
</thead>
<tbody>
<tr>
<td>Item/service</td>
<td>Reason for denial</td>
<td>Estimated Cost</td>
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</table>

**What you need to do now:**
Item E Medicare does not pay for the (item or service)...

- for your condition
- more often than “_____”
Option 1

• Wants the service
• Bill Medicare for decision
  – Medical Necessity denial anticipated
• Pay now or later
• Appeals available

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 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.

☐ 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:
Non Participating Providers
Special instruction

• Non-participating suppliers and providers not accepting 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 co-pays or deductibles.

• This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished
Non Participating Providers

• The Stricken line can not be concealed entirely
• No requirement to date, initial or sign the stricken line. By either the beneficiary or the notifier
Option 2

- Want service
- Don’t bill Medicare
  - Excluded services
- Pay now
- No Appeals rights

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 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.

- 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:
Option 3

- Do not want service
- No bill to Medicare
- No financial liability

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<th>G. OPTIONS:</th>
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<tr>
<td>□ OPTION 1.</td>
<td>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 <strong>I can appeal to Medicare</strong> 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.</td>
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<tr>
<td>□ OPTION 2.</td>
<td>I want the D.___________listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. <strong>I cannot appeal if Medicare is not billed.</strong></td>
</tr>
<tr>
<td>□ OPTION 3.</td>
<td>I don’t want the D.___________listed above. I understand with this choice I am not responsible for payment, and <strong>I cannot appeal to see if Medicare would pay.</strong></td>
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H. Additional Information:
Item H

• Clarification
• Additional information
  – Translations
• 1 (800) MEDICARE

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.

(__________) Signature

(______) Date
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: ________________________________

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.
Authorized Representative

- Legal authorization
- Beneficiary’s best interest at heart
  - A spouse
  - A parent
  - An adult child
  - An adult sibling
  - A close friend
Authorized Representative

- Person indicated by beneficiary
- Disinterested 3rd party
Other Considerations

• Beneficiary refuses to sign the ABN
  – Notifier should consider not furnishing the service, unless the consequences are such that is not an option (health and safety of the patient)

• Beneficiary changes their mind
  – The annotation must include a clear indication of the new option selection, along with their signature and date
  – A copy of the annotated ABN must be provided to the beneficiary as soon as possible
ABN Modifiers

• GA - Waiver of liability statement issued as required by payer policy

• GZ – Item or service expected to be denied as not reasonable and necessary
ABN Modifiers

- GX – Notice of liability issued, voluntary under payer policy

- GY – Item or service statutorily excluded, does not meet the definition of any Medicare benefit
ABN Tips
ABN Tips

• HICNs or Social Security numbers must not appear on notice
• Form must not exceed one page
• Provider copy should be kept in patient’s file for 5 years
• Providers are prohibited from issuing ABNs on a routine basis
• ABNs should not be issued in emergency situations
ABN Tips

• Providers bill the GA or GX modifier on the LIDOS when an ABN is given
  – GA has been redefined to mean “Waiver of Liability Statement Issued as Required by Payer Policy” and should be used to report when a required ABN was issued for a service
  – GX has been created with the definition “Notice of Liability Issued, Voluntary Under Payer Policy” and is to be used to report when a voluntary ABN was issued for a service
Ambulance - Voluntary ABN
Verbiage for Non-covered Services

• Medicare does not pay for ambulance trips when other means of transportation could have been used without endangering your health

• Medicare does not pay for ambulance trips for the convenience of the doctor or staff
Ambulance - Voluntary ABN Verbiage for Non-covered Services

- Medicare does not pay for ambulance trips for your own or your family’s convenience.
- Medicare does not pay for ambulance trips to your doctor’s office for a routine appointment.
- Medicare does not pay for mileage beyond the nearest appropriate facility.
Lab Tips

• Medicare may not pay this for this cardiovascular disease screening lab (Lipid panel) test; performed less than five years ago
• Screening pays once every 5 years; more frequently, need ABN (unless diagnostic)
• Physicians - forward ABN copy to labs
Therapy Examples

• Therapists are required to issue ABN for therapy that is not medically reasonable and necessary

• Therapy cap is not met—ABN Mandatory
  – Patient has meet her treatment goals, and has been discharged from care. Patient wants her therapist to continue to work with her even though continued therapy is not medically necessary
  – Therefore an ABN is issued prior to her treatment session.
  – GA modifier
Therapy Examples

• Therapy cap is met – ABN Mandatory
  – When a patient has achieved the maximum benefit that can be provided through therapy and the therapist believes continuation of services is for maintenance it no longer meets the criteria for payment.
  – An exhausted cap makes the service a statutorily excluded benefit.
Therapy Examples

- Therapy cap is met – ABN not required
- Therapy is three days per week. Patient has met the cap. Additional therapy above the cap is medically reasonable and necessary. When therapist submits the claim, the KX modifier is used.
- In this example, an ABN is not issued since the ABN is only issued for therapy above the cap that is not medically reasonable and necessary
Podiatry Examples

• Modifier GA (ABN on file)
  – LCD requirements for diagnosis not met
• Modifier GY (no ABN needed)
  – Routine foot care
    • No requirements for coverage
Medically Unlikely Edits

• MUE is a coding denial, not a medical necessity denial

• Advance Beneficiary Notice (ABN) shall not shift liability to the beneficiary for UOS denied based on an MUE
Additional Information

• CR 8853 – Denial of services due to MUE
• Blank or routine waivers should never be issued
• When appealing a service or item the ABN should be included in the submission
Resources

• ABN Form – (CMS-R-131)

• Internet Only Manual (IOM)
  – 100-04 Chapter 30, Section 50

• Beneficiary Notices Initiative (BNI)

• MLN Article MM7821/CR7821

• ABN Form Instructions
Questions?

Thank you!