



Advance Beneficiary Notice of Noncoverage (ABN)

Published August 2009



Part A and Part B



IMPORTANT



The information provided in this manual was current as of July 2009. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after July 2009, are available at:

<http://www.trailblazerhealth.com/Medicare.aspx>

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Beginning March 3, 2008, providers (including independent laboratories), physicians, practitioners and suppliers may use the revised Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131) for all situations where Medicare payment is expected to be denied. The revised ABN replaces the ABN-G (Form CMS-R-131G), ABN-L (Form CMS-R-131L) and Notice of Excluded Medicare Benefits (Form CMS-20007). Beginning March 1, 2009, the revised ABN will be the only valid ABN accepted.

OVERVIEW

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.

Medicare notifies the providers of limited coverage and medical necessity on the TrailBlazer Health Enterprises® Web site. The information is posted as notices and can be found on the Local Coverage Determination (LCD) Web page at:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1>

ICD-9-CM Coding

All services reported to the Medicare program by a physician or non-physician practitioner must demonstrate medical necessity through the use of ICD-9-CM diagnostic coding carried to the highest level of specificity for the date of service.

Definition of Limited Coverage

Coverage of certain procedures is limited by the diagnosis. If the diagnosis listed on the claim is not the same as one of those listed as covered for the procedure, the procedure is denied.

Limited coverage may be the result of national policy or an LCD. National Coverage Determinations (NCDs) are published on the CMS Web site at:

<http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS014961>

The official version of LCDs may be viewed on the TrailBlazerSM Web site:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1>

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EXPECTATIONS

Despite the fact some physicians, providers or suppliers may have a limited degree of contact with patients, they are expected to be aware of both national coverage policy and current LCD. In the absence of national coverage policy, LCD indicates which items/services will be considered reasonable, medically necessary and appropriate. In most cases, the availability of this information indicates the physician, provider or supplier knew, or should have known, the item/service would be denied as not medically necessary.

If there is a question regarding the number of times a service has been furnished to the beneficiary within a specific period, the physician, provider or supplier should clarify this information with either the beneficiary or the physician who ordered the tests.

REASONS FOR NON-COVERAGE

Services denied by the Medicare program as not medically necessary or reasonable fall into these general categories:

- Experimental and investigational.
- Not safe and effective.
- Limited coverage based on certain criteria.
- Obsolete tests.
- Number of services exceeds the norm and no medical necessity demonstrated for the extra number of services.

PATIENT RESPONSIBILITY

Services denied by the Medicare program as not medically necessary can be billed to the patient if the physician, provider or supplier had the patient sign a proper ABN prior to the service(s) being furnished.

WHAT IS AN ABN?

An ABN is a written notice that a provider/supplier gives to a Medicare patient before items or services are rendered when the provider/supplier believes Medicare probably/certainly will not pay for some or all of the items or services.

ABNs should only be provided to Medicare beneficiaries. The ABN allows the beneficiary to make an informed decision about whether to receive services that he may be financially responsible for paying. The ABN serves as proof the patient had knowledge prior to receiving the service that Medicare might not pay. If a provider does not deliver a proper ABN to the patient, the patient cannot be billed for the service.

Note: Providers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments (e.g., National Correct Coding Initiative). ABNs cannot be used when the beneficiary would otherwise not be financially liable for

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payments for the service because Medicare made full payment.

Note: The newly revised ABN replaces the following notices:

- ABN-G (CMS-R-131-G).
- ABN-L (CMS-R-131-L).
- Notice of Excluded Medicare Benefits (NEMB) (CMS-20007).

HOW THE ABN PROTECTS THE PROVIDER

- When a valid ABN has been given, the provider is free to bill the patient for the denied services.
- If an ABN is not valid, the provider may not bill the patient for the services.
- ABNs may not be used to bill patients for services that are denied as bundled into other payments.

WHEN SHOULD AN ABN BE GIVEN?

Mandatory ABN Uses

An ABN should be given when Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare program standards.

Voluntary ABN Uses

ABNs are not required for care that is statutorily excluded. However, the ABN can be issued voluntarily in place of the NEMB.

Examples of Medicare program exclusions are:

- Personal comfort items.
- Self-administered drugs and biologicals (i.e., pills and other medications not administered by injections).
- Cosmetic surgery (unless required for prompt repair of accidental injury or for improvement of a malformed body member).
- Eye exams for the purpose of prescribing, fitting or changing eyeglasses or contact lenses in the absence of disease or injury to the eye.
- Routine immunizations (except influenza vaccine, pneumococcal vaccine and hepatitis B vaccine; these services have specific regulations regarding patient responsibility).
- Physicals, laboratory tests and X-rays performed for screening purposes (except screening mammograms, screening Pap smears and various other mandated screening services; these services have specific guidelines regarding patient responsibility and when an ABN should be obtained).

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- X-rays and physical therapy provided by chiropractors.
- Hearing aids and hearing examinations.
- Routine dental services (i.e., care, treatment, filling, removal or replacement of teeth).
- Supportive devices for the feet.
- Routine foot care (i.e., cutting or trimming corns or calluses, unless inflamed or infected; routine hygiene or palliative care or trimming of nails).
- Custodial care.
- Services furnished or paid by government institutions.
- Services resulting from acts of war.
- Charges made to the Medicare program for services furnished by a physician or supplier to his immediate relatives or members of his household. The following relationships are included in the definition of immediate relative: husband and wife; natural parent, child and sibling; adopted child and adoptive parent, adopted sibling; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; grandparent and grandchild; and spouse of grandparent or grandchild. By definition, members of the household include those persons sharing a common abode with the physician as part of a single family unit, including those related by blood, marriage or adoption; domestic employees; and others who live together as part of a single family unit.

ROUTINE NOTICE PROHIBITION

Providers are prohibited from issuing ABNs on a routine basis (i.e., where there is no reasonable expectation of non-coverage). Providers will not violate the routine notice prohibition solely on the basis of the number of ABNs issued as long as there is a reasonable basis for issuing an ABN.

TO WHOM SHOULD AN ABN BE GIVEN?

- The Medicare beneficiary.
- The Medicare beneficiary's representative under applicable state or other law. A representative is an individual who may make health care and financial decisions on a beneficiary's behalf (e.g., legal guardian or someone appointed according to a properly executed "durable medical power of attorney").

HOW TO EFFECTIVELY DELIVER AN ABN

ABN delivery is considered to be effective when the notice is:

- Delivered and comprehended by a suitable recipient.
- The correct ABN approved notice with all required blanks completed.

Note: Failure to use the correct notice may lead to providers being found liable.

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- Delivered to the beneficiary in person if possible.
- Provided far enough in advance of potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options.
- Explained in its entirety and all beneficiary-related questions are answered.
- Signed by the beneficiary or his representative.

Options for Delivery Other Than In-Person

In circumstances when in-person delivery is not possible, an ABN may be delivered through the following means:

- Telephone.
- Mail.
- Secure fax machine.
- Internet e-mail.

When delivery is not in-person, the contact must be documented in the patient's records. To be considered effective, the beneficiary cannot dispute such contact. Telephone contacts must be followed immediately by either a hand-delivered, mailed, e-mailed or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the provider for the retention in the patient's record.

The provider 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 provider must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

GENERAL NOTICE REQUIREMENTS

- A minimum of two copies, including the original must be made so the beneficiary and provider each have one. Beneficiaries should be given a copy of the signed and dated ABN immediately and the provider should retain the original copy with the patient's records.
- The ABN must not exceed one page in length; however, attachments are permitted for listing additional items and services. If an attachment sheet is used, a notation such as "See Attached Page" must be inserted in the Items/Services area of the ABN. Attached pages must include the following:
 - Beneficiary's name.
 - Identification number (optional).
 - Date of issuance.
 - Table listing the additional items/services, the reasons Medicare may not pay and the estimated costs.

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- A space below the table in which the beneficiary inserts his initials to acknowledge receipt of the attachment page.
- A visually high-contrast combination of dark ink on a pale background must be used.
- Customization of the ABN is permitted, such as preprinting information in certain blanks to promote efficiency and to ensure clarity for beneficiaries.

COMPLETING THE ABN

The revised ABN can be found at:

http://www.cms.hhs.gov/BNI/02_ABN.asp#TopOfPage

The ABN is composed of five sections and 10 blanks, which must appear in the following order from top to bottom on the notice:

Notifier (A)

- Provider must place his name, address and telephone number at the top of the notice.
- If the billing and notifying entities are not the same, the name of more than one entity may be given in the notifier area.

Patient Name (B)

- Provider must enter first and last name of the beneficiary receiving the notice. The middle initial should also be used if there is one on the beneficiary's Medicare card.

Identification Number (C)

- Medicare numbers or Social Security numbers **must not** appear on the notice.

Body (D)

- Providers must list the specific items or services believed to be non-covered in the blank of the note as well as in the first block of the table.
- In the case of partial denials, providers must list in the blank the excess component(s) of the item or service for which denial is expected.

Table (D, E, F)

- First Block (D).
 - Providers must list the specific items or services believed to be non-covered.
- Reason Medicare May Not Pay (E).
 - Providers must explain in beneficiary-friendly language why they believe the

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items or services may not be covered by Medicare. Commonly used reasons for non-coverage are:

- “Medicare does not pay for this test for your condition.”
- “Medicare does not pay for this test as often as this (denied as to frequency).”
- “Medicare does not pay for experimental or research use tests.”

Note: To be a valid ABN, there must be at least one reason applicable to each item or service listed. The same reason for non-coverage may be applied to multiple items.

- Estimated Cost (F).
 - Provider must complete the Estimated Cost blank to ensure the beneficiary has all available information to make an informed decision about whether to obtain potentially non-covered services.
 - Providers must make a good faith effort to insert a reasonable estimate for all the items or services listed. In general, we would expect the estimate be within \$100 or 25 percent of the actual costs, whichever is greater. Examples of acceptable estimates would include, but not be limited to the following:
 - For a service that costs \$250:
 - “Between \$150–\$300.”
 - “No more than \$500.”
 - Multiple items or services that are routinely grouped can be bundled into a single-cost estimate.

Options 1, 2, or 3

The beneficiary or his representative must choose only one of the three options listed.

- Option 1:
 - This allows the beneficiary to receive the item or services at issue and requires the provider to submit a claim to Medicare. This will result in a payment decision that can be appealed.
- Option 2:
 - This option allows the beneficiary to receive the non-covered items or services and pay for them out-of-pocket. No claim will be filed and Medicare will not be billed. Therefore, there are no appeal rights associated with this option.
 - Providers will not violate mandatory claims submission rules under 1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary’s written request when selecting this option.
- Option 3:
 - This option means the beneficiary does not want the care in question. By

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checking this box, the beneficiary understands that no additional care will be provided and, thus, there are no appeal rights.

Additional Information (H)

Providers may use this space to provide additional clarification they believe will be of use to beneficiaries. For example:

- A statement advising the beneficiary to notify his provider about certain tests that were ordered but not received.
- An additional dated witness signature.
- Other necessary annotations:
 - Annotations will be assumed to have been made on the same date as that appearing with the beneficiary's signature.

Signature Box (I, J)

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary or representative.

- Signature:
 - The beneficiary or representative must sign the notice to indicate that he received the notice and understands its contents. If a representative signs, he should indicate "representative" after his signature.
- Date:
 - The beneficiary or representative must write the date he signed the ABN. If the beneficiary has physical difficulty writing and requests assistance in completing this blank, the date may be inserted by the provider.

OTHER THINGS TO CONSIDER DURING THE ABN COMPLETION

Beneficiary Changes His Mind

If after completing and signing the ABN the beneficiary changes his mind, the provider should present the previously completed ABN to the beneficiary and request that he annotate the original ABN. The annotation must include a clear indication of his new option selection along with his signature and date of annotation. In situations where the provider is unable to present the ABN to the beneficiary in person, the provider 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.

Note: In both situations, a copy of the annotated ABN must be provided to the beneficiary as soon as possible.

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Beneficiary Refuses to Complete or Sign the Notice

If the beneficiary refuses to choose an option and/or refuses to sign the ABN, the provider 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 provider 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.

ABN FOR AN EXTENDED COURSE OF TREATMENT

An ABN is not needed every time for an extended course of treatment. A single ABN covering an extended course of treatment is acceptable if the ABN identifies all items/services and duration of the period of treatment for which the provider believes Medicare will not pay. If the provider believes Medicare will deny additional services furnished during the course of treatment, a separate ABN is needed.

A single ABN for an extended course of treatment is valid for one year. If the course of treatment extends beyond one year, a new ABN is needed for the remainder of the course of treatment.

Once the patient has signed the ABN, it cannot be modified or revised. When the patient needs to be notified of new information, a new ABN must be given.

ABN IN A MEDICAL EMERGENCY

An ABN should not be obtained from a beneficiary in a medical emergency or otherwise under great duress (i.e., when circumstances are compelling and coercive). ABN usage in the emergency room may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

HOW LONG SHOULD AN ABN BE KEPT ON FILE?

In general, the ABN should be kept for five years from discharge/completion of delivery of care when there are no other applicable requirements under state law. Providers are required to keep a record of the ABN in all cases, including those cases in which the beneficiary declined the care, refused to choose an option or refused to sign the notice.

WHAT HAPPENS WHEN MULTIPLE ENTITIES ARE INVOLVED IN RENDERING CARE?

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 issue the ABN 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

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of the same service (e.g., radiological test that an independent diagnostic testing facility renders and a physician interprets).

- The entity that obtains the signature on the ABN is different from the entity that bills for the service (e.g., when one laboratory refers a specimen to another laboratory, which then bills Medicare for the test).

Regardless of who gives the notice, the billing entity will always be held responsible for effective delivery. In these situations, it is permissible to enter the names of more than one entity in the header of the notice.

LACK OF ABN NOTIFICATION

A provider will likely have financial liability for items/services if 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 provider cannot collect funds and is required to make prompt refunds if funds were previously collected.

COLLECTION OF FUNDS AND REFUNDS

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. The provider may bill and collect funds for non-covered items/services immediately after an ABN is signed.

If Medicare ultimately denies payment, the provider retains the funds collected. However, if Medicare pays all or part of the claim for items/services previously paid by the beneficiary or if Medicare finds the provider liable, the provider must refund the beneficiary the proper amount in a timely manner. Refunds are considered timely when made within 30 days of the notice of the claim denial from Medicare or within 15 days after a determination on an appeal if an appeal is made.

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EXAMPLE OF ABN

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) _____ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

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 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:

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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/08)

Form Approved OMB No. 0938-0566

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CLAIM INSTRUCTIONS WHEN A VALID ABN IS ON FILE

When the previous instructions have been followed and a valid ABN on file, the following modifiers should be used to notify Medicare:

GA Use to indicate that an ABN is on file. A copy of the ABN does not have to be submitted but must be made available upon request.

GZ Use to indicate an ABN was not signed by the beneficiary.

REVISION HISTORY

Date	Section	Revision
February 2009	ABN-G and ABN-L Instructions	Removed based on Change Request (CR) 6136.
<i>August 2009</i>	<i>All Sections</i>	<i>Updated the links for LCD and ABN. Changed the manual to Part A/B.</i>