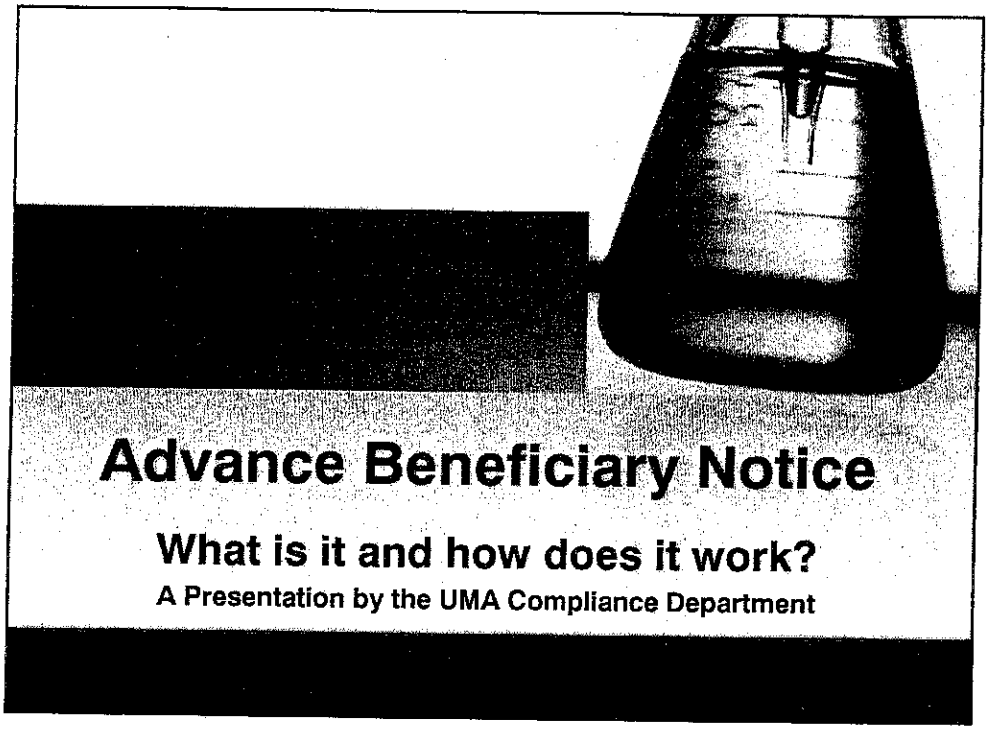
ABN



Advance Beneficiary Notice

What is it and how does it work?

A Presentation by the UMA Compliance Department

Purpose:

- The purpose of the Medicare Advance Beneficiary Notice (ABN) is to inform a Medicare beneficiary **before** he/she receives specified items or services that otherwise might be paid for, that Medicare probably will not pay for them on that particular occasion and that the patient will be held responsible for payment for the service. The ABN form will include the reason why the physician believes the service provided that day will not be paid for by Medicare.

Who's Responsibility is it?

- Individuals involved in the ordering of the services and/or registering of patients must review the patient's diagnosis, signs/symptoms, disease or ICD-9-CM code for medical necessity to determine if an ABN is necessary.

Approved Form CMS-R-131

- In order for CMS to accept and ABN as valid, the approved Form CMS-R-131 must be used.
- A copy of this form can be found at http://mcintranet.musc.edu/uma/compliance/policies.htm

Statutorily Excluded Items:

- ABN's are not required for services or items Medicare is expected (or certain) to deny payment on the basis of statutorily excluded (always non-covered) items e.g. routine eye care, routine physicals, and most screening tests, most vaccinations, cosmetic surgery, dental care, acupuncture services, routine foot care and flat foot care, and services by immediate relatives.
- However, this form may be used for voluntary notifications.

ABN Form Instructions:

- Form CMS-R-131 requires:
  - Legibility if handwritten
  - Acceptable typed fonts on form are Arial, Arial Narrow with font range of 10 to 12 points
  - Visually high contrast combination of dark ink on a pale background is required
  - Identifying information of billing provider group practice in header
  - Patient name
  - Service or Item expected to be denied and reason item expected to be denied
  - Date of service
  - Estimated cost
  - 1 of the 3 options in the "Options" box to be checked, by the beneficiary or authorized representative
  - Personally signed and dated by beneficiary or authorized representative

Services with Technical and Professional Components:

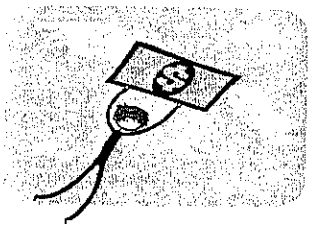
- When the service being provided consists of a technical component and a professional component, one ABN may be obtained, provided the description of the service clearly indicates both components e.g. radiologic test with technical and professional components.
  - The cost estimate should include both parts of the service.

Blanket ABN's:

- Obtaining ABN's for ALL claims and services is **NOT** an acceptable practice.

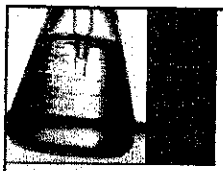
What happens if a necessary ABN is not obtained?

- If one of the conditions from the previous slide did apply and an ABN was not obtained prior to rendering the service, neither Medicare nor the beneficiary may be billed for the service.



Timeliness:

- ABN delivery must take place before a procedure is initiated and before physical preparation of the patient begins.
  - This allows the patient to make a rational, informed consumer decision whether or not to receive services without undue pressure.
  - A provider may not request an ABN if a patient requires immediate care as per EMTALA guidelines.



(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 in general, 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: 7 SEL, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/05) Form Approved OMB No. 0938-0566

Determining if an ABN is necessary:

- An ABN is necessary if any of the following conditions applies and the provider intends to bill the patient, should Medicare deny payment.
  - The service/test provided does not meet definitive medical necessity guidelines as outlined in federal government regulations, program memorandums, or NCD's.
  - The service/test may only be paid for a limited number of times within a specified time frame and this service/test may exceed that limit.
  - The service/test is for investigational or research use only e.g. the service/test/biological/drug has not been approved by the FDA.

Crucial Note:

- **It is imperative that the patient must personally select one of the Option boxes.**
  - ☐ **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.**
- **If one of the Option boxes is not selected, the ABN is not valid, and if Medicare denies payment, the patient cannot be billed.**

ABN Delivery:

- The ABN should be hand delivered to the beneficiary/authorized representative by the provider or the provider's staff.
- The provider or staff must respond to any questions the beneficiary may have.
- Forms must be signed and dated by the beneficiary/authorized representative.

ABN Delivery: cont.

- A copy of the signed and dated form is retained by the beneficiary/authorized representative.
- The provider retains the original ABN, which is then attached to the charge ticket, for scanning into IDX.
- In a case where the provider or staff that gives an ABN is not the entity which ultimately bills Medicare, e.g. when a provider draws a specimen and sends it to a laboratory for testing, the provider should give a copy of the signed ABN to the entity that ultimately bills Medicare.

Patient Refusals:

- Should a patient refuse to pay or sign the ABN form, yet still demands the service:
  - Two witnesses should sign the ABN form and a note should be made that the beneficiary refused to sign.
    - In this case, the service may be provided and if Medicare denies payment, the beneficiary can be billed for payment.

Billing:

- Billing modifiers GA, GZ , GY, and/or GX are required to report ABN status.
  - GA – is required on a claim anytime you obtain a signed ABN for an item or service expected to be denied as not reasonable and necessary or you have a patient's refusal to sign an ABN witnessed properly.
  - GZ – is required on a claim when an item or service is expected to be denied as not reasonable and necessary and an ABN was not obtained e.g. emergency care situation, patient not personally at premises (lab specimen) or you realized too late that you should have obtained one.
  - GY – is used when you submit a claim for a Medicare statutorily excluded service or item e.g. submit a claim to obtain a Medicare denial for secondary payor purposes.
  - GX – is a "Notice of Liability Issued, Voluntary Under Payer Policy." This should be used when a voluntary ABN was issued for service. You may report the –GX modifier in conjunction with the –GY modifier. The modifier becomes effective 04/01/10.

Questions:

- For questions, please contact your Compliance Manager:

Dixie McMahan, CPC, CEMC, CPMA
Compliance Manager
UMA Compliance Dept.
Phone: 843-792-0331
Fax: 843-792-8688
Pager ID: 12700

- Thank you for your time and attention.