

Advance Beneficiary Notice of Noncoverage (ABN)



Disclaimer

- This presentation was current at the time it was published or uploaded onto the CGS website. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
- This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Objectives

- Offer an overview of CMS Form CMS-R-131 (ABN)
- Identify situations appropriate for issuing an ABN
- List requirements for ABNs
- Review how to complete an ABN
- Provide educational resources and links to assist you with ABN questions

The 4 W's of ABNs

What

- The ABN Notice is the official form CMS-R-131 from the Centers for Medicare & Medicaid Services (CMS).

Who

- For your beneficiaries who are enrolled in Original (Fee-For-Service (FFS)) Medicare.

When

- Complete required fields on this form and ask the beneficiary to sign it before providing certain services under Medicare Part B.

Why

- To allow the beneficiary to make an informed decision about receiving services and accept financial liability if Medicare does not pay.

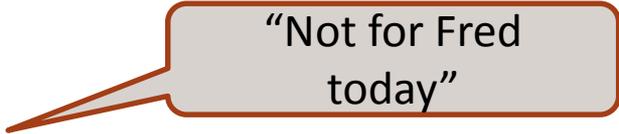
More About “When”: Mandatory and Voluntary Use

- “Mandatory” ABNs are applicable to services or items you expect will be denied under section 1862(a)(1)(A) of the Social Security Act.
- “Voluntary” ABNs are applicable to services or items that are never covered by Medicare and for which no ABN is required.

Guidelines for mandatory and voluntary use are located in the CMS [Medicare Claims Processing Manual \(Pub. 100-04\)](#), [chapter 30](#), beginning with section 50

More About “When”: Mandatory Use

- Examples of when you are required to issue ABNs include:
 - You believe Medicare may not pay for an item or service, and
 - Medicare usually covers the item or service, and
 - Medicare may not consider it medically reasonable and necessary for this patient in this particular instance.



“Not for Fred today”

More About “When”: Mandatory Use

ABNs are often appropriate for services you expect will be denied, such as the following types of services:

- Therapy services that are “not medically reasonable and necessary,” including those that exceed the therapy cap
- Experimental and investigational
- Not indicated for diagnosis and/or treatment in this case
- Not considered safe and effective by Medicare
- Performed more frequently than Medicare allows in a specific period for the corresponding diagnosis

More About “When”: How Do I Know Medicare May Not Pay?

Medicare does not cover all services. The general rule, based on the Social Security Act, is that Medicare covers services that are considered medically necessary.

- There are some exceptions to the “medically necessary” rule, which are also specified in the Social Security Act. Exceptions include some preventive services, like flu shots.
- There are some coverage limitations, generally explained in detail in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). CMS guidelines also specify some limitations on coverage.
 - NCDs and LCDs are located in the CMS [Medicare Coverage Database](#)
 - Find other coverage limitations in the CMS [Medicare Benefit Policy Manual \(Pub. 100-02\)](#)

More About “When”: How Do I Know Medicare May Not Pay?

- It pays to stay informed! Find out when there are changes in LCDs, NCDs, and other coverage guidelines by signing up for the CGS email distribution list (listserv).
 - We'll provide a link to register at the end of the course.

More About “When”: Voluntary Use

ABNs are not required in all cases, such as services that are never covered by Medicare based on statute. You may, but are not required to, issue ABNs in these cases. Examples include:

Voluntary Use of ABN	
Personal comfort items	Routine eye care
Cosmetic surgery	Routine dental services
Routine immunizations	Routine foot care
Hearing aids	Services required as a result of war
*Services paid by a government entity other than Medicare	

*this exclusion does not apply to services paid for by Medicaid on behalf of dual-eligible beneficiaries

More About “When”: Voluntary Use

- You may provide a voluntary ABN as a courtesy to the beneficiary.
- In these cases, do not ask the beneficiary to select an Option (section G).
- Most other “ABN requirements” do not apply in voluntary use situations.

Knowledge Check

Which of the following situations, by itself, is NOT appropriate for issuing an ABN?

- a) Experimental or investigational treatment
- b) Treatment which will cost more than \$1000
- c) Treatment that does not meet diagnosis qualifications
- d) Treatment that will be provided is not considered safe and effective.

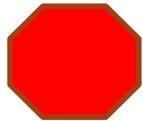
Knowledge Check

Which of the following situations, by itself, is NOT appropriate for issuing an ABN?

- a) Experimental or investigational treatment
- b) Treatment which will cost more than \$1000**
- c) Treatment that does not meet diagnosis qualifications
- d) Treatment that will be provided is not considered safe and effective.

Prohibited Use

- If the beneficiary is in a medical emergency or under great duress, you **may not** ask him or her to sign an ABN.
- It is generally not appropriate to ask a beneficiary to sign an ABN for ambulance transports.
 - This [CMS document](#) explains in detail the use of ABNs for ambulance transports. If you provide ambulance transports for Medicare beneficiaries, **stop now and review this document** before continuing with the course.



Prohibited Use

- It is not appropriate to issue ABNs for services that you expect will be denied based on National Correct Coding Initiative (NCCI) edits or Medically Unlikely Edits (MUEs).
 - Learn more about NCCI and MUE edits on the [CMS website](#).



Do not use the Medicare FFS ABN for beneficiaries enrolled in Medicare Advantage (MA) plans or for Medicare Part D services.

Multiple Entities

When multiple entities are involved in providing care, either party involved in the delivery of care can issue the ABN when:

- There are separate ordering and rendering providers.
- One health care provider delivers the technical component and another the professional component of the same service.
- The entity that obtains the signature on the ABN is not the same entity that bills for the service.

Completing the ABN

Now that we've covered the situations when it is appropriate to issue an ABN, let's take a quick look at the actual form.

After that, we'll cover the requirements for completing it!

ABN Form

This is the official ABN form. We'll review each section in detail later in this course.

A. Notifier: _____
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: _____
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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 21266-1850.

Instructions for completing the ABN are also available on the [CMS website](http://www.cms.gov).

Requirements

- Use the standardized notice format, one page in length.
- Include the following information on the ABN:
 - Any additional notations such as “See Attached Page” in section D
 - The beneficiary’s name
 - The date that the ABN was issued.
 - The table listing the additional items or services, the reason Medicare may not pay, and the estimated cost for the patient.
 - A space in which the beneficiary inserts his or her initials to acknowledge receipt of the attachment page.
 - Optional: an internally assigned number for that patient (*do not use the beneficiary’s Health Insurance Claim (HIC) number*)
- Must be on a visually high-contrast combination of dark ink on a pale background and the print must be readable.

Requirements

- The ABN must be issued (preferably in person) to and comprehended by a suitable recipient.
 - May issue by telephone, mail, secure fax machine, or email
 - Telephone contacts must be followed immediately by a hand-delivered, mailed, faxed, or emailed ABN
- The notice must be provided far enough in advance of potentially non-covered items or services to allow sufficient time for the beneficiary to consider available options and make an informed choice.
- **Important: review the ABN verbally with the beneficiary or his/her representatives and answer any questions.**
- It must be signed and dated by the beneficiary or his or her representative after he or she selects one option box.

Requirements

- Telephone contacts:
 - The beneficiary or representative must sign and retain a copy and send a signed copy to you to retain in the beneficiary's record.
 - Keep a copy of the unsigned ABN while awaiting receipt of the signed ABN.
 - If the beneficiary fails to return a signed copy, document the initial request and subsequent attempts to obtain a signature in appropriate records or on the ABN.

Knowledge Check

You must issue ABNs in person.

- a) True
- b) False

Knowledge Check

You must issue ABNs in person.

- a) True
- b) False**

Knowledge Check

It may be appropriate to issue an ABN for services you believe will be denied based on a Medically Unlikely Edit, as long as you check the CMS MUE listing first.

- a) True
- b) False

Knowledge Check

It may be appropriate to issue an ABN for services you believe will be denied based on a Medically Unlikely Edit, as long as you check the CMS MUE listing first.

- a) True
- b) False**

Completing the ABN

Completing an ABN is simple for your office. We are going to break it down for you in the next few slides.

Pay close attention to the information given and what is required for a valid ABN.

Option: [download a copy of the official ABN form from this web page](#) and follow along as we go through each requirement.

Completing the ABN

Term to know: "notifier" means the entity that is issuing the ABN

A. Notifier: ABC Facility, 123 Any Street, Somewhere, ST 12345, 123.456.7890

B. Patient Name: John X. Doe

C. Identification Number: 12345

A. Notifier's name, address, and telephone number.
 B. Patient's name as it appears on his or her Medicare card.
 C. Optional. An internal filing number assigned by the notifier, such as a medical record number, is acceptable. Do NOT enter an HIC or SSN.

... (ABN)
 ... to pay.
 ... care provider have
 ... below.

	... ay:	F. Estimated Cost

Completing the ABN

A. Notifier: **ABC Facility, 123 Any Street, Somewhere, ST 12345, 123.456.7890**

B. Patient Name: **John X. Doe**

C. Identification Number: **12345**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. test 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. test below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
	<p>D. The following descriptors may be used in the header:</p> <ul style="list-style-type: none"> * item * service * laboratory test * test * procedure * care * equipment 	

Completing the ABN

A. Notifier: ABC Facility, 123 Any Street, Somewhere, ST 12345, 123.456.7890

B. Patient Name: John X. Doe

C. Identification Number: 12345

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. test 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. test below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
<p>Screening Mammography</p> <div data-bbox="338 1135 966 1292" style="border: 1px solid blue; border-radius: 15px; padding: 10px; width: fit-content; margin: 10px auto;"><p>List the specific item(s)/service(s) believed to be non-covered.</p></div>		

Completing the ABN

A. Notifier: **ABC Facility, 123 Any Street, Somewhere, ST 12345, 123.456.7890**

B. Patient Name: **John X. Doe**

C. Identification Number: **12345**

Advance Beneficiary Notice

NOTE: If Medicare doesn't pay for D. test below, you have a good reason to think you need. We expect Medicare may not pay for everything, even some care.

E. There must be one reason applicable to each item/service listed in D. have

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
<p>Screening Mammography</p> <p>Examples of acceptable reasons include:</p> <ul style="list-style-type: none"> • “Medicare does not pay for this test for your condition.” • “Medicare does not pay for this test as often as this (denied as too frequent).” • “Medicare does not pay for experimental or research use tests.” 	<p>Medicare does not pay for this test as often as this (denied as too frequent).</p>	

Completing the ABN

A. Notifier: ABC Facility, 123 Any Street

B. Patient Name: John X. Doe

Advance Beneficiary

NOTE: If Medicare doesn't pay for **D. test**

Medicare does not pay for everything, even so...
 good reason to think you need. We expect Medicare may not pay for the **D. test** below

F. The estimated cost is expected to be within \$100 or 25% of the actual cost, whichever is greater. Examples for a service that costs \$500 would include:

- * A dollar amount greater than or equal to \$375
- * Between \$400 and \$600
- * No more than \$700

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Screening Mammography	Medicare does not pay for this test as often as this (denied as too frequent).	No more than \$700

Completing the ABN

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. **test** 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. **test** 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.**

Completing the ABN

H. Additional Information:

Examples:

- * A statement advising the beneficiary to notify his/her provider about certain tests that were ordered, but not received
- * Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable
- * An additional dated witness signature
- * Identify the billing entity if more than one entity is listed in the header.

Medicare decision. If you have other questions on (1-800-633-4227/TTY: 1-877-486-2048). Understand this notice. You also receive a copy.

J. Date:

...a collection of information unless it displays a valid OMB control number. ...required to complete this information collection is estimated to average 7 ...sources, gather the data needed, and complete and review the information ...suggestions for improving this form, please write to: CMS, 7500 Security ...50.

Form CMS-R-131 (03/11)

Form Approved OMB No. 0938-0566

Completing the ABN

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: <i>Annie Scriven</i> (representative) <i>Annie Scriven</i>	J. Date: 8.28.13
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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.

Completing the ABN

Let's review!

- Use the required form and provide it in advance.
- Fill in the blanks, including a description of the item/test/service, estimated cost, and why you believe Medicare may deny the service.
- Give the beneficiary a copy of the signed form and maintain a copy in his/her medical records.
- Submit the appropriate modifier on your claim.

Knowledge Check

On the ABN, the “Notifier” (Field A) refers to:

- a) The federal entity in charge of Medicare
- b) The Medicare Administrative Contractor that will process the claim
- c) 1-800-MEDICARE
- d) The name of the health care provider or entity that is issuing the notice

Knowledge Check

On the ABN, the “Notifier” (Field A) refers to:

- a) The federal entity in charge of Medicare
- b) The Medicare Administrative Contractor that will process the claim
- c) 1-800-MEDICARE
- d) The name of the health care provider or entity that is issuing the notice

Knowledge Check

Which of the following areas of the ABN must be completed by the beneficiary or his/her representative and not by the health care provider who is issuing the notice?

- a) Section G: Options
- b) Section B: Beneficiary's name
- c) Section D: description of the test, item, or service
- d) All of the above

Knowledge Check

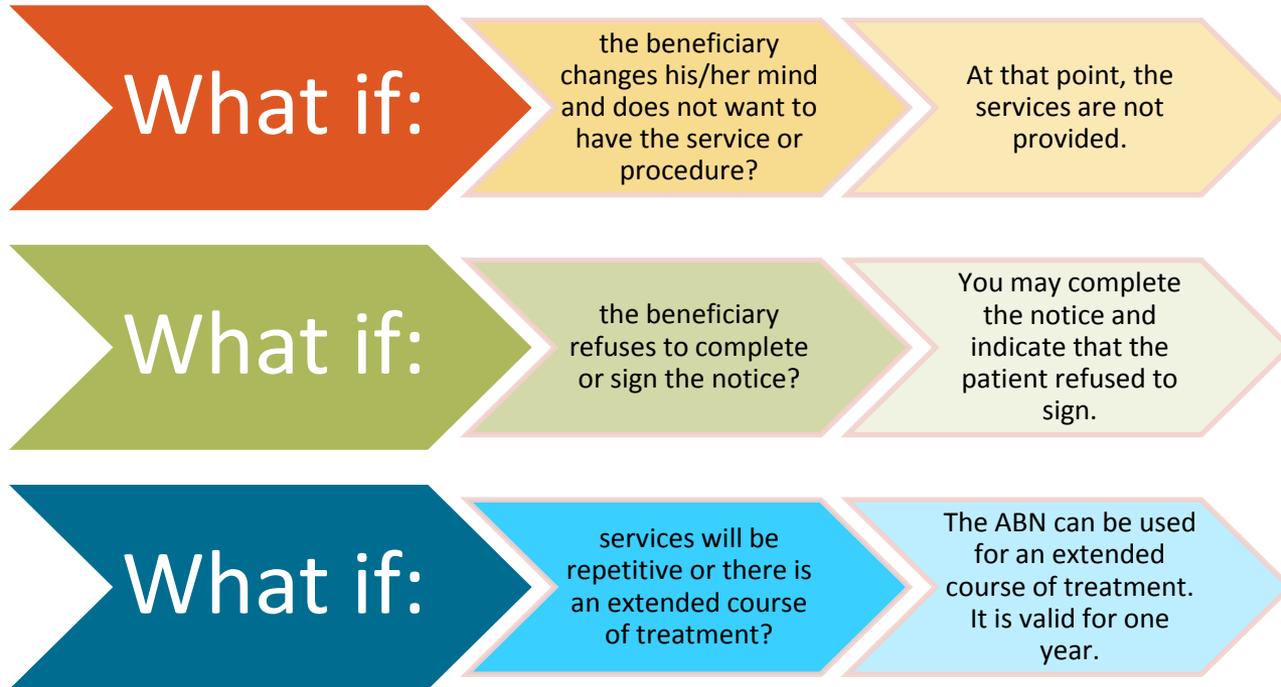
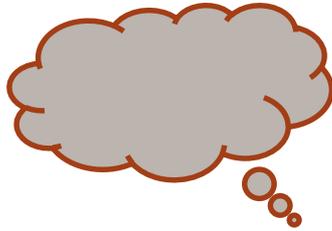
Which of the following areas of the ABN must be completed by the beneficiary or his/her representative and not by the health care provider who is issuing the notice?

- a) **Section G: Options**
- b) Section B: Beneficiary's name
- c) Section D: description of the test, item, or service
- d) All of the above

Retention Requirements

- Give the beneficiary a copy of the signed form.
- Retain a signed copy in the beneficiary's records for at least five years from the date of discharge.
 - Electronic retention is acceptable.
- If requested by CGS or another CMS-contracted entity (such as the Comprehensive Error Rate Testing (CERT) contractor, Zone Program Integrity Contractor (ZPIC), Recovery Auditor (RA), or Supplemental Medical Review Contractor (SMRC)), include a copy of the signed ABN with other applicable supporting documentation.

Other Considerations



Collection of Funds/Refunds

- You are permitted to charge and collect the usual and customary fee after a valid ABN is signed.
- If Medicare subsequently pays all or part of a claim or finds the provider liable, you must refund the beneficiary in a timely manner:
 - Within 30 days of the date of the Remittance Advice (RA)
 - Within 15 days after the determination of an appeal

Claim Submission Requirements

Situation	Modifier and Documentation Requirements
Mandatory ABN issued	Submit HCPCS modifier GA with services included on the ABN <ul style="list-style-type: none"> Remember: keep a copy of the signed ABN and provide it upon request
Mandatory ABN should have been issued but was not	Submit HCPCS modifier GZ with services included on the ABN <ul style="list-style-type: none"> Services will be automatically denied and will not be subject to complex medical review
Voluntary ABN issued	Submit HCPCS modifier GX with services included on the ABN <ul style="list-style-type: none"> This modifier is informational only
Statutorily denied service (no ABN required, and “voluntary use” provisions apply), but no voluntary ABN issued, and: <ul style="list-style-type: none"> You want a denial from Medicare, or The patient requests you submit the claim 	Submit HCPCS modifier GY with the non-covered service <ul style="list-style-type: none"> Service will be denied

Resources

CMS Resources

- CMS FFS ABN web page: <http://cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html> - includes:
 - Instructions for completing the ABN
 - The official ABN form
- CMS Medicare Learning Network ABN Booklet: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf
- CMS Medicare Claims Processing Manual (Pub. 100-04), chapter 30: <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf>

CGS Resources

- CGS website: <http://www.cgsmedicare.com/>
- CGS Electronic Mailing List registration:
http://www.cgsmedicare.com/medicare_dynamic/lis/001.asp