ADVANCED BENEFICIARY NOTICE (ABN)

"It is the policy of Nebraska Medicine (Nebraska Medical Center, Bellevue Medical Center, and UNMCP) to comply with the procedures set forth below"

**PURPOSE:**
To ensure an Advance Beneficiary Notice (ABN) is obtained when the provider believes Medicare may not pay for an item or service that Medicare usually covers, because it is considered not medically reasonable and necessary for this patient in this particular instance. The ABN allows a Medicare beneficiary to make an informed decision about whether to receive services and accept financial responsibility for those services if Medicare does not pay. A properly completed ABN serves as proof that the beneficiary had knowledge prior to the service that Medicare might not pay, and allows the provider to bill the beneficiary for the service if not covered by Medicare.

**POLICY:**
It is the policy of Nebraska Medicine to follow and support Medicare policy related to issuance of an Advance Beneficiary Notice of Noncoverage (ABN). This policy is based on the Center for Medicare and Medicaid Service’s CMS Manual System Pub 100-04 Medicare Claims Processing Manual, Chapter 30 – Financial Liability Protections, CMS Manual System Pub 100-04 Medicare Claims Processing Manual Transmittal 1587, Change Request 6136, Date: September 5, 2008, and Transmittal 2480, Change Request 7821, June 1, 2012 and CMS Manual System Pub 100-04 Medicare Claims Processing Manual, Chapter 01 section 60.4; references to the Social Security Act (the Act).

**PROCEDURE:**
The policy applies to Beneficiaries receiving Part B items or services and in the Medicare Fee-For-Service (FFS) program, which includes Railroad Medicare Beneficiaries. The Medicare ABN is not appropriate for the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). Failure to follow these requirements will result in an inability to bill the Beneficiary for services Medicare determines not reasonable and necessary.

I. When to complete an ABN
   a. Mandatory use of the ABN is required when Medicare is expected to deny some or all of the involved services as not medically necessary under Medicare program standards, or because Medicare considers the service custodial care. For example:
      i. The service is experimental or investigational;
      ii. The service is not indicated for the patient’s diagnosis or treatment;
      iii. The service is not considered safe or effective (e.g., has not been approved by the FDA); or
      iv. The service may only be covered by Medicare for a limited number of times and/or within a specified time period, and this service exceeds the quantity or frequency limitation.
   b. ABNs are not required for care that is statutorily excluded or services that are never a Medicare covered benefit; however, the informational ABN (which does not need to be signed) may be voluntarily issued as a means to inform the Medicare beneficiary of their financial responsibility. For example:
      i. Personal comfort items;
      ii. Routine eye, dental or foot care;
      iii. Routine physicals;
      iv. Hearing aids; or
      v. Elective cosmetic procedures.
c. Use of an ABN may also be triggered by service ‘reductions’ or ‘terminations’:
   i. – 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 Physician believes that the Beneficiary’s therapy goals can be met with only three days of therapy weekly.”
   ii. Termination is the discontinuation of certain items or services when it is no longer considered reasonable and necessary. Upon notice of discontinuation of services, if the Beneficiary wishes to continue treatment, an ABN must be presented to the Beneficiary.

d. An ABN is to be obtained for initial orders for an extended course of treatment (e.g., for up to one year) which contains a service that may not be covered. However, it is not necessary to obtain a new ABN each time the service is performed in accordance with the orders. A new ABN should be completed if/when the extended treatment remains in effect for more than one year,

e. Routine use of an ABN is prohibited. There must be a specific reason to believe Medicare will not pay for the service.

f. The ABN must be completed prior to the Beneficiary receiving the potentially non-covered care, and far enough in advance of providing the item or service to allow sufficient time for the Beneficiary to consider all available options. It is not considered sufficient time if the Beneficiary has already been prepped for their procedure (undressed, pre-medicated or undergone other physical preparations).

II. How to Complete an ABN

a. The ABN form generated by the electronic health record and/or provided in Attachment A is the only form acceptable to Medicare.
   i. There is a choice of an English or Spanish form, as is best suited to the needs of the patient.
      1. All subsequent entries entered into the form must be in the language of the form.
   ii. Verbal translator assistance is available in other languages, and use of such should be noted in the “Additional Information” section of the form.

b. Customization of the form is permitted in Blanks A-F only. The ABN form may not be otherwise modified.

c. Entries in blanks may be as generated by the electronic health record system, and/or typed or legibly handwritten.

d. For specific instructions concerning appropriate entries for each Blank on the form, see Attachment B.

e. The ABN must not exceed one page in length; however, attachments are permitted for listing additional items or services.
   i. If an attachment sheet is used, a notation such as “See Attached Page” must be inserted in the Items/Services area of the form.

f. The ABN must be fully explained to, and understood by, the Medicare beneficiary or his/her representative (an individual who may make health care and financial decisions on behalf of the Beneficiary; e.g., the Beneficiary’s legal guardian or properly appointed “durable medical power of attorney”)

g. As soon as the Medicare beneficiary has selected his/her option and signed the ABN, the completed form must be scanned into the beneficiary’s electronic health record (where the minimum 5 year retention requirement will be satisfied) and a copy must be provided to the beneficiary.

h. At times the ABN may need to be completed in accordance with appropriate HIPAA policies via secure telephone, mail, email or fax.
   i. The provider must verify that contact was made with the recipient and document that contact.
   ii. The beneficiary or representative must sign and retain the ABN and send a copy of this signed ABN back to the provider to be scanned into the Beneficiary’s electronic health record.
   iii. Telephone contacts must be followed immediately by either a hand-delivered, mailed, emailed, or faxed notice. The provider must keep a copy of the unsigned notice on file while awaiting receipt of the signed form from the beneficiary. Should the beneficiary fail to return a signed form, the provider must document initial contact and all subsequent attempts to obtain a signature (may be noted on the notice itself).

III. Other Considerations

a. Beneficiary changes his/her mind after completing and signing an ABN:
   i. The provider should present the beneficiary with a photocopy of the scanned original ABN, requesting the beneficiary annotate the desired changes and then date, sign and return the revised ABN to the provider. The beneficiary must receive a copy of the revised ABN, and the provider will scan the revised ABN into the electronic health record.

b. The beneficiary refuses to choose an option and/or sign an ABN:
i. The provider should annotate the original ABN indicating the beneficiary’s refusal in Blank H. A witness signature and date for the annotation is recommended. CMS states the beneficiary cannot properly refuse to sign the ABN at all and still demand the item or service. The provider may consider not furnishing the item or service to the beneficiary unless the consequences (health, safety of the beneficiary, or civil liability in case of harm) are such that this is not an option. The provider must provide a copy of the annotated ABN to the beneficiary.

c. The Beneficiary refuses to choose an option and/or sign the ABN, but demands the item or service:
   i. The provider should annotate the original ABN indicating the Beneficiary’s refusal in Blank H. Two members of the provider staff should serve as witness with their signatures, date and attest to having witnessed provision of the ABN and its refusal (an unused patient signature line on the form may be used, and it is also permissible to write in the margin of the form). The item or service is provided and a claim may then be submitted with an indication that an ABN was given. The beneficiary will be held liable per §1879© of the Social Security Act in case of a denial.

d. When multiple entities are involved in providing an item or service:
   i. When multiple entities in conjunction provide items or services, it is not necessary for each to deliver a separate ABN. A single ABN may be used if each entity identifies itself and provides appropriate cost estimates;
   ii. The entity that is billing for the service is ultimately responsible for effective completion of an ABN even if another entity is presenting the ABN to the Beneficiary;
   iii. The entity that does not ultimately bill Medicare but obtains the ABN must give a copy of the signed ABN to the billing entity. The copy must be legible and may be a carbon, fax, electronically scanned, or photo copy.

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

IV. Invalid ABNs
   a. An ABN is not acceptable if:
      i. Any section is unreadable or illegible excluding signatures;
      ii. The beneficiary is incapable of understanding the ABN;
      iii. It is given during an emergency; if the beneficiary is under duress; or is, in any way, coerced or misled, by the contents of the ABN, and/or by the manner of the delivery of the ABN;
      iv. It is given routinely (i.e. where there is no reasonable expectation of noncoverage), as a generic or blanket notice (i.e. statements such as “Medicare may not pay”, or “unknown whether Medicare will deny payment”);
      v. It is more than one year from completion; or
      vi. It is incomplete or has not been completed in accordance with the requirements of this policy.

Sections and Blanks:
There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or handwritten, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

A. Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier’s logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for questions.
**Blank (B) Patient Name:** Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary’s Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

**Blank (C) Identification Number:** Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers must not appear on the notice.

**B. Body**

**Blank (D):** The following descriptors may be used in the header of Blank (D):

- Item
- Service
- Laboratory test
- Test
- Procedure
- Care
- Equipment

- The notifier must list the specific items or services believed to be noncovered under the header of Blank (D).
- In the case of partial denials, notifiers must list in Blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.14.3 for additional information.
- General descriptions of specifically grouped supplies are permitted. For example, “wound care supplies” would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs, notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering “wound care supplies decreased from weekly to monthly” would be appropriate to describe a decrease in frequency for this category of supplies; just writing “wound care supplies decreased” is insufficient.

**Blank (E) Reason Medicare May Not Pay:** In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

- “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.”

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D).

**Blank (F) Estimated Cost:** Notifiers must complete Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs $250:
● Any dollar estimate equal to or greater than $150
● "Between $150-300"
● "No more than $500"

For a service that costs $500:

● Any dollar estimate equal to or greater than $375
● "Between $400-600"
● "No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

C. Options

Blank (G) Options: Blank (G) contains the following three options:

☐ 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.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. See Ch. 30, §50.14.1 of the online Medicare Claims Processing Manual for instructions on the notifier’s obligation to bill Medicare.

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

☐ 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.

This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

☐ 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.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary’s request, notifiers may enter the beneficiary’s selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.
If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: “beneficiary refused to choose an option”.

In the case in which the beneficiary demands the service(s) and refuses to pay or sign the ABN form, then two employee witnesses should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case, the services may be provided and if Medicare payment is denied, the beneficiary will be responsible for payment.

D. Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or 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; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

E. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out “representative” in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

In the case in which the beneficiary demands the service(s) and refuses to pay or sign the ABN form, two employee witnesses should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case, the services may be provided and if Medicare payment is denied, the beneficiary will be responsible for payment.

Disclosure Statement: The disclosure statement in the footer of the notice is required to be included on the document.

1. Routine use of the Advanced Beneficiary Notice is prohibited. There must be a specific reason to believe Medicare will determine that the test ordered may not be considered reasonable and necessary.

2. The physician's office or department initiating the ABN should keep a copy of the ABN and a copy must be given to the beneficiary. Facilities must maintain copies of the ABN with the patient’s records according to record retention guidelines.

3. An Advanced Beneficiary Notice is to be obtained for initial standing orders (for extended course of treatment - for up to 1 year) which contain a test that may not be covered. However, it is not necessary to obtain a new ABN each time the test is performed in accordance with the standing order.

IMPLEMENTATION:
1. Ancillary Service, Patient Access including Financial Counseling and Patient Financial Services personnel must obtain the applicable Local Coverage Determinations (LCD) or Medicare National Coverage Determination (NCD) as issued by the Medicare Administrative Contractor and organize the material so that it is readily available for staff use.

2. Ancillary Service, Utilization Management, Patient Access and Patient Financial Services personnel must educate all staff associates responsible for registering, performing, and billing services on the contents of this policy.

3. LCDs/NCD’s are available for review by staff and department via the The Nebraska Medical Center intranet under Department-JCAHO/Compliance and Accreditation.

**DAILY PRACTICE:**

1. Individuals ordering services and performing tests must review diagnosis for LCD’s/NCD’s when processing every outpatient Medicare order.

2. If the patient presents with a completed Advanced Beneficiary Notice from the physician's office, proceed with performing the ordered tests. Skip to step 6 of the daily process.

3. If the patient presents with no Advanced Beneficiary Notice and the diagnosis provided does not meet Medical Necessity Guidelines for the test(s) being ordered, ancillary or hospital clinic staff must complete an Advanced Beneficiary Notice. Note: see #2 completing the notice.

4. If a specimen is received and the test(s) ordered do not meet medical necessity guidelines for the diagnosis provided, and an ABN is not present, laboratory personnel are to contact the ordering physician to determine if an ABN was obtained. If there is no ABN present, laboratory personnel must inform the physician that medical necessity requirements were not present for the test(s) being ordered. The physician must verify that the test order and diagnosis provided is correct. If the physician verifies that the test order is correct, laboratory personnel may perform the test(s) as ordered. ABN will be obtained by lab personnel and scanned into imaging system.

5. If the services are considered excluded from Medicare coverage (e.g., tests associated with routine checkups, glasses, hearing aids, routine foot care, dental work, cosmetic surgery, immunizations, custodial care, personal comfort items, etc.) but the patient requests that the bill be submitted to the payor, a condition code 20 is to be entered on the claim to indicate the provider realizes the services are non-covered or excluded but the patient requests a determination by the payor.

6. The beneficiary is given his or her copy of the signed and dated ABN immediately. A copy of the signed ABN will be maintained in the imaging system.

7. If the patient denies payment responsibilities and declines the test(s), then perform only those tests that met the Medical Necessity Guidelines and inform ordering physician of those services not performed. If the patient agrees to pay for the service(s) then perform all tests ordered.

8. If a claim errors due to LCD or NCD, Patient Financial Services will review patient records to determine if an ABN is present.
   - The service will be billed with a GA modifier.
   - The patient will be liable for ABN non-covered balances.

   If an ABN is not present: the services will be moved to non-covered and billed with GZ modifier. The patient will not be liable for non-covered charges.

**REFERENCES:**

Medicare Claims Processing Manual – Chapter 30

**STAFF ACCOUNTABILITY:**

Patient Access
Patient Financial Services
Compliance
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<td><strong>Title:</strong>                          Director, PFS, Director, Patient Access., Mgr. of Audit/Compliance</td>
<td><strong>Title:</strong>                          Executive Director, Revenue Cycle</td>
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