DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Advance Beneficiary Notice of Noncoverage for Physician Professional Services and Non-Hospital Entities
PAGE: 1 of 5	**REPLACES POLICY DATED:** 10/1/11, 10/1/15
EFFECTIVE DATE: June 21, 2017	**REFERENCE NUMBER:** REGS.OSG.002
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All non-hospital entities and personnel responsible for providing and/or billing for services, including but not limited to:

Ambulatory Surgery Centers (ASCs)
HCA Physician Services Group (PSG)
Independent Diagnostic Testing Facilities (IDTFs)
Freestanding Imaging Centers
Freestanding Radiation Oncology Centers
Administration/Practice Management
Office Staff
Service Centers
Registration
Coding and Billing
Employed and Managed Physicians
Ordering/Referring/Rendering Physicians
Hospitalists
Non-Physician Practitioners
Nursing Staff

PURPOSE: To outline the use of the mandatory Advance Beneficiary Notice of Noncoverage (ABN) for services not covered by Medicare fee-for-service.

POLICY:

Prior to rendering a service, entities should issue ABNs to Medicare fee-for-service patients if they plan to hold the patient financially liable and:

a. The item/service provided does not meet medical necessity guidelines. For example, the service does not meet the requirements of a National Coverage Determination (NCD)/Local Coverage Determination (LCD).
b. The item/service may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
c. The item/service is for experimental or research use only. For example, the service or drug/biological has not been approved by the Food and Drug Administration.

Prior to issuing an ABN, the ordering physician may be contacted for additional information regarding the patient's case.

If there is ambiguity as to whether the requirements of an NCD/LCD have been met, entities should proceed with obtaining an ABN in order to allow the Medicare Contractor to adjudicate the claim.

ABNs must not be issued to patients who are unable to comprehend the ABN, under duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies. However, **for cases where EMTALA applies**, if after completion of the medical screening examination and necessary stabilization, if required, the patient will be receiving further services that are not medically necessary according to NCD/LCD; the entity may choose to obtain an ABN for these non-medically necessary services. ABNs may be obtained for an extended course of treatment provided it identifies all items and services that may not be covered and does not extend more than one year.

Services for which ABNs are issued must be billed in accordance with the requirements within this policy.

If a proper ABN is not obtained for a service determined not to be reasonable and necessary, the patient cannot be held financially liable.

The use of the ABN for statutorily excluded services (*e.g.*, self-administered drugs, cosmetic surgery) is not required by CMS.

PROCEDURE:

USE OF THE ABN FORM

1. If the service to be provided is governed by an NCD or LCD, the pertinent information, including CPT/HCPCS codes and ICD-10-CM codes, if applicable, must be reviewed to determine if the service meets the requirements specified in the NCD and/or LCD and to determine if an ABN is necessary.

2. If the decision to issue an ABN is made, the ABN must **not** be provided:
   a. after services have been rendered;
   b. to a beneficiary when payment for an item or service is bundled or packaged into another payment (*e.g.* under ASC Prospective Payment System), even when those items or services do not meet medical necessity guidelines;
   c. without genuine reason to believe that Medicare may deny the item/service; or
   d. when the beneficiary is unable to comprehend the ABN (*e.g.*, if the patient is comatose, confused or legally incompetent, he/she is unable to understand the implications of signing the ABN) and his/her authorized representative is not available.

COMPLETION OF THE ABN FORM

1. Entities must use the CMS-approved form (CMS-R-131), which may not be altered (see Attachment A). All fields on the ABN form must be completed in sufficient detail to specify the potentially non-covered service. All entries must be in Arial or Arial Narrow font in the size range of 10 – 12 point font or legibly handwritten. When Spanish-language ABNs are used, the insertions on the form must also be in Spanish.

2. Once the ABN is signed it may not be altered in any way. If additional services will be provided for which an ABN will be needed, a new ABN must be obtained. The signed ABN form should be distributed as follows: retain the original copy at the notifier's office, give one copy to the patient, and retain one copy in the patient's financial record.

3. The entity must include its name, address and telephone number in "Notifier(s)" section. Entities may also include their logo.

4. The first and last name of the patient must be entered in the "Patient Name" section.

5. The "Identification Number" section is optional; however, if completed, this section should include an identification number that ties the notice to the specific claim for which the ABN applies. Entities may enter the patient account number in this section. Medicare numbers or Social Security numbers must not appear on the notice.

6. The "Items and Services" section must include a general description of the items and services for which the ABN is being obtained in a language that is easy for the beneficiary to understand. It is not appropriate to only include a CPT/HCPCS code as a description. If a CPT/HCPCS is used then additional language must be provided describing the service. Whenever possible the general description of the service to be provided should be used. For example, use "CT Scan of the Head" as the description instead of "CT Scan of the Head without contrast."

7. The ABN form section titled Reason Medicare May Not Pay can be populated with the following four options:
   a. "Medicare does not pay for the items(s) or service(s) for your condition."
   b. "Medicare does not pay for the item(s) or service(s) more often than_____."
   c. "Medicare does not pay for experimental or research use items or services."
   d. "Other reason: _____."

   When completing the ABN form one of the four options must be utilized to indicate the reason why Medicare may not pay. If the "Other" option is used a reason must also be entered as to why the provider believes Medicare may not pay for the item or service.

8. The Estimated Cost section of the ABN **must** be completed for any items or services listed as not being covered by Medicare. If multiple items or services are listed the estimated cost may reflect the total cost of all the potentially non-covered items and services. The ABN will **not** be considered valid if a good faith estimated cost is not included.

   In general, the estimate should be within $100.00 or 25% of the actual cost, whichever is greater. For example, for a service that costs $250.00, the estimate could be listed as:
   a. Any dollar estimate equal to or greater than $150.00
   b. "Between $150.00 - $300.00"
   c. "No more than $500.00"

9. The beneficiary must select one of the three options listed in the Options section on the ABN form. Only one of the three options may be selected. If an option is not marked or more than one option is marked then the ABN will **not** be valid. The beneficiary may choose:
   a. **Option 1** where they receive the item or service and Medicare is billed;
   b. **Option 2** where they receive the item or service and are responsible for payment; or
   c. **Option 3** where they refuse the item or service.

10. The Additional Information section may be used to insert additional clarification that will be of use to beneficiaries.

11. The beneficiary or his/her representative must sign and date the ABN form. If the ABN form is not signed and dated it will not be considered valid.

12. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment, the ordering physician should be contacted to determine if non-performance of the services will compromise patient care.

13. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment and demands that the services be performed, a second person should witness the provision of the ABN and the beneficiary's refusal to sign. The witness should sign an annotation on the ABN stating that he/she witnessed the provision of the ABN and the beneficiary's refusal to sign. The claim will be filed as if an ABN was obtained. In the case of a denial by Medicare, the beneficiary will be held liable per Section 1879(c) of the Social Security Act.

BILLING FOR SERVICES

1. If the services are not medically necessary and the beneficiary chose **Option 1** on the ABN:
   a. The services must be reported on the claim.
   b. The GA modifier must be appended to the CPT/HCPCS code representing the service(s) for which an ABN was obtained.
   c. The GY modifier may be appended to the CPT/HCHCS code when billing for a service that is statutorily excluded or is not a Medicare benefit for which an ABN was obtained.

   The Medicare Contractor will make a determination whether or not the services will be paid by Medicare.
   a. If the Medicare Contractor determines that the services are non-covered, the entity must bill the beneficiary for the services for which an ABN was obtained.
   b. If the Medicare Contractor pays for the services then the beneficiary must not be billed for the services for which an ABN was obtained.

2. If the services are not medically necessary and the patient chose **Option 2** on the ABN, the services must not be billed to Medicare. The appropriate billing personnel must be informed of this decision.

3. If the services are not medically necessary and the patient chose **Option 3** on the ABN, the beneficiary is choosing not to receive the items/services and no services will be billed to Medicare.

4. If the services have frequency limits:
   a. The services should be reported on the claim.
   b. The GA modifier must be appended to the CPT/HCPCS code representing the frequency limited service(s) if an ABN was obtained.

c. The beneficiary must not be billed for the services if the Medicare Contractor pays for the services.
d. The entity must bill the beneficiary for the services for which an ABN was obtained if the Medicare Contractor determines that the services have exceeded the frequency limits.
e. The entity must not bill the beneficiary if the Medicare Contractor determines that the services have exceeded the frequency limits and an ABN was not obtained.

5. If the services are outside the scope of the LCD and/or NCD, the services should be reported as covered on the claim.

6. If the services are not medically necessary and an ABN was not obtained prior to rendering the non-covered services, the GZ modifier may be appended. The GZ modifier represents that an **ABN was NOT** obtained but the provider is billing Medicare for a service that is expected to be denied.

EDUCATION

Administration, Practice Management, and Service Center personnel must educate all staff associates and medical staff members responsible for ordering, referring, registering, performing, charging, coding and billing services regarding the contents of this policy. **Note**: The Company offers a web based course, Understanding the Advance Beneficiary Notice of Noncoverage for Outpatient Services Group Entities, available through HealthStream, which includes detailed information regarding the ABN and meets the education requirement of this policy.

Administration/Practice Management is responsible for the implementation of this policy within the entity.

REFERENCES:

1. Medicare - National and Local Coverage Determinations Policy, REGS.OSG.007
2. Medicare Contractor Local Coverage Determinations
3. CMS National Coverage Determinations
4. CMS Pub. 60AB, Transmittal No. AB-02-114, July 31, 2002 – ABNs and DMEPOS Refund Requirements
5. Medicare Claims Processing Manual (Pub 100-4), Chapter 30 – Financial Liability Protections, Sections 40 – 50.7.8
6. Medicare Program Integrity Manual (Pub 100-8), Chapter 13, Sections 1.1 and 1.3
7. CMS Form Instructions for Advance Beneficiary Notice of Noncoverage (ABN), OMB Approval Number: 0938-0566
8. CMS Revised ABN Frequently Asked Questions
9. Social Security Act Section 1862

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:

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.

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If Medicare will not pay for a service, does that mean I do not need the service?

No. Your doctor bases decisions on a wide range of factors including your personal medical history, any medications you might be taking, and generally accepted medical practices. Even if your doctor believes a particular item/service is "good medicine," and useful information to have in order to provide the best care for you, it is possible Medicare may not consider the service to be medically necessary for patients with your diagnosis.

What if I have questions?

If you have questions, you should discuss them with your physician and/or healthcare provider at the time of service.

For additional Information contact your Medicare Representative

Important Information for Medicare Patients Concerning Non-covered Services

What is "Medical Necessity"?

Medicare covers only those services which are reasonable and necessary for your treatment. Medicare requires providers to report information regarding the patient's diagnosis when seeking payment so that they can determine whether the services ordered were medically necessary.

What is an ABN?

An ABN is an Advance Beneficiary Notice of Noncoverage. The purpose of the ABN is to give you advance notice that Medicare may not pay for your services. The ABN tells you which item(s)/service(s) may not be reasonable and necessary and informs you that you will be financially responsible for the services should Medicare deny payment. When it is required, you will be asked to sign the ABN before services are performed.

What options do I have?

You have three options when an ABN form is presented to you. You may 1) receive the services and request that Medicare be billed for a determination. You agree to be responsible for payment of the services if Medicare does not consider them reasonable and necessary; 2) receive the services and Medicare not be billed. You will be responsible for the payment; or 3) refuse to be responsible for payment of services that Medicare will not cover and, therefore, not receive the items or services.

What are my rights as a patient?

As a Medicare beneficiary, you have certain guaranteed rights. These rights protect you when you receive health care; assure you access to needed health care services; and protect you against unethical practices. Your rights include, but are not limited to:

- The right to information about what services are covered and how much you will have to pay
- The right to information about all treatment options available to you
- The right to appeal decisions to deny or limit payment for medical care

How does the billing process work?

Generally, your doctor will bill Medicare when you receive a service at his/her office. However, when your doctor orders items or services from a hospital or outside of his or her office, the hospital performs the items/services which were requested and the hospital, not your doctor, bills Medicare directly for the services being performed for you. The hospital provides Medicare with your Medicare number, the services performed, and your diagnosis provided by your doctor.