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Medical Necessity and the Advance Beneficiary Notice

7/19/2023

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2179_6/30/2023

Today's Presenters

Provider Outreach and Education Consultants

- Arlene Dunphy, CPC
- Michele Poulos

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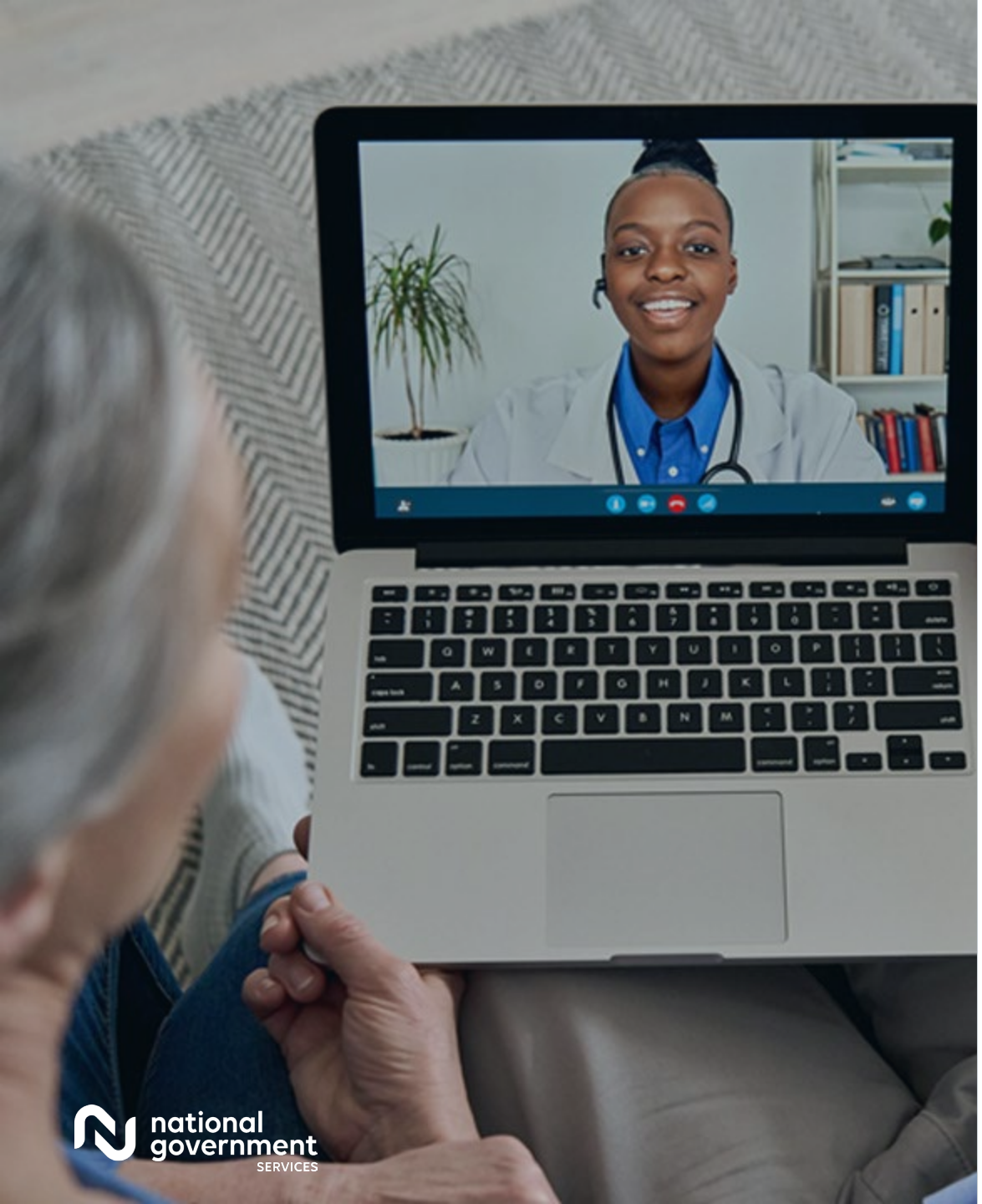

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Objective

Provide guidance to physician offices on when and how to issue a proper ABN to a Medicare beneficiary.

Agenda

- Medical Necessity
- What is an ABN?
- Mandatory and Voluntary Uses
- Notifiers
- Triggering Events
- Instructions for Completing the ABN
- Modifiers
- Resources

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Medical Necessity

Medical Necessity

- Medicare defines medical necessity as services that are
  - reasonable and necessary for the diagnosis or treatment of illness or injury
  - not excluded under another provision of the Medicare Program
- Remittance remark code
  - CO-50 Medical necessity denial

Frequency Limits

- Refer to how often Medicare will reimburse for a specific item or service
- Check the limitations of coverage and/or utilization guidelines
  - Remark code CO-57

Medicare Coverage Policies

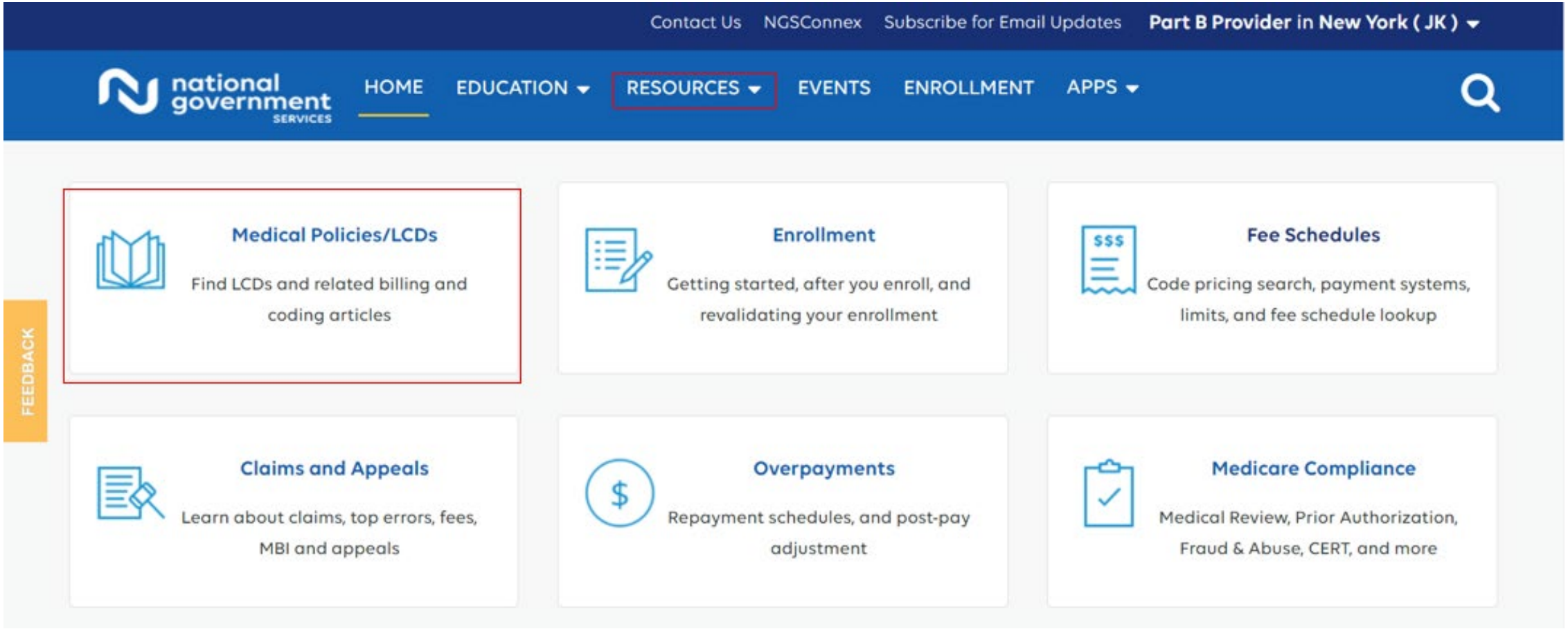
National Coverage Determinations

- NCDs
  - Made through an evidence-based process with opportunities for public participation
  - Will describe whether Medicare pays for specific medical items, services, treatment procedures or technologies

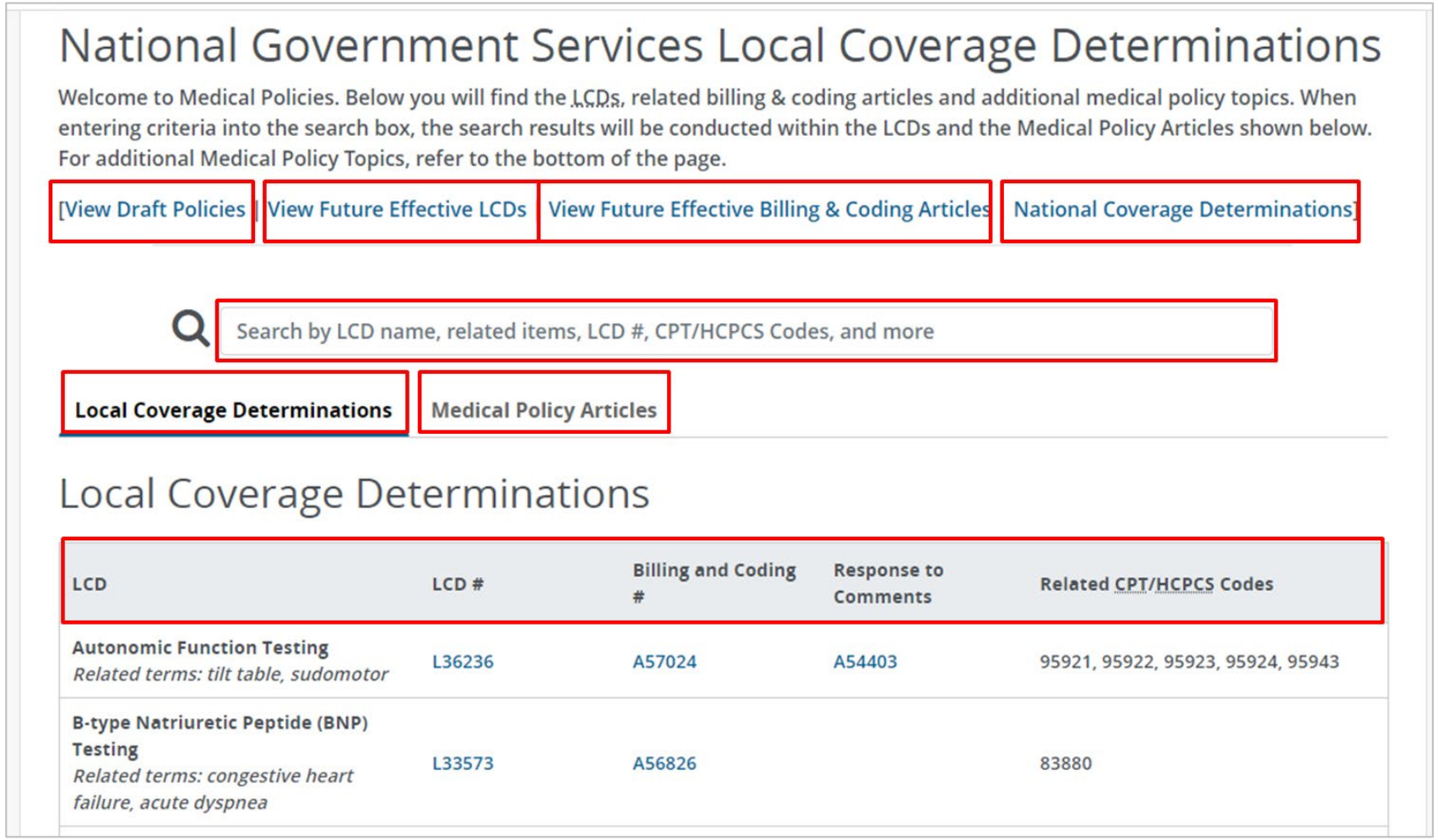
Local Coverage Determinations

- LCDs are Medicare regulations formulated on the concept of a reasonable and necessary service, in the absence of an NCD
  - There may be two parts to the LCD
    - ✓ LCD
    - ✓ Medical Policy Article (when needed)

NGSMedicare.com - Resources



National Government Services Local Coverage Determinations



National Government Services Local Coverage Determinations

Welcome to Medical Policies. Below you will find the LCDs, related billing & coding articles and additional medical policy topics. When entering criteria into the search box, the search results will be conducted within the LCDs and the Medical Policy Articles shown below. For additional Medical Policy Topics, refer to the bottom of the page.

[View Draft Policies | View Future Effective LCDs | View Future Effective Billing & Coding Articles | National Coverage Determinations]

Search by LCD name, related items, LCD #, CPT/HCPCS Codes, and more

Local Coverage Determinations | Medical Policy Articles

Local Coverage Determinations

LCD	LCD #	Billing and Coding #	Response to Comments	Related CPT/HCPCS Codes
Autonomic Function Testing *Related terms: tilt table, sudomotor*	L36236	A57024	A54403	95921, 95922, 95923, 95924, 95943
B-type Natriuretic Peptide (BNP) Testing *Related terms: congestive heart failure, acute dyspnea*	L33573	A56826		83880

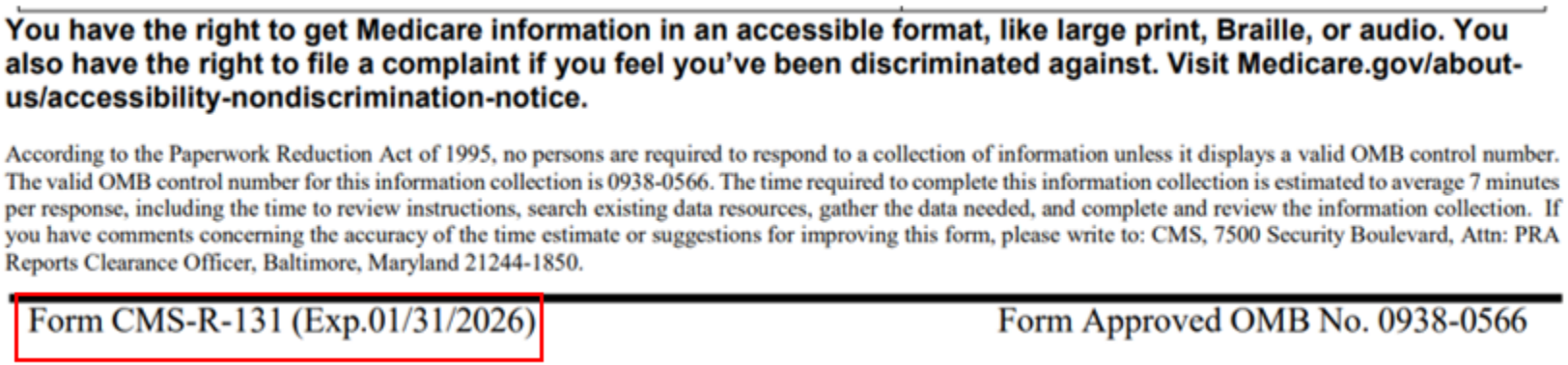
Utilizing the ABN

What Is an ABN?

- Standardized written notice
- Given prior to services rendered when you believe Medicare may not pay for services
- Informs patient that Medicare may not pay for services
- Fee-for-Service Medicare only

ABN

- CMS-R-131
  - Mandatory 1/1/2012
  - New expiration date (1/31/2026)
    - ✓ Renewed form mandatory as of 6/30/2023



You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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 (Exp.01/31/2026) Form Approved OMB No. 0938-0566

Mandatory ABN Use

- Services not reasonable and necessary
  - Experimental and investigational or considered “research only”
  - Not indicated for diagnosis and/or treatment
  - Not considered safe or effective
  - More than the number of services allowed
- Custodial Care
- Care for hospice patients not terminally ill
- Outpatient therapy services in excess of the therapy cap amounts and do not qualify for a therapy cap exception
- Preventive services usually covered but not covered in this instance because of frequency limitations

Voluntary ABN Use

- Not required for care that is either statutorily excluded from coverage or care that fails to meet a technical benefit requirement
  - Courtesy to beneficiary in forewarning them of impending financial obligation
  - Beneficiary should not be asked to choose an option box or sign
  - MLN® Booklet: *Items and Services Not Covered Under Medicare*

Voluntary ABN Use

- Statutorily excluded services may include
  - Personal comfort items
  - Routine physicals, foot care, and eye care
  - Dental care
  - Cosmetic surgery
- Fails to meet a technical benefit requirement, may include
  - Ambulance service provided that is beyond the nearest appropriate facility
  - Self-administered drugs and biologicals

Not Acceptable Use of ABN

- Services that will be denied due to NCCI/MUE
- Patients in a medical emergency or under great duress
- Component services when full payment is made through the comprehensive service
- Transfer liability when items/services would have otherwise would have been paid
- Routinely – no specific identifiable reason service will not be paid

Acceptable Routine ABNs

- Services always denied for medical necessity
- Experimental devices
- Frequency limits

Generic ABNs

- Not an acceptable practice
- Merely stating denial of payment is possible, or provider never knows whether Medicare will deny payment
  - Considered defective notices
  - Will not protect the notifier from liability

Blanket ABN

- Not an acceptable practice
- Given for all claims or items or services
- Must be given on basis of a genuine judgment of Medicare payment for individual's claim

Blank ABN

- Not an acceptable practice
- Cannot obtain a signature on a blank ABN and then completing ABN later
  - Considered defective notices
  - Will not protect the notifier from liability

Issuance of ABN

Issuance of ABN

- Those who issue an ABN are notifiers
  - Physicians
  - Practitioners
  - Providers (including laboratories)
  - Suppliers

Issuance of ABN

- Notifiers
  - Should be prepared to fully explain to their patient why services may not be paid
  - May direct an employee or a subcontractor person ultimately responsible for effective delivery

Issuance of ABN

- Regardless of who issues ABN, billing entity is held responsible
- When multiple entities are involved in rendering care, it is not necessary to give separate ABNs

Multiple Entities

- Either party involved in delivery of care can be a notifier when
  - There are separate “ordering” and “rendering” providers
  - One provider delivers “technical” and another delivers “professional” components
  - Entity that obtain a signature on ABN is different from entity that bills for services

Qualified Recipients

- Beneficiary or someone who has been appointed as an authorized representative
- Inability to give an ABN does not allow the notifier to shift financial liability to the beneficiary

Authorized Representative

- Notifiers are responsible for determining who is an authorized representative for the purpose of issuing an ABN
  - An individual who may make health care and financial decisions on a beneficiary's behalf
    - ✓ Known legally appointed representatives must be issued to the existing representative

What Is a Triggering Event?

- Triggering events may prompt you to issue an ABN
- May occur at any one of three points
  - Initiation
  - Reduction
  - Termination

ABN Triggering Events Initiation

- Initiation
  - Beginning of a new patient encounter
  - Start of plan of care
  - Beginning of treatment
- Example of an initiation trigger
  - Beneficiary insists on having an EKG due to family history but has no diagnosis that warrants the service
    - ✓ Beneficiary is willing to pay out of pocket

ABN Triggering Events
Reduction of Service

- A decrease in a component of care (frequency or duration)
- Example of a reduction trigger
  - A beneficiary is receiving therapy five times a week, and would like to continue
  - However, the notifier believes the beneficiary's goals can be met with therapy three days a week
    - ✓ ABN issued prior to providing additional days of therapy

ABN Triggering Events
Termination of Services

- Discontinuation of certain items or services
- Example of termination of services
  - A speech language pathologist no longer considers outpatient speech therapy described in a plan of care reasonable and necessary
    - ✓ ABN would be issued prior to speech therapy resuming

Completing the ABN

Language Choice

- ABN Form CMS-R-131
  - Available in English and Spanish
  - Insertions must be in same language
  - Notifiers should document any types of translation assistance used in “Additional Information” section

Preparation Requirements

- ABN Form CMS-R-131
  - Minimum of two copies – beneficiary and notifier (notifier should keep original)
  - Reproduction – photocopying or any other appropriate method
  - Length and size of page – not to exceed one page, attachment permitted
  - Visually high-contrast combination for print

Preparation Requirements

- No reverse print (i.e., white print on dark paper) or highlighted text
- Changes limited to the notifier's software/hardware
- Customization
  - ✓ Pre-printing is permitted to promote efficiency and to ensure clarity for beneficiaries
    - Items may be crossed out or checked off
  - ✓ Blanks G-I may never be prefilled
- No other modification may be made to ABN

Preparation Requirements
Attachment Pages

- A notation such as “See Attached Page” must be inserted in Items/Services area of ABN
- Space below table in which beneficiary inserts his/her initials to acknowledge receipt of attachment page

Preparation Requirements Attachment Pages

- Attached pages must include
  - Beneficiary's name
  - Identification number (optional)
  - Date of issuance
  - Table listing additional items/services, reasons Medicare may not pay, and estimated costs

Retention Requirements

- Originals should be maintained, however in certain situations signed copy would be acceptable (i.e., fax)
- In case of multiple entities, notifier should send a copy to billing entity

Retention Requirements

- Electronic retention is acceptable
- ABNs should be retained for five years from discharge/completion of delivery of care
  - Retention is required in all cases
    - ✓ Declined care
    - ✓ Refused to choose an option
    - ✓ Refusal to sign notice

Periods of Effectiveness

- ABN can remain effective for up to one year
- A single ABN can be used for an extended/repetitive course of noncovered treatment
  - All services must be listed
  - Must specify the duration of period for treatment
  - Any changes (within one year), a new ABN must be given

Special Considerations

- Beneficiary changes mind
  - Present previously completed ABN
  - Request beneficiary annotate
  - Unable to present in person, notifier may annotate
  - Beneficiary must sign, date and return
- Beneficiary refuses to complete or sign
  - Provider annotates original with refusal
  - May list witnesses
  - Consider not furnishing the service

Emergency or Urgent Situation

- An ABN should not be obtained
  - In medical emergencies
  - Patients under great duress
    - ✓ An individual cannot be expected to make an informed decision
  - If patient is not capable of receiving notice, CMS will consider the patient has not received proper notice and cannot be held liable

Ambulance Transport

- ABN issuance is mandatory if all of the following three criteria are met
  - The service is a Medicare covered benefit
  - Will part or all of this services be denied as “not reasonable and necessary”
  - The transport is a nonemergency situation and patient stable

Delivery Options

Effective Delivery

- Delivery requirements
  - CMS-R-131 (01/31/2026)
    - ✓ In person if possible
    - ✓ Prior to services being rendered
    - ✓ To capable recipient
    - ✓ Explained in its entirety
    - ✓ Beneficiary or representative signature

Options for Delivery

- In-person delivery not possible
  - Direct telephone contact
  - Mail
  - Secure fax machine
  - Internet email (statutory privacy requirements, no SS numbers or HICNs/MBIs)
- Notifier must document all contacts made

Options for Delivery

- May be done electronically
  - Must give the beneficiary the option of requesting a paper ABN
  - Signatures may be digitally captured
  - Beneficiary must receive a paper copy of the completed ABN
  - Electronic retention of the signed ABN is permitted

Item Instructions

Completing the ABN

- Composed of five sections and ten blanks
  - Header (Blanks A–C)
  - Body (Blanks D–F)
  - Option box (Blank G)
  - Additional Information (Blank H)
  - Signature box (Blanks I–J)

Header
Blank Descriptors A-C

- A, B, and C header information must be completed by notifier prior to delivery
  - A: Notifier's name, address and telephone number
  - B: Complete name of beneficiary
  - C: An optional field
  - May enter an identification number that will assist in linking notice with a related claim sent to Medicare
  - Must not use an MBI

ABN Form

(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.

Body
Blank D Descriptors

- What Medicare may deny
  - Item
  - Service
  - Laboratory test
  - Test
  - Procedure
  - Care
  - Equipment

ABN Form

(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.

Body
Blank E Descriptors

- Explain in beneficiary friendly language why you believe Medicare may deny
  - Medicare does not pay for this test for your condition
  - Medicare does not pay for this test as often as this
  - Medicare does not pay experimental/research tests

ABN Form

(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.

Body
Blank F Descriptors

- Mandatory
- Estimate for all services listed in Blank D
- Expect estimates to fall within $100 or 25% of actual costs
- Service that cost $250
  - Between $150–$300
  - No more than $500

ABN Form

(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.

Options
Blank G Descriptors

- Notifier must not preselect
- Only one option may be selected
- Option 1
  - Wants the service, accepts financial responsibility, claim submitted with appeal rights
- Option 2
  - Wants the service, no claim submitted, no appeal rights
- Option 3
  - No services rendered, no claim submitted, no appeal rights

ABN Form

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.

Blank G
Option 1

- Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary [QMB] Program and/or Medicaid coverage) **only**
  - Dually eligible beneficiaries must be instructed to check Option Box 1 on the ABN in order for a claim to be submitted for Medicare adjudication

Blank G
Option 1

Strike through **Option Box 1** as provided below:

☐ **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.~~

Additional Information
Blank H

- Additional clarification
  - Statement regarding certain tests that were ordered
  - An additional dated witness signature
  - Other necessary annotations
- Medigap coverage
- Assumed annotations made same date as entered in Blank J

ABN Form

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:**

Additional Information
Blank H

- Special guidance for nonparticipating suppliers and providers (those who don't accept Medicare assignment) ONLY
  - Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: If Medicare does pay, you will refund any payments I made to you, less co- pays or deductibles

Additional Information Blank H

- When this sentence is stricken, the supplier should include the following CMS-approved unassigned claim statement in the (H) Additional Information section
  - This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge."

Signature Box

- Blank I (Signature)
  - Signature after review and explanation
  - Representative indicated in parentheses
  - Assumed annotations made same date as entered in Blank J
- Blank J (Date)
  - Beneficiary or representative must write date signed
  - Notifier may date if beneficiary requests assistance

ABN Form

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.**

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I. Signature:	**J. Date:**

ABN Modifiers

ABN Modifiers

- Item 24D: CMS-1500 claim form or electronic equivalent
- MSN message to beneficiary indicating their responsibility to pay, when applicable
- Maintain ABN in patient's file

Modifier – GA

- Waiver of liability statement issued as required by payer policy
- Indicates that an ABN is on file and allows provider to bill beneficiary if not covered
- Beneficiary liable
- Appeal rights

Modifier – GX

- Notice of liability issued, voluntary under payer policy
- Indicates that a voluntary ABN was issued for services that are not covered
- Services will auto deny
- Can be used with GY and TS (follow up service)

Modifier – GY

- Notice of liability not issued, not required under payer policy
- Used to obtain a denial on a noncovered service
- ABN not required
  - Statutorily noncovered
  - Without a benefit category
- Auto-deny

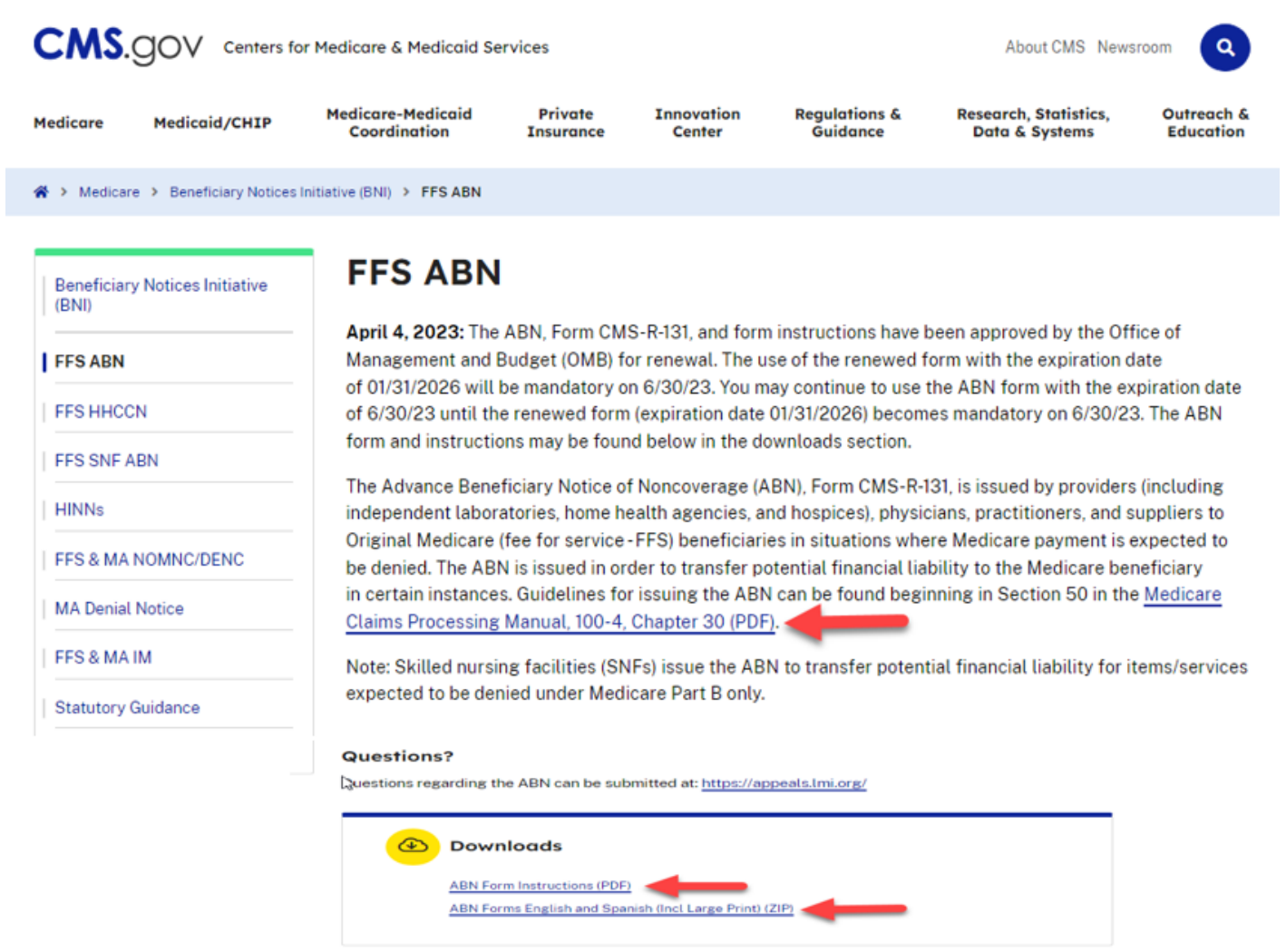
Modifier – GZ

- Item or service expected to be denied as not reasonable and necessary
- ABN may be required but was not obtained
- Auto-deny
- Provider liable
- Appeal rights

ABN Resources

- MLN® Booklet: *Medicare Advance Written Notices of Non-coverage*
- ABN Form CMS-R-131 and Manual Instructions
- Medicare Coverage Database
  - MCD assists you with the latest information related to NCDs and LCDs, local policy articles, and proposed NCD decision
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Financial Liability Protections
- Medicare University Self Paced Training Course
  - PTB-C-0055: Advance Beneficiary Notice of Noncoverage
- NGS Medicare Appeals
- MLN® Educational Tool: *Advance Beneficiary Notice of Non-coverage Tutorial*

CMS Website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Beneficiary Notices Initiative (BNI)
FFS ABN
FFS HHCCN
FFS SNF ABN
HINNs
FFS & MA NOMNC/DENC
MA Denial Notice
FFS & MA IM
Statutory Guidance
FFS ABN
April 4, 2023: The ABN, Form CMS-R-131, and form instructions have been approved by the Office of Management and Budget (OMB) for renewal. The use of the renewed form with the expiration date of 01/31/2026 will be mandatory on 6/30/23. You may continue to use the ABN form with the expiration date of 6/30/23 until the renewed form (expiration date 01/31/2026) becomes mandatory on 6/30/23. The ABN form and instructions may be found below in the downloads section.
The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service - FFS) beneficiaries in situations where Medicare payment is expected to be denied. The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances. Guidelines for issuing the ABN can be found beginning in Section 50 in the Medicare Claims Processing Manual, 100-4, Chapter 30 (PDF).
Note: Skilled nursing facilities (SNFs) issue the ABN to transfer potential financial liability for items/services expected to be denied under Medicare Part B only.
Questions?
Questions regarding the ABN can be submitted at: https://appeals.lmi.org/
Downloads
ABN Form Instructions (PDF)
ABN Forms English and Spanish (Incl Large Print) (ZIP)

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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