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National Government Services

NGS Medicare Virtual Conference

Fall 2021

Medical Necessity and the Advance Beneficiary Notice

11/9/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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  - Provider Outreach and Education Consultant

Disclaimer

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- 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

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

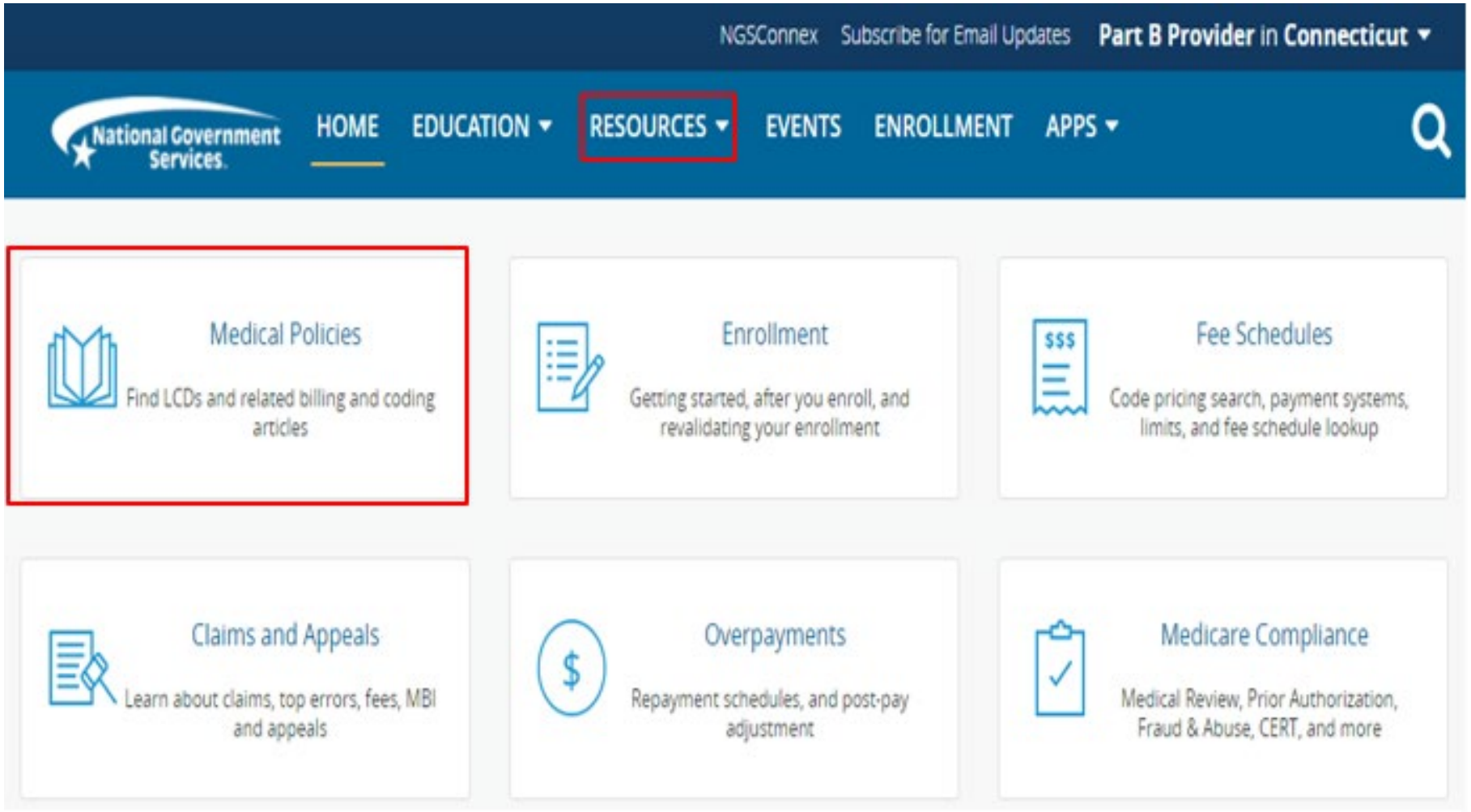
Medicare Coverage Policies

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
    - Article (when needed)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RESOURCES
EVENTS
ENROLLMENT
APPS
Medical Policies
Find LCDs and related billing and coding articles
Enrollment
Getting started, after you enroll, and revalidating your enrollment
$$$
Fee Schedules
Code pricing search, payment systems, limits, and fee schedule lookup
Claims and Appeals
Learn about claims, top errors, fees, MBI and appeals
$
Overpayments
Repayment schedules, and post-pay adjustment
Medicare Compliance
Medical Review, Prior Authorization, Fraud & Abuse, CERT, and more

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

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Additional Medical Policy Topics

- Conflict of Interest Disclosure
- Contractor Advisory Committee (CAC)
- Investigational Device Exemption Request
- LCD Open Meetings
- LCD Reconsideration Process
- Medical Policy Contact Information
- New LCD Request Process
- Self Administered Drugs

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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
  - Minimal changes to the form
  - New expiration date (6/30/2023)
  - Revisions include guidelines for Dual Eligible beneficiaries

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

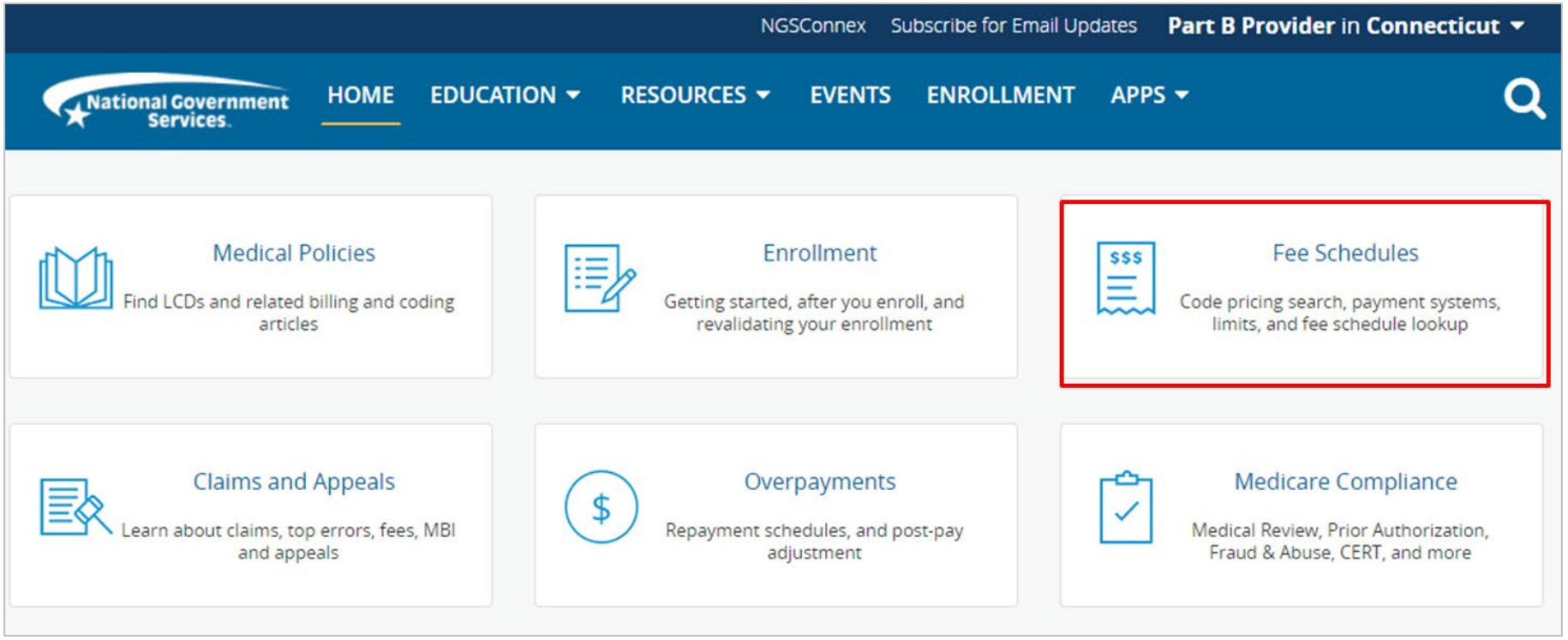
Voluntary ABN Use

- 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

Fee Schedules



Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

Select a Fee Schedule: *
Medicare Physician Fee Schedule Pricing

Result Type: *
- Full Fee Schedule
- Specific To Fee Code

Date of Service: *
11/11/2021

Procedure Code: *
99397

Region: *
Connecticut

Search

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Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
99397	01/01/2021	13102	00	Per pm reeval est pat 65+ yr

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

OPPS Capped Payment Rates (OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

The full Fee Schedule for this code can be downloaded in the following formats below:

Excel File CSV File

Medicare Physician Fee Schedule Pricing Fee Schedule

Procedure Code	Effective Date	State/Territory	Locality	Short Description
99397	01/01/2021	13102	00	Per prm reeval est pat 65+ yr

Non-OPPS Capped Payment Rates (NON-OPPS)

Modifier	NON FAC PAR	NON FAC NON PAR	NON FAC LC	FAC PAR	FAC NON PAR	FAC LC
(Details)	0.00	0.00	0.00	0.00	0.00	0.00

Modifier Selected: (blank)

Status	Conversion Factor	Update Factor	Work RVU	FAC PE RVU	NON FAC PE RVU
N	0.0000	0.0000	0.00	0.00	0.00

Malpractice RVU	Work GPCI	Practice GPCI	Malpractice GPCI	Reduced Therapy Amt	Endoscopic Base
0.00	1.037	1.114	0.934	0.00	

Global Surgery	Facility Pricing	PC/TC	Preoperative Percentage	Interoperative Percentage	Postoperative Percentage
XXX	9	9	00.00%	00.00%	00.00%

Multiple Surgery	Bilateral Surgery	Assistant At Surgery	Two Surgeons	Team Surgery
9	9	9	9	9

Fee Schedule Assistance

The fee schedule assistance page provides access to information about fee schedule definitions and acronyms.

Fee Schedule Assistance

- Illinois Locality/Area and County Information
- Maine, Massachusetts, New Hampshire, Rhode Island, Vermont Locality/Area and County Information
- New York Locality/Area and County Information
- Locate and Download Fee Schedule Pricing
- Description of Medicare Physician Fee Schedule Database Policy Indicators
- CMS Physician Fee Schedule Search and RVU Information

National Fee Schedules

Access the CMS website to view and download the following **national fee schedules**:

- Ambulance Fee Schedule
- Ambulatory Surgical Center (ASC) Payment
- Clinical Laboratory Fee Schedule
- Medicare Part B Drug Average Sales Price
- DMEPOS Fee Schedule
- Vaccines and Administration Pricing

Fee Schedule Lookup Details

Short Description

This field includes a brief description of the procedure code.

Procedure Status Indicators

This field indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered. The presence of an active (or valid) status code does not mean the service is covered by Medicare. A service may be valid according to the list but may not be considered covered due to other criteria such as medical necessity or global surgery rules.

Indicator	Description
A	**Active code**: These codes are separately paid under the physician fee schedule if covered. There will be RVUs and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B	**Bundled code**: Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)
C	**Carriers price the code**: Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis, following review of documentation such as an operative report.

Procedure Status Indicators

This field indicates whether the code is in the fee schedule and whether it is separately payable if the service is covered. The presence of an active (or valid) status code does not mean the service is covered by Medicare. A service may be valid according to the list but may not be considered covered due to other criteria such as medical necessity or global surgery rules.

E	**Excluded from Physician Fee Schedule by regulation**: These codes are for items and/or services that the CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, generally continues under reasonable charge procedures.
I	**Not valid for Medicare purposes**: Medicare uses another code for reporting of, and payment for, these services (code not subject to a 90-day grace period).
M	**Measurement Codes**: Used for reporting purposes only.
N	**Noncovered Services**: These services are not covered by Medicare.
P	**Bundled/Excluded codes**: There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.) If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

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 and 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
  1. The service is a Medicare covered benefit
  2. Will part or all of this services be denied as “not reasonable and necessary”
  3. The transport is a nonemergency situation and patient stable

Delivery Options

Effective Delivery

- Delivery requirements
  - CMS-R-131 (06/30/2023)
    - 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

(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

(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

(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

(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

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

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

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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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

Resources

Beneficiary Notices Initiative (BNI)

- FFS ABN
- FFS HHCCN
- FFS SNF ABN
- HINNs
- FFS & MA NOMNC/DENC
- MA Denial Notice
- MA Expedited Determination Notices
- FFS & MA IM
- Statutory Guidance
- FFS & MA MOON

FFS ABN

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)
ABN Alternative Format Sample for Labs (PDF)

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

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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