Everybody's Favorite Form: New Advance Beneficiary Notice of Noncoverage (ABN) Form Begins in 2012

NOTE: We have just added an educational webinar on using the ABN form. This is an expanded webinar with 75 minutes of content and 15 minutes of Q & A with the attendees. **Click here to go to our webinar page for more information.**

_____

CMS recently released an updated version of the Advance Beneficiary Notice of Noncoverage (ABN) (form CMS-R-131), which will replace the 2008 version of this form. The 2008 and 2011 ABN notices are identical except that the release date of "3/11" is printed in the lower left hand corner of the new version. The ABN is used by all providers, practitioners, and suppliers paid under **Medicare Part B**, as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under **Medicare Part A.**

Providers and suppliers may use either the 2008 or 2011 version of the ABN through the end of 2011; beginning Sunday, January 1, 2012, they must begin using the 2011 version. ABNs issued after Sunday, January 1, that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors. 2008 versions of the ABN that were issued prior to Sunday, January 1 as long-term notification for repetitive services delivered for up to one year will remain effective for the length of time specified on the notice.

Okay, here's the good stuff that I get questions on all day every day – how do I use the ABN?

First, let's understand WHEN you should use the ABN.

The ABN's reason for being is to allow the physician practice to collect from the patient for services that the patient wants, but are not covered by Medicare. Practices are not expected to give ABNs to patients to cover services that are never covered (called statutory exclusions), however, many find that it helps the patients understand when they receive a bill for the service. (Note: you may collect in full at time of service if you so choose.) With 2011's new wellness benefits, some of the primary reasons for using the ABN have gone away. Patients receive a Welcome to Medicare Visit (not an exam) within the first 12 months of the effective date of Medicare Part B coverage. Medicare beneficiaries are eligible for one Annual Wellness Visit (AWV) every 12 months after they have had Medicare Part B for more than 12 months. This is a "visit" and not a physical examination.

Here's a good example of WHEN you would use the ABN.

A Medicare patient wants an EKG even though she does not have any diagnoses that would point to an EKG being medically necessary. She is not in her first 12 months of Medicare coverage, therefore she does not qualify for an EKG as a part of her Welcome to Medicare Visit (not an exam.) She believes there may be something wrong with her heart, even though she cannot name any symptoms that would warrant a diagnostic EKG.

In this case, without a diagnosis to support the EKG, an ABN would be appropriate. You would advise the patient that Medicare may not pay for the EKG, in fact probably won't pay for the EKG, and you complete the ABN, showing the patient what she will be paying out of pocket for the test. In the case of Medicare not covering the test, you may charge the patient your full rate for an EKG and are not restricted by the Medicare allowable. If the patient agrees to have the test and signs the ABN stating she understands she will be responsible for the cost of the test if Medicare does not pay, you will provide the patient with a copy of the signed form and will will attach the completed form to the patient's encounter form so the EKG will be billed with the modifier "GA" which indicates an ABN was executed for a service that might be covered by Medicare. In the case where a service is never covered (i.e. statutory exclusions) your Medicare Administrative Carrier (MAC) may require you to append a modifer "GY" when an ABN is signed and on file.

The ABN should be scanned with the encounter form or any other financial paperwork from the visit so it can be retrieved if requested by Medicare during an audit. If you do not archive your paperwork electronically, you should file the ABNs alphabetically by patient name by month. You can also scan the ABN into your EMR.

What are statutory exclusions (services that are never covered) under Part B?

- Oral drugs and medicines from either a physician or a pharmacy. **Exceptions: oral cancer drugs, oral antiemetic cancer drugs and inhalation solutions.**
- Routine eyeglasses, eye examinations, and refractions for prescribing, fitting, or changing eye glasses. **Exceptions: post cataract surgery. Refer to benefits under DME prosthetic category.**
- Hearing aids and hearing evaluations for prescribing,

fitting, or changing hearing aids.
- Routine dental services, including dentures.
- Routine foot care without evidence of a systemic condition.
- Injections which can be self-administered. **Exceptions: EPO, and clotting factors.**
- Naturopath's services.
- Nursing care on a full-time basis in the home and private duty nursing. (Refer to benefits under Medicare Part A).
- Services performed by immediate relatives or members of the household. Services payable under another government program.
- Services for which neither the patient nor another party on his or her behalf has a legal obligation to pay.
- Immunizations. **Exceptions: Influenza, Pneumovax and Hepatitis B .**
- Wheelchair van ambulance services.
- Cosmetic surgery.

What services doesn't Medicare cover that you would use an ABN for?

Services that are covered under the Medicare Program may be limited in coverage due to the following:

- **Certain diagnoses** – a service may be covered, but that coverage may be limited to certain diagnoses. For example, vitamin B-12 injections are covered, but only for diagnoses such as pernicious anemia and dementias secondary to vitamin B-12 deficiency.

- **Frequency/Utilization parameters** – a service may be covered, but that coverage may be limited if the service is provided more frequently than allowed under a national coverage determination (NCD), a local coverage determination (LCD), or a clinically accepted standard of practice. For example, a screening colonoscopy (G0105) may be paid once every 24 months for beneficiaries who are at high risk for colorectal cancer otherwise the service is limited to once every 10 years and not within 48 months of a screening sigmoidoscopy.
- **Proven clinical efficacy** – if a service is considered investigational, experimental, or of questionable usefulness, the service may be denied as not reasonable and necessary. For example, Acupuncture is considered experimental/investigational in the diagnosis or treatment of illness or injury. Claims will deny because procedure/treatment has not been deemed "proven to be effective" by the payer.

Probably the hardest question to answer is : WHO should be responsible for getting the ABN signed by the patient?

The Answer is : EVERYONE!

Remember, you can't have a patient sign a "blanket ABN" to use any time Medicare denies a service as non-covered. That's fraud. You cannot have the patient sign the ABN after the procedure or service is provided. That's fraud, too. The only time you may get the ABN signed is before the patient receives the service and after you clearly explain what Medicare might not cover, why they might not cover it, and if they don't cover it, what the cost will be to the patient.

The WHO is so hard because often the person who has the most

knowledge about Medicare (your coder, biller, or manager) sits in the back of the office and might never even see the patient on their way in or out the office. Many practices have given up on the ABN process because figuring out the workflow can be challenging.

Don’t give up! You can implement ABNs in your practice and here’s how:

If you have an EMR, this is a slam dunk because your system should be preloaded with the Medicare service limitations and when you place an order for a service that may not be covered, your EMR should warn you and generate an ABN. Nice!

If you don’t have an EMR, follow these steps:

1. Review the Medicare coverage guidelines and **compile a list of services** your group provides or orders.
2. **Print the list with price range**s on the back of the ABN form (turn them over and run them through your printer or copier). You can print your own ABNs with your services and prices, but if you have very many services, you may not have enough room on the ABN. You may also choose to have more than one preprinted ABN – one with labs, one with services.
3. **Have a full staff meeting** to discuss the ABN and your plan to implement a program to use ABNs when appropriate. Discuss the Medicare guidelines and what services your practice provides and educate the staff on the circumstances for which an ABN is appropriate. EVERYONE needs to help each other learn and master ABNs. Make sure everyone understands that the ABN is not in place to take money from Medicare patients – it is an opportunity to educate the Medicare patient
4. **Create a custom chart** for your group that combines the services you provide with the associated rules. Post the chart in each exam room, the lab, the check-out station,

on the EKG or other medical test equipment and anywhere where an employee should stop and think “Do I need an ABN for this?” Make sure blank ABN forms are available nearby. If you dislike having charts everywhere, create a short word or phrase and print it on bright paper, then post it appropriately. It might be “ABN CHECK” or something like that. Every few months, move the paper to a different place in the exam room, etc. and/or print it on a different color paper. Make sure those most likely to identify the need for an ABN – physicians, mid-level providers, nurses, medical assistants, referral clerks, lab techs – know they can ask for help with the ABN process when they need it.

5. **Some in-house or referral lab systems** also furnish ABN information for mismatches on lab services and supporting diagnoses. Make sure and check the lab system before you begin a service!

You can find information and a copy of the 2011 version of the ABN (form CMS-R-131) **here** under the “FFS Revised ABN” link.