

The ABN: The Most Misunderstood and Underutilized Document in Healthcare

There's a new ABN form required to be in use in January 2012 – read about it [here in my article “Everybody’s Favorite Form: New Advance Beneficiary Notice of Noncoverage \(ABN\) Form Begins in 2012”](#)

Note from Mary Pat: The Advance Beneficiary Notice of Noncoverage (ABN) is a collection tool that many medical practices do not know how to implement. It is particularly difficult to determine who has ownership of this process, because the form must be completed and signed by the patient before the service is provided. The patient is in the exam room or the lab, ready for the service or test, and a knowledgeable staff person must step in, explain the rules and pricing and obtain the patient’s signature.

*Blogger Charlene Burgett does a great job of explaining the ins and outs of using the ABN, and has agreed to share an article originally published on her blog “**Conundrum**” with MMP readers.*



The use of the ABN is required by Medicare to alert patients when a service will not be paid by **Medicare** and to allow the patient to choose to pay for the service or to refuse the service.

If the practice does not have a signed ABN from the patient and Medicare denies the service, the charge must be written off and the patient cannot be billed for it. The only

exception is for statutorily excluded services (those that Medicare never covers like cosmetic surgery and complete physicals for example). In this case, a practice can bill the patient for the non-covered service despite not having an ABN. It is, however, a good idea to have the ABN signed for non-covered services so the patient is made aware that they are responsible.

If the patient signs the ABN and is made aware of their financial responsibility **you may require the patient to pay for this service on the date the service is provided.** You may also charge the patient 100 percent of your fee. You do not have to reduce your charge to the Medicare allowable.

With a signed ABN, the practice has proof of the patient's informed consent to provide the service and their agreement to be financially responsible for the service. In the past, Medicare had a "Notice of Exclusion of Medicare Benefits" (NEMB) that we could provide to the patient (no signature required) to alert them of Medicare's non-covered services. The ABN has replaced the NEMB.

The typical reasons that Medicare will not cover certain services and that would be applicable are:

1. **Statutorily Excluded service/procedure (non-covered service)**
2. **Frequency Limitations**
3. **Not Medically Necessary**

Statutorily Excluded items are services that Medicare will never cover, such as (not a complete list):

- Complete physicals (excluding Welcome to Medicare Screenings, with caveats)
- Most immunizations (Hepatitis A, Td)
- Personal comfort items
- Cosmetic surgery

For these items, it is a good idea (not a requirement) to complete the ABN and have the patient check the appropriate box under options and sign the ABN. For the sake of the billing department, I strongly encourage the use of ABN's for statutorily excluded items.

Frequency Limitations are for services that have a specific time frame between services. For example, Medicare allows one pap smear every 24 months if the pap is normal. If the patient wants one every 12 months for their peace of mind, Medicare will pay for year one and the patient will pay for year two and that pattern continues. The ABN needs to be on file for the year that the patient is responsible for paying. If the patient fits Medicare's guidelines for "high risk" they are allowed to have the pap every 12 months and no ABN is required.

Services that are not considered **Medically Necessary** are those that do not have a covered diagnosis code based on Local Coverage Determinations (LCD). One example is for excision of a lesion. If the lesion is being removed because the patient just doesn't like how it looks, that is considered cosmetic surgery. If the lesion is showing some changes (i.e. bleeding, growing, changing color, etc), then it is considered medically necessary because it potentially can be malignant. The removal needs to have diagnosis coding to substantiate the medical necessity and Medicare has Local Coverage Determinations that list all the codes/coding combinations that Medicare will approve for payment.

A rule of thumb in trying to discern the necessity of ABNs is to ask yourself if there may be some times that the service isn't covered by Medicare. The times the service isn't covered, an ABN is required. To illustrate this point, here are two examples:

- *EKGs are covered for certain cardiac and respiratory conditions. The only time an EKG is covered for*

preventive screening is during the patient's first year enrolled in the Medicare program and when being done during the Welcome to Medicare screening. After that time, Medicare will never cover an EKG for preventive screening. To notify the patient of this and to show that the patient agrees to be financially responsible for the EKG, an ABN should be completed.

- *Another example is for the Tetanus immunization. Medicare will cover tetanus when medically necessary; if the patient has cut themselves and the tetanus is provided due to that injury. If the tetanus is provided to the patient because it has been ten years since the last tetanus and the tetanus is not in response to a recent injury, then it will be non-covered because it is not "medically necessary" and the ABN will need to be on file.*

ABNs need to be completed in their entirety. The "Options" box can only be completed by the patient and it states that "We cannot choose a box for you". That would appear to be coercion.

A "blanket" ABN, one that is signed by the patient for all services provided within a certain time period, is not acceptable and is illegal.

In addition, there is a small area to provide additional information that can be used by either the patient or the provider's office. This could be anything pertinent to the information that the ABN covers. The bottom of the form is where the patient signs and dates. We keep the original ABN in the chart behind the progress note for that day. Providers

MUST provide a copy of the signed ABN to the patient.

The current ABN form with instructions can be found **here**.

If a service is denied by Medicare and the physician does not have a signed ABN prior to the service being rendered, the service can not be billed to the patient and will need to be written off. Sometimes a patient may refuse to sign the ABN – if this happens it is appropriate for the physician to document the refusal and sign, along with having a witness sign. Medicare will accept this and the patient can be billed for the service if denied by Medicare.

How does Medicare know whether or not you have a signed ABN? You tell them, by adding a modifier to the CPT code when completing the claim form. The appropriate modifiers are:

GA: The ABN is signed, but the service may not be covered.

GY: A “statutorily excluded” service.

GZ: The service is expected to be denied as not reasonable or necessary. This is typically used when there is a secondary payer that requires the Medicare denial before they pay benefits.

The use of the ABN is often misunderstood; however, it is the only way a patient can be informed about their financial responsibility prior to agreeing to a service being rendered. This is an issue that the OIG has reportedly been interested in investigating for fraud and abuse.

Charlene Burgett, MA-HCM

Note: Readers, how do you make the ABN work in your practice? Do you train the clinical staff, the physicians, or other staff to recognize the “ABN Moment”? How do you make it work? Please share your ideas by responding with a comment.