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.**

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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.

Have You Been Ignoring the January 1, 2012 Deadline for 5010? Wake Up – It’s Time to Get Serious!

Just in case you haven’t had a chance (what have you been doing?) to focus on the January 1, 2012 deadline for the transition to 5010, take 5 minutes to read this post and make sure your healthcare group is on track. It is critical to have

NO interruption in cash flow in January – a time when cash flow is already lower due to the new deductibles in play for many plans including Medicare.

The American Medical Association (AMA), in its **"5010 Implementation Steps: Getting the Work Done in Time for the Deadline**" recommends the following to protect your cash in January:

- Submit as many transactions as possible before Jan. 1, 2012.
- Decrease expenses before Jan. 1, 2012, to increase cash reserves.
- Consider establishing a line of credit with a financial institution.
- Research payers' advance payment policies.
- Consider using manual or paper processes to complete transactions until the electronic transactions are fixed.

Note that HIPAA standards, including the ASC X12 Version 5010 and Version D.0 standards are national standards and apply to your **transactions with all payers**, not just with FFS Medicare. Therefore, you must be prepared to implement these transactions for your non-FFS Medicare business.

Beginning January 1, 2012 all electronic claims, eligibility and claim status inquiries must use Version 5010 or D.O.

Version 4010/5.1 claims and related transactions will no longer be accepted. The electronic remittance advice will only be available in 5010. For Part B and DME providers, download the free Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices, available **here.**

How Does the Transition to Version 5010 Relate to the Adoption of the ICD-10-CM and ICD-10-PCS Code Sets?

Version 5010 is essential to the adoption of the ICD-10 codes and includes the following infrastructure changes in preparation for the ICD-10 codes:

- Increases the field size for ICD codes from 5 bytes to 7 bytes;
- Adds a one-digit version indicator to the ICD code to indicate Version 9 versus Version 10;
- Increases the number of diagnosis codes allowed on a claim; and
- Includes additional data modification in the standards adopted by Medicare FFS.

What are the Improvements in Version 5010?

Version 5010 improvements in front matter, technical, structural, and data content, include the following:

- Standardizes the business information related to the transaction
- Utilizes Technical Reports Type 3 (TR3) guidelines that represent data consistently and are less confusing;
- Is more specific in defining what data needs to be collected and transmitted;
- Accommodates the reporting of clinical data, such as ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes;
- Distinguishes between principal diagnosis, admitting diagnosis, external cause of injury, and patient reason for visit codes;

- Supports monitoring of certain illness mortality rates, outcomes for specific treatment options, some hospital length of stays, and clinical reasons for care; and
- Addresses currently unmet business needs, such as an indicator on institutional claims for conditions that were “present on admission.”

Are you at risk of not being able to access electronic information and file claims?

If you can answer NO to any of the following questions, you are at risk of not being able to meet the January 1, 2012, deadline and **not being able to submit claims**:

1. Have you contacted your software vendor to ensure that they are on track to meet the deadline OR if you are submitting claims directly to Medicare, contacted your MAC to get the free Version 5010 software (PC-Ace Pro32)?

2. Alternatively, have you contacted clearinghouses or billing services to have them translate your Version 4010 transactions to Version 5010 (if not converting your older software)?

3. Have you identified changes to data reporting requirements?

4. Have you started to test with your trading partners – practice management software vendor, clearinghouses, or billing service?

5. Have you started testing with your MAC, **which is required before being able to submit bills** with the Version 5010?

6. Have you updated MREP software to view and print compliant HIPAA 5010 835 remittance advices?

If you answered NO, it’s time to get started!

Resources for 5010 and Version D.O.

Educational Resources & Downloads

“**5010 Implementation Steps: Getting the Work Done in Time for the Deadline**” American Medical Association

If you have questions, contact your Medicare contractor (carrier, FI, A/B MAC, HH+H MAC, and DME MACs) at their toll-free number, which may be found **here.**

Accreditation Countdown: If You Are Billing Medicare the Technical Component for Advanced Diagnostic Imaging, You Better Get Started

Image via Wikipedia

If you are a physician, non-physician practitioner or Independent Diagnostic Testing Facility (IDTF) who supplies

imaging services and submits claims for the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) procedures to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MACs)), you should know that you must be accredited by *Sunday, January 1, 2012*. If your facility uses an accredited mobile facility, and you bill for the TC of ADI, you must also be accredited. The accreditation requirement is attached to the biller of the services.

Those not accredited by that deadline will not be able to bill Medicare until they become accredited.

For those planning on seeking accreditation to continue performing the technical component of ADI services, know that accreditation is dependent on the demonstration of quality standards, including (but not limited to):

- Qualifications and responsibilities of medical directors and supervising physicians;
- Qualifications of medical personnel who are not physicians;
- Procedures to ensure that equipment used meets performance specifications;
- Procedures to ensure the safety of beneficiaries;
- Procedures to ensure the safety of person who furnish the imaging; and
- Establishment and maintenance of a quality assurance and quality control program to ensure the reliability, clarity and accuracy of the technical quality of the image.

Additionally, the accreditation process may include:

- Unannounced, random site visits;

- Review of phantom images;
- Review of staff credentialing records and maintenance records;
- Review of beneficiary complaints and patient records;
- Review of quality data and ongoing data monitoring; and
- Triennial surveys.

Frequently Asked Questions

Q: What are ADIs?

A: ADI procedures are defined as MRI, CT and Nuclear Medicine/PET.

Q: As a supplier, what information will I need to transmit to CMS when I become accredited for the TC of advanced imaging?

A: The designated accreditation organization (AO) will transmit the findings of all accreditation decisions to CMS or its contractor when the decision becomes final. The information will include identifying information, the accreditation effective date and those modalities that are included in the accreditation.

Q: What is the process for denying claims after January 1, 2012?

A: Contractors will deny claims with a date of service on or after January 1, 2012, submitted for the TC of the ADI codes with denial code N290 ("Missing/incomplete/invalid rendering provider primary identifier.") when the provider is not enrolled or accredited by a designated CMS accreditation organization. Contractors shall deny claims with codes submitted with a date of service on or after January 1, 2012,

for the TC if the code is not listed on the provider's eligibility file using claim adjustment reason code (CARC)185 (The rendering provider is not eligible to perform the service billed.)

Q: What happens if I am already accredited and will be up for re-accreditation in 2012?

A: In the case of a supplier that is accredited before January 1, 2010 by one of the designated accreditation organizations, the supplier is considered to have been accredited by an organization for the period such accreditation is in effect. The supplier would have had to remain in good standing and have an active accreditation on 1/1/2012 and must apply for reaccreditation within the time frame specified by the accreditation organization.

Q: Do hospitals have to receive imaging accreditation for the Technical Component (TC) of advanced imaging that is performed under the prospective payment system?

A: Hospitals are generally exempt from this requirement. In Section 1834(e) of the Social Security Act and codified in §414.68(a), it is stated that the imaging accreditation requirement applies only to suppliers of the TC of advanced diagnostic imaging services for which payment is made under the physician fee schedule. Since hospitals generally are not paid pursuant to such schedule, this accreditation rule is inapplicable. Thus, providers will list ADI equipment and CPT code information in their initial and updated enrollment applications. Accreditation status will be provided to the Medicare Administrative Contractors by the ACO's.

Q: Do the accreditation requirements apply to the radiologists that interpret the images?

A: The accreditation will apply only to the suppliers producing the images themselves, and not to the physician's interpretation of the image. However, all interpreting

physicians must meet the accreditation organizations published standards for qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program and expertise obtained through experience or continuing medical education. Oral surgeons and dentists must be accredited if they perform the Technical Component of MRI, CT or Nuclear Medicine for the technical component of the codes that require ADI accreditation.

Q: Is Fluoroscopy covered under the new accreditation requirement?

A: MIPPA (Section 135 (a) of the Medicare Improvements for Patients and Providers Act of 2008) expressly excludes from the accreditation requirement x-ray, ultrasound, screening and diagnostic mammography and fluoroscopy procedures. The law also excludes from the CMS accreditation requirement diagnostic and screening mammography which are subject to quality oversight by the Food and Drug Administration under the Mammography Quality Standards Act.

Q: How do I choose which AO to accredit my organization?

A: As a supplier, you will need to contact each of the three designated organizations to determine which accrediting organization meets your specific business model and philosophy for patient care. Some of the factors affecting your decision should be review of the quality standards, accreditation cycle, accreditation processes and price.

Q: Who are the accreditation organizations recognized by CMS to comply with the MIPPA accreditation requirement?

A: The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations – the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission – to provide accreditation services for suppliers of the TC of advanced

diagnostic imaging procedures.

Q: What does it cost to be accredited?

A: The accreditation costs vary by accreditation organization. The average cost for one location and one modality is approximately $3,500 every 3 years.

Q: How do I contact the accreditation organizations (AOs)?

A: Call or e-mail each of the accreditation organizations to determine the one
that best fits your business needs. The accreditation organizations each have
their own published standards. Follow all of the application requirements so that your application is not delayed. It may take up to 5 months to be accredited. So, **you really must start now** to be sure to meet the January 1, 2012, date.To obtain additional information about the accreditation process, please contact the accreditation organizations shown below.

American College of Radiology (ACR)
1891 Preston White Drive
Reston, VA 20191-4326

www.acr.org

1-800-770-0145

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Intersocietal *Accreditation* Commission (IAC)
6021 University Boulevard, Suite 500
Ellicott City, MD 21043

www.intersocietal.org

1-800-838-2110

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The Joint Commission (TJC)
Ambulatory Care *Accreditation* Program
One Renaissance Boulevard
One Renaissance, IL 60181

www.jointcommission.org

1-630-792-5286

For more information about the enrollment procedures, see the Medicare Learning Network® (MLN) article MM7177, “Advanced Diagnostic Imaging Accreditation Enrollment Procedures,” available **here.**

If you are a physician or non-physician practitioner supplying the Technical
Component of ADI, see the MLN article MM7176, “Accreditation for Physicians and Non-Physician Practitioners Supplying the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) Service,” available **here.**