The Mysteries of the Advanced Beneficiary Notification of Non-Coverage (ABN) Revealed

By

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Medicare! The mere mention of the word conjures images of secrets deeper and darker than those of the Skull and Bones or the Illuminati. One of the deepest and darkest of those secrets is how to properly use the ABN. This has been exacerbated by well-meaning consultants that have spread inaccuracies and mis-information. By the time you finish this article you will have a clear understanding of when, why, and how to use the ABN in your office.

Let's start this journey by clearing up the myths, inaccuracies, and mis-information surrounding the ABN.

Myth: The ABN will allow me to see Medicare patients without being enrolled in Medicare.

This is absolutely wrong. Section 1848 of the Social Security Act requires that you bill Medicare for all covered services performed on a Medicare Beneficiary. You must be enrolled in Medicare as a provider in order to file a claim with Medicare. The Medicare Claims Processing Manual, Chapter 30, Section 50.3 states that; ..."providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries." To put it directly, if you are not enrolled in Medicare you cannot issue an ABN or treat a Medicare beneficiary for a covered service.

Myth: I can use the ABN to effectively "opt out" of Medicare.

This is also absolutely wrong. First let's establish exactly what Opting Out means. Opting out of Medicare means that the doctor has filed paperwork with the Medicare Administrative Contractor(s) (MAC) with whom he files claims stating that he will not bill Medicare for covered services that he provides to Medicare beneficiaries but rather will provide the Medicare beneficiary with a private contract and the beneficiary will pay for all care out of pocket as per the terms of the contract. The

Medicare Benefits Policy Manual, Chapter 15, Section 40.4 states; “The opt out law does not define “physician” to include chiropractors; therefore, they may not opt out of Medicare and provide services under private contract.”

That is a fairly definitive statement. The use of the ABN to accomplish something similar is an abuse of the ABN and can result in potential problems (such as significant fines) for the doctor that uses it that way.

Myth: I’ll just give every Medicare patient an ABN when they come in just in case.

This practice will result in all of your ABNs being ruled as invalid. The Medicare Claims Processing Manual, Chapter 30, Section 40.3.6 states; “In general, the “routine” use of ABNs is not effective. By “routine” use, CMS means giving ABNs to beneficiaries where there is no specific, identifiable reason to believe Medicare will not pay.”

You need to have a reason why you believe that Medicare will not pay for the service that you are providing and that reason needs to be stated on the ABN.

Myth: I will just list my reason as “I don’t ever know if Medicare will pay or not”

This will also result in your ABN being ruled as ineffective. The Medicare Claims Processing Manual, Chapter 30, Section 40.3.6.1 states; ““Generic ABNs” are routine ABNs to beneficiaries which do no more than state that Medicare denial of payment **is possible**, or that the notifier never knows whether Medicare will deny payment. Such “generic ABNs” are not considered to be acceptable evidence of advance beneficiary notice.”

Myth: I’ll just have the patient sign an ABN and I’ll fill it out when I need it.

Once again, this is an improper use of the ABN. The Medicare Claims Processing Manual, Chapter 30, Section 40.3.6.3 states;” A notifier is prohibited from obtaining beneficiary signatures on blank ABNs and then completing the ABNs later. An ABN, to be effective, must be completed before delivery to the beneficiary. The contractor will hold any ABN that was blank when it was signed to be a defective notice that will not protect the notifier from liability.”

Now that we have discussed what you can’t do with the ABN, let’s get into the proper use of this form. The proper designation for the ABN is CMS-R-131. You will probably only see it referenced this way in a Medicare publication. The ABN is an Office of Management and Budget approved form designed specifically for this use. The approval needs to be renewed every three years so you can expect to see some changes to the form every three years. The current ABN was approved in 2017 and required to be used after June of that year.

The first question you are probably asking is “Why do I use an ABN?” The short answer (no pun intended) is so you can get paid by the patient if Medicare should deny the claim. The ABN is a written agreement between you and the patient where the patient agrees to pay you should Medicare not pay. Medicare’s position is that the ABN provides the beneficiary with the information that they need to make an informed decision regarding their health care.

Your next question is probably “When can I use the ABN?” The Medicare Claims Processing Manual, Chapter 30, Section 50.5 states that there are three potential triggering events for the use of the ABN. These are:

Initiations: This is the beginning of a new patient encounter. If the patient’s condition justifies a full episode of care then the care would probably be medically necessary. If the patient’s condition does not justify an episode of care then the care would not be medically necessary and you would give the patient an ABN.

Reductions: This is when you reduce the duration or frequency of the patient care and the patient wants to continue at the previous level. For example, you recommend a reduction to two times per week and the patient wants to continue at three times per week. You would give the patient an ABN for the third visit in each week.

Terminations: This is the end of an episode of care. When the patient reaches maximum medical improvement you would terminate the episode of care and give the patient an ABN covering future care until there is another initiating event.

Now we get into the good part. How do you use the ABN.

There are two conditions for the effective delivery of the ABN. The Medicare Claims Processing Manual, Chapter 30, Section 50.7.1 states: “ABN delivery is considered to be effective when the notice is:
1. Delivered by a suitable notifier to a capable recipient and comprehended by that recipient.

2. Provided using the correct OMB approved notice with all required blanks completed.”

A “suitable notifier” is either you or one of your staff. The ABN needs to be delivered to the patient before the service is provided and the patient (or their representative) needs to be given enough time to read and understand the form. You (or one of your staff) also need to answer all of the patient’s questions regarding the ABN. If you cannot answer a question that the patient (or their representative) has then you need to refer them to 1-800-Medicare for the answer. If this doesn’t happen then Medicare could rule that the ABN is ineffective and you could be required to refund the money. How would they know you may ask? If Medicare suspects that there is a problem they will call the patients and ask.

The ABN has ten blanks that need to be completed. I will go over them one at a time with the information coming from the current copy of the ABN Form Instructions published by the Center for Medicare and Medicaid Services (CMS). This applies only to the mandatory use of the ABN when dealing with covered services.

Blank A Notifier: “Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier’s logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.”

Blank B Patient Name: “Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary’s Medicare (HICN)

card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary." It is important to copy the patient's name *exactly* as it appears on their Medicare card. Medicare has gotten strict about this in recent years.

Blank C Identification Number: "Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice."

Blank D: There are two parts to Blank D. The first part is a header that appears in several parts of the form. The word "service" or "procedure" can be used in this part. The second part is a column just below the header. "The notifier must list the specific names of the items or services believed to be noncovered in the column directly under the header of Blank (D)." The only covered service provided by a chiropractor is the adjustment so only information regarding the adjustment would be placed in this column.

Blank E Reason Medicare May Not Pay: "In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare." A sample reason that would be suitable for a chiropractor to use would be:

Medicare will consider your care after this point to be maintenance care and Medicare does not pay for maintenance care provided by a chiropractor.

If you have Novitas or Cahaba for a MAC you can use the following as appropriate:

Medicare does not allow more than 25 (for Cahaba) 30 (for Novitas) visits per year for chiropractic service.

"To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D) when appropriate."

Blank F Estimated Cost: "Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted."

Medicare will also accept a range of costs that will cover the service. The cost that you list should be your usual and customary fee not the Medicare fee.

Blank G Options: "The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly. If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option.""

Blank H Additional Information: "Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations."

Blank I Signature: "Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice. The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print."

Blank J Date: "The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier."

Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document.

Special guidance ONLY for non-participating suppliers and providers (those who don't accept Medicare assignment): "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.
This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN.

The sentence must be stricken and can't be entirely concealed or deleted.

There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier shall 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.”

This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.

An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice. Similarly, when the unassigned claim statement is included in the “Additional Information” section, the last sentence in Option 1 should be stricken.”

Let me translate that last part to English for you. If you are a non-participating doctor you need to modify your ABN for it to be a proper and effective ABN. There is a link at the end of this article that you can use to get an ABN that has already been modified. Also, Medicare recommends that you remove the letters from each of the blanks before you give the ABN to the patient.

Now that you have given the patient an ABN and they have signed it, what’s next? You need to make a copy of the signed ABN and give it to the patient. You keep the original on file for at least the next 5 years. You then inform Medicare that you have given the patient the ABN by placing the GA modifier after the CPT® code on the CMS 1500 form. This tells Medicare that the patient has agreed to assume the liability for the cost of the service.

Once the patient has signed the ABN you are freed from the limitations of the Medicare Fee Schedule. In other words you can charge the patient your usual and customary fees.

The ABN can also be used on a voluntary basis to inform patients that Medicare will not pay for statutorily non-covered services. These services would be exams, x-rays, therapy, or any service that is not the adjustment. You would complete the form normally up through Blank F. The reason that you would put in Blank E is “Medicare will not pay for these services when provided or ordered by a chiropractor”. The patient is not to choose an option in Blank G or sign the form. This is a courtesy notification only. If you should bill any of these services to get a denial for a secondary insurance you would use the GX modifier to signify that you have given the patient a voluntary ABN.

Now let’s summarize. The ABN has one purpose, protecting your right to be paid for the work you do. Beware of those consultants for whom DC means Doctor of Creativity that will tell about all the wonderful magical things that the ABN will do for you. Concerning Medicare, if it sounds too good to be true it will probably get you in trouble.

To get a free copy of the current ABN for participating providers go here;
http://www.chiromedicare.net/forms/abn-english-2020/

To get a free copy of the current ABN for non-participating providers go here;
http://www.chiromedicare.net/forms/non-par-abnenglish2020v508/

To get a free copy of the current ABN for in Spanish go here;
http://www.chiromedicare.net/forms/abn-spanish-2020/

To get a free copy of the ABN form instructions go here; http://www.chiromedicare.net/forms/abn-form-instructions/

To purchase a copy of my book Medicare Documentation System go here;
https://www.chirocode.com/store/196/