ABN Changes for 2013

eRX Limiting Charge

- There is a new column on the Medicare Physician Fee Schedule.
- It is called the eRX Limiting Charge.
- The footnote for this column states: “LIMITING CHARGE REDUCED BASED ON STATUS AS AN UNSUCCESSFUL E-PRESCRIBER”
- There are some consultants out there who state that this applies to chiropractors.
- This is not the case.
- To quote the Federal Register from September 6, 2011:
- *Comment:* Several commenters stated that chiropractors should be exempt from the 2012 eRx payment adjustment.
- *Response:* With respect to chiropractors, as we mentioned previously in section II.B.1. of this final rule, we note that we finalized limitations to the 2012 eRx payment adjustment in the CY 2011 PFS final rule (75 FR 73562). Because chiropractors are not within the category of eligible professionals to which the 2012 eRx payment adjustment applies, chiropractors are not subject to the 2012 eRx payment adjustment.

Jurisdiction 6 Changes

- Jurisdiction 6 (Illinois, Wisconsin, and Minnesota) will be getting a new Medicare Administrative Contractor.
- The protests against the new contract were settled in mid January.
- National Government Services will be the new MAC.
- The transition will take place over the next five to seven months.
- The contract will last at least one year up to three years.

Palmetto Railroad Widespread Review of Chiropractic

- Palmetto GBA/Railroad Medicare has identified chiropractic services as a program vulnerability, due to the high percentage of errors identified during the post-payment review process, as well as the results from the May 2009 Office of Inspector General report 'Inappropriate Medicare Payment for Chiropractic Services (OEI-07-07-00390).'
- To resolve this vulnerability, Railroad Medicare will change the process for reviewing claims submitted with CPT codes 98940 and 98941 along with HCPCS modifier AT.
- Shortly we will begin requesting documentation for 10 percent of the claims submitted with these codes.
- This review will be performed on a pre-payment basis.

ABN Forms

- Medicare regulations state that all Medicare reviewers are to request ABNs with records requests associated with complex medical reviews.
- This regulation took effect January 12, 2012.
- If the reviewer determines that the claim is not medically necessary then they will look at the ABN to determine if it is completed correctly.
- The Face Validity assessments do not include contacting beneficiaries or providers to ensure the accuracy or authenticity of the information.
- Face Validity assessments will assist in ensuring that liability is assigned in accordance with the Limitations of Liability Provisions of Section 1879 of the Social Security Act.

When to Use the ABN

- According to the Medicare Claims Processing Manual, Chapter 30, Section 50.5, there are three specific "triggering events" that require the issuance of an ABN.
    - Initiation of care
    - Reduction of care
    - Termination of care
- Initiations
    - An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment.
    - If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.
- In other words:
    - If you believe that a normally covered service will be denied from the beginning of care then you must give the patient an ABN.
- Reductions
    - A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.).
    - The ABN is not issued every time an item or service is reduced.
    - But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.
- In other words:
    - If you are decreasing the visit frequency from three times a week to two times a week and the patient wants to continue at three times a week then you must give the patient an ABN.
- Terminations
    - A termination is the discontinuation of certain items or services.
    - The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

- In other words:
    - When you determine that the patient has reached Maximum Medical Improvement and the patient wants to continue care, you should issue an ABN.
- For chiropractors the primary times that we would need to issue an ABN would be at the initiation of care (non-covered services) and the termination of care (maintenance care).
- The only time that we would need to issue an ABN at the reduction of care would be if the patient wants to continue at the previous level of care instead of reducing to the current recommended level of care.
- ABNs are to be used primarily in Part B Fee For Service Medicare.
- They are not to be used with Medicare Advantage programs (Part C)
- They are not to be used with Medicare Drug Program (Part D)
- Providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries.

Delivery Requirements

- ABN delivery is considered to be effective when the notice is:
    - Delivered by a suitable notifier to a capable recipient and comprehended by that recipient.
    - Provided using the correct OMB approved notice with all required blanks completed.
    - Failure to use the correct notice may lead to notifiers being found liable since the burden of proof is on the notifier to show knowledge was conveyed to the beneficiary according to CMS instructions.
    - Delivered to the beneficiary in person if possible.
    - Provided far enough in advance of delivering potentially noncovered items or services to allow sufficient time for the beneficiary to consider all available options.
    - Explained in its entirety, and all of the beneficiary's related questions are answered timely, accurately, and completely to the best of the notifier's ability.
    - The notifier should direct the beneficiary to call 1-800-MEDICARE if the beneficiary has questions he or she cannot answer. If a Medicare contractor finds that the notifier refused to answer a beneficiary's inquiries or direct them to 1-800-MEDICARE, the notice delivery will be considered defective, and the notifier will be held financially liable for noncovered care.
    - Signed by the beneficiary or his or her representative.

Electronic Delivery

- Electronic issuance of ABNs is not prohibited.
- If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers.

- Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records.
- Electronic retention of the signed ABN is permitted.

ABN Retention

- Retention periods for the ABN are five years from discharge/completion of delivery of care when there are no other applicable requirements under State law.
- Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice.
- Electronic retention of the signed paper document is acceptable.
- Notifiers may scan the signed paper or "wet" version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

Beneficiary Liability

- A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable.
- The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule.
- The beneficiary is relieved from liability if he or she does not receive proper notice when required.

Provider Liability

- A notifier will likely have financial liability for items or services if he or she knew or should have known that Medicare would not pay and fails to issue an ABN when required, or issues a defective ABN.
- In these cases, the notifier is precluded from collecting funds from the beneficiary and is required to make prompt refunds if funds were previously collected.
- Failure to issue a timely refund to the beneficiary may result in sanctions.
- A notifier may be protected from financial liability when an ABN is required if he or she is able to demonstrate that he or she did not know or could not reasonably have been expected to know that Medicare would not make payment.
- Issuance of a defective notice establishes the notifier's knowledge of potential noncoverage.

Defective Notice

- An ABN is not acceptable evidence if:
    - The notice is unreadable, illegible, or otherwise incomprehensible, or the individual beneficiary is incapable of understanding the notice due to the particular circumstances;
    - The notifier routinely gives this notice to all beneficiaries for whom the notifier furnishes items or services.

    - The notice is no more than a statement to the effect that there is a possibility that Medicare may not pay for the items or services; or
    - The notice was delivered to the beneficiary (or authorized representative) more than one year before the items or services are furnished.
- **NOTE:** A previously furnished ABN is acceptable evidence of notice for current items or services if the previous ABN cites similar or reasonably comparable items or services for which denial is expected on the same basis in both the earlier and the later cases.

Advanced Beneficiary Notification (ABN)

- "The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case.
- "Notifiers" include physicians, providers…, practitioners, and suppliers paid under Part B….
- They must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice."
- "Also, note that while previously the ABN was only required for denial reasons under section 1879 of the Act, the revised version of the ABN may also be used to provide voluntary notification of financial liability.
- Thus, this version of the ABN should eliminate any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations.
- The revised ABN *is* used to fulfill both mandatory and voluntary notice functions."
- When, for a particular purpose, an approved standard form (e.g., Form CMS-R-131, Form CMS-R-296) exists, it constitutes the proper notice document.
- Notices not using a mandatory standard notice form may be ruled defective.
- In the absence of such a standard form, approved model notice language constitutes the proper notice document.
- A notifier's unapproved modification of either a standard form or model notice language may render that notice defective.
- The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation.
- When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice.
- The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice when using the ABN for voluntary notification.
- "Step by step instructions for notice completion are posted along with the notice on the CMS website and can be downloaded via this link: https://www.cms.gov/BNI/Downloads/ABNFormInstructions.zip."
- "ABNs must be reproduced on a single page.
- The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used."

- The purpose of the ABN is to inform the patient of their financial responsibility for a covered Medicare service that is performed in your office.
- The ABN preserves your right to collect money from the patient for services that you have performed.

Steps to Completing the ABN

- I will not cover how to complete the ABN blank by blank in this webinar.
- You can find this in previous webinars at:
- ChiroCode Premium Support
- ChiroMedicare.net On Demand Webinars
- Blank (E)
    - "In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D)."
    - Suggested reasons for CMT;
        - "Charges are paid at the discretion of Medicare Part B and are based on *their* interpretation of medical necessity."
        - "Medicare will not pay for chiropractic adjustments when functional improvement cannot be demonstrated to their satisfaction."
    - If you are in a jurisdiction where the MAC has indicated that they will only pay for a specified number of visits in a year you may use;
        - "Medicare does not pay for more than X chiropractic adjustments in a year."
    - For all other services listed in Blank (D);
        - "Medicare never pays for this service when it is provided or ordered by a chiropractor."
- Blank (G)
    - Option 2; This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.
    - Note: Providers/suppliers will not violate mandatory claims submission rules under Section1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary's request *by their choice of* Option 2 on the revised ABN.

Important Considerations

- Notifiers are permitted to do some customization of ABNs, such as pre-printing information in certain blanks.
- Lettering of the blanks (A-J) should be removed prior to issuance of an ABN.
- Blanks (G)-(I) must be completed by the beneficiary and may **never** be pre-filled.

Patient Refusal

- What do you do when a beneficiary refuses to sign an ABN?
- "The beneficiary cannot properly refuse to sign the ABN at all and still demand the item or service."
- "If a beneficiary refuses to sign a properly executed ABN, the notifier should consider not furnishing the item or service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option.
- Additionally, the notifier may annotate the ABN, and have the annotation witnessed, indicating the circumstances and persons involved."
- The Annotation should be in Blank H.
- Be sure and have a witness and have the witness sign the annotation.
- The signature is the patient's agreement to pay.
- No signature = no agreement to pay.
- You should keep the annotated ABN on file in the patient's file.

Routine Use

- "By "routine" use, CMS means giving ABNs to beneficiaries where there is no specific, identifiable reason to believe Medicare will not pay."
- "Notifiers should not give ABNs to beneficiaries unless the notifier has some genuine doubt that Medicare will make payment as evidenced by their stated reasons."
- "ABNs may be routinely given to beneficiaries and considered to be effective notices which will protect notifiers in the following exceptional circumstances:
    - **Services Which Are Always Denied for Medical Necessity -** In any case where a national coverage decision provides that a particular service is never covered, under any circumstances, as not reasonable and necessary under §1862(a)(1) of the Act (e.g., at present, all acupuncture services by physicians are denied as not reasonable and necessary), an ABN that gives as the reason for expecting denial that: "Medicare never pays for this item/service" may be routinely given to beneficiaries, and no claim need be submitted to Medicare."
    - **Frequency Limited Items and Services -** When any item or service is to be furnished for which Medicare has established a statutory or regulatory frequency limitation on coverage, or a frequency limitation on coverage on the basis of a national coverage decision or on the basis of the contractor's local medical review policy (LMRP), because all or virtually all beneficiaries may be at risk of having their claims denied in those circumstances, the notifier may routinely give ABNs to beneficiaries. In any such routine ABN, the notifier must state the frequency limitation as the ABN's reason for expecting denial (e.g., "Medicare does not pay for this item or service more often than **frequency limit**").
- You cannot give an ABN to a patient if there is not a legitimate reason for doing so.

- The only legitimate reason is that you believe that Medicare will not cover a service.
- Medicare only covers the adjustment, represented by codes 98940, 98941 and 98942 for chiropractors, therefore any other service ordered or provided by a chiropractor will be denied.

Generic ABN

- "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.

Blanket ABN

- Giving ABNs for all claims or items or services (i.e., "blanket ABNs") is not an acceptable practice.
- Notice must be given to a beneficiary on the basis of a genuine judgment about the likelihood of Medicare payment for that individual's claim.

Signed Blank ABN

- 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.

Collection of Funds

- A beneficiary's agreement to be responsible for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare that the beneficiary may have.
- The notifier may bill and collect funds from the beneficiary for noncovered items or services immediately after an ABN is signed, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law.
- Regardless of whether they accept assignment or not, providers and suppliers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts.
- If Medicare ultimately denies payment of the related claim, the notifier retains the funds collected from the beneficiary.
- However, if Medicare subsequently pays all or part of the claim for items or services previously paid by the beneficiary to the notifier, or if Medicare finds the notifier liable, the notifier must refund the beneficiary the proper amount in a timely manner.
- You can collect your usual and customary fee from the patient at the time of service if you believe that Medicare will not pay.

- You should be prepared to refund the money to the patient if Medicare pays of if they find that the patient is not liable.
- Refunds are considered timely if they are made within 30 days.

When to use the ABN

- With the change in regulations you would use the ABN at two distinct times during the average care plan.
- Voluntarily issue an ABN at the initial assessment visit to inform the patient of their financial liability for non-covered services.
- Issue another ABN when the patient reaches MMI or when the treatment plan reaches the maximum number of visits that the Medicare Administrative Contractor will pay.

Summary

- CMS continues to increase its' efforts to recover "overpayments".
- If you are required to refund an overpayment and do not have an ABN on file for that patient, you cannot bill the patient for that service.
- Having an ABN on file allows you to bill the patient for the service should Medicare deny the service.
- This protects you from loss.
- The ABN has the additional benefit of educating the patient to the limitations of Medicare.