American Society of Anesthesiologists®

Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

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Medicare Updates the Advance Beneficiary Notice

We should all already know how to use the Advance Beneficiary Notice of Noncoverage form (ABN) since it has been around since 2008. However, since its introduction, the Centers for Medicare & Medicaid Services (CMS) has issued many updates and clarifications on proper use of this form.

The purpose of this Timely Topic is two-fold. First, it will provide some new information since a new version of the form has been recently issued. Second, this Timely Topic will review additional details on when and how to use an ABN. For the purposes of this discussion, we will only address ABNs used in an outpatient or office setting.

A New ABN Form

Per the Paperwork Reduction Act of 1995, the Office of Management and Budget (OMB) is responsible for approving and maintaining the Advance Beneficiary Notice of Noncoverage form (ABN). The form is reviewed every three years and that process is open to public comment. As a result of this review process, a new version is now in place. *Use of this updated form is required as of 6/21/2017 and this version will remain in effect until 03/2020.*

The new ABN includes language that informs patients of their rights to nondiscrimination practices. It also advises patients on how to request the form in an alternative format if needed. The updated form and corresponding instructions are available here in both English and Spanish. *Be sure you are using the correct form per its effective date and the date you are performing the related service or procedure.*

Specifics for Using ABNs

You are required to obtain a signed ABN before providing any services that are normally covered by Medicare Part B but may not be seen as meeting Medicare's medical necessary criteria at the time of service. The following situations explain when services may not meet that CMS criteria and would require an ABN:

1. The patient's condition or symptoms do not support the services,
2. The service is beyond the published Medicare frequency allowances,
3. The patient desires treatment beyond the time/number when services would be considered effective, or
4. The services are considered by Medicare to be experimental or for investigational use only.

ABNs are not required for services that are statutorily excluded from Medicare coverage. However, you may use the ABN voluntarily in the following circumstances:

1. Care that does not meet the definition of a Medicare covered benefit
2. Care that is specifically excluded from Medicare benefits

In these cases, the ABN serves as a Notice of Exclusion from Medicare Benefits. If you are not certain whether Medicare will consider a service to be medically necessary you may decide to issue an ABN as a precautionary measure. However, ABNs should not be issued routinely; there should be a reasonable expectation of noncoverage when asking a patient to sign an ABN.

You must issue the ABN, with all applicable fields already completed in the patient's preferred language (Spanish or English), to the patient for signature prior to rendering the service if you expect to hold him or her liable for the payment. It must be the *current effective version* of the ABN and printed with contrasting dark ink on light paper. If the ABN is not current, not legible, or does not have all the required fields completed it may not be valid.

You may use a single ABN for an extended course of treatment if the ABN appropriately outlines the treatment and specific duration of time up to one year. Any changes to the treatment or extension of the duration would require execution of an additional ABN. Keep the original executed copy with your records and provide a copy to the patient. The ABN must be retained for five years from the date of service.

If you did not obtain a signed ABN from the patient for the service prior to delivery of the care, and should reasonably have been aware that the service may not meet CMS's medical necessity criteria, the patient is absolved of liability.

Patients Have a Choice

A patient has a choice when presented with an ABN. Section G of the ABN lists three options from which the patient may choose.

- Option 1: The patient wants the service, can be billed for the service but wants you to submit a claim to Medicare to see if the claim will be paid. This option may also be appropriate if a secondary insurance might cover the service even if Medicare will not.
- Option 2: The patient is responsible for the payment and does not want you to submit a claim to Medicare. This option clarifies that since no claim is submitted, the patient will not have any appeal rights with Medicare.

- Option 3: The patient does not want the service, will not be liable for any payment and cannot appeal to Medicare to see if the claim would have been paid.

You may not preselect one of these options for your patients, they are required to make their own choice.

A patient may also refuse to sign the ABN. In that case you should notate the ABN with the patient's refusal. Witnesses may be listed also but are not required. A patient may also change his/her mind after signing the ABN. You should provide the ABN to the patient and ask the patient to clearly annotate the change and then sign and date the change.

Billing With an ABN

The following table outlines modifiers that should be used when issuing an ABN.

Modifier	When to Use the Modifier
GA Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case	Report when you issue a mandatory ABN for a service as required and it is on file. You do not need to submit a copy of the ABN, but you must have it available on request.
GX Notice of Liability Issued, Voluntary Under Payer Policy	Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.
GY Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit	Report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.
GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary	Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

ABN's are most commonly used when a service may not be considered medically necessary per Medicare's policy. If you have questions regarding Medicare policy, review our Timely Topics:

NCDs, LCDs and the MCD: How to Learn What CMS Does or Does Not Cover (January 2017)
National Correct Coding Initiative Policy Manual for Medicare Services (January 2016).

These Timely Topics cover where to find Medicare policy documents what information is included in the different types of policy documents available.

For additional information on ABNs, please see the Timely Topic: Advance Beneficiary Notices (April 2016).

Sources:
Medicare.com Advance Beneficiary Notice of Noncoverage
Medicare Advance Beneficiary Notices