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ABN Form: Gain a Better Understanding to Avoid Denials

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An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice a supplier gives to a Medicare beneficiary before providing an item and/or service. It must be issued when the health care provider (including independent laboratories, physicians, practitioners and suppliers) believes that Medicare may not pay for an item or service which is expected to be denied by Medicare based on one of the following statutory exclusions.

- ⇒ Lack of medical necessity
- ⇒ Prohibited, unsolicited telephone contacts
- ⇒ No supplier number
- ⇒ Denial of an Advanced Determination of Medicare Coverage (ADMC) request
- ⇒ Non-contract supplier furnishing an item listed in a Competitive Bid area
- ⇒ Frequency limitations have been exceeded

An ABN gives a beneficiary the opportunity to make an informed decision prior to the item or service being provided to decide whether to receive it and accept financial responsibility (out of pocket or through another insurance) if denied by Medicare and serves as proof that the beneficiary had knowledge prior to receiving the item/service that Medicare might not cover. If the provider does not deliver a valid ABN to the beneficiary when required, the beneficiary cannot be billed for the service and the provider may be held financially liable.

Form

For an ABN form to be acceptable, it must:

- ⇒ Be on approved CMS-R-131 form;
- ⇒ Clearly identify item and/or service; and
- ⇒ Give reason(s) for belief that Medicare is likely (or certain) to deny payment for item and/or service

ABNs apply to assigned and non-assigned claims, as there are financial liability provisions under Medicare law for both claim types.

Limitations of Liability (LOL)

Applies to assigned claims for DMEPOS services disallowed because of medical necessity, due to prohibition on unsolicited telephone calls, no supplier number, or no ADMC. Under LOL, a beneficiary can be held liable for a service denied due to reasons cited on the ABN.

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The financial liability protections (FLP) provisions of the Social Security Act (the Act) protect beneficiaries and health care providers (physicians, practitioners, suppliers, and providers) under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The FLP provisions include:

⇒ LOL under Section 1879(a)-(g) of the Act.
⇒ Refund Requirements (RR) for Non-assigned Claims for Physicians Services under Section 1842(l) of the Act.
⇒ Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under Sections 1834(a)(18), 1834(j)(4), and 1879(h) of the Act.

Refund Requirements (RR)

Apply to assigned and non-assigned claims for DMEPOS services allowed because of medical necessity, due to prohibition on unsolicited telephone calls, no supplier number, or no ADMC. If the beneficiary was not properly notified of possible disallowed Medicare claims, the RR state that suppliers must refund any amounts collected. The RR provisions require that a beneficiary is notified and agrees to the financial liability.

Prior to rendering a service in which Medicare may consider not medically necessary, a supplier should notify the beneficiary, in writing, that Medicare will likely deny his/her claim and that he/she will be responsible for payment. The supplier will submit the appropriate HCPCS and append modifier GA (Waiver of Liability statement on file).

Example Statements Which Provide Reasons Suppliers Believe Medicare May Deny Claim

⇒ Medicare does not usually pay for this many treatments or services
⇒ Medicare usually does not pay for this service
⇒ Medicare does not pay for this because it is a treatment that has yet to be proved effective (experimental)
⇒ Medicare does not pay for this many services within this period
⇒ Medicare does not pay for such an extensive treatment

General statements, such as "Medicare may not pay," are not acceptable.

If there is dissatisfaction with the amount of payment, denial of coverage for services or supplies, or if the original claim was not acted upon within a reasonable time, a beneficiary or his/her representative has the right to appeal a claim decision. A supplier has the right to appeal a claim decision when assignment has been accepted.

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Section E Examples

Appropriate	Not Appropriate
"The patient does not have the required diagnosis to qualify for this item per the policy."	"Medicare might not pay for this item."
"The patient currently has a nebulizer (E0570) paid for by Medicare on 12/2/2013 which is same or similar to this nebulizer (E0570)."	"Patient might have same or similar item on file."
"There are no test results available to determine the patient qualifies for oxygen equipment under Medicare guidelines."	"Not enough supporting documentation in the medical record"

Statutorily Excluded Items or Situations (Not all inclusive)

⇒ Durable Medical Equipment and related accessories and supplies provided to patients in nursing facilities;

⇒ Personal comfort items; and

⇒ Orthopedic shoes or shoe inserts -other than those covered under the therapeutic shoes for diabetics benefit or those that are attached **to a covered leg brace.**

Items or Situations Which Do Not Meet Definition of a Medicare Benefit (Not all inclusive)

⇒ Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin;

⇒ Irrigation supplies that are used to irrigate the skin or wounds;

⇒ Nondurable items (that are not covered under any other benefit category), e.g., compression stockings and sleeves;

⇒ Durable items that are not primarily designed to serve a medical purpose, e.g., exercise equipment.

Click link below for CPR Portal ABN Instructions (includes a link to download the current form):

http://www.nyspma.org/aws/NYSPMA/asset_manager/get_file/303777