THE ABCs of ABNs

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Learning Points

- What is the history of the ABN
- What is an ABN
- When you should use an ABN
- How you should use an ABN
What is the history of the ABN?

Since 1972 providers have been required to notify Medicare Beneficiaries when outpatient services may not be covered by Medicare. This is called the “limitation on liability” provision.

The ABN provision is found in section 1879 of the Social Security Act (Public Law 92-603), 42 CFR §411.404 and §411.408

What is the history of the ABN?

The current ABN form is a combination of two separate ABNs. Form CMS-R-131-G, ABN-G (referred to as the General Use ABN) and form CMS-R-131-L, ABN-L (referred to as the laboratory ABN). In addition, the current ABN replaces the Notice of Excluded Medicare Benefits (NEMB) (CMS 2007).

Although called an ABN, CMS officially changed the title to “Advanced Beneficiary Notice of Noncoverage” in order to more clearly convey its purpose.
What is an ABN?

An ABN is an Advance Beneficiary Notice of Noncoverage for Medicare Beneficiaries

It is a written notice that should be given to the patient PRIOR to the service being rendered when the provider believes Medicare will not pay for the service or item.

The ABN allows for an informed decision by the Medicare beneficiary for services/supplies that might not be covered by Medicare in which they would be financially responsible for if not covered.

What is an ABN?

An ABN is an Advance Beneficiary Notice of Noncoverage for Medicare Beneficiaries

If a service is deemed not medically necessary and denied by Medicare, and the provider had the beneficiary sign a proper ABN PRIOR to rendering the service/supply, the provider MAY bill the patient for the financial liability of the service/supply.

The signed ABN serves as proof that the beneficiary was informed PRIOR to the service/supply that Medicare might not pay.
**What is an ABN?**

An ABN is an Advance Beneficiary Notice of Noncoverage for Medicare Beneficiaries.

If an ABN is not valid, the provider may not bill the patient.

An ABN cannot be used when a service/supply is denied as part of a NCCI edit to recoup payment from a beneficiary.

When there is no reasonable expectation of non-coverage a provider is prohibited from issuing ABNs on a routine basis.

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**When to use an ABN?**

An ABN is not required when a service or supply is specifically excluded from Medicare payment. But, it may be issued voluntarily in place of a Notice of Excluded Benefits.

- Personal items
- Cosmetic surgery
- Self-administered drugs and biologicals
- Custodial care
- X-rays & PT provided by chiropractors
How to Use an ABN?

The ABN should be given to any of the following:
- The Medicare Beneficiary
- The Medicare Beneficiary’s representative

The ABN is considered to be delivered effectively when:
- It is comprehended by the recipient & delivered to the beneficiary in person if possible
- The correct ABN approved form with all required blanks completed is delivered
- Provided enough in advance to allow the beneficiary to consider all available options
- Explained entirely and all beneficiary questions answered
- Signed by the beneficiary or the beneficiary’s representative

General Requirements
- 2 copies of the ABN and any additional attachments
  - 1 for the beneficiary
  - 1 for the provider
- ABN must be the original approved form
  - A notice for additional attachments must be noted on the ABN such as “See Attachment”
    - Attached pages must include the following
      - Beneficiary’s name
      - Identification number
      - Date of issue
      - Table listing additional services/supplies, the reason Medicare may not pay and the estimated cost for each
      - A space where the beneficiary can initial to acknowledge receipt of attachments
How to Use an ABN?

Completing the ABN

The newly revised Advanced Beneficiary Notice can be found at:
http://www.cms.hhs.gov/BNI/02_ABN.asp#TopOfPage

This site includes the official instructions on completing the form

How to Use an ABN?

WHAT IF . . . .

1. The beneficiary changes their mind after signing?
   1. Simply have them write their reason on the executed ABN and date and sign it
   2. Make sure you provide the beneficiary with a copy of the original and the updated signed one

2. The beneficiary refuses to sign the ABN?
   1. Simply note on the form their refusal, date and sign it
   2. The provider must then make the decision whether or not to provide the service/supply

3. The beneficiary refuses to choose an option?
   1. Note the refusal on the ABN, date and sign
   2. The provider must then make the decision whether or not to provide the service/supply

4. The provider did not get an ABN signed?
   1. The provider may bear the financial responsibility if they knew and did not properly execute an ABN
   2. The provider MAY NOT bill the patient and must refund the patient immediately if funds are collected
### How to Use an ABN?

**SPECIAL CONSIDERATIONS**

**Medical Emergencies**

When a beneficiary is under extreme circumstances during a medical emergency an ABN SHOULD not be obtained. If the beneficiary is medically stable, with no emergent circumstances, an ABN may be appropriate.

**Extended Treatment Courses**

A single ABN for an extended course of treatment is acceptable practice if the ABN identifies all the services/supplies, the duration of the treatment, and the reason it is believed Medicare will not pay. Additional services/supplies encountered during the extended treatment course not identified on the original ABN must be completed on an additional separate ABN form. An ABN is valid for a period of one (1) year for an extended course of treatment.

### How to Use an ABN?

**SPECIAL CONSIDERATIONS continued**

Multiple Entities as in:
- Ordering and Rendering Providers
- Technical Component and Professional Component Providers
- One facility sends out to another facility

Regardless of who initiates the ABN it is the responsibility of the BILLING ENTITY to make sure that the ABN was executed correctly therefore the ABN may list multiple providers in the header.
**How to Use an ABN?**

Collections of Fees for Noncovered Services/Supplies
Immediately after the complete and accurate execution of an ABN in which the beneficiary has agreed to accept the financial responsibility for the noncovered service/supply, the provider may bill and collect the fees for the stated noncovered service/supply.

If Medicare ultimately denies payment, the provider is free to retain the fees collected.
If Medicare pays all or part of the service/supply, the provider must refund the beneficiary within 30 days.
If Medicare finds the provider liable for the service/supply, the provider must refund the beneficiary within 30 days.

**Questions and Information**

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