The ABN 2020

By
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ABN Myths

- Over the years there have been some well-meaning consultants that have spread inaccuracies and mis-information about how to use the ABN.
- These myths can at best cause you problems and at worst can put you in legal jeopardy.
- Let's go over some of the more common myths and find out why they are false.
- **Myth:** The ABN will allow me to see Medicare patients without being enrolled in Medicare.
    - Section 1848 of the Social Security Act requires that you bill Medicare for all covered services performed on a Medicare Beneficiary.
    - 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."
- **Myth:** I can use the ABN to effectively "opt out" of Medicare.
    - 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."
- **Myth:** I'll just give every Medicare patient an ABN when they come in just in case.
    - 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."
- **Myth:** I will just list my reason as "I don't ever know if Medicare will pay or not"
    - 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.
    - 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."

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- The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA).
- As part of this process, the notice is subject to public comment and re-approval every 3 years.
- A new version of the ABN is required to be in use in your office as of January 1, 2021.
- The new form has: "Form CMS-R-131 (Exp. 06/30/2023)" in the lower left corner.

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- If your form does not have this, get the new form and replace all of your current ABN forms by the first of the year.
- If you are not using this form by the due date, CMS will determine that your ABNs are ineffective and you will have to pay money back.
- The old ABN form and the new ABN for are virtually identical to each other.
- The difference is in the form instructions.
- In accordance with Title 18 of the Social Security Act, guidelines for Dual Eligible beneficiaries have been added to the ABN form instructions.
- Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals.
- Dually Eligible beneficiaries must be instructed to check Option Box 1 on the ABN in order for a claim to be submitted for Medicare adjudication.
- Strike through Option Box 1 as provided below:
    - "□ OPTION 1. I want the (D)_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN."
- These edits are required because the provider cannot bill the dual eligible beneficiary when the ABN is furnished.
- Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries.
- Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:
- If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.
- If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.
- Note: These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances.
- More information on dual eligible beneficiaries may be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glan ce.pdf
- One feature of the new ABN that has carried over from the previous version is that special language is needed on the form if you are a non-par doctor.
- If you are a non-par doctor and have not been using this modified ABN you will need to get a copy and replace your current ABNs immediately.
- Special guidance for non-participating suppliers and providers (those who don't accept Medicare assignment) ONLY:

- Strike the last sentence in the Option 1 paragraph with a single line.
    - □ OPTION 1. I want the D_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- When this sentence is stricken, the supplier should 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.
- I have prepared each of these special ABNs and have included them with the link to the notes for this webinar.
- Additionally, the form instructions from CMS and a regular blank ABN are supplied.
- These links are in the email notice that I sent to you or, if you are not a subscriber, you can sign up for my newsletter and these links will be in the final welcome email.

Summary

- The ABN is critically important to your practice as it allows you to be paid by the patient if Medicare should deny your claim.
- However that only works if the ABN is completed correctly and the correct version of the form is used.
- There are now special modifications to the ABN that are required for non-participating doctors and for dual eligible beneficiaries.
- If these modifications are not made correctly the ABN will be ruled to be incorrect and will be ineffective.
- The result will be that you cannot bill the beneficiary if Medicare should deny the claim and you will have effectively worked for free.