The Mysteries of the ABN Revealed

By
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Patient Relationship Modifiers

- There is a new modifier that has been released and is supposed to be used starting January 1.
- This modifier indicates the type of relationship that you have with the patient.
- The modifiers are X1 through X5.
- At this point these modifiers seem to be related to the Quality Payment Program (MIPS).
- The problem is that Medicare has not yet released clear guidance on the proper use of these modifiers.
- Without clear guidance in writing it would be irresponsible to determine which modifier to use.
- Indications are that the use of this modifier will be optional to start, so we have some time.
- I will keep you up to date as information becomes available.

MIPS

- This is the second year for MIPS and there are some changes.
- Chiropractors are excluded from the e-prescribing performance measure starting in 2017.
- In 2018 Medicare expects only 632 chiropractors out of the 45,000 enrolled to be eligible for MIPS.
- You are excluded from MIPS if you had $90,000 or less in Part B allowed charges or 200 or fewer Part B beneficiaries.
- You would report the same measures that you used for PQRS using the same G-codes.
- If you are reporting these G-codes continue to do so.
- It will help your score on the Physician Compare website.

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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.

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- 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."

The ABN 2018

- A new version of the ABN was required as of June of 2017.
- The new form has: "Form CMS-R-131 (Exp. 03/2020)" in the lower left corner.
- If your form does not have this, get the new form and replace all of your current ABN forms immediately.
- If you are not using this form CMS will determine that your ABNs are ineffective and you will have to pay money back.
- Another unique feature of the new ABN is that special language is needed on the form if you are a non-par doctor.
- I have prepared one of these special ABNs and have it on my website Chiromedicare.net under the "Forms" section.
- If you are a non-par doctor and have not been using this modified ABN you will need to get a copy from my website and replace all of your current ABNs immediately.
- 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.
- There are specific reasons to use the ABN in your practice.
- 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
        - 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.
    - Reduction of care
        - 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.
    - Termination of care
        - 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.
- 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.

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.

The ABN 2018

- **Note:** Providers/suppliers will not violate mandatory claims submission rules under Section 1848 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.

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.

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.

The Form Instructions from CMS are included below:

Form Instructions
Advance Beneficiary Notice of Noncoverage (ABN)
OMB Approval Number: 0938-0566

Overview

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 (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A.

Since 2013, home health agencies (HHAs) providing care under Part A or Part B issue the ABN instead of the Home Health Advance Beneficiary Notice (HHABN) Option Box 1 to inform beneficiaries of potential liability. The HHABN has been discontinued.

All of the aforementioned physicians, suppliers, practitioners, and providers 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. Medicare inpatient hospitals and skilled nursing facilities (SNFs) use other approved notices for Part A items and services when notice is required; however, these facilities must use the ABN for Part B items and services.

The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must *retain a copy of the ABN delivered to the beneficiary* on file.

The ABN may also be used to provide voluntary notification of financial liability for items or services that Medicare never covers. When the ABN is used as a voluntary notice, the beneficiary doesn't choose an option box or sign the notice. CMS has issued detailed instructions on the use of the ABN in its on-line Medicare Claims Processing Manual (MCPM), Publication 100-04, Chapter 30, §50. Related policies on billing and coding of claims, as well as coverage determinations, are found elsewhere in the CMS manual system or website: www.cms.gov.

ABN Changes

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. With the 2016 PRA submission, a non-substantive change has been made to the ABN. In accordance with Section 504 of the Rehabilitation Act of 1973 (Section 504), the form has been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed.

Completing the Notice

ABNs may be downloaded from the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html . Notices should be used as is since the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned in these instructions and the on-line manual instructions for those choosing to integrate the ABN into other automated business processes. Instructions for completion of the form are set forth below:

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.

Sections and Blanks:
There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that notifiers remove the lettering labels from the blanks before issuing the ABN to beneficiaries. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into all of the blanks labeled (D) within the Option Box section, Blank (G). One of the check boxes in the Option Box section, Blank (G), must be selected by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre- printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for billing questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

Body

Blank (D): The following descriptors may be used in the Blank (D) fields:

Item
Service
Laboratory test
Test
Procedure
Care
Equipment

The notifier must list the specific names of the items or services believed to be noncovered in the column directly under the header of Blank (D).

In the case of partial denials, notifiers must list in the column under Blank (D) the excess component(s) of the item or service for which denial is expected.

For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.*7.1 (b) of the MCPM, Chapter 30* for additional information.

General descriptions of specifically grouped supplies are permitted in this column. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.

When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

Please note that there are a total of 7 Blank (D) fields that the notifier must complete on the ABN. Notifiers are encouraged to populate all of the Blank (D) fields in advance when a general descriptor such as "Item(s)/Service(s)" is used. All Blank (D) fields must be completed on the ABN in order for the notice to be considered valid.

Blank (E) Reason Medicare May Not Pay: In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

"Medicare does not pay for this test for your condition."
"Medicare does not pay for this test as often as this (denied as too frequent)."
"Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D) when appropriate.

Blank (F) Estimated Cost: Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs $250:
• Any dollar estimate equal to or greater than $150
• "Between $150-300"
• "No more than $500"

For a service that costs $500:
• Any dollar estimate equal to or greater than $375
• "Between $400-600"
• "No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices,but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimatesand determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

Options

Blank (G) Options: Blank (G) contains the following three options:

□ **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 ordeductibles.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. See Ch. 30, §50.15.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare. Suppliers and providers who don't accept Medicare assignment may make modifications to Option 1 only as specified below under *"***D. Additional Information**.*"*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

□ **OPTION 2.** I want the (D) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare isnot billed.**

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.

□ **OPTION 3**. I don't want the (D)listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided*;* thus, there are no appeal rights associated with this option. The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option."

Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable;
An additional dated witness signature; or
Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

Special guidance ONLY for non-participating suppliers and providers (those who don't accept Medicare assignment):

Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: ~~If Medicare does pay, you will refund any payments I made to you, less co- pays or deductibles.~~
This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN.
The sentence must be stricken and can't be entirely concealed or deleted.
There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier shall 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.

B. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document.