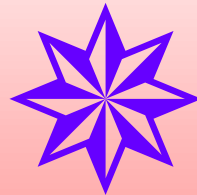
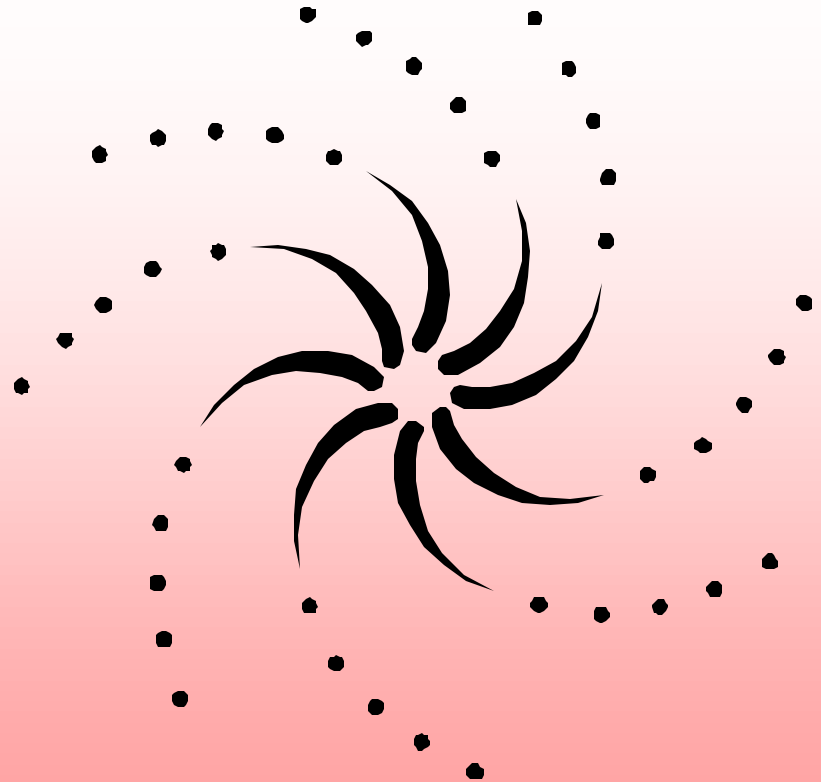


**Medicare Part B
NON-COVERED SERVICES
and
Advanced Beneficiary
Notices**



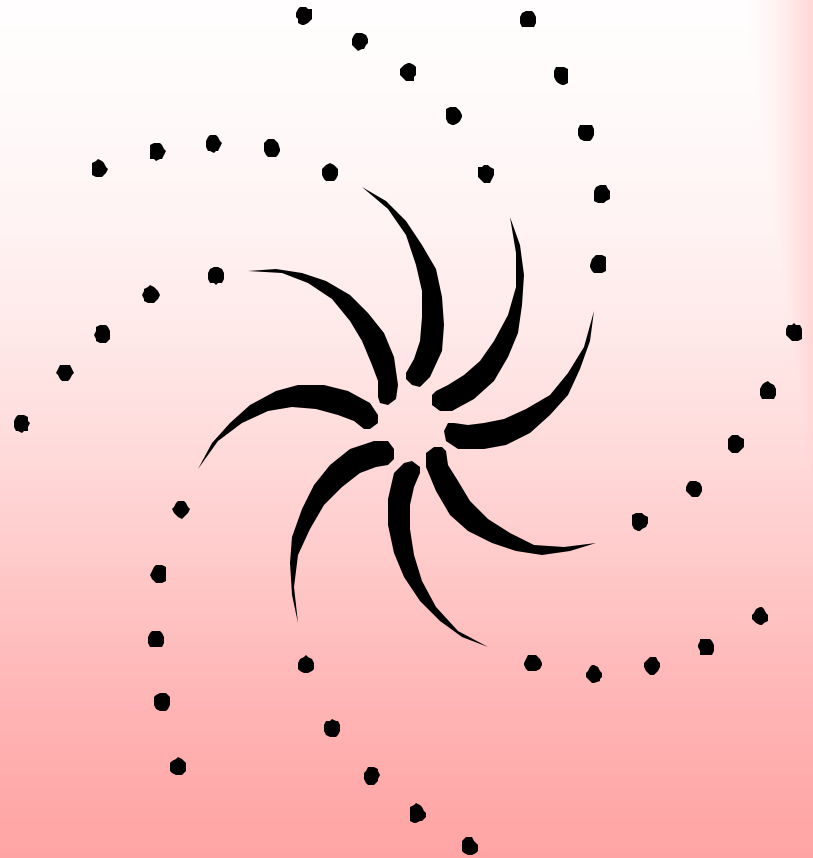
Overview of Medicare Policy Development

- ➔ **Who decides what is covered?**
 - ➔ Congress
 - ➔ Dept. of Health and Human Services (DHHS)
 - ➔ Centers for Medicare and Medicaid Services (CMS)
 - ➔ Medicare Carrier's Manual (MCM)
 - ➔ National Coverage Decisions (NCDs)
 - ➔ Federal Register
 - ➔ Local Carrier
 - ➔ Local Medical Review Policy (LMRP)
- ➔ **Limitation of Liability**
Social Security Act of 1988



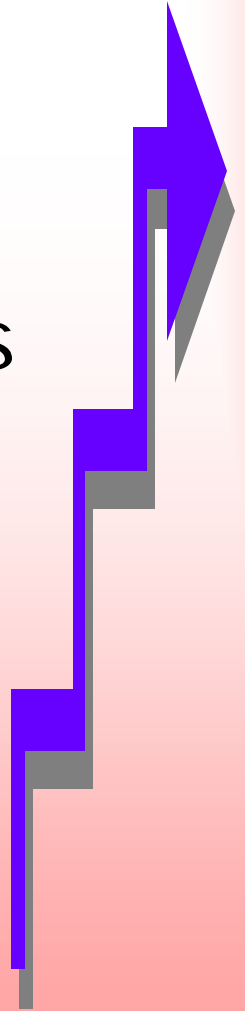
How Can You Know What's Covered?

- How do beneficiaries know what is covered?
 - Medicare and You Handbook
 - 1-800-Medicare
 - www.medicare.gov
- How do providers know what is covered?
 - MPFSDB status code
 - Communique' newsletter
 - POLICY
 - Past remittances/experiences
 - www.cms.hhs.gov
 - WPS website



Purpose of Advanced Beneficiary Notice (ABN)

- Protect the beneficiaries from liability when services are denied as not reasonable and necessary
- Protect the provider's bottom line by shifting financial liability to the patient in the event of denial
- Provide documentation in the event of an audit by Medicare



ABN applies:



- Assigned claims



- Non-Assigned claims



- If a beneficiary did not know and could not have been expected to know a service was not reasonable and necessary and would not be paid under Medicare guidelines, they are not liable for the charges



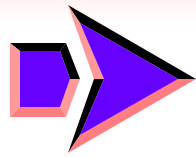
- NECESSARY = depends on the diagnosis which is being treated and the specialty/expertise of the provider(s)



- REASONABLE = depends on frequency (times per day or week) and duration (over a span of time; hours, days or weeks)

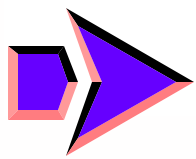
Examples for when ABN is recommended;

- Services that are expected to deny as not reasonable and necessary
- Services that exceed frequency limits
- Services that Medicare considers experimental or for research use



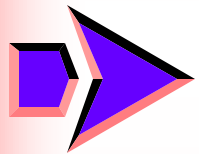
What are Covered Services?

- **Services That May Be Covered by Medicare B:**
- ***IN THE PRESENCE OF SIGNS/SYMPTOMS OF ILLNESS WHICH MEET MEDICAL NECESSITY REQUIREMENTS***
 - Physician's services
 - Outpatient hospital services
 - Outpatient diagnostic services
 - Outpatient physical therapy and outpatient speech pathology services
 - Diagnostic x-rays, laboratory tests, and other diagnostic tests
 - X-ray, radium and radioactive isotope therapy



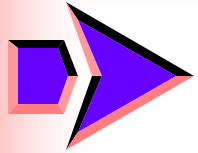
What are Covered Services?

- **Services That May Be Covered by Medicare B continued:**
 - Rental or purchase of durable medical equipment for use in the patient's home
 - Ambulance services
 - Prosthetic devices
 - Leg, arm, back and neck braces and artificial legs, arms, and eyes
 - Certain medical supplies used in connection with home diagnosis delivery systems
 - Rural health clinic services
 - Ambulatory Surgical Center services
 - Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations



What are NON-Covered Services?

- ABNs are not required in the case of statutorily excluded items and services. Examples include, but are not limited to:
 - Personal comfort items
 - Routine physicals and most tests for screening
 - Routine eye care, eyeglasses and examinations
 - Immunizations and vaccines other than influenza, pneumococcal pneumonia, hepatitis B or tetanus for treatment of injury or exposure to disease
 - False teeth



What are NON-Covered Services?

- Services statutorily excluded (cont.):
 - Routine foot care and flat foot care
 - Most outpatient prescription drugs
 - Cosmetic surgery
 - Services by immediate relatives
 - Orthopedic shoes and foot support
 - Hearing aids and hearing examinations

Using ABNs

- Date of service January 1,2003 or after, **mandatory** use of forms CMS-R-131-G or CMS-R-131-L



TWO TYPES OF ABN FORMS

- CMS-R-131-G
 - Can use for all services that may not be covered including Labs
- CMS-R-131-L
 - Can only be used for Labs that may not be covered



New ABN forms

- FORMS:
www.cms.hhs.gov/medlearn/refabn.asp
- FAQs:
www.cms.hhs.gov/medlearn/faqabns.asp



Complete ABN Instructions

- Reference Program Memorandum
AB-02-168

Dated: November 22, 2002

Highlights of ABN Requirements

- *Header must identify name, address and phone number of the billing entity.*
- *“Items or Services” and “Because” boxes can be customized.*
- *ABN must be signed and dated prior to services being rendered.*
- *Patient must be given a signed copy of ABN.*

Modifier "GA"

- National modifier for waiver of liability on file.
- Signifies an Advance Beneficiary Notice was given to the Medicare beneficiary.
- Generates different message to beneficiary when appended to the service on the claim. If denied, the message will indicate patient is responsible for payment to the provider.

Questions? Concerns?

- 1-800-633-4227 (1-800-MEDICARE)
- 1-800-944-0051 Beneficiary to WPS
- 1-877-567-7176 Provider to WPS
- www.wpsic.com/medicare_web

