



www.wpsmedicare.com

Advance Beneficiary Notice (ABN) Script

Hello, today we are here to talk about the Advance Beneficiary Notice (ABN).

The Advance Beneficiary Notice is a very important communication tool for providers and beneficiaries regarding services which Medicare may deem medically unnecessary.

Before we talk about the ABN, let's discuss another category of services: non-covered services.

Non-covered services are those which cannot be paid by Medicare and are statutorily excluded from being a covered benefit. The Centers for Medicare & Medicaid Services (CMS) notifies beneficiaries about Non-covered services in their annual *Medicare and You* handbook. CMS sends a copy of the updated version of the *Medicare and You* handbook to all Medicare beneficiaries on an annual basis. Providers may access this handbook by going to:

<http://www.medicare.gov>

Medicare expects providers to have knowledge of both the Medicare rules for the services he/she performs and the patient's condition. Medicare publications, such as our Listserv messaging and contractor newsletters, are important resources.

It is important for providers to be aware of published medical policy. Medicare has three primary categories of published medical policy. You can find National Coverage Determinations (NCDs) on CMS' Website and the WPS Medicare Website. Other types of medical policy include National Coverage Provisions (NCP) and Local Coverage Determinations (LCD) and are available at the WPS Medicare Website.

CMS also has a manual with the NCDs in numeric order. You can access this information at the following Website and choose the Internet Only Manual (IOM)

National Coverage Determination manual 100-03:

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>

By utilizing the tools above, providers can determine if a carrier will deem services as statutorily non-covered or deemed not medically necessary. Providers can bill a patient for non-covered services and are not required to provide a patient anything in writing. If the patients request something in writing, the provider may access the Notice of Exclusion from Medicare Benefits (NEMB) form at <http://www.cms.hhs.gov/BNI/Downloads/CMS20007English.pdf> for this purpose.



www.wpsmedicare.com

Some patients have Medicare supplemental insurance policies which may offer coverage for services or supplies which Medicare considers non-covered. However, in order to do so, they will need Medicare's denial to consider payment. Bill these services to Medicare using the modifier **GY**: Item or service is statutorily excluded or does not meet the definition of any Medicare benefit.

An Advance Beneficiary Notice (ABN) is a very important communication tool for providers and beneficiaries regarding services which Medicare may deem medically unnecessary. These are not the same as the non-covered service. Not medically necessary services are services Medicare can pay for, but are *not* paying for in a particular situation. Proper usage of an ABN establishes financial liability for services which are denied based upon medical necessity guidelines.

Unlike non-covered services, services which may be deemed medically necessary are services which Medicare does cover, and can pay. The remarks codes on the Provider Remittance Advice indicate the patient's liability. Medically unnecessary services are those which Medicare covers, but in specific circumstances Medicare does not pay. There are two primary categories by which Medicare may deem a billed service as medically unnecessary: diagnosis, and frequency.

When a provider anticipates Medicare may deny a service, then he/she can provide the patient with an Advance Beneficiary Notice (ABN). The ABN allows the patient to become an informed consumer. The information allows the patient to decide to have the service knowing Medicare may not pay or not to have the services.

There are two forms available:

- CMS-R-131-G Advance Beneficiary Notice (General Use)
- CMS-R-131-L Advance Beneficiary Notice (Laboratory Tests)

You can access these forms on the CMS Website

<http://www.cms.hhs.gov/CMSForms/> where you can scroll down or perform a search to locate the form.

Providers may not alter the ABN *except* for the following changes:

- Providers may add his/her letterhead on the form.
- Providers may expand the form to legal size.
- Providers must add the patient's information.
- Providers must add a description of the services in question. (More than a procedure code)
- Providers must add a reason why Medicare will deny the service.
- Providers should indicate the approximate charge for the service



www.wpsmedicare.com

Once the provider has completed the ABN and has presented it to the patient, the patient will decide between one of two options.

Option 1: indicates the patient will have the service and agrees to be liable for the charges should Medicare deny.

Option 2: indicates the patient chooses not to have the service.

If the patient agrees to proceed with the service, the provider gives the patient a copy of the signed and dated ABN form, and places the original in the patient's file in their office.

The provider then bills the service with a GA Modifier appended to the procedure code.

The modifier GA means that you have an Advance Beneficiary Notice on file.

This establishes the patient's financial liability for the rendered service(s), should Medicare deny as expected.

Thank you.