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COMPLIANCE NEWSLETTER

NAVIGATING THE MAZE

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ADVANCED BENEFICIARY NOTICES

The use of an Advanced Beneficiary Notice (ABN) remains a source of confusion for many providers. As such, there are still facilities that do not have processes in place to ensure the use of ABN's. In some cases, ABN's are not issued at all, or blanket ABN's are provided for all services; which is a practice that is illegal. Understanding what an ABN is and what the requirements are, will aid in the development of appropriate process and prevent non-compliance.

BACKGROUND

The Social Security Act contains financial liability provisions to protect both beneficiaries and health care providers from unexpected liability arising from certain charges that are associated with claims not paid for by Medicare.

The provisions include:

- Limitation On Liability (LOL) under §1879(a)-(g) of the Act.
- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l) of the Act.
- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical
- Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act. [1]

Based on these provisions, a notice was developed and subsequently approved by the Office of Management and Budget (OMB) called the Advanced Beneficiary Notice. The ABN is a document issued by providers and suppliers for items or services provided under Medicare Part B and some services under Medicare Part A to fulfill mandatory and voluntary notice requirements[2]. By receiving this document, patients are able to make informed decisions as to whether or not they want to proceed with a service or item knowing that they may be financially responsible for the bill.

MANDATORY USE

There are situations in which the use of an ABN is considered mandatory.

Those situations include:

- Care is not reasonable and necessary
- There was a violation of the prohibition on unsolicited telephone contacts
- Medical equipment and supplies supplier number requirements not met
- Medical equipment and/or supplies denied in advance
- Custodial care
- A hospice patient who is not terminally ill[3]

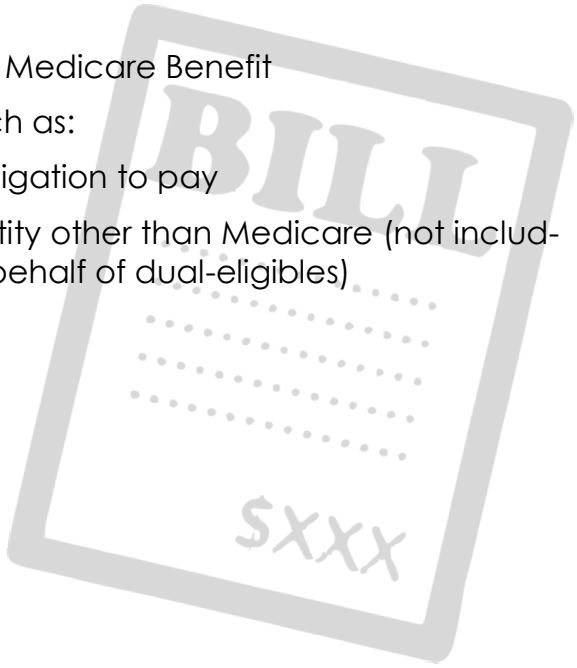
The mandatory situations that require the use of an ABN was expanded in 2011 based upon the Patient Protection and Affordable Care Act. That expansion indicates that an ABN is required to be provided when Medicare Personalized Prevention Plan services are performed more frequently than indicated on the coverage guidelines and therefore not covered by Medicare[4].

VOLUNTARY USE

In other situations, providers can choose whether to issue an ABN. In these cases, the notice serves more as a courtesy so that the patient is aware of their financial obligation. These instances include charges for services that are never covered or care that does not meet a technical benefit requirement. According to CMS, the ABN can be issued in place of the Notice of Exclusion from Medicare Benefits (NEMB) form in situations where the service is never covered[5].

Examples would include:

- Care that fails to meet the definition of a Medicare Benefit
- Care that is excluded from coverage such as:
  - Services for which there is no legal obligation to pay
  - Services paid for by a government entity other than Medicare (not including services paid for by Medicaid on behalf of dual-eligibles)
  - Services required as a result of war
  - Personal comfort items
  - Routine eye care
  - Dental Care
  - Routine foot care[6]



PROHIBITIONS

CMS has indicated that there are processes that are not acceptable as it relates to ABNs. Those include providing routine, generic, blanket, or signed blank ABNs. Routine notices are those notices that do not provide a reason as to why Medicare may not pay. There are a few exceptions when routine notices could be provided such as when a situation arises and it is expected that all or virtually all patients may be at risk for having their claim denied[7]. For additional exceptions that allow the use of routine ABNs, refer to the Medicare Claims Processing Manual, Chapter 30: 40.3.6.4.

Generic ABNs lack the information needed for the notice to be effective. This would include listing the services and the reason a denial is anticipated[8]. Giving every patient an ABN every time he/she accesses services is also prohibited. Providers should only be providing notices when they believe that it is likely that Medicare will not pay. Another prohibited practice is the issuance of blank ABNs for patients to sign. ABNs obtained in this way are considered defective notices and do not protect the provider from liability[9].

CONCLUSION

Issuing Advanced Beneficiary Notices can be a source of confusion for providers. This confusion has led to some providers developing processes that are prohibited or not issuing the notices at all. By understanding what constitutes an effective notice and when to issue the notice, providers will be able to develop appropriate policies and procedures. This will ensure that the notices are issued timely, effectively and decrease provider liability.

[1] Medicare Claims Processing Manual. Chapter 30, 50.2-General Statutory Authority-financial Liability Protections Provisions (FLP) of Title XVIII.

[2]Medicare Claims Processing Manual. Chapter 30, 50.3-ABN Scope

[3]MLN Matters Number: MM6136

[4] Medicare Claims Processing Manual. Chapter 30, 50.3.1-Mandatory ABN Uses

[5] Medicare Claims Processing Manual. Chapter 30, 50.3.2-Voluntary ABN Uses

[6] Indem

[7] Medicare Claims Processing Manual. Chapter 30, 40.3.6 Routine Notice Prohibition

[8] Medicare Claims Processing Manual. Chapter 30, 40.3.6.2-40.3.6.3

[9] Indem

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