



Advance Beneficiary Notice of Noncoverage

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Today's Presenters

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- NGS + Aunt Bertha
 - *Locate federal, state and local free and reduced cost resources in your area*
 - *Programs for COVID-19, food services, emergency support*
- USA.gov
 - *Educational guide with information about federal programs*

aunt
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Objectives

- Provide guidance on when and how to issue a proper ABN (Form CMS-R-131)
- Review guidelines for submitting a claim to Medicare when an ABN has been issued for outpatient services that Medicare may deny as not reasonable and necessary
- Review guidelines for using CC 20 or 21

Agenda

- ABN Form
- Completing the ABN
- Submitting the Medicare Claim
- Liability Consideration for Bundled Services
- OC 32
- Modifiers
- Condition Code 20 and 21
- Questions

What is an ABN

- Used for FFS Medicare only
- Written notice given to patient in certain circumstances for services when Medicare payment expected to be denied
- Allows patient to make informed decision before services rendered
- Transfers liability for payment to patient if they choose to still obtain those services

Form CMS-R-131 ABN

- Available on CMS website
 - [FSS ABN](#)
 - [Beneficiary Notices Initiative \(BNI\)](#)
- Guidelines for mandatory and voluntary use
 - [CMS Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50](#)
- FYI: [SNF noncoverage notices](#)
 - SNF ABN for Part A items and services
 - ABN (CMS-R-131) for Part B items and services

Revised ABN Form CMS-R-131

- FFS ABN form and instructions:
<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN>
- Updated ABN form and instructions with mandatory use date of 1/1/2021; expiration date 6/30/2023
- Available in English and Spanish versions
- OMB renewed ABN with changes to the instructions
 - Do not include on ABN: Medicare numbers (HICNs), Medicare beneficiary identifiers (MBIs), or Social Security number
 - Cannot use MBI as patient identification number
 - Other clarifying updates to the instructions

Revised ABN Form CMS-R-131

- Revised wording for Option One to accommodate billing of Medicare/Medicaid dually eligible patients
 - [ABN instructions](#) contain special guidance for people who are dually enrolled in both Medicare and Medicaid (dually eligible) individuals:
 - Provider must revise Option 1 per instructions
 - Beneficiary must check Option 1
 - Cannot bill a dually eligible beneficiary prior unless certain circumstances apply
- ✓ Additional Information on dually eligible beneficiaries

CMS MLN Pub. ICN MLN006977 “[Dually Eligible Beneficiaries Under Medicare and Medicaid](#)”

Mandatory ABN

- Services not reasonable and necessary
 - Experimental items and services
 - Custodial care
 - Preventive services exceeding frequency limitations
 - Hospice patient not terminally ill
 - Not meeting Home Health requirements such as not confined to home or intermittent skilled care not medically necessary
 - Certain DME medical equipment/supply situations
 - Personalized prevention plan services exceeding frequency

Voluntary ABN

- Voluntary use of the ABN is allowed, but not required for certain services to serve as courtesy/forewarning of impending financial obligation
 - Beneficiary not asked to choose option box or sign notice
- Voluntary ABN can be issued for care that is
 - Statutorily excluded (Social Security Act [SSA] Section 1862) from coverage; or
 - Fails to meet technical benefit requirement (SSA Section 1861)

Routine Notice Prohibition

- Routine use not effective
 - Routine – issue ABN when no specific identifiable reason to believe Medicare will not pay
- Provider must have some doubt that Medicare will make payment
- Routinely issued = defective notice

Routine ABN Prohibition – Exceptions

1. Services always denied for medical necessity – NCD provides service never reasonable and necessary
2. Experimental items and services
3. Services where Medicare established statutory or regulatory frequency limitation on coverage or frequency limitation on coverage based on NCD/LCD
4. DME/Medical Equipment related

ABN Timeliness

- Must be issued far enough in advance to make rational informed consumer decision without undue pressure
- Last minute notification can be coercive
- Delivery should take place before service initiated

The Notifier

- Entity who issues ABN
 - Notifier may include physician, practitioner, provider, supplier or member of provider Utilization Review Committee
 - Responsible for effective delivery of ABN
 - When multiple entities are involved separate ABNs not necessary

The Recipient

- Medicare beneficiary or their authorized representative
 - An authorized representative is an individual who may make health care and financial decisions on behalf of beneficiary
 - For example, legal guardian or someone appointed according to properly executed “durable medical power of attorney”

ABN Triggering Events

- Notifier required to issue ABN whenever limitation on liability applies
- Typically occurs at three points during course of treatment - known as “triggering events”
 - Initiation
 - Reduction
 - Termination

Initiation

- Start of new patient encounter
- Start of POC
- Beginning of treatment
 - Provider believes certain otherwise covered services will be noncovered (e.g., not reasonable and necessary) at initiation
 - ABN must be issued prior to providing service

Reduction

- Decrease in component of care
- Example
 - Patient receiving outpatient PT five days a week and wishes to continue at same rate
 - Upon review, provider believes patient therapy goals can be met with only three days of therapy weekly
 - Reduction in therapy would trigger requirement for ABN

Termination

- Discontinuation of certain items or services
- Example
 - Therapist no longer considers outpatient SLP therapy described in POC as reasonable and necessary
 - ABN would be issued prior to termination of SLP

Delivery Requirements

- ABN considered to be effective when
 - Delivered to capable recipient by suitable notifier
 - Issued appropriate, fully completed ABN form
 - Delivered in person (if possible)
 - Provided far enough in advance – patient considers all options
 - Explained in full – patient questions answered
 - Signed by recipient

Alternate Options for Delivery

- Should be delivered in person and prior to rendering noncovered service
- When in-person delivery not possible, provider may deliver ABN via
 - Telephone contact
 - Mail
 - Secure fax
 - Internet email

Notice By Telephone

- Telephone notice not sufficient evidence of proper notice
 - Unless content of telephone contact verified and not disputed by beneficiary
- Time of telephone notice can be accepted as time of ABN delivery
 - Only if telephone notice followed up immediately with mailed notice and beneficiary signed written notice

Beneficiary Changes Their Mind After Signing

- Notifier should
 - Request that beneficiary annotate original signed ABN
 - Annotation must include clear indication of new option and beneficiary's signature/date
 - If unable to present in person, annotate ABN reflecting new choice and immediately send copy for beneficiary's signature and date

Beneficiary Refuses to Complete or Sign

- Notifier should
 - Annotate original copy indicating refusal – may list witness to refusal
 - Consider not furnishing service unless that not an option
 - Provide patient copy of annotated ABN

Delivery Guidance During COVID-19 Public Health Emergency

- COVID-19 PHE institutional care ABN delivery flexibilities for beneficiaries in isolation
 - Delivery
 - Hard copies of notices may be dropped off with patient by any hospital worker able to enter room safely; or
 - Notice delivery may be made via telephone or secure email to off site beneficiary representatives
 - If hard copy cannot be dropped off, notices to beneficiaries may also delivered via email (if available in isolation room)
 - Contact phone number should be provided for patient to ask questions, if person delivering notice unable to answer

Delivery Guidance During COVID-19 Public Health Emergency

- Notices must be annotated with circumstances of delivery, including person delivering notice via telephone and time of the call, or when and to where email sent
- ✓ CMS Special Edition article [SE20011 “Medicare Fee-For-Service \(FFS\) Response to the Public Health Emergency on the Coronavirus \(COVID-19\)”](#)

Beneficiary Liability

- Beneficiary who has been issued properly written and delivered ABN and agrees to pay may be held liable
- Beneficiary relieved from liability if he/she does not receive proper notice when required

Provider Liability

- Provider will be liable if knew or should have known that Medicare would not pay and fails to issue ABN when required or issues defective ABN

General Preparation Notice Requirements

- Number of copies
 - Minimum two copies – patient and notifier
 - Notifier retains original
- Length and size of page
 - Must not exceed one page in length
 - Attachments permitted for listing additional services

General Notice Requirements

- Contrast of paper and print
 - Dark ink on pale background
 - Do not use reversed print – white print on black paper
- Font
 - Font size – 12 point
 - Title font – 14 to 16 point

General Notice Requirements

- Customization and modification
 - May preprint information in certain blanks to promote efficiency and ensure clarity
 - May develop multiple versions specialized to common treatment scenarios
 - May not be modified except as specifically allowed and approved by CMS
 - Alterations could invalidate ABN – provider liable for noncovered charges

Completing ABN

- Composed of five sections and ten blanks which must appear in following order
 - Header (Blanks A–C)
 - Body (Blanks D–F)
 - Option box (Blank G)
 - Additional information (Blank H)
 - Signature box (Blanks I–J)
- [Form Instructions Advance Beneficiary Notice of Noncoverage \(ABN\)](#)
[OMB Approval Number: 0938-0566](#)

The Header – Blanks A–C

- Blank A: Notifier(s) – Name, address and telephone number including TTY when needed
- Blank B: Patient Name – First and last name of beneficiary receiving notice
- Blank C: Identification Number – optional
 - Can be medical record number
 - Do not use HICN or SSA number

The Body – Blank D

- Provider must list specific service believed to be noncovered under Header of Blank (D)
 - Item
 - Service
 - Laboratory test
 - Procedure
 - Care
 - Equipment

The Body – Blank E

- Reason Medicare May Not Pay
 - Use beneficiary-friendly language explaining why service described in Blank D may not be covered
 - Provide at least one reason applicable to each service listed in Blank D

The Body – Blank F

- Estimated Cost
 - Complete to ensure beneficiary has information to make informed decision
 - Must make good faith effort to insert a reasonable estimate for all services listed in Blank D
 - Estimate should be within \$100 or 25% of actual costs

Options – Blank G

- Blank G – beneficiary must choose 1 of three options
 - Option 1 – I want the item or service 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.
 - Option 2 – I want the item or service 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 is not billed.
 - Option 3 – I don't want the item or service listed above, I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Blank G – Qualified Medicare Beneficiary Program (QMB)

- Special guidance for QMB only: Must check
 - **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.**
 - Notifier must strike through the area in red text above
- ✓ CMS MLN Booklet, ICN MLN006977: [“Dually Eligible Beneficiaries Under Medicare and Medicaid”](#)

Additional Information – Blank H

- May use this space to provide additional clarification that may be of use to patient
- Example
 - A statement advising beneficiary to notify his/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

Signature Box – Blanks I and J

- Once patient/representative reviews and understands – ABN signature box must be completed
 - Blank I Signature – Beneficiary/representative must sign to indicate he/she received and understands notice
 - Blank J Date – Beneficiary/representative must complete date he/she signed ABN signature box cannot be completed in advance

Emergency/Urgent Situation

- Must not issue ABN in medical emergency or when beneficiary is under duress
- ABN issued in ER may be appropriate in some cases
 - Is beneficiary medically stable with no emergent health issues?
- When EMTALA applies, no ABN should be issued
 - May reconsider if beneficiary is capable after completion of medical screening exam and stabilization of any emergency medical condition

Period of Effectiveness/Repetitive or Continuous Noncovered Care

- ABN may remain effective up to one year as long as no other triggering event occurs
 - New triggering event = new ABN must be issued
- Allegations of improper or incomplete notices will be investigated by MAC
 - If ABN is found to be improper or incomplete – patient will not be held liable

ABN Retention

- Retention period is five years from discharge/ completion of care
- Retention required in all cases including those cases in which beneficiary
 - Declined care
 - Refused to choose an option
 - Refused to sign

Submitting the Medicare Claim for ABN Services



Basic Payment Liability Conditions

Scenario	Payment Condition 1
Description	Items and services being billed are statutorily excluded from Original Medicare coverage, meaning it is not defined as a specific Medicare benefit defined in the Act; therefore, it is never paid.
Notification (prior to billing)	Liability notices are voluntary (i.e., ABN); for statutory exclusions, there are no required Medicare notices.
Billing	Items and services may be billed as noncovered on Medicare claims.
Liability	Always denied in Medicare claims processing; beneficiaries are liable for these denials unless providers code their claims to transfer liability to themselves.

Payment Liability Condition One

- ABN not required if patient elects to receive services excluded from Medicare by statute
 - ABN may be used for voluntary notification purposes
- Situations where patient informed service not covered must also be documented in patient records
 - Making clear specific reason patient was told service would be billed as noncovered and patient would be financially liable

Basic Payment Liability Conditions

Scenario	Payment Condition 2
Description	Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or provider.
Notification (prior to billing)	Liability notices are required (i.e., expedited determination notice, ABN).
Billing	Billing of such items and services can vary, and can depend on the ability to segregate its covered and noncovered portions (if both exist).
Liability	For any services that are not paid by Medicare itself, properly notified beneficiaries are usually liable for resulting denials.

Payment Liability Condition Two

- Provider must issue ABN when services reduced or terminated and thought to be not covered
 - Delivery of ABN can permit shift of liability
- Provider must issue ABN to beneficiary before services are delivered
 - Failure to issue ABN when required means provider will not be able to shift liability to beneficiary
- When mandatory ABN issued patient records must be documented

Basic Payment Liability Conditions

Scenario	Payment Condition 3
Description	Items or service is presumed to be a Medicare benefit and can be paid.
Notification (prior to billing)	Liability notices, mandatory or voluntary, are never used in advance of such billing.
Billing	Items and services are billed as covered.
Liability	If Medicare doesn't pay itself as expected, the specific reason for rejection or denial will determine liability according to established Medicare policy.

Payment Liability Condition Three

- Condition occurs when providers billing for what they believe to be covered services
- No ABN requirements for this condition
- Noncovered charges are not involved
- Denials may result from processing

Liability Conditions for Bundled Services

- ABN has to apply to all of a bundled service or to none of it
 - Full bundled service must be billed as noncovered or none of it
- Can billing entire bundled service as covered as long as part of bundled service certain to be covered or medically necessary
 - If entire bundle certain to be noncovered, should be billed as noncovered

Obligation to Bill Medicare

- If ABN issued, patient has right to request claim submission to Medicare for official payment decision
- Patient must receive service described in ABN and choose option one in order to request Medicare claim submission

Claim for Mandatory ABN

- Report OC 32 with date mandatory ABN issued
 - Services related to ABN are billed with covered charges
 - If multiple ABNs were issued, bill multiple OC 32s
- Report GA modifier when applicable
 - GA modifier (Waiver of Liability Statement on file, as Required by Payer Policy) used when only some services on claim relate to mandatory ABN
 - Do not report the GA modifier with any other liability-related modifier
- Normal billing regulations apply

Claim for Mandatory ABN

- When billing for mandatory ABN-related services, other covered and noncovered services may be included on the claim
 - Use OC 32 and GA modifier (with covered charges) to identify services related to ABN but do not include any other liability-related modifier(s)
- Medicare systems automatically deny lines submitted with OC 32 and/or modifier GA (charges billed as covered)
- Medicare systems assign beneficiary liability to claims
 - CARC 50 - “These are noncovered services because this is not deemed a medical necessity”

Liability Modifier: Modifier GX

- GX modifier (Notice of Liability Issued, Voluntary Under Payer Policy) - used to report voluntary ABN issued
 - Applies to services excluded from Medicare coverage by statute
- Lines with GX modifier must be submitted with noncovered charges only
- Medicare systems allow modifier GX to be reported on same line as modifier GY (service statutorily excluded)
- Claim denied as beneficiary liable

Liability Modifier: Modifier GZ

- Provider expects denial due to lack of medical necessity
 - GZ modifier indicates ABN was not issued for services
 - Submit charges as noncovered
 - Provider will be liable for services billed with GZ modifier
- NGS will not perform complex Medical Review and will automatically deny claim line(s) submitted with CARC 50/Group Code CO

FYI

- Applicable to all liability modifiers discussed today as well as those included in [CMS IOM 100-04, Chapter 1](#), Section 60.4.2 table “Definition of Modifiers Related to Non-covered Charges/ABNs for Institutional Billing”
 - Liability modifiers are required when noncovered services cannot be split into entirely non-covered claims
 - Provider liability modifiers cannot be used on entirely noncovered claims where there are some services that are beneficiary liable

Demand Bill: Condition Code 20

- Report CC 20 in situations where issuing ABN not appropriate and beneficiary demands Medicare determination
 - Charges related to CC 20 billed as noncovered
 - TOB frequency = 0 when all charges billed as noncovered
 - Unrelated covered charges are allowed
 - TOB as applicable
 - OC 32 and/or CC 21 cannot be billed with CC 20
- ✓ [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 60](#)

Insurance Denial: Condition Code 21

- Report CC 21 for Medicare denial to use when billing secondary or other insurances
 - Submit services on a claim with CC 21 showing all charges as noncovered (total charges = noncovered charges)
 - Report CC 21; no modifier; TOB frequency = 0
 - No services are in dispute by beneficiary
 - Billing for denial
- ✓ [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 60](#)

Resources



Resources

- [Beneficiary Notices Initiative \(BNI\)](#)
 - [FFS ABN Form and Instructions](#)
- **CMS Internet-Only Manuals**
 - [Publication 100-04, Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections](#)
 - [Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 60 - Provider Billing of Non-covered Charges on Institutional Claims](#)
 - [CMS IOM 100-02, Chapter 16 - General Exclusions From Coverage](#)

Resources

- CMS MLN Booklet® [Medicare Advance Written Notices of Noncoverage \(ICN 006266\)](#)
- MLN Booklet® [Items and Services Not Covered Under Medicare \(ICN 906765\)](#)
- CMS [Advance Beneficiary Notice of Noncoverage Interactive Tool](#)
- MLN Matters® [MM10848: Medicare Claims Processing Manual, Chapter 30 Revisions](#)

Resources

- MLN Matters® [MM8597: Correction CR - Advance Beneficiary Notice of Noncoverage \(ABN\), Form CMSR-131](#)
- MLN Matters® [MM8408: Advance Beneficiary Notice of Noncoverage \(ABN\), Form CMS-R-131](#)
- MLN Matters® [MM7821: Advance Beneficiary Notice of Noncoverage \(ABN\), Form CMS-R-131, Updated Manual Instructions](#)
- MLN Matters® [MM7228: Auto Denial of Claims Submitted With a GZ Modifier](#)

Resources

- MLN Matters® [MM7228: Auto Denial of Claims Submitted With a GZ Modifier](#)
- MLN Matters® [MM6563 Revised: Billing for Services Related to Voluntary Uses of Advance Beneficiary Notices of Noncoverage \(ABNs\)](#)
- Transmittal A-03-039, [Change Request CR2590: Clarification to Correction to Updated Instruction on Receipt and Processing of Non-Covered Charges on Other Than Part A Inpatient Claims \(Condition Codes 20 and 21, Occurrence Code 32\)](#)

NGS Resources

- NGS Job Aids & Manuals > [Outpatient Occupational and Physical Therapy Services Billing Guide: “Advance Beneficiary Notice of Noncoverage and When to Use It”](#)
- NGS Job Aid: [Billing for a Denial – Condition Code 21](#)
- NGS Job Aid: [Medicare Coverage Exclusion: Dental Services](#)
- NGS Job Aid: [Refunds Due to Beneficiaries by Providers](#)
- NGS Medical Policy article [“Capable Recipients for the Advance Beneficiary Notice of Noncoverage”](#)

Thank You!

- Follow-up email
 - Attendees will be provided a Medicare University Course Code
- Questions?

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