

Policies and Procedures: WVU Physicians of Charleston
Medicare Advance Beneficiary Notice

Section: Compliance
Chapter: Billing
Policy: Medicare Advance Beneficiary Notice

I. Purpose

The purpose of this policy is to ensure that an appropriate Advance Beneficiary Notice ("ABN") is obtained from Medicare beneficiaries for laboratory tests, procedures and other medical services that are not paid by Medicare because they are deemed to be not reasonable and necessary.

II. Scope

This policy applies only to services provided to Medicare beneficiaries. This policy does not apply to Medicare General Program Exclusion services (i.e. services that are never covered by Medicare, such as preventative annual examinations, cosmetic surgery, etc.).

This policy applies to all employees and agents of West Virginia University Physicians of Charleston ("WVUPC").

III. Statement of Policy

Section 1862(a) of the Medicare law prohibits payment for services/items that are not medically reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. A service/item may be considered not reasonable and necessary when, for example, the service/item is not covered based on the diagnosis/condition of the patient, when the frequency/duration of the service was provided beyond the accepted standards of medical practice, when the medical documentation does not justify the medical necessity of a service/item, and/or when the service was not rendered in a certified facility.

The physician is considered to know, or will be expected to know, that a service/item may be denied payment as not medically reasonable and necessary when:

- The specific medical necessity requirements were published by the contractor;
- The physician has received a previous review, waiver of liability or hearing decision or other notice for the service/item which informs him/her of medical necessity requirements;
- The physician has received a denial or reduction of payment on the same or similar service/item; or

- The physician can reasonably be expected to know the requirement based on standard medical practice within the community.

In cases where the physician believes that a service/item may not be covered as medically reasonable and necessary, an acceptable advance notice of Medicare's possible denial of payment must be given to the patient if the physician does not want to accept financial responsibility for the service/item. This notification serves as protection for both the physician and the patient and requires the following:

Patient: The patient should be notified before the service is rendered that payment might be denied or reduced. The patient can then decide if he/she wants the service to be rendered and is willing to pay for it.

Physician: If the physician notifies the patient in advance that payment for the service may be denied or reduced, then the physician is not held financially liable for his/her services; he/she may seek payment from the patient.

The billing staff of each clinical department of WVUPC is responsible for knowing the current Medicare rules for services that may be denied by Medicare as not "reasonable and necessary." Medicare coverage rules can be found in the Medicare Carrier's Manual, local medical review policies ("LMRPs"), and in notices provided by the federal government to individual providers.

IV. Procedure

The guidelines set forth in this policy, as well as Medicare rules, must be followed to ensure that an ABN is obtained in accordance with Medicare requirements. Failure to follow these guidelines will result in an inability to bill the patient for any services that Medicare determines are not reasonable and necessary.

A. Advance Beneficiary Notice Required. An ABN must be obtained when one or more of the following circumstances exist:

- The service or test may not or does not meet Medicare's medical necessity requirements as stated by Medicare in federal statute/regulations, Carrier's Manuals, LMRPs or individual notices to providers.
- The service or test may only be paid for a limited number of times within a specified time period and this service or test may exceed that limit (i.e., screening tests, etc.)
- The service or test is for investigative, research or experimental use only.

- The patient requests a more extensive service or test than is deemed to be medically necessary by the provider

B. Obtaining an Advance Beneficiary Notice.

1. Format and Content

- a. The ABN must be in writing, and in easy to read using no less than 12 point font with no other hard to recognize type.
- b. The ABN must contain the following information:
 - Patient's name, account number & Medicare number
 - Description of service(s) or item(s) that may be denied
 - Reason why the service(s) or item(s) may be denied
 - Must be signed and dated by the patient each time a service will be rendered, indicating that the patient assumes financial liability for the service/item if payment is denied or reduced for the reasons indicated on the advance notice.

2. ABN Forms. For services other than screening pap smears, use Medicare ABN forms CMS-R-131-L (laboratory items/services) and CMS-R-131-G (other items/services) when obtaining an ABN. See Attachments A & B. These forms and their instructions (English and Spanish versions) are also available on Medicare's web site.

- a. ABN Form CMS-R-131-L
http://cms.hhs.gov/medicare/bni/CMSR_131L_June_2002.pdf – English

(Use this form for laboratory items and services, specifically listing the item/service and reasoning in the appropriate Medicare "denial" column.

- b. ABN Form CMS=R-131-G
http://cms.hhs.gov/medicare/bno/CMSR_131G_June_2002.pdf – English

(Use this form for non-laboratory items and services. List the item and/or service in the box labeled "items or services." List with specificity the reason for Medicare denial in the "because" box).

The following statements are acceptable to place in the "because" box:

- 1) If the services are always denied for medical necessity, use the following: "Medicare never pays for this [list the item or service]."

2) If the items or services are experimental use the following:
“Medicare does not pay for services which it considers to be experimental or for research use.”

3) If certain frequency limitations apply to the items or services, use the following:
“Medicare does not pay for this item or service more often than [state the frequency limit].”

3. Process. The ABN must be explained and delivered to the beneficiary (or his/her legal guardian) by knowledgeable staff (i.e. physician, resident, nurse, medical assistant or managed care assistant) prior to the beginning of the service or procedure. The ABN form must be completed and signed by the beneficiary (or his/her legal guardian) **AT OR BEFORE THE START OF THE CARE**. The patient shall not be asked to sign an ABN until all information on the form is completed.

4. Beneficiary Signature. The patient has two choices when services may not be considered reasonable and necessary and therefore may not be covered by Medicare:

- Agree to obtain the service(s) and be responsible for payment should Medicare deny payment; or
- Refuse and not be responsible for payment and not obtain the service(s).

The beneficiary or his/her legal guardian must select one of the above-options on the form and then sign the ABN **BEFORE** services/items are provided.

5. Patient Demands Services But Refuses to Sign. If the patient demands the service(s) and refuses to pay or sign the ABN form, then two witnesses should sign the ABN form and a note should be made that the beneficiary refuses to sign. In this case, the service(s) may be provided and if Medicare payment is denied, the beneficiary can be billed for payment.

6. Routine Use of ABNs. Routine use of the ABN is **prohibited**. There must be a specific reason to believe that Medicare will determine that the service(s) ordered may not be considered **reasonable and necessary**.

7. Delivery of Signed ABN. The completed and signed ABN should be distributed by the physician, nurse, medical assistant, managed care assistant and/or other knowledgeable staff as follows:

- a. Original to the patient's medical record.
- b. One copy to the patient.
- c. If tests are ordered off site, one copy to the entity providing the testing services (i.e. laboratory, radiology, cardiology, etc.)
- d. One copy to billing staff.

C. Billing Modifiers.

1. Medicare modifiers should be used as follows:
 - GA Modifier. Use this modifier when the ABN was signed and is on file. You should also use this modifier when the beneficiary refuses to sign the ABN but still demands the service if two witnesses have signed the ABN form noting the patient's refusal to sign.
 - GZ Modifier. Use this modifier when the claim is expected to be denied as "not reasonable and necessary" but no ABN was obtained. Beneficiaries may not be billed for any claim to which the "GZ" modifier is appended.
 - GY Modifier. Use this modifier when the claim is expected to be denied as "non-covered." ABNS are not required when these types of services are provided (i.e. routine physicals). This modifier is for informational use by the Carrier and does not prevent direct billing to the patient for the service. The "GY" modifier should be used when the beneficiary refuses to pay until Medicare denies the claim.

D. Implementation

1. Each clinical department of WVUPC shall educate their respective staff (i.e. physicians, nurses, coding/billing staff and front staff) on the contents of this policy and Medicare's requirements, and shall designate staff who are responsible for obtaining the ABN.
2. It is the responsibility of each Practice Administrator to ensure that the staff of their respective departments are educated and adhere to the specifics of this policy and Medicare's requirements for ABNs.

V. Administration and Interpretations

Questions regarding this policy must be addressed with your Primary Departmental Clinical Biller, Practice Administrator, the WVUPC Coding Committee, or the WVUPC Compliance Officer.

VI. Amendment or Termination of this Policy

This policy may be amended or terminated at any time.

VII. References

42 U.S.C. §1395pp
Medicare Carriers Manual, Waiver of Liability Provision Section
Program Memorandum (CMS), Transmittal AB-02-168
CMS web site: <http://cms.hhs.gov/medicare/bni/default.asp>.
Palmetto GBA ABN Memo, 2003, <http://palmettogba.com>