DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Advance Beneficiary Notice of Noncoverage for Physician Professional Services and Non-Hospital Entities
PAGE: 1 of 7	**REPLACES POLICY DATED:** 10/1/11, 10/1/15, 6/21/17, 12/1/20, 12/1/21
EFFECTIVE DATE: September 1, 2023	**REFERENCE NUMBER:** REGS.OSG.002
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE:

All non-hospital entities and colleagues responsible for providing and/or billing for services, including, but not limited to:

- Administration
- Advanced Practice Professionals (APPs)
- Ambulatory Surgery Division (ASD)
- Coding/Billing
- Employed and Managed Physicians
- Ethics and Compliance Officers (ECOs)
- Freestanding Imaging Centers
- Freestanding Radiation Oncology Centers
- Independent Diagnostic Testing Facilities (IDTFs)
- Nursing Staff
- Office Staff
- Ordering/Referring/Rendering Physicians
- Parallon
- Physician Services Group (PSG)
- Physician Service Center (PSC)
- Shared Service Center (SSC)

PURPOSE:

To outline the use of the mandatory Advance Beneficiary Notice of Noncoverage (ABN) for services not covered by Medicare fee-for-service.

POLICY:

Prior to rendering a service, non-hospital entities should issue ABNs to Medicare fee-for-service patients if they plan to hold the patient financially liable and:

1. The item/service provided does not meet medical necessity guidelines. For example, the service does not meet the requirements of a National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA).
2. The item/service may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
3. The item/service is for experimental or research use only.

Prior to issuing an ABN, the ordering provider may be contacted for additional information regarding the patient's case.

If there is ambiguity as to whether the requirements of an NCD/LCD/LCA have been met, non-hospital entities should proceed with obtaining an ABN in order to allow the Medicare Contractor to adjudicate the claim.

ABNs must not be issued to patients who are unable to comprehend the ABN, under duress, in a medical emergency, or in any case where the Emergency Medical Treatment and Active Labor Act (EMTALA) applies. However, **for cases where EMTALA applies**, if after completion of the medical screening examination and necessary stabilization, if required, the patient will be receiving further services that are not medically necessary according to NCD/LCD/LCA; the non-hospital entity may choose to obtain an ABN for these non-medically necessary services.

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ABNs may be obtained for an extended course of treatment provided it identifies all items and services that may not be covered and does not extend more than one year.

Services for which ABNs are issued must be billed in accordance with the requirements within this policy.

If a proper ABN is not obtained for a service determined not to be reasonable and necessary, the patient cannot be held financially liable.

The use of the ABN for statutorily excluded services (e.g., self-administered drugs, cosmetic surgery) is not required by CMS. The guidance in this policy does not apply to situations where a voluntary ABN may be issued.

Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage: ABNs may be issued to beneficiaries with QMB coverage (i.e., Medicaid coverage of Medicare premiums and cost sharing) and/or Medicaid coverage. If the provider has any indication that the beneficiary is a QMB and/or has Medicaid coverage, special guidelines outlined in the Procedure section of this policy must be followed.

PROCEDURE:

USE OF THE ABN FORM

1. If the service to be provided is governed by an NCD/LCD/LCA, the pertinent information, including CPT/HCPCS codes and ICD-10-CM codes, if applicable, must be reviewed to determine if the service meets the requirements specified in the NCD/LCD/LCA and to determine if an ABN is necessary.
2. If the decision to issue an ABN is made, the ABN must **not** be provided:
    a. after services have been rendered;
    b. to a beneficiary when payment for an item or service is bundled or packaged into another payment (e.g. under ASC Prospective Payment System), even when those items or services do not meet medical necessity guidelines;
    c. without genuine reason to believe that Medicare may deny the item/service; or
    d. when the beneficiary is unable to comprehend the ABN (e.g., if the patient is comatose, confused or legally incompetent, he/she is unable to understand the implications of signing the ABN) and his/her authorized representative is not available.

COMPLETION OF THE ABN FORM

1. HCA Healthcare non-hospital entities must use the CMS-approved form (CMS-R-131), which may not be altered (see Attachment A). All fields on the ABN form must be completed in sufficient detail to specify the potentially non-covered service. All entries must be in Arial or Arial Narrow font in the size range of 10 - 12 point font or legibly handwritten. When

Spanish-language ABNs are used, the insertions on the form must also be in Spanish.

2. Once the ABN is signed it may not be altered in any way. If additional services will be provided for which an ABN will be needed, a new ABN must be obtained. The signed ABN form should be distributed as follows: retain the original copy at the notifier's office, give one copy to the patient, and retain one copy in the patient's financial record.
3. The non-hospital entity must include its name, address and telephone number in the "Notifier(s)" section. Non-hospital entities may also include their logo.
4. The first and last name of the patient must be entered in the "Patient Name" section. A middle initial should also be used if there is one on the patient's Medicare card.
5. The "Identification Number" section is optional; however, if completed, this section should include an identification number that ties the notice to the specific claim for which the ABN applies. Non-hospital entities may enter the patient account number in this section. Medicare numbers or Social Security numbers must not appear on the notice.
6. The "Items and Services" section must include a general description of the items and services for which the ABN is being obtained in a language that is easy for the beneficiary to understand. It is not appropriate to only include a CPT/HCPCS code as a description. If a CPT/HCPCS is used then additional language must be provided describing the service. Whenever possible the general description of the service to be provided should be used. For example, use "CT Scan of the Head" as the description instead of "CT Scan of the Head without contrast."
7. The ABN form section titled Reason Medicare May Not Pay can be populated with the following four options:
   a. "Medicare does not pay for the items(s) or service(s) for your condition."
   b. "Medicare does not pay for the item(s) or service(s) more often than_____."
   c. "Medicare does not pay for experimental or research use items or services."
   d. "Other reason: _____."

   When completing the ABN form, one of the four options must be utilized to indicate the reason why Medicare may not pay. If the "Other" option is used a reason must also be entered as to why the provider believes Medicare may not pay for the item or service.
8. The Estimated Cost section of the ABN **must** be completed for any items or services listed as not being covered by Medicare. If multiple items or services are listed the estimated cost may reflect the total cost of all the potentially non-covered items and services. The ABN will **not** be considered valid if a good faith estimated cost is not included. In general, the estimate should be within $100.00 or 25% of the actual cost, whichever is greater.

9. The beneficiary must select one of the three options listed in the Options section on the ABN form. Only one of the three options may be selected. If an option is not marked or more than one option is marked then the ABN will **not** be valid. The beneficiary may choose:
   a. **Option 1*** where they receive the item or service and Medicare is billed;
   b. **Option 2** where they receive the item or service and are responsible for payment; or
   c. **Option 3** where they refuse the item or service.

   *** Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage) ONLY:**

   Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted for Medicare adjudication. **This is the only instance where the provider may indicate what option the beneficiary should choose.**

   Strike through **Option Box 1** as provided below:

   □ **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~~.

   These edits are required because the provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries. These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances.

10. The “Additional Information” section may be used to insert additional clarification that will be of use to beneficiaries.
11. Once the beneficiary reviews and understands the information in the ABN, the beneficiary or their representative must sign and date the ABN form. If a representative signs on behalf of a beneficiary, he or she should write out “representative” in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print. If the ABN form is not signed and dated it will not be considered valid.
12. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment, the ordering provider should be contacted to determine if non-performance of the services will compromise patient care.
13. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment and demands that the services be performed, a second person

should witness the provision of the ABN and the beneficiary's refusal to sign. The witness should sign an annotation on the ABN stating that they witnessed the provision of the ABN and the beneficiary's refusal to sign. The claim will be filed as if an ABN was obtained. In the case of a denial by Medicare, the beneficiary will be held liable per Section 1879(c) of the Social Security Act.

BILLING FOR SERVICES

1. If the services are not medically necessary and the beneficiary chose **Option 1** on the ABN:
   a. The services must be reported on the claim.
   b. The GA modifier must be appended to the CPT/HCPCS code representing the service(s) for which an ABN was obtained.
   c. The GY modifier may be appended to the CPT/HCHCS code when billing for a service that is statutorily excluded or is not a Medicare benefit for which an ABN was obtained.

   The Medicare Contractor will make a determination whether or not the services will be paid by Medicare.

   a. If the Medicare Contractor determines that the services are non-covered, the non-hospital entity must bill the beneficiary for the services for which an ABN was obtained.
   b. If the Medicare Contractor pays for the services then the beneficiary must not be billed for the services for which an ABN was obtained.

   Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage:

   a. If Medicare denies a claim as not medically reasonable and necessary and a Remittance Advice (RA) is received, the claim may be crossed over to Medicaid for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue an RA based on this determination.
   b. If both Medicare and Medicaid deny coverage the beneficiary may be billed, subject to any state laws that limit beneficiary liability.
   c. Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the beneficiary in the following circumstances:
      - If Medicare denies the claim as not reasonable and medically necessary and the beneficiary has QMB coverage without full Medicaid coverage, the ABN would allow the provider to shift liability to the beneficiary per Medicare policy.
      - If Medicare denies the claim as not reasonable and medically necessary for a beneficiary with full Medicaid coverage, and subsequently, Medicaid denies coverage (or will not pay because the provider does not participate in Medicaid,) the ABN would allow the provider to shift liability to the beneficiary per Medicare policy,

subject to any state laws that limit beneficiary liability.

2. If the services are not medically necessary and the patient chose **Option 2** on the ABN, the services must not be billed to Medicare. The appropriate billing colleagues must be informed of this decision.
3. If the services are not medically necessary and the patient chose **Option 3** on the ABN, the beneficiary is choosing not to receive the items/services and no services will be billed to Medicare.
4. If the services have frequency limits:
   a. The services should be reported on the claim.
   b. The GA modifier must be appended to the CPT/HCPCS code representing the frequency limited service(s) if an ABN was obtained.
   c. The beneficiary must not be billed for the services if the Medicare Contractor pays for the services.
   d. The non-hospital entity must bill the beneficiary for the services for which an ABN was obtained if the Medicare Contractor determines that the services have exceeded the frequency limits.
   e. The non-hospital entity must not bill the beneficiary if the Medicare Contractor determines that the services have exceeded the frequency limits and an ABN was not obtained.
5. If the services are outside the scope of the NCD/LCD/LCA, the services should be reported as covered on the claim.
6. If the services are not medically necessary and an ABN was not obtained prior to rendering the non-covered services, the GZ modifier may be appended. The GZ modifier represents that an **ABN was NOT** obtained but the provider is billing Medicare for a service that is expected to be denied.

EDUCATION

Administration, Practice Management, and Parallon colleagues must educate all staff associates and medical staff members responsible for ordering, referring, registering, performing, charging, coding and billing services regarding the contents of this policy.

Note: HCA Healthcare offers a web based course, *Understanding the Advance Beneficiary Notice* available through HealthStream, which includes detailed information regarding the ABN and meets the education requirement of this policy.

Administration/Practice Management is responsible for the implementation of this policy within the non-hospital entity.

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REFERENCES:

1. CMS Form Instructions for Advance Beneficiary Notice of Noncoverage (ABN), OMB Approval Number: 0938-0566
2. Medicare Advance Written Notices of Noncoverage ICN MLN006266
3. REGS.GEN.003, Advance Beneficiary Notice of Noncoverage – Outpatient Services (for services in a hospital outpatient department that is located on or off the campus of the hospital)
4. REGS.OSG.007, Medicare - National and Local Coverage Determinations for Physician Professional Services & Non-Hospital Entities
5. Medicare Contractor Local Coverage Determinations and Local Coverage Articles
6. CMS National Coverage Determinations
7. CMS Pub. 60AB, Transmittal No. AB-02-114, July 31, 2002 – ABNs and DMEPOS Refund Requirements
8. Medicare Claims Processing Manual (Pub 100-4), Chapter 30 – Financial Liability Protections, Section 50 – Form CMS-R-131 ABN
9. Medicare Program Integrity Manual (Pub 100-8), Chapter 13 – Local Coverage Determinations
10. Social Security Act Section 1862
11. CMS Frequently Asked Questions - Qualified Medicare Beneficiary Program – FAQ on Billing Requirements, July 2018
12. Attachment A: CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN) (Expires 01/31/2026)
13. Attachment B: Important Information for Medicare Patients Concerning Non-covered Services