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What's Up with Needing So Many ABNs?

It's a matter of compliance.

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Do you hate doing ABNs? Do you even do them at all, or just assume it will all be okay without one? If you are not using them in the appropriate situations, I suggest you rethink that…and fast. Yes, it is time-consuming and a regulatory annoyance, but they are a critical part of compliance in your practice.

What is a Medicare waiver/Advance Beneficiary Notice (ABN)?

An ABN is a written notice from Medicare (standard government form CMS-R-131), given to a patient before receiving certain items or services, notifying them that:

1) Medicare may deny payment for that specific procedure or treatment.

2) They will be personally responsible for full payment if Medicare denies payment.

The ABN helps the beneficiary decide whether to get the item or service Medicare may not cover and accept financial responsibility for it. If the beneficiary does not get written notice when required, the provider or supplier may be financially liable if Medicare denies payment.

An ABN gives the patient the opportunity to accept or refuse the items or services and protects them from unexpected financial liability in cases where Medicare denies payment. It also offers you and the patient the right to appeal Medicare's decision. It affords the patient the choice to have a claim sent on their behalf to Medicare even if expecting it to not be covered. Most of the time they are hoping it is, of course, so they have no payment to make. We providers often cringe as Medicare pays for a non-covered service and then we must battle with the patient and Medicare over the payment which should not have been made. A classic example is the "routine foot care" patient.

When the patient signs an ABN and becomes liable for payment, they will have to pay for the item or service out-of-pocket or by some other insurance coverage that they may have in addition to Medicare. Medicare fee schedule amounts and balance billing limits do not apply. The amount of the bill is a matter between the patient and the provider. It is prudent to provide a cost estimate before presenting the patient with the ABN.

Certain items or services that are covered by Medicare are only covered up to a certain number of times within a specified amount of time.

Why do I routinely have to provide an ABN for certain items or services? It's because under Medicare Program Standards, some items or

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services are considered not reasonable or necessary—even when we disagree and feel they should be.

Certain items or services that are covered by Medicare are only covered up to a certain number of times within a specified amount of time. Examples of these are "frequency limited" services such as at-risk foot care, non-covered routine foot care, or even some DME products.

In the case of certainly non-covered routine foot care, it is not mandatory, but is suggested. Medicare does not require you to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability.

Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. I typically did them in my practice for patients in the event that patient would say I should have sent it in even knowing it should be denied.

Giving a patient an ABN that gives a frequency limit as its reason means that Medicare will not pay if you exceed that limit on the service. This would apply, for example, on that patient who wants to come in for at-risk care more often than the prescribed and covered 60+ days.

One of the more recent developments may be with your DME goods and our non-payments due to the "same or similar" regulation being enforced now. A patient needs a new CAM walker, but had one from the walk-in down the street just 18 months ago for another issue. That particular item was covered, but due to the same or similar issue now, the patient is likely not going to be covered this time, not being outside that 5-year window of time since the last device was received. By having them sign the ABN you have effectively let them know that Medicare is more than likely not going to pay for this boot. Of course, most patients have no idea about such ridiculous rules, and it will take some good explaining as to why it is not covered today but it was a few months ago. Medicare guidance on use of the ABN notes three major events to trigger the use of an ABN. These three "triggering events" may prompt an advance written notice of non-coverage:

1) Initiations
2) Reductions
3) Terminations

If you believe at initiation that Medicare will not cover certain items or services because they are not reasonable and necessary, you must issue the notice before the beneficiary gets the non-covered care.

Initiations

Initiations happen at the beginning of a new beneficiary encounter, or when treatment begins. If you believe at initiation that Medicare will not cover certain items or services because they are not reasonable and necessary, you must issue the notice before the beneficiary gets the non-covered care.

Reductions

Reductions occur when a component of care decreases (for example, frequency or service duration). Do not issue the notice every time there is a reduction in care. If a reduction occurs and the beneficiary wants to continue getting care no longer considered medically reasonable and necessary, you must issue the notice before the beneficiary gets the non-covered care.

Terminations

Terminations stop all or certain items or services. If you terminate services and the beneficiary wants to continue getting care no longer considered medically reasonable and necessary, you must issue the notice before the beneficiary gets the non-covered care. Perhaps you have utilized all the covered biologic grafts allowed in the LCD or LCA (Local Coverage Article) and yet the patient wants to proceed seeing good healing occurring with the grafts. The patient then becomes responsible for the payment and agrees to that in advance of the treatment.

When You Can't Issue an ABN

You cannot issue an advance written notice of non-coverage to:

- Simply bill the beneficiary for the services denied due to a Medically Unlikely Edit (MUE)—say, an extra hammertoe surgery that was not covered due to an MUE.
- A beneficiary in a medical emergency or under great duress (compelling or coercive circumstances). The provider cannot use the circumstance of fear or injury or risk to act as a lever to get the patient to agree to pay for something.
- Charge a beneficiary for a component of a service when Medicare fully pays through a bundled payment. We cannot use it to get the extra procedure paid for because we know Medicare will not pay for it.
- Transfer liability to the beneficiary when Medicare would otherwise pay for items and services. Big no-no. Providers cannot bill those patients for a service Medicare would cover and relate to the patient it is not covered. Do not go down this path.

The proper use of the ABN can be of a great benefit to one's practice and to relieving the communication burdens of both staff and doctor. Using ABNs in the necessary circumstance is not an option; it is a requirement. Start using them and stay compliant. **PM**

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