CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE MANAGEMENT

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What Doctors Need to Know about the

ADVANCE BENEFICIARY NOTICE (ABN)

Medicare Learning Network

Helping Physicians and Providers Navigate Medicare

CENTERS FOR MEDICARE & MEDICAID SERVICES

THE ADVANCE BENEFICIARY NOTICE

An Advance Beneficiary Notice (ABN) is a written notice which a physician or supplier gives to a Medicare beneficiary. The purpose of the ABN is to inform a beneficiary before he or she receives specified items or services that otherwise might be paid for by Medicare that Medicare probably will not pay for them for that particular beneficiary on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance.

ABN Decision Tree #1

Standard Decisions

Will Medicare deny payment for this service (or item)?

1. "No, I do not expect Medicare to deny payment." ➔

Do not give any ABN. Do submit a claim to Medicare.

- **If Medicare pays:** You may collect charges from Medicare, and any coinsurance & deductible from the patient. On an unassigned claim, you also may collect up to a 15% balance billing amount from the patient.
- **If Medicare denies payment for medical necessity, you may:**
  A. Provide additional documentation of medical necessity so Medicare will pay. (This may happen even before the initial determination is made for the claim, during "claims development.") [If Medicare agrees, Medicare pays because the service is covered.]
  B. Appeal on the basis that the service should be covered. [If Medicare agrees, Medicare pays as covered.]
  C. Appeal on the basis that you did not know and could not reasonably have been expected to know that Medicare would not pay. [If Medicare agrees, then Medicare will pay (for assigned claims) under the Limitation On Liability provision, AS IF the service were covered.]
- **If Medicare denies payment on the basis of a statutory exclusion or failure to meet technical coverage requirements under the program benefits sections of the law:** You may collect full charges from the patient.

[End #1 & #2]

2. "I don't know. I never know what Medicare will deny." ➔

3. "Yes, I have a genuine reason to expect that Medicare will deny payment, based on other Medicare denials, LMRPs, local standards of medical practice, etc.."
Then, ask this question: **"On what basis do I expect that Medicare will deny payment?"**

MEDICAL NECESSITY	EXCLUSIONS & TECHNICAL DENIALS
Denial as "not reasonable and necessary."	**All other exclusions from Medicare benefits; and failure to meet technical coverage requirements under the program benefits sections of the law.**
• DMEPOS denials – prohibited telephone solicitation; no supplier number; payment denied in advance – also are handled in the same way as "medical necessity" denials.	
Do give an ABN (either a General Use form ABN-G or laboratory test form ABN-L). If the patient receives the services or items you must always submit a claim to Medicare (it is called a "demand bill").	**Do not give an ABN (neither the General Use form ABN-G nor laboratory test form ABN-L).**
• If you do not submit a claim, timely, you violate the mandatory claims submission provision, which can result in sanctions.	You do not need to submit a claim unless the patient demands it. If you do not submit a claim, you may collect full charges from the patient.
When you have submitted a claim: ➔	**If you submitted a claim:** ➔

- **If Medicare pays:** Collect payment from Medicare, and any coinsurance & deductible from the patient. On an unassigned claim, you also may collect up to a 15% balance billing amount from the patient.
- **If Medicare denies payment:** You may collect full charges from the patient.

[End # 3]

ADVANCE

ABN Decision Tree #2

EMTALA

Premise: You see a patient in a setting in which, and in circumstances to which, EMTALA provisions apply.

Has a Medical Screening Examination [MSE] by a qualified individual been completed?

No.		Yes.	
		Is the patient stabilized?	
		No.	**Yes**
1. Do **not** give an ABN. 2. If you do not complete an MSE, no ABN may be given.	1. Do **not** give an ABN. 2. First, complete an MSE. 3. Stabilize the patient. 4. Then give an ABN, but only if appropriate. (see Decision Tree #1).	1. Stabilize the patient. 2. Give an ABN, but only if appropriate (see Decision Tree #1).	1. Give an ABN, but only if appropriate (see Decision Tree #1).

Do **not** routinely give ABNs to all emergency department patients who are Medicare beneficiaries.

Even after a patient has received an MSE and is stabilized, do **not** give the patient an ABN **unless** you have a genuine reason to expect Medicare to deny payment for the services, per the directions in Decision Tree #1. Giving routine ABN notices is a prohibited practice.

EXCLUSIONS FROM MEDICARE BENEFITS

*Medicare does **not** pay for **all** health care costs for a beneficiary. Medicare **only** pays for **covered** benefits. Listed below, for your information, is a general summary of some exclusions from Medicare benefits.*

SUMMARY OF EXCLUSIONS*

- Personal comfort items.
- Routine physicals and most tests for screening.
- Most shots (vaccinations).
- Routine eye care, eyeglasses and examinations.
- Hearing aids and hearing examinations.
- Cosmetic surgery.
- Most outpatient prescription drugs.
- Dental care and dentures (in most cases).
- Orthopedic shoes and foot supports (orthotics).
- Routine foot care and flat foot care.
- Health care received outside of the USA.
- Services by immediate relatives.
- Services required as a result of war.
- Services under a physician's private contract.
- Services paid for by a governmental entity that is not Medicare.
- Services for which the patient has no legal obligation to pay.
- Home health services furnished under a plan of care, if the agency does not submit the claim.
- Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- Items and services furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility, unless they are furnished under arrangements by the skilled nursing facility.
- Services of an assistant at surgery without prior approval from the peer review organization.
- Outpatient occupational and physical therapy services furnished incident to a physician's services.

** This is only a general summary of exclusions from Medicare Benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.*

BENEFICIARY NOTICE