TITLE: ADVANCE BENEFICIARY NOTICE

PURPOSE: To ensure an Advance Beneficiary Notice (ABN) is obtained from Medicare beneficiaries when a procedure/service may not be covered by Medicare according to the Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs).

POLICY: Medicare will only pay for a procedure/service/test that is determined to be medically necessary. An ABN must be obtained when an ordered procedure/service/test does not meet medical necessity requirements as defined in the LCD or NCD.

Valid Reasons for Medicare Denial

An ABN must be obtained when one or more of the following circumstances exist before an outpatient procedure/service/test (the “Service”) is conducted:

- The diagnosis provided by the physician does not meet medical necessity requirements.
- Medicare allows payment for the procedure/service requested a limited number of times within a specified time period and the patient may have exceeded the limit (example: screening mammogram).
- Medicare does not pay for experimental or research use items/services.
- The procedure/service is a maintenance program.
- The procedure/service does not require skilled professional procedure/services.

Services provided as a medical emergency: (example: Emergency Department, Trauma Center, Operating Room, etc.), are excluded from this requirement.

PROCEDURE:

1. When a Service is ordered for a Medicare patient and the diagnosis does not meet medical necessity according to their guidelines, the EPIC system will alert the provider.

   A. The alert box will allow the provider to view the LCS reference information which lists diagnosis that would meet medical necessity.

   B. From the LCD lists, the provider can choose an acceptable diagnosis that meets medical necessity or to print an ABN form.

   i. If the provider chooses to not change the diagnosis and print an ABN form

   ii. The Notifier will inform the patient that the ordered Service does not meet Medicare medical necessity guidelines and that the patient will be asked to sign an ABN before the Service is performed. The patient must select either Option 1 – I want service, bill Medicare; Option 2 – I want the service, do not bill Medicare; or Option 3 – I do not want service.

      a) The Notifier will review the “Medical Necessity Form” with the patient and provide the patient with a copy. If an interpreter is needed to communicate with the patient, utilize the standard procedure to obtain interpreter services.

      b) If the patient has further questions concerning the reason the Service was ordered, contact his/her physician/provider prior to patient signing an ABN. Note: it is a Medicare requirement that the patient understand that the Service will not be covered and why before signing the ABN.
iii. When completing the ABN, the following items must be completed:

- Notifier’s name
- Ordering clinic name, address and telephone number
- Patient’s name
- Patient’s medical record number
- Include in the “Items or Services” box the CPT code and description
- Include in the “Reason Medicare May Not Pay” box, the reason why the Service may be denied. Refer to the “Valid Reasons for Medicare Denial” section of this procedure for the appropriate language to include in this box.
- In the “Estimated Cost” box, include the charge for the service.
- The patient must place a checkmark in Option 1, Option 2, or Option 3
- The patient or the patient’s legal representative must sign and date the appropriate boxes at the bottom of the form. If the ABN is unsigned and not dated, it is not valid.

iv. The completed/signed ABN will be distributed as follows:

- Original: Official Medical Record
- 2 copies to the patient, 1 for the patient’s record & 1 for the patient to present at the time of the scheduled service. Service area staff ensures signed ABN is scanned into the official Medical Record system.
- Copy must go with diagnostic specimen. Service area ensures signed ABN is scanned into the official Medical Record system.

v. When scheduling the Service, inform the scheduler that the patient has signed an ABN and has been instructed to bring the signed copy to the appointment.

vi. If the patient refuses to have the Service or refuses to sign the ABN, document on the ABN the persons and circumstances involved and ensure that the ABN is scanned into the official Medical Record, and inform the ordering physician/provider regarding the outcome.

2. Procedures that will not be covered by Medicare, as determined by the LCD or NCD, should not be ordered without a signed ABN form. Contact your departmental supervisor to discuss with the patient and the ordering physician.

3. Billing Instructions

A. Physician bill – a “GA” modifier must be appended to each procedure code listed on the signed ABN.

B. If the patient selects Option 2, enter the physician charge in self-pay FSC S12. If the patient pays at time of service, the Self-Pay Discount policy, EA-06-07-001 will apply.

4. For diagnostic laboratory tests, when the integrity of the specimen is at risk, the laboratory personnel may perform the test(s) ordered even if they do not meet medical necessity guidelines for the diagnosis, sign, symptom or ICD-9-CM code provided and an ABN is not present. When an ABN has not been signed and the procedure or test is being performed, make sure to choose “NO” in HBOC when prompted if ABN has not been signed. The physician’s office must forward the original ABN when ordering a non-covered test. If the patient presents without an ABN, the physician ordering the test will be contacted to determine if an ABN was obtained. If an ABN was obtained, proceed to register the specimen indicating that an ABN has been obtained.