The Advance Beneficiary Notice of Noncoverage (ABN) is a collection tool that many medical practices do not know how to implement and sustain after implementation. ABNs become particularly difficult when providers have multiple potential points of care as the form must be completed and signed by the patient before a health care service is provided.

THE BASIC ABN REQUIREMENTS

Use of the ABN is required to alert patients when a service that is ordinarily covered by Medicare will not be paid by the program and to allow the patient to choose to either pay for the service or to refuse the service. ABNs function, more or less, as a financial liability protection for Medicare patients.i

ABNs revolve around covered items or services. Therefore, a covered entity must issue an ABN if 1) the service or item is not medically necessary, 2) if a non-contract supplier provides the service, 3) if the service or item is denied in advance, 4) if the item includes a Competitive Bidding Program for a Competitive Bidding Area and the item is included in the Durable Medical Equipment program, or 5) if hospice care is provided when the patient is not terminally ill.ii

Form requirements vary as well. Medicare Part A services must use a skilled nursing ABN, whereas Part B labs require the CMS-R-131 form.iii Home Health Agencies must use their own Home Health ABN. It is also important to note that ABNs must be current.iv An out of date ABN will remove the financial obligations from the beneficiary and back onto the provider.v

Since 2012 the Centers for Medicare & Medicaid Services (CMS) has issued several updates to the ABN process. Most of these issued transmittals served to align ABN requirements with those of the Affordable Care Act (ACA). The ACA’s implementation further expanded the ABN requirements. Under the ACA, preventative medicine became a focus of reimbursement to combat higher costs down the road. Accordingly, the preventative annual wellness visit and physical exam now require ABNs. These preventative services have limitations as to how often a beneficiary can utilize them. If a beneficiary has maxed out the covered exams, a provider must issue an ABN to that beneficiary.vi

If a practice does not have a signed ABN for the patient and Medicare denies the service, the charge must be written off and the patient may not be billed for the service. The only exception is for statutorily excluded services (those that Medicare never covers like cosmetic surgery and complete medical physicals). A practice may bill patients for these services, despite not having an ABN. It is a good idea to have an ABN signed for non-covered services so the patient is made aware that they are responsible. With a signed ABN, the practice has proof of the patient’s informed consent to provide the service and their agreement to be financially responsible for the service.

WHO SHOULD BE RESPONSIBLE FOR GETTING THE ABN SIGNED

The “who” proves more difficult because often the employee who has the most knowledge about Medicare (a coder, biller, or manager) is not a clinical provider. Many practices have given up the ABN process because figuring out the workflow can be challenging.

However, every member of a practice is responsible for obtaining a patient’s signed ABN.vii A practice cannot have

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ii Id.

iii Id.

iv Id.

v Id.

a patient sign an ABN after the procedure or service is provided.iii That is an example of fraud. The only time a practice can have an ABN signed by the patient is prior to a procedure or service, and after the practice has clearly explained what Medicare may not cover, why they might not cover it, and if not covered, what the cost will be to the patient.iv

**STEPS TO IMPLEMENT ABN’S IN A PRACTICE**

If a practice has Electronic Medical Records (EMR), this process should be much easier because the system should already be preloaded with the Medicare service limitations and when the practice places an order for a service that may not be covered, the practice’s EMR should warn the employee and generate an ABN automatically.

For practices that do not have an EMR, they should follow these steps:

- Review Medicare coverage guidelines and complete a list of services that your group provides and orders.
- Print the list with price ranges on the back of the ABN form.
- Have a full staff meeting to discuss the ABN and your plan to implement a program to use the ABN when appropriate. Discuss Medicare guidelines and the services that your practice provides and educate the staff. Reinforce both guidelines and process regularly during staff meetings. Provide feedback on usefulness of ABNs to the practice and to your patients.
- Create a custom chart for your group that combines the services you provide with the associated rules. Post charts in each exam room, the lab, the checkout station, on the EKG or other medical test equipment, and anywhere an employee should stop and think “Do I need an ABN for this?”.
- Some in-house or referral lab systems also furnish ABN information for mismatches on lab services and supporting diagnoses.

**IN SUMMARY**

While the ABN serves as a warning that Medicare may not pay for the care a provider recommends, it is possible that Medicare will pay for the service. To get an official decision from Medicare, remember to get an ABN form signed, agreeing that the patient will pay for services if Medicare does not. Either way, practices will need to obtain an ABN.

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**INSIGHTS**

viii Id.