

ADVANCE BENEFICIARY NOTICE (ABN)

EFFECTIVE OCTOBER 1, 2002

The following pages contain the updated general use ABN form with new instructions that explain its proper use. These instructions are excerpts selected by the ChiroCode Institute from the July 31, 2002 *Program Memorandum to Intermediaries and Carriers*, Transmittal #AB-02-114, from the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS).

The **complete** Program Memorandum can be downloaded from:

http://cms.gov/manuals/pm_trans/AB02114.pdf

Note:

"ABN-G" refers to the general use ABN form.

"ABN-L" refers to the ABN form for laboratory tests (not included).

Patient's Name:

Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$** _____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

Program Memorandum Intermediaries/Carriers

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal AB-02-114

Date: JULY 31, 2002

Section 1.3 The Proper Use of the ABN (CMS-R-131).--

A. When An ABN Should Be Given.--

1. Whether an ABN should be given in a particular instance depends on the physician's or supplier's expectation of Medicare payment or denial.
 - a. If the physician or supplier expects Medicare to pay, an ABN should not be given.
 - b. If the physician or supplier "never knows whether or not Medicare will pay," an ABN should not be given.
 - c. If the physician or supplier expects Medicare to deny payment, the next question is: "On what basis is denial expected?"
 - i. If the item or service is not a Medicare benefit (e.g., routine physical and tests in the absence of signs and symptoms, routine foot care, dental care), neither the ABN-G nor the ABN-L should be given.
 - ii. If Medicare is expected to deny payment for an item or service which is a Medicare benefit because it does not meet a technical benefit requirement (e.g., an ambulance service denied due to an unapproved destination, diabetic care shoes not prescribed by a podiatrist or other qualified physician), neither the ABN-G nor the ABN-L should be given.
 - iii. If Medicare is expected to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary under Medicare program standards (viz., "medical necessity denials" under §1862(a)(1) of the Act), the ABN-G or the ABN-L, as appropriate, should be given (this is applicable to all assigned Part B items and services, and to unassigned physicians' services and medical equipment and supplies). Certain screening tests (mammography, pap smear, pelvic exam, glaucoma, prostate cancer, colorectal cancer) have frequency limits under §1862(a)(1) of the Act, therefore, LOL applies and ABNs should be given when Medicare denial of payment for frequency is expected for any of these tests.
 - iv. If Medicare is expected to deny payment for medical equipment and supplies because it is not covered: (i) under §1834(a)(17)(B) of the Act, violation of the prohibition on unsolicited telephone contacts; (ii) under §1834(j)(1) of the Act, supplier number requirements not met; or (iii) under §1834(a)(15) of the Act, failure to obtain advance determination of coverage, the ABN-G should be given (this is applicable to both assigned and unassigned medical equipment and supplies).
2. Do not find a physician or supplier to have violated the prohibition on routine ABNs solely on the basis of the number of ABNs which the physician or supplier gives to beneficiaries, when those ABNs are justified by the physician or supplier having a genuine reason to give an ABN. Some physicians or suppliers (e.g., a physician furnishing acupuncture services) may give ABNs to most or all of their Medicare patients without violating the routine ABNs prohibition.

B. **To Whom An ABN May Be Given.**--An ABN may be given to a Medicare beneficiary or to the beneficiary's authorized representative, that is, to a person who is acting on the beneficiary's behalf when the beneficiary is temporarily or permanently unable to act for himself or herself. (See the definition of an authorized representative for ABN purposes in Section I.1.F.)

C. **How An ABN May Be Given.**--Delivery of an ABN occurs when the beneficiary or authorized representative (i.e., the person acting on the beneficiary's behalf) both has received the notice and can comprehend its contents. An incomprehensible notice, or a notice which the individual beneficiary or his/her authorized representative is incapable of understanding due to the particular circumstances (even if others may understand), cannot be used to fulfill notice requirements. (See the applicable standards for delivery of an ABN in Section I.1.C.)

D. **Choosing The Form To Use.**--Physicians and suppliers must use the OMB-approved ABNs (ABN-G and ABN-L) for use with Part B items and services. The ABN-G may be used for all situations, including laboratory tests, by all physicians and suppliers. The ABN-L may be used for laboratory tests, by any person or entity furnishing laboratory tests.

E. **Filling Out The Forms.**--

1. Form Instructions for ABN-G and ABN-L

a. **Format of Insertions on ABN.**--The physician or supplier must ensure that the readability of the ABN facilitates beneficiary understanding. No insertion into the blanks and boxes of the ABN, if typed or printed, should use italics nor any font that is difficult to read. An Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. If insertions are handwritten, they must be legible. In all cases, both the originals and copies of ABNs must be legible and high-contrast. When Spanish language ABNs are used, the physician or supplier should make insertions on the form in Spanish to the best of their ability. If this is impossible, the physician or supplier needs to take other steps as necessary to ensure that the beneficiary understands the notice.

b. Filling in the Form.--

i. **The ABN's header** should have the identifying information of the billing entity. If the billing entity is a group practice, then the group practice may have its identifying information in the header. It may be prudent for each member of a group practice to also include their name in the header, but it is not required. A laboratory should put its own identifying information in the header where a client physician is delivering the ABN form to a beneficiary on behalf of the laboratory. ABNs included on laboratory requisition forms should have the identifying information of the laboratory in the header, not the client physician's information, even when stocks of the ABNs are provided to client physicians for their use in ordering tests. The physician or supplier puts his/her/its name, address, and telephone number at the top of the notice header; and may elect to include his/her/its logo (if any). Within these general rules, a notice header may be customized by the physician or supplier.

ii. **"Patient name" Line**—The physician or supplier enters the name of the patient, not substituting the name of an authorized representative.

iii. **"Medicare Health Insurance Claim Number (HICN) Line"**—The physician or supplier enters the patient's Medicare HICN. Do not invalidate an ABN solely for the lack of a Medicare HICN unless the beneficiary recipient of an ABN alleges that the ABN was signed by someone else of the same name and you cannot resolve the matter with certainty.

iv. **ABN-G Customizable Boxes**—In the section of the ABN-G beginning "We expect that Medicare will not pay for the item(s) or service(s) ...", in the first box "Items or Services:", the physician or supplier specifies the health care items or services for which he/she/it expects Medicare will not pay. The items or services at issue must be described in sufficient detail so that the patient can understand what items or services may not be furnished. HCPCS codes by themselves are not acceptable as descriptions. The use on the ABN of a list of the items and/or services which the particular physician or supplier frequently furnishes, with check-off boxes or some similar method of identifying the particular items or services for which denial is predicted, is an acceptable practice. Listing several items and/or services without indicating which is/are applicable in the beneficiary's particular situation is not an acceptable practice and such an ABN is defective and will not protect the physician or supplier from liability. In the second box "Because:", the physician or supplier gives the reason why they expect Medicare to deny payment. The reason(s) must be sufficiently specific to allow the patient to understand the basis for the expectation that Medicare will deny payment. The physician or supplier may customize these two boxes for their own use.

v. **ABN-L Customizable Boxes**—*not included in this excerpt*

- vi. **“Estimated Cost” Line**—The physician or supplier may provide the patient with an estimated cost of the items and/or services. The patient may ask about the cost and jot down an amount in this space. The physician or supplier should respond to such inquiries to the best of their ability. The lack of an amount on this line, or an amount which is different from the final actual cost, does not invalidate the ABN; an ABN should not be considered to be defective on that basis. In the case of an ABN which includes multiple items and/or services, it is permissible for the physician or supplier to give estimated amounts for the individual items and/or services rather than an aggregate estimate of costs. Amounts may be provided either with the description of items and services or on the “Estimated Cost” line.
 - vii. **Options 1 & 2 Boxes**—The patient must personally select an option. Do not accept as evidence of beneficiary notice any ABN on which the physician or supplier has pre-selected an option; pre-selecting options is prohibited.
 - viii. In the **“Date” blank**, the patient, or his or her authorized representative, should enter the date on which he or she signed the ABN. If the date is filled in by the physician or supplier and the beneficiary or his or her authorized representative does not dispute the date, you should accept that date. Do not reject ABNs simply because the date is typed or printed. In the “Signature of patient ...” blank, the patient, or person acting on his or her behalf, must sign his or her name.
2. Signature Requirements for ABN-G and ABN-L.
 - a. The beneficiary himself or herself may sign an ABN. In the case of a beneficiary who is incapable or incompetent, his or her “authorized representative,” as defined for ABN purposes in Section I.1.F may sign an ABN. The policy enunciation in Section I.1.F of who may be an “authorized representative” supersedes the previous policy that “generally applicable rules of the Medicare program with respect to who may sign for a beneficiary apply to signing notices, including ABNs.” The regulations on signature requirements for claims purposes at 42 CFR 424.36(b) do not apply to ABNs except that, with respect solely to ABNs for unassigned claims for physicians’ services, someone eligible to sign for the beneficiary under 42 CFR 424.36(b), who is an “authorized representative” as defined for ABN purposes in Sections I.1.F and I.1.F.3 notwithstanding, may sign an ABN.
 - b. If the beneficiary’s (or authorized representative’s) signature is absent from an ABN, in case of a dispute as to the beneficiary’s (or authorized representative’s) receipt of the ABN, give credence to the beneficiary’s (or authorized representative’s) allegations regarding the ABN, except as specified in Section I.3.F.2.
 - c. The physician or supplier must obtain the signed and dated ABN from the beneficiary, either in person or, where this is not possible, via return mail from the beneficiary or authorized representative acting on the beneficiary’s behalf as soon as possible after the ABN has been signed and dated. The beneficiary retains the patient’s copy of the signed and dated ABN and returns the original. The physician or supplier retains the original ABN. These copies will be relevant in case of any future appeal. Do not require physicians and suppliers to routinely submit copies of all ABNs to you.