

Policies and Procedures - School of Medicine

SECTION: COMPLIANCE	Approved: 05/12/99	Effective Date: 07/01/99	Revised: 11/07/02
CHAPTER: BILLING	Replaces Policy Revised: 05/09/02		
POLICY: MEDICARE ADVANCE BENEFICIARY NOTICE (Waiver of Liability)	Retired:		
	PAGE 1 OF 5		

I. PURPOSE

This Policy is to ensure that an appropriate Advance Beneficiary Notice (ABN) is obtained from Medicare beneficiaries for laboratory tests, procedures and other medical services that are not paid by Medicare because they are deemed to be not reasonable and necessary.

II. POLICY

An ABN must be obtained from the Medicare beneficiary or his/her legal guardian prior to providing any services that may be denied by Medicare as not "reasonable and necessary."

Each Department is responsible for knowing the current Medicare rules for services that may be denied by Medicare as not "reasonable and necessary." Medicare coverage rules can be found in the Medicare Carrier's Manual, local medical review policies (LMRPs) and in any notices provided to an individual Creighton provider.

III. SCOPE

This policy only applies to services provided to Medicare beneficiaries. This policy does not apply to Medicare General Program Exclusion services (i.e. services that are never covered by Medicare, such as preventative annual examinations, cosmetic surgery, etc.).

This policy applies to all employees and agents of Creighton Medical Associates and the School of Medicine.

IV. PROCEDURE

The guidelines set forth below must as well as Medicare rules be followed to ensure that an ABN is obtained in accordance with Medicare requirements. Failure to follow these guidelines will result in an inability to bill the patient for any services that Medicare determines are not reasonable and necessary.

A. **Advanced Beneficiary Notice Required.** An Advanced Beneficiary Notice must be obtained when one or more of the following circumstances exist:

- The service or test may not or does not meet Medicare's medical necessity requirements as stated by Medicare in federal

Policies and Procedures - School of Medicine

SECTION: COMPLIANCE	Approved: 05/12/99	Effective Date: 07/01/99	Revised: 11/07/02
CHAPTER: BILLING	Replaces Policy Revised: 05/09/02		
POLICY: MEDICARE ADVANCE BENEFICIARY NOTICE (Waiver of Liability)	Retired:		
	PAGE 2 OF 5		

statute/regulations, Carrier's Manuals, LMRPs or individual notice to providers.

- The service or test may only be paid for a limited number of times within a specified time period and this service or test may exceed that limit (i.e. screening tests, etc.)
- The service or test is for investigative, research, or experimental use only.
- The patient requests a more extensive service or test than is deemed to be medically necessary by the provider.

B. Obtaining an Advanced Beneficiary Notice.

1. Format and Content.

- a. The ABN must be easy to read using no less than 12 point font with no italics or other hard to recognize type face.
- b. The ABN must contain the following information:
 - Patient's name, account number and Medicare number.
 - Description of service(s) or item(s) that may be denied.
 - Reason why the service(s) or item(s) may be denied.
 - Signature and date line.

2. **ABN Forms.** For services other than screening pap smears use Medicare ABN forms CMS-R-131-L (laboratory items/services) and CMS-R-131-G (other items/services) when obtaining an ABN. See Attachments A and B. These forms and their instructions (English and Spanish versions) are also available on Medicare's web site <http://cms.hhs.gov/medicare/bni/default.asp>

Policies and Procedures - School of Medicine

SECTION: COMPLIANCE	Approved: 05/12/99	Effective Date: 07/01/99	Revised: 11/07/02
CHAPTER: BILLING	Replaces Policy Revised: 05/09/02		
POLICY: MEDICARE ADVANCE BENEFICIARY NOTICE (Waiver of Liability)	Retired:		
	PAGE 3 OF 5		

- a. ABN Form CMS-R-131-L
<http://www.cms.hhs.gov/BNI/Downloads/CMSR131L.pdf> - English
<http://www.cms.hhs.gov/BNI/Downloads/CMSR131LSpanish.pdf> - Spanish

Use this form for laboratory items and services, listing the item/service in the appropriate Medicare "denial" column.

- b. ABN Form CMS-R-131-G
<http://www.cms.hhs.gov/BNI/Downloads/CMSR131G.pdf> -English
<http://www.cms.hhs.gov/BNI/Downloads/CMSR131LSpanish.pdf> - Spanish

Use this form for non-laboratory items and services. List the item and/or service in the box labeled "Items or Services". List the reason for Medicare denial in the "Because" box. The following statements are acceptable to place in the "Because" box:

- 1) If the services are always denied for medical necessity, use the following: "Medicare never pays for this [*list the item or service*]."
 - 2) If the items or services are experimental use the following: "Medicare does not pay for services which it considers to be experimental or for research use."
 - 3) If certain frequency limitations apply to the items or services use the following: Medicare does not pay for this item or service more often than [*state the frequency limit*].
3. Process. The ABN must be explained and delivered to the beneficiary (or his/her legal guardian) by knowledgeable staff (i.e. physician, resident, nurse, medical assistant) prior to beginning the service or procedure. Registration personnel should not be explaining the ABN. The ABN form must be completed and signed by the beneficiary (or his/her legal guardian) **AT OR BEFORE THE START OF CARE**. The patient shall not be asked to sign an ABN until all information on the form is completed.

Policies and Procedures - School of Medicine

SECTION: COMPLIANCE	Approved: 05/12/99	Effective Date: 07/01/99	Revised: 11/07/02
CHAPTER: BILLING	Replaces Policy Effective: 05/09/02		
POLICY: MEDICARE ADVANCE BENEFICIARY NOTICE (Waiver of Liability)	Retired:		
PAGE 4 OF 5			

5. Beneficiary Signature. The patient has two choices when services may not be considered reasonable and necessary and therefore may not be covered by Medicare:
 - Agree to obtain the service(s) and be responsible for payment should Medicare deny payment, or
 - Refuse to be responsible for payment and not obtain the service(s).

The beneficiary or his/her legal guardian must select one of the above options on the form and then sign the ABN **BEFORE** services/items are provided.

6. Patient Demands Service But Refuses to Sign. If the patient demands the services(s) and refuses to pay or sign the ABN form, then two witnesses should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case, the service(s) may be provided and if Medicare payment is denied, the beneficiary can be billed for payment.
7. Routine Use of ABNs. Routine use of the ABN is **prohibited**. There must be a specific reason to believe Medicare will determine that the service(s) ordered may not be considered **reasonable and necessary**.
8. Delivery of signed ABN. The completed and signed ABN should be distributed as follows:
 - a. Original to the patient's medical record
 - b. One copy to the patient
 - c. If tests are ordered off site, one copy to the entity providing the testing services (i.e. laboratory, radiology, cardiology, etc.)

C. Billing Modifiers.

1. Medicare modifiers should be used as follows:
 - **GA Modifier.** Use this modifier when the ABN was signed and is on file. You should also use this modifier when the beneficiary refuses to sign the ABN but still demands the service if two witnesses have signed the ABN form noting the patient's refusal to sign.

Policies and Procedures - School of Medicine

SECTION: COMPLIANCE	Approved: 05/12/99	Effective Date: 07/01/99	Revised: 11/07/02
CHAPTER: BILLING	Replaces Policy Effective: 05/09/02		
POLICY: MEDICARE ADVANCE BENEFICIARY NOTICE (Waiver of Liability)	Retired:		
	PAGE 5 OF 5		

For services provided by the laboratory and billed to the intermediary on UB-92 forms, utilize occurrence code "32" when there is a signed ABN on file.

- **GZ Modifier.** Use this modifier when the claim is expected to be denied as "not reasonable and necessary" but no ABN was obtained. Beneficiaries may not be billed for any claim to which the "GZ" modifier is appended.
- **GY Modifier.** Use this modifier when the claim is expected to be denied as "non-covered". ABNs are not required when these types of services are provided (i.e., routine physicals). This modifier is for informational use by the Carrier and does not prevent directly billing the patient for the service. The "GY" modifier should be used when the beneficiary refuses to pay until Medicare denies the claim.

D. Implementation

1. It is the responsibility of each Department, and Creighton Medical Associates (CMA) to educate staff (i.e. physicians, nurses, coding/billing staff and front-end staff) on the contents of this policy and Medicare's requirements and to designate staff who are responsible for obtaining the ABN.
2. It is the responsibility of each Department Administrator to ensure adherence to this policy/procedure and Medicare requirements for ABNs.

V. ADMINISTRATION AND INTERPRETATIONS

Questions regarding this policy may be addressed to your Billing Supervisor/Manager, Department Administrator, the Billing Compliance Officer, or Associate General Counsel, Compliance Regulatory Support.

VI. AMENDMENTS OR TERMINATION OF THIS POLICY

This policy may be amended or terminated at any time.

VII. REFERENCES

42 U.S.C. §1395pp, Medicare Carriers Manual - 7300.5, Blue Cross/Blue Shield of Kansas, Medicare Part B Physician's Manual, Waiver of Liability Provision Section, and CMS' web site: <http://cms.hhs.gov/medicare/bni/default.asp>