051017 NEWS BLAST

ATTN: MEDICARE PROVIDERS

Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131 Renewal

The Centers for Medicare and Medicaid Services (CMS) has renewed the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131.

The expiration date on the lower left corner of the form is 03/2020.
The effective date to implement this form is June 21, 2017.
Practices in which MEDDATA (MDS) maintains an ABN can expect to receive the new form by June 1, 2017.

There are two notable changes to the form listed below. Aside from these updates, ***the form itself has not changed***.

- New expiration date
- Verbiage from CMS that they do not discriminate in their programs or activities.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

CMS has posted the new form and instructions on their Fee for Service Advance Beneficiary Notice of Noncoverage webpage (available via: https://www.cms.gov/medicare/medicare-general-information/bni/abn.html). The ABN, Form CMS-R-131 is available in English and Spanish by clicking the 'Download the ABN' link on the webpage. A WINZIP file will open and provide the user the option to open the document in either WORD or PDF format.
A link to the ABN Form Instructions is also available (https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-Instructions.pdf).

WHAT IS AN ABN?
An Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is a standardized notice that a health care provider must give to a Medicare/Medicaid/Managed Care beneficiary, before providing certain items or services.
ABNs are utilized when a provider believes that the carrier may not pay for a service (CPT) that is usually covered because at this particular visit or use of the CPT it may not be considered medically reasonable and/or necessary.
Typical reason deemed not medically necessary: use of ICD code not listed on a Local Coverage Determination (LCD) or too frequent use of a specific service.

The ABN allows the beneficiary to make an informed decision about whether to receive services and accept financial responsibility for those services if the carrier does not pay. The ABN serves as proof that the beneficiary had knowledge prior to receiving the service that the carrier may not pay. If a health care provider does not provide a valid ABN to the beneficiary when required by statute, the beneficiary cannot be billed for the service and the provider may be held financially liable.

The contractor will hold any provider financially liable who either failed to give notice when required or presents defective notice. A provider who can demonstrate that he/she did not know and could not reasonably have been expected to know that the carrier would not make payment will not be held financially liable for failing to give notice. However, a provider who gave defective notice may not claim that he/she did not know or could not reasonably have been expected to know that the carrier would not make payment as the issuance of defective notice is clear evidence of knowledge. The beneficiary is not protected from liability if there is clear evidence that he/she knew that the carrier would not make payment.

Review information below to better assist your practice's proper use of ABNs.

For Medicare Patients:
Key ABN Usage Points:

- Only **required** for beneficiaries enrolled in traditional (Fee for Service) Medicare.
- Not required in order to bill a beneficiary for a service that is not a covered benefit and thus is never covered.
- Must be issued prior to providing care.
- Should not be issued on a routine basis.
- Should not be obtained from a beneficiary in a medical emergency or under duress.
- If ABN signed for CPT; the CPT must be filed on claim with correct modifier
- Providers are not permitted to use ABNs to bill a beneficiary for a component of a service when full payment is made through a bundled payment, i.e., not appropriate to bill patient if NCC edit indicates CPT included in another CPT and modifier flag = Ø. (unbundling)

ABN Modifiers:
Use one of these four G-modifiers associated with an ABN, Medicare should auto-deny claims submitted with modifiers GX, GY, and GZ. However, if modifier GX appended to a covered claim, the carrier will return it as unprocessable.

- GA – ABN required to be signed
  Description: "Wavier of liability statement issued, as required by payer policy"
  Used to report a mandatory ABN was issued for a service. Add modifier GA to the relevant charge lines. This indicates the beneficiary knows he/she may have to pay for the service(s), and will change the language that will appear on the Explanation of Medicare Benefit (EOB) statement sent to provider and beneficiary stating same.
- GX – ABN issued voluntarily
  Description: "Notice of liability issued, voluntary under payer policy"
  Used to report a voluntary ABN was issued. Modifier GX can be paired with modifier GY (see below) to further indicate that Medicare never covers the service and the carrier will notify the patient that he/she is responsible for the fee.
- GY – Service excluded by law
  Description: "Notice of liability not issued, it is not required under the payer policy"
  Used to report an ABN was not issued because an item or service is statutory excluded or does not meet the definition of any Medicare benefits. It should be submitted as a non-covered line item on a claim when there are other covered services and should only be used when provider is unable to split out non-covered services on to a separate claim.
- GZ – No ABN, denial likely
  Description: "An item or service expected to be denied as not reasonable and necessary"
  Used to report an ABN was not issued for a service that is expected to be denied as not reasonable and necessary. These claims cannot be billed to the patient.
  NOTE: Effective 07/01/11, CMS gave its contractors discretion to auto-deny claims that arrive with the GZ modifier. Apply this modifier only when there is good reason to believe the claim will be denied based on medical necessity, because the charge will end up having to be written off.

For Medicaid Patients:
Per the Louisiana Medicaid Program Provider Training Manual, Chapter 1, Section 1.4, a provider can only bill a recipient for non-covered services, if the recipient was informed in advance, verbally and in writing, that the service(s) were not covered by Medicaid and the recipient agrees to accept the responsibility for payment. The provider **should obtain a signed statement or form** which documents that the recipient was verbally informed of the out-of-pocket expense.

Do Not Bill Recipient for Services if:

- Charges are above the Medicaid maximum allowable fee amount
- Claims are denied due to provider error
- Errors are made by the Bureau of Health Services Financing (BHSF), the Fiscal Intermediary (FI), or the Third Party Liability (TPL) collection contractor or changes in state and federal mandates
- Service(s) are denied because the provider failed to request prior authorization or failed to meet procedural requirements
- Claim balances are remaining after another third party sources such as Medicare, health insurance, Champus, etc has made payments
- Completion and submission of a Medicaid claim form fee
- Telephone calls and missed appointments
- Cost associated with copying medical records

MEDDATA Clients ~ MEDDATA slightly modified the ABN to encompass it's use for Medicare, Medicaid and Managed Care carriers.

Resources:

ABN Manual Instructions and ABN Form CMS-R-131: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html
The Medicare Coverage Database is available at: www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx
Medicare Coverage Center: www.cms.gov/center/coverage.asp
NCD Manual, visit the IOM web page at: www.cms.gov/Manuals/IOM/list.asp
CMS ABN Booklet: http://www.cms.gov/MLNProducts/downloads/abn_booklet_icn006266.pdf
Medicare Claims Processing Manual, Chapter 30, Section 50: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-CMS-Manual-Instructions.pdf
Medicare.gov: http://www.medicare.gov/claims-and-appeals/medicare-rights/abn/advance-notice-of-noncoverage.html
LA Medicaid Program Provider Training Manual: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

Contact Software Support for assistance or any questions via:

From **MED**PM or **MED**EHR Sign On screens, double click on 'support@medtronsoftware.com' to compose an email to the Software Support Dept.

-OR-

Phone: (985) 234-0599 (local)
(800) 978-0599 (toll free)

-OR-

Fax: (985) 234-0609