

Good afternoon everyone! My name is Barry Parker and I am an Education Specialist in the Provider Outreach and Education Department at Highmark Medicare Services. On behalf of my associates in Camp Hill, Hunt Valley, and Pittsburgh, we welcome you to the Highmark Medicare Services Lunch and Learn teleconference on Advance Beneficiary Notice today, July 30, 2008. This teleconference is being recorded and will be available as an MP3 download on the Highmark Medicare Services website in the same area where you received the teleconference materials. The handouts for today's call have been posted to our website and hopefully you've all had a chance to download them. Your handouts include: The slide presentation and the evaluation form. We value your feedback, so at the end of the teleconference, please complete the evaluation and fax it to the number listed on the form.

To protect Medicare beneficiaries and providers from financial liability CMS has developed the Beneficiary Notices Initiative (BNI). There are BNIs for both fee-for-service Medicare (FFS) and Medicare Advantage Plans (MA). Today, we will only discuss FFS Medicare. BNIs forms were designed to serve and protect Medicare beneficiaries and providers. The BNI lets each party know their financial liability. BNI forms are located on the website on this slide. There are also additional resources located on this website like frequent ask questions, implementation announcements, and instructions to name a few. Let's start talking about the ABN revisions.

The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance. An Advance Beneficiary Notice (ABN) is a written notice which a physician, provider, or supplier give to a Medicare beneficiary **before** items or services are furnished when the physician, provider, or supplier believes that Medicare **probably or certainly** will not pay for some or all of the items or services.

Medicare beneficiaries are protected from unexpected bills. If a notifier expects that Medicare will not pay for certain items or services, in many situations the beneficiaries will receive a notice that says Medicare probably (or certainly) will not pay. This notice is called an ABN. The ABN-General is used by doctors, DME suppliers, and certain health care providers. The ABN-Laboratory is used only for laboratory services.

The purpose of the ABN is to inform a beneficiary before he or she receives specified items or services that otherwise might be paid for by Medicare that Medicare probably will not pay for them for that particular beneficiary on that particular occasion. There are also Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or denial letters, Home Health Advance Beneficiary Notice (HHABN), and Hospital Issued Notice of noncoverage (HINN).

The new official title is the Advance Beneficiary Notice of Noncoverage. Beginning March 3, 2008 notifiers can start to use the revised ABN. The revised ABN combines ABN-G and the ABN-L into a single notice, with an identical Office of Management and Budget (OMB) form number. CMS has allowed a 6 month grace period for the revised ABN. After September 1, 2008 the old ABN-G and ABN-L cannot be used. The revised

ABN can be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB). It also has a mandatory field for cost estimates of the services or items issued. CMS does not expect the cost estimates to be the exact price but as close as possible. The revised ABN has a new option which allows a beneficiary to receive an item/service, and pay for it out-of-pocket, rather than have a claim submitted to Medicare.

Occurrence code 32 on a claim signifies that an ABN, Form CMS-R-131, was given to a beneficiary on a specific date. The provider will be held liable unless occurrence code 32 is present on the claim. Contractors **may** request an ABN to review in any circumstance from the provider. Any claim with a service or item where an ABN was given must include Occurrence Code 32 and the date it was given.

A GA modifier is when a waiver of liability statement (ABN) is on file. If a service not pertaining to the ABN was rendered in the same period as a service requiring an ABN, such services must be submitted on a separate claim and the statement dates of these claims cannot overlap. If the time periods cannot be separated, a single claim must be submitted, just for the overlapping period, using occurrence code 32 (date ABN given) showing all services as covered and placing modifier GA on the HCPCS code to identify the service line for which the ABN was given. If items or services can be split then a modifier is not needed.

GY modifiers are items or services statutorily excluded or do not meet the definition of any Medicare benefit. If using statutorily excluded items when the beneficiary needs a denial notices it must include condition code 21. Modifier GY is reported when you believe a service will be denied because the service is statutorily excluded (i.e. acupuncture) or does not meet the definition of any Medicare benefit. The GY modifier is submitted as a non-covered line item on a claim with other covered services. GY modifier is used on all line items for statutory exclusions. **This option should be used only when providers are unable to split non-covered services onto a separate claim.** When a beneficiary wants a denial that can be passed on to subsequent payers. A provider may submit claims, for initial determination, for statutorily excluded services, if the beneficiary requests it. On claims for statutorily excluded services, the provider should enter condition code 21 to indicate that it realizes that the furnished services are excluded, but that it is requesting a denial notice from Medicare in order to bill other insurers. This is also known as a “no pay” claim.

An ABN must be delivered by a qualified notifier and reviewed verbally with the beneficiary or his/her representative. It must also be written in lay language, clear, and legible. HCPCS codes cannot be used to describe a service or item. The beneficiary/representative must receive the ABN far enough in advance so the beneficiary/representative can make an informed decision. The ABN must be specific on what service or item that will be provided and given a genuine reason why the service will be denied by Medicare. ABNs are not used for Medicare Advantage Plans.

The ABN cannot be changed once the ABN has been signed by the beneficiary or representative. If the provider expects Medicare will pay then an ABN should not be given. ABNs should not be given on a routine basis, during an emergency, or when the beneficiary is under duress. All sections of the ABN must be completed. Once the ABN is signed the notifier keeps the original and the beneficiary/representative receives a copy of the signed ABN.

CMS recommends the use of font size 10 to 12 and the use of font Arial, Times Roman, or Courier. The provider must use black or dark blue ink on a white background. Both low-contrast and highlighting are prohibited. All insertions must be typed or legibly handwritten. The ABN can be one page in length (legal or letter). ABNs are available in both English and Spanish. When the beneficiary or representative does not speak English or Spanish the notifier may provide verbal assistance to help the beneficiary understand the notice. Notifiers should document any verbal assistance in “Additional Information” section H of the ABN.

If the beneficiary does not have a Power Of Attorney then you must use an Authorized Representative. An authorized representative is a person who is acting on the beneficiary’s behalf and in the beneficiary’s best interests, and who does not have a conflict of interests with the beneficiary, when the beneficiary is temporarily or permanently unable to act for himself or herself. The order of priority of authorized representatives is:

The spouse, unless legally separated

An adult child

A parent

An adult sibling

A close friend

*close friend (defined as “an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values, and who is reasonably available”)

If the beneficiary refuses to sign the ABN then the notifier should consider not furnishing services or items. The notifier should consider the health and safety of the beneficiary before denying services. If the beneficiary health and safety are at risk, denying services or items is not an option. If the beneficiary demands the service and refuses to pay, the notifier should have a second person witness the provision of the ABN and the beneficiary’s refusal to sign. They should both sign an annotation on the ABN attesting to having witnessed said provision and refusal.

Routinely issued ABNs are permitted in the following situations:

- For items and services never covered, under any circumstances, as not reasonable and necessary under §1862(a)(1) of the Act (e.g., acupuncture).
- For items and services which Medicare considers to be experimental (e.g., “Research Use Only” and “Investigational Use Only” laboratory tests) and, therefore, not reasonable and necessary under §1862(a)(1) of the Act.

- Any item or service for which Medicare has established a statutory or regulatory frequency limitation on coverage, or a frequency limitation on coverage on the basis of a national coverage decision or on the basis of Local Coverage Determination (LCD), because all or virtually all beneficiaries may be at risk of having their claims denied in those circumstances. The ABN must state that “Medicare does not pay for this item or service more often than [frequency limit].
- For DMEPOS that likely will be denied because the supplier has no supplier number or because the supplier made an unsolicited telephone contact (“cold call”), because these denials apply to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally.

Until the revised ABN is available SNFs should continue to use SNFABN (CMS 10055) and denial letters for Part A services or items. For Part B services or items continue to use ABN-G (CMS-R-131G) until revised ABNSNF is available. The revised SNFABN will cover all Part B services or items delivered in a SNF and will be available before September 1, 2008. Until then SNFs can continue using the current ABN-G. Staff of a SNF cannot sign an ABN as an authorized representative. A SNF can have ABN signed up to one year in advance.

This concludes my presentation. We will now begin our question and answer session. We request you limit your questions to those of relevance to all participants of the call rather than claim specific questions. If we need to research your question further, we will request your telephone number. We will now activate the Q&A session. As a participant you will hear instructions on how to be placed in the Q&A queue. We will pause for a moment to collect questions.