

February 18, 2009

Advance Beneficiary Notice (ABN)

Resources

- [Advance Beneficiary Notice of Noncoverage form](#)
- [Form Instructions: Advance Beneficiary Notice of Noncoverage](#)
- [Revised ABN Frequently Asked Questions](#)

The American Optometric Association recently discussed the new Advance Beneficiary Notice of Noncoverage (ABN) with an expert from the Centers for Medicare & Medicaid Services (CMS) to confirm that the use of ABNs by optometrists should not change with the new form. The new ABN has been available for use since March 3, 2008, and it will be the only acceptable ABN for Medicare patients beginning March 1, 2009.

See <http://www.aoa.org/abn.xml> for a copy of the form and instructions. Doctors will notice the new form is formatted differently, requires a cost estimate, and gives an additional beneficiary option (to receive the service and agree to pay for it without submitting the claim to Medicare or having a right of appeal).

According to CMS, the situations that call for an optometrist's patient to sign an ABN should remain the same when using the new form. "The ABN is only issued when the provider has an expectation of noncoverage," CMS reiterated. The ABN provides written notice of noncoverage before care is provided, which informs the beneficiary that Medicare may not pay for an item or service, allows the beneficiary to make an informed decision whether to receive the item or service, makes the beneficiary liable for payment, and protects the doctor or clinic from liability for the cost of the item or service.

The question of whether to have the patient sign an ABN comes up most when providing covered services that the provider feels may be rejected by CMS as "not reasonable and necessary," but also arises when providing eyeglasses to Medicare beneficiaries. Medicare pays for one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with the insertion of an intraocular lens. If eyeglasses are provided at any other time (other than the very rare cases providing glasses or contact lenses for patients who are aphakic), they are not covered by Medicare. The ABN is used to notify the patient that an item might not be covered by Medicare and to establish beneficiary agreement to pay for the item or service. If there is no ABN, then the doctor *must* not hold the patient liable for payment.

The ABN is necessary for the physician to bill a Medicare beneficiary for services which are always denied for medical necessity (e.g. visual fields for a patient without a covered diagnosis), frequency limited items (repeat of visual fields or other test more frequently than covered by the carrier or contractor), denial of advanced determination of Medicare coverage (ADMC), and certain instances of upgrades. The ABN is voluntary for items that are statutorily excluded (never covered by Medicare, such as refraction) or do not meet the definition of a Medicare benefit.

Here are some common situations, and the advice from CMS:

-- The doctor provides a pair of eyeglasses to a patient who has not had cataract surgery. According to CMS, "ABNs are not required [to provide eyeglasses] for beneficiaries who have not had cataract surgery. ... The ABNs are not required in these situations because such denials do not trigger beneficiary liability protections. However, the ABN could be delivered voluntarily as a courtesy to patients to inform them that Medicare will not pay, but again it is not required."

-- The doctor provides one pair of conventional or standard eyeglasses to a patient following cataract surgery. CMS said, "The ABN is not required for post-cataract eyeglasses or contact lenses because the provider has no reason to anticipate noncoverage." In other words, the Medicare benefit is one pair of glasses (two lenses and one frame) when the patient has cataract surgery with implant on the first eye and another pair (two lenses and one frame) when the patient has cataract surgery with implant on the second eye.

-- The doctor provides an upgraded pair of eyeglasses with extras such as tint or a deluxe frame that Medicare does not cover. CMS explained, "The only situation where an ABN would be required for post-cataract surgery eyeglasses would be where the beneficiary is receiving a pair of glasses that cost more than what Medicare allows. This would be considered an 'upgrade' that would not be considered reasonable and necessary. The ABN would be issued advising the beneficiary that s/he would be responsible for the additional cost." In these cases, the doctor indicates the extra cost associated with 'deluxe' lenses or a 'deluxe' frame using the appropriate HCPCS codes, V2702 for the lenses and V2025 for the frame, reporting the extra cost on the ABN form for the patient to sign before the glasses are ordered.

-- The doctor provides more than one pair of eyeglasses to a patient following cataract surgery. CMS told AOA, "The ABN would also not be required if the beneficiary is seeking an additional pair of post-cataract glasses/contact lenses, since the statute specifies that only 1 pair is covered."

Refractions and so-called "routine" eye care are not covered by Medicare, so an ABN is usually not required to be able to bill the patient. CMS stated: "With regard to routine eye care, such as refractions, the ABN would also not be required since Medicare never covers these services and limitation on liability provisions requiring issuance of the ABN do not apply." However, if the patient insists that they will not pay for not-covered services, such as refraction, unless they get a denial from Medicare, completing the ABN may assist the patient in understanding her/his responsibility for payment for those services. If the provider includes a noncovered service on a claim, the service (e.g. refraction 92015) should be accompanied by the GY modifier, indicating the service is not covered by Medicare.

CMS also explained that an ABN was not necessary to accompany a claim that is submitted merely to get a Medicare denial that a patient can use for purposes of

supplementary coverage. The doctor can submit such a claim and obtain a denial without including an ABN. CMS said, “However, the provider may issue the ABN voluntarily to notify the beneficiary that Medicare will not cover the service or the provider may submit the claim to Medicare at the beneficiary’s request and once the payment is denied, the beneficiary can submit the claim to his/her secondary insurance. If the beneficiary chooses Option 1, asking to have a claim submitted to Medicare, the provider must submit the claim. Once the claim is denied, it can be submitted to the beneficiary’s secondary insurance.” Once again, even though the ABN is not required by Medicare in this situation, it can be beneficial in helping the patient to understand her/his responsibility to pay for all services not covered by Medicare.

The new ABN makes the old Notice of Exclusions From Medicare Benefits (*NEMB*) unnecessary, because the new form can also be used instead of the NEMB (CMS Form 20007). Please be advised that the old ABN forms (CMS ABN-G and CMS ABN-L) cannot be used after March 1, 2009.

Chapter 30 of the Medicare Claims Processing Manual covers financial liability protections for Medicare beneficiaries. See <http://www.cms.hhs.gov/BNI/Downloads/RevABNManualInstructions.pdf> for the revised instructions.

For example, Section 50.8 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) states: “Notifiers must give an ABN when they expect Medicare to reduce the level of payment for an item or service because part of the item or service is not reasonable and necessary. For example, an ABN must be issued when a notifier expects a partial denial of a more extensive part of a usually covered item or service because that part is not reasonable and necessary. Examples of excess parts include increased charges attributable to furnishing something that is more in number, more frequent, given for a longer period of time, or that has added features or specific additional uses that are not medically necessary [e.g. deluxe lens features or deluxe frames].”

ABNs cannot be used to charge beneficiaries for premium quality services described as ‘excess components.’ Similarly, ABNs cannot be used to shift liability for an item or service that is described on the ABN as being ‘better’ or ‘higher quality’ on an ABN.”

Also note that the doctor may need to use modifiers on the claim submitted to Medicare when an ABN is signed by the patient. The GA modifier must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they have an ABN on file signed by the beneficiary. The EY modifier indicates there is no physician order for the item, as with a patient preference item such as a deluxe frame or tint. For coordination of benefit purposes, DMEPOS suppliers should use the modifier EY (no physician or other licensed health care provider order for this item or service) on each line item on the claim and report their own name and National Provider Identifier (NPI) in the “Ordering/Referring Provider Name” fields to secure a Medicare denial. An ABN is not necessary when the

KX modifier is used because the KX modifier indicates to the payer that the services (which would otherwise be denied) are medically necessary and that the provider has supporting documentation. Other coding and coverage rules may apply.