



## ABN Changes Script

Hello, today we are here to talk about the recent changes to the Advance Beneficiary Notice (ABN).

On March 3, 2008, The Centers for Medicare & Medicaid Services (CMS) implemented use of the revised ABN form. The new form, CMS R-131, combines the general Advance Beneficiary Notice (ABN-G) and Laboratory Advance Beneficiary Notice (ABN-L) into a single form.

Beginning March 3, 2008, but prior to March 1, 2009, providers could use either the ABN-G and ABN-L or the revised ABN (CMS R-131) as valid notification. However, beginning on March 1, 2009, Medicare contractors will accept only a properly executed ABN CMS R-131 as valid notification.

All providers and suppliers must begin using only the revised ABN (CMS R-131) on March 1, 2009.

The Advance Beneficiary Notice is a very important communication tool for providers and beneficiaries regarding services which Medicare may deem medically unnecessary. Medicare expects providers to have knowledge of both the Medicare rules for the services he/she performs and the patient's condition. Medicare publications, such as our eNews messaging and *Communiqué* newsletter are important resources to help you stay informed of Medicare updates. It is also important for providers to be aware of published medical policy which can be found on the WPS Medicare Website at <http://www.wpsmedicare.com>. Here you will also find the *Communiqué* and can sign up for our eNews messaging.

The CMS also has a manual with the National Coverage Determinations (NCDs) in numeric order. You can access this information on CMS' Website <http://www.cms.hhs.gov/Manuals/IOM/list.asp> and choose the Internet Only Manual (IOM) *National Coverage Determination Manual*, publication 100-03.

By utilizing these tools providers can determine if Medicare will deem services as not medically necessary. Not medically necessary services are services Medicare can pay for, but may *not* pay for in a particular situation because of the patient's condition or frequency limitations. Proper usage of an ABN establishes financial liability for services which are denied based upon medical necessity guidelines. The remarks codes on the Remittance Advice indicate the patient's liability.

There are two primary categories by which Medicare may deem a billed service as medically unnecessary: diagnosis and frequency. When a provider anticipates Medicare may deny a service because of diagnosis or frequency, then he/she can provide the patient with an Advance Beneficiary Notice (ABN). The ABN allows the patient to become an informed consumer. Once the provider has completed the ABN and has presented it to the patient, the patient will decide whether to proceed with the service. If they agree to proceed with the service, the provider gives the patient a copy of the signed and dated ABN form, and places the original in the patient's file in their office.



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The provider then bills the service with a GA modifier appended to the procedure code. Billing with the GA modifier indicates to Medicare that you have an Advance Beneficiary Notice on file. This establishes the patient's financial liability for the rendered service(s), should Medicare deny as expected.

Information regarding the use of the Advanced Beneficiary Notice (ABN) is available on the CMS Website at [http://www.cms.hhs.gov/BNI/02\\_ABNGABNL.asp#TopOfPage](http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage) .

Additional information regarding use of the ABN form is available in the Medicare Learning Network (MLN) Matters article MM 6136, found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6136.pdf> .