

CENTERS FOR MEDICARE & MEDICAID

THE ADVANCE BENEFICIARY NOTICE

An Advance Beneficiary Notice (ABN) is a written notice which a physician or supplier gives to a Medicare beneficiary. 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. 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.

ABN Decision Tree #1

Standard Decisions

Will Medicare deny payment for this service (or item)?

1. "No, I do not expect Medicare to deny payment." →

Do **not** give any ABN. **Do** submit a claim to Medicare.

- **If Medicare pays:** You may collect charges from Medicare, and any coinsurance & deductible from the patient. On an unassigned claim, you also may collect up to a 15% balance billing amount from the patient.
- **If Medicare denies payment for medical necessity, you may:**
 - A. Provide additional documentation of medical necessity so Medicare will pay. (This may happen even before the initial determination is made for the claim, during "claims development.") [If Medicare agrees, Medicare pays because the service is covered.]
 - B. Appeal on the basis that the service should be covered. [If Medicare agrees, Medicare pays as covered.]
 - C. Appeal on the basis that you did not know and could not reasonably have been expected to know that Medicare would not pay. [If Medicare agrees, then Medicare will pay (for assigned claims) under the Limitation On Liability provision, AS IF the service were covered.]

2. "I don't know. I never know what Medicare will deny." →

- **If Medicare denies payment on the basis of a statutory exclusion or failure to meet technical coverage requirements under the program benefits sections of the law:** You may collect full charges from the patient.

[End #1 & #2]

3. "Yes, I have a genuine reason to expect that Medicare will deny payment, based on other Medicare denials, LMRPs, local standards of medical practice, etc.."

Then, ask this question: "On what basis do I expect that Medicare will deny payment?"

MEDICAL NECESSITY

Denial as "not reasonable and necessary."

- DMEPOS denials – prohibited telephone solicitation; no supplier number; payment denied in advance – also are handled in the same way as "medical necessity" denials.

Do give an ABN (either a General Use form ABN-G or laboratory test form ABN-L). If the patient receives the services or items you must **always** submit a claim to Medicare (it is called a "demand bill").

- If you do not submit a claim, timely, you violate the mandatory claims submission provision, which can result in sanctions.

When you have submitted a claim: ↓

EXCLUSIONS & TECHNICAL DENIALS

All other exclusions from Medicare benefits; and failure to meet technical coverage requirements under the program benefits sections of the law.

Do **not** give an ABN (neither the General Use form ABN-G nor laboratory test form ABN-L).

You do **not** need to submit a claim unless the patient demands it.

If you do not submit a claim, you may collect full charges from the patient.

If you submitted a claim: ↓

- **If Medicare pays:** Collect payment from Medicare, and any coinsurance & deductible from the patient. On an unassigned claim, you also may collect up to a 15% balance billing amount from the patient.
- **If Medicare denies payment:** You may collect full charges from the patient.

[End # 3]

ADVANCE