

Medicare Fee for Service (FFS) – Advanced Beneficiary Notice of Noncoverage (ABN)

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Real Time Captioning Transcript

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>> Good afternoon I'm Evelyn Blaemire as practitioner here at semester I will be starting off the presentation and then Charlayne Van-Skinner my attorney colleague from this will provide the second half of our webinar. We are excited to be able to use the interactive tools that WebEx offers and as explained by our host, you may submit in ABN related question anytime during this will never go please note that we will begin answering questions after we get through the presentation portion. If you do submit a question and it is not selected for webinar discussion, please check our web portal blink. It is at the bottom of the first slide. We will post a Q&A document providing answers to questions that are not covered during our allotted time today. I will start off by briefly reviewing the purpose and goals of today's webinar. To familiarize everyone with the ABN new features and requirements, to give you an opportunity to test your knowledge on souvenirs and to allow you to participate in a sea one question and answer session dry clay with CMS staff. Let's begin discussing the advanced beneficiary notice noncoverage which is also called the ABN. Here are the overview of the ABN, the ABN is a CMS approved written notice that is issued to fee-for-service beneficiaries are the beneficiaries representative when appropriate. By providers, practitioners, suppliers and laboratories. Prior to delivery of certain items and services provided under Medicare Part B including outpatient hospital services covered by Part B or under the hospice and religious nonmedical healthcare institutions benefits of Medicare Part A. The revised ABN can be used by providers and its suppliers [Indiscernible]. Here are the ABN explosions from US. The ABN is never used for items and services provided under the Medicare advantage program, part C. with a Medicare prescription drug program, parts of the. It is also not used to care provided to hospital in patients under Medicare Part A. There are six that you tour a proficient meaning provisions that are part of the Social Security act which is also referred to as the acts. Requiring delivery of the soon-to-be beneficiary before care is provided. If a situation falls under one of these provisions a ABN must be issued to the beneficiary or his or her representative. The first provision is items and/or services that are not reasonable and necessary for the patient and detailed in section 1862 A1 of the act. These are commonly referred to as medical necessity denial. Second, items provided by suppliers violate the prohibition on unsolicited telephone contacts as excited in 1834 A.

17 be. Third on the list, medical equipment and supplies provided by a supplier who does not meet Medicare supplier number requirements from section 1834 J. one. For is medical equipment and/or supplies denied in advance which is cited in 1834 A. 15. The fifth stipulation for mandatory use is custodial care. Which is noted in section 186289. And lastly, ABN issuance is mandatory before a hospice provides care to a patient who is not terminally ill perception 18179 gee to. If one of these provisions that I just mentioned applies to the service or item been provided to the beneficiary the ABN must be issued to the beneficiary before he or she received that care.

>>> Our webinar includes several case studies for your understanding of appropriate ABN US and as I read each case study you will see a multiple-choice polling question in the lower right-hand of your screen. If you are viewing the PowerPoint presentation in full screen mode, you are going to need to modify your view by clicking the bar graph icon at the bottom right-hand corner of the screen so the polling questions are visible to you. And I asked our viewers please click and submit the best answers for each polling question. The best answer for each polling question for first case study is Mr. Lombardo. Mr. Lombardo has original of Medicare Part B coverage and has a history of chronic low back pain without supplication for those who don't know is a displacement or misalignment of a joint or body part. He sees his chiropractor for spinal manipulation once every two months for maintenance therapy. Medicare covers manipulation of the spine if medically necessary to correct a subluxation when provided by character actors or other qualified providers. So the first polling question is in the box on the right side of your screen and it beats it should be chiropractic office issue in ABN to Mr. Lombardo before three saves his spinal manipulation? Why? I will give everyone a little time to answer.

>> We will move the polling question to the main screen. There are two general questions that providers and suppliers can use to determine if ABN issuance is mandatory in particular scenario is. If they are number one, is a service covered by Medicare Part B and number two, this Medicare consider this service medically necessary for the patient's condition in this particular case. Said to answer these questions is this treatment covered by Medicare Part B? Yes. Spinal manipulation by a chiropractor is a service covered under Medicare Part B if the treatment is to correct subluxation. If a treatment is never covered by Part B the provider would not be required under statute to issue the ABN. Does Medicare consider this treatment medically necessary for the patient's condition in this case? No. Mr. Lombardo does not have subluxation of the spine. Therefore Medicare does not consider car parked at manipulation and clean necessary.

>> Because Mr. Lombardo is receiving Medicare Part B covered service that is not medically necessary for diagnosis -- a ABN must be issued to him before the service is

provided to. The answer is whether A. Yes, the ABN is mandatory. Here's the next polling question regarding Mr. Lombardo. It would test your knowledge of the ABN policy. Since Mr. Lombard or sees the same chiropractor every two months for spinal manipulation of the same area of the spine, how often will he be issued a ABN? I will give everyone a few seconds to answer this question.

>> Let's go through the answer options. A, never it is not required in his case. This is incorrect to go if you were paying attention during question when you would know this is not the answer. Once every two months before receiving each treatment. This answer is correct, but it is not the best answer because it would be a waste of time and trees and paper and I will explain more what we do get to the best answer. Once before his first spinal manipulation than it is no longer require. This answer would be correct or could be correct if Mr. Lombardo's treatments are limited to less than 1 year's time on the same spinal area. The ABN issued before his first treatment would also have to include information on his receiving a series of treatments. This again is not the best answer. The best answer is D, once before his first spinal manipulation and every year as long as there is no change in the service provided. Won the ABN can be issued for reprint repetitive items and services and is effective for up to 1 year. The period of treatment should be included on that type of ABN that's going to be good for 1 year anything new if ABN must be issued when the specified treatment extends beyond one year's time.

>> Now we will move on to voluntary use of the ABN. Notice of the exclusion of Medicare benefits for any.

>>> Was discontinued in 2009 in providers and suppliers have been instructed to use the ABN as a voluntary notice in its place. What care falls under the voluntary notice? Care that is explicitly excluded from coverage under 1862 of the act which includes service for which there is no legal obligation to pay, services paid for by a government entity other than Medicare and this exclusion does not include services paid for by Medicaid on behalf of dual eligibles. Service is required as result of war, personal comfort items, routine physicals and screening test, routine I care, dental care, and routine foot care. Involuntary ABN can also be issued for care that fills to meet a tactical benefit requirement Pagosa just lacking the required certification as defined in 1861 of the Social Security act. He would do a voluntary use case study. Mrs. Runner has been a Medicare but a Medicare beneficiary for six years. She's at her primary care physicians office for her yearly physical. Her family insists that she obtained nearly physicals if she continues to run marathons competitively. She knows that you would physicals are not covered by Medicare and her children routinely pay for this field office is. During your exam, her Dr. Finds a newly detected abnormal heart rhythm and orders an in office EKG. Medicare usually pays for a EKG when it is order for diagnosis such as Hearst. So Mrs. Runner will be billed for two

services from an annual physical exam which is a service that Medicare never covers and an EKG which Medicare covers when medically reasonable and necessary. So please take a few moments to choose the best answer. To the polling question on the right side of the screen.

>> Prior to Mrs. Runner receiving her physical EKG, her Dr. 'S office should issue, you are getting a list of noticed options but let's break down the services that will be listed on a claim for this office visit in order to make the best choice. The annual physical exam, does Medicare ever cover annual physical exams? No. Who will be responsible for payment of the service? The patient or in her case, her children or her secondary insurance may provide some coverage if she does have a policy. Does the office need to issue a mandatory see what you transfer financial priest liability for this service to the patient? No, because Medicare never paid for this service. At the office issue a voluntary ABN to the patient? Yes, as a courtesy to the patient the office could provide a voluntary ABN Sochi is aware of the financial responsibility. So that's the first service. The second service that she will be billed for it is the EKG. Does Medicare cover EKG provided in outpatient settings? Yes. Is medically reasonable and necessary for the patient and is instant? Yes. Should be mandatory ABN be issued? No, because this is a covert medically necessary service for this patient got the best answer for question one is A. E is a possible answer but the rationale is incorrect. No notice would be given because there are no mandatory requirements to issue. Here's another question about care provided to Mrs. Runner at this office is. Because Mrs. Runner has a newly acquired abnormal heart rhythm her Dr. 'S orders a teacher, a thyroid blood tests. Under a diagnosis code cardiac district via unspecified. Medicare does cover TSH testing for this diagnosis. Divisions office should issue? And I will give everyone a few moments to use the polling box to select the best answer.

>> The service to be provided is a teacher level. Does Medicare covered this in an outpatient setting? Yes. Is this just medically reasonable and necessary for this patient? Yes. Is a ABN needed? No. This is a Medicare covered service. Said the correct answer is T. 10.

>> -- let's return to factual information regarding the revised ABN. The revised ABN replaces the ABN G., which is also known as the general ABN, the ABN.

>>> Known as the LAT ABN and the NEMB CMS 2007 which was the notice of exclusion for Medicare benefits. These three notices are no longer in use, providers or suppliers should only be using the revised ABN.

>> With this release in March 20–0/9, several notice revisions occurred. Number one, the ABN was given a new name to more clearly convey the purpose of the notice it was formally titled the advanced beneficiary notice and it is now called the advanced beneficiary notice of noncoverage. Number two, the requirement to include the beneficiaries health insurance claim number or the HICN on the notice was removed and conversely specific instructions were included in our revised form infrastructure and prohibiting they use of the health insurance claim number on the ABN. Number three, a mandatory cost estimates section to the items and/or services listed on the ABN with added to the beneficiary could be informed regarding the possible financial impact of their decision to receive or not receive services that might not be paid for by Medicare. And number four, a new option box was added to the form which allows the beneficiary to choose to receive the item or service in question and request that Medicare not be built. This is option two of the three options on the ABN. When the beneficiary checks off the option to box and signs the form, the provider or supplier is not required to submit a claim to Medicare and may directly build the beneficiary. As a note to issue a notice formatting it is important for providers and suppliers to recognize their are other Medicare liability notices that closely resemble the ABN and working in appearance. Those notices are the skilled nursing facility ABN or the snip ABN, CMS 10055 and eight the home health ABN H. H. ABN CMS are to 96 to go with the ABN is not interchangeable with these two notices. Now my colleague and the ABN expert, Charlayne Van–Skinner will tell you more about notice requirements and policies of the revised ABN and present a final case example. Charlayne.

>> Thank you, to an. I want to remind everyone that questions regarding the ABN should be submitted to a today's presentation. We will be answering as many questions as we can at the conclusion of today's webinar. With that in mind, I'm going to pick up where Evelyn left off and start off with the second portion of today's presentation with a brief discussion [Indiscernible] electronic medical record, and electronic signature. We received numerous questions regarding they use of the electronic signature. Currently, beneficiaries or their representatives must select an ocean on the ABN and physically sign the notice. Currently, they use of digital signatures is not permitted at this time. The beneficiary or his or her representative must select an option &–and–sign the notice. The reason why we cannot accept digital signatures at this time is because CMS does not have the ability to monitor providers -- we don't have the ability to monitor the providers encryption software to ensure that the beneficiary private health insurance information is protected. At this time providers must physically provide the beneficiary with an advanced beneficiary notice. That were going to move on and talk about Representatives. A representative is an individual who may make healthcare or financial decisions on the beneficiary's behalf. Notifier is are responsible for determining who may act as a beneficiaries are presented at one of the applicable state or other law. To appoint a

representative the beneficiary may use CMS form 1696 or conforming written instrument such as a power of attorney. In the event the beneficiary does decide to appeal Medicare's [Indiscernible] documentation appointing a representative should be filed along with the appeal request.

>> And providers they referred to the Internet only manual publication 100 -- go 04, chapter 29, section 270 for instructions related to use of 1696 and the appointment of Representatives.

>> Oftentimes beneficiaries are faced -- providers are faced with a situation with the big picture refuses to sign the notice. Are often than not the beneficiary just doesn't understand what he or she is being asked to sign. A lot of the times these refusals can be avoided if notifier is to get time to thoroughly explain the notice to the beneficiary. If after thorough be expanding to notice the beneficiaries to refuses to sign, we recommend that notifier is won an ATP original copy of the ABN indicating the refusal to sign and two, consider not finishing the items and services unless the consequences are such that this is not an option. Or three, provide a copy of the annotated ABN to the beneficiary and keep the original version of the notice any patients filed.

>> Let's move on and talk about modifications. Modifications or preprinted information on the ABN are permitted if they are consistent with the manual instructions. Modifications beyond what is allowed by the instructions must be approved by the appropriate CMS regional or central office. It is important to work with the regional office in your area when considering a modification. Since providers run the risk of having the ABN and validated if the modification is done improperly.

>> There are many instances where multiple entities are involved in rendering care to a beneficiary. In such cases separate ABN are not necessary. For example, in cases where a physician orders left has for a beneficiary it at the ordering physician or the lab conducting the test may issue the ABN. However it is important to remember that the billing entities will always be held responsible for effective delivery since this is the entity that will be spinning the claims made care for payment. The contractor which will always look to the billing entity if there any deficiencies and delivering the ABN. When the notifier is not the billing entity and notifier must know how to direct the beneficiary to the billing entity for questions. And should also indicate the additional information section of the ABN with this contact information. The name of more than one entity may be entered in the header of the notice. That we are going to move into another polling questions along with a case that the.

>> Ms. Sugarbaker is a diabetic who recently underwent a right below the knee amputation. At her last visit with her primary care provider, her blood sugar was well-controlled. Her nurse practitioner ordered her a glucose in a one seat left test in three months. Physical therapy three times weekly for two weeks for continued ambulation training and a bedside commode for patient comfort. It is important to note that Medicare covers hemoglobin A-1 C. test team and told diabetics every three months. And physical therapy that Medicare does not cover [Indiscernible] medical inclement ordered for patient comfort. We are going to move into our first polling question. Remember you can access the polling question at the right bottom corners of your screen. The first question, as Sugarbaker tends to be forgetful and cannot remember what she is posed go to the lab for her cubicle than just. Her daughter takes her and immediately upon finding a loud slip in Ms. Sugarbaker's purse. Only three weeks have elapsed since her last hemoglobin A-1 C. and the LAT issues a mandatory ABN. Ms. Sugarbaker refuses to sign the ABN because Medicare always pays for my sugar test she says. How should the leprosy? Should the lab draw the blood for hemoglobin A-1 C. without a signed ABN? Annotate the ABN with information about the beneficiary refusing to sign the notice and give the patient a copy and explained to her that hemoglobin A-1 C. on record was three weeks ago and she should contact her Dr. For further information. Do-nothing, allow the patient to exercise this right. Or call the provider's office to see if this test is really necessary and have the patient sign the ABN. We will give you a minute to select an answer.

>> Okay, I see most of you selected B, and they take the notice with information about the beneficiary refusing to sign in to be patient a copy. That is the right answer. In a situation where you have a beneficiary refusing to sign the notice the provider should annotate the ABN with this information. And give the patient a copy and also explain to the patient in their last test was furnished and that they should contact their Dr. For more information. Everyone did very well about 94% of you selected the correct answer to this question. Let's move onto the second polling question. The supply issues a ABN to Ms. Sugarbaker before providing her with the bedside commode. Based on this case, this issuance of the ABN voluntary or mandatory? I will give you another moment to answer this question. And I would recommend that you refer back to slides four through 10 which discusses mandatory versus voluntary issuance of the ABN.

>> I see it is about half and half between voluntary and mandatory issuance. And the correct answer is A, ABN issuance would be voluntary and the situation took a voluntary ABN would be issued in this case because the decrease since we stayed at the beginning of the case study Medicare never pays for DME that has been ordered for patient comfort. This would not fall within one of the mandatory use case studies as explained in slides four through six. Going to move onto the third polling question. As Sugarbaker has progressed in reaching her goal is for ambulation and physical therapy. And her Dr. Has

ordered a decreased to two visits per week. She wants to continue three visits per week and is willing to pay out-of-pocket for the extra physical therapy visit. What should happen when Ms. Sugarbaker arranges for this request for additional therapy? I will give you another moment to answer this question.

>> Okay, I see most of you answered option to six and the correct answer is actually A. These questions confuse a lot of providers and let me explain why option A is the correct answer. A voluntary ABN would be issued in this case because the decrease in physical therapy is being done in accordance with the Dr. 'S orders. Many of you may think the decrease in physical therapy is a triggering event for a mandatory issuance of the ABN. However, the decrease does not trigger mandatory issuance because the requirement to issue a ABN is predicated on the existence of a Doctor's order for continued care. 'S service is denied because there were no doctors order for continued care at that level would not require issuance of the ABN. I will refer you back to slides four and five which list all of the denounce of the required delivery of the ABN. Let's move on to polling question number for. In physical therapy practice uses electronic medical records for Ms. Sugarbaker. Which of the following statements is true? The ABN can be issued and stored electronically. The ABN must be issued as a hardcopy but then stored electronically in the patient's electronic medical record. The ABN cannot be converted into an electronic documents. The ABN can be issued electronically by the beneficiary must receive a printed hard copy for his or her records. I will give you a moment to answer this question.

>> And I see most of you selected option T. six. It must be issued as a hard copy but then can be stored electronically in the patient electronic medical record. And that is the correct answer. The ABN must be issued as a hardcopy. I will refer you back to slide 13 for the discussion on electronic medical record and electronic signature. That concludes our PowerPoint presentation for today. To access more information on use of the ABN, you may refer to our website. And to access copies of all of our notices in the access of thoseWe are now going to open up the webinar to questions.

>> And the first question we receive from one of our participants is do I need to give a ABN to a patient who has Medicare and a secondary insurance? Medicare will likely not pay for this item with the patient's secondary insurance will pay in full. Answer to that question is yes to go if a patient has Medicare coverage and he or she is receiving an item that may be covered benefit but will likely be denied Medicare payment, issuance of the ABN is mandatory. This holds true even when you know that a secondary insurer will pay for the item in full. In many cases the beneficiary will need to choose option one, sign and date the ABN so a claim can be submitted to Medicare for denial purposes. In a secondary insurers require the Medicare claim [Indiscernible] before they provide payment.

>> We've received many questions throughout today's webinar regarding the availability of a slide presentation. Decides can be accessed at our website they will be available on what the transcript and recording of today's webinar within 24 to 48 hours.

>> We've received another question, is the revised ABN the one that hospice has used or should they use the home help ABN? Hospices should use the revised ABN. The home help ABN is specific to home healthcare.

>> Another question we received today is can the words identification number at boxy to remove and replace with language specific to our particular practice? For example, medical record number or HICN number health insurance care number of. The answer to that question is the ABN is an OMB approved form and therefore this wording should not be removed. However you can preprint medical record number of long side or over the identification number on the form if you think this might help with compliance and record keeping for your purposes. Please note that completion of a box seat is optional and absence of an identification number on not cause contractors to invalidate the notice. He must not include the beneficiary's health insurance number on the revised ABN.

>> This is Evelyn, we are getting Charlayne a water break and I will answer some of the other questions that have been coming in. This next question beats if the beneficiary chooses option to three, can we still deliver the service? What do we do when the beneficiary refuses to choose an option? No, you would not deliver the service of option three is chosen by the beneficiary. If the beneficiary refuses to [Indiscernible] option on a form in provision of the services at your discretion for both the provider's discretion and a provider would be to document that the beneficiary refused to choose an option. If the provider does decide to deliver the item or service to the beneficiary, Medicare claim for the service could then be filed, but Medicare does not have to pay -- at Medicare does not pay for the item or service the provider could be held financially liable for that service.

>> Here's another question, do I need to issue in ABN when my patient receiving outpatient occupational therapy has reached his therapy Cap? Know, in ABN is not required for a therapy that exceeds the Cap. Because his therapy false-positive the benefit category. Providers they issued the ABN or some other type of notification voluntarily to over the beneficiary that she is approaching the Cap. But it is not required. For therapy and access of Cap.

>> I'm next question is if the beneficiary chooses option to does the provider still have to file a claim to comply with mandatory claim submission rules? The answer to this question is option two is no. The provider does not have to file a claim, option two serves as a beneficiary's written request to waive his or her right to having a claim submitted and

eliminates right or obligation to submit a claim to Medicare. So providers are prohibited from submitting claims without the beneficiaries express authorization. Under section 1848 of the act. The answer to that question is no.

>> Okay, we received follow-up questions on one of our polling questions regarding a decrease in physical therapy. I will go over that case to the question for you one more time. Ms. Sugarbaker has progressed in reaching your goals for emulation and physical therapy. And her order is decreased from three visits per week to two visits per week. However, Mr. Sugarbaker wants to continue three visits per week and is willing to pay out-of-pocket. What should happen when Ms. Sugarbaker arranges for this request for additional therapy? The answer to that question was A, a voluntary ABN should be issued. And again, the issuance of the ABN is predicated upon the existence of a Doctor's orders for continued care. End this case, we do not have a Doctor's order for continued care since the Dr. Decreased a physical therapy from three visits per week to two visits per week. Therefore, the ABN would not be required in this instance.

>> Received a very good question it is if we issued a non-Sun across the scared in a family appeals and notice and wants to continue with hospice care during the appeal, do we issue in ABN? First we want to make it clear that new is up -- but notices of noncovered are issued to an a and release only and do not apply to see for service beneficiary. If the hospice determines that the patient is no longer terminally ill, the hospice must deliver the ABN prior to furnishing any additional purposes. -- services.

>> Okay, just to repeat the last question that came in. The question was if we issue a

>> -- revised notice was implemented and made available to providers.

>> Another question we've received is do I need to issue an ABN for a home care Medicare case that decides to hire a homemaker? The answer to that question would be no, the ABN would not be mandatory in this case because Medicare never covers home care services. As a homemaker, custodial type services.

>> This concludes today's session. We'd like to thank you for participating go and we would like to remind you that a recording of today's webinar along with the PowerPoint presentation and a transcript of the questions and answers can be accessed on our website via the web link. At www.cms-cpcevents.org/. Questions regarding the revised ABN can also be e-mailed to RevisedABNODF@cms.gov. Thank you.

>> [Event concluded]