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Complete Healthcare Compliance Manual
Revenue Cycle: Advance Beneficiary Notice of Noncoverage

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What Is the Advance Beneficiary Notice of Noncoverage?

The Advance Beneficiary Notice of Noncoverage (ABN) is a form issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare beneficiaries in situations where Medicare payment is expected to be denied and the beneficiary is expected to pay for the service. This can occur with the initiation of a service, the termination of a service, or the reduction of a service. Preparation and delivery of the ABN is complex, and each step must be followed properly or the notice is considered void and liability cannot be shifted to the beneficiary.

When an ABN is provided, the provider must indicate on the claim that there is a properly completed and signed ABN on file by attaching the -GA modifier to the claim. The -GA modifier is a code that is placed on the line item for the service when the claim is created that tells the claims processing system that the provider expects no payment from Medicare and will be charging the patient for the service. Services can be provided to Medicare beneficiaries that are not medically necessary, but the provider will not be expecting payment from Medicare. In this situation, the provider would attach modifier -GZ on the appropriate line item(s) on the claim. In this case, the -GZ tells the claim processing system that the provider expects no payment and will not be charging the patient.

ABNs are only used for Original Medicare beneficiaries. For any other payer, including Medicare Advantage (MA), the provider should contact the payer for instructions on how to shift financial liability to the patient. Furthermore, ABNs are only given to outpatients. If an inpatient is going to receive a service that is not expected to be covered, or their admission is determined by the hospital not to be medically necessary, the appropriate Hospital-Issued Notice of Noncoverage (HINN) must be used to shift financial liability to the beneficiary.[2]

Use of the ABN can be further broken down based on the location of use. Physicians may provide ABNs to Medicare beneficiaries if they are providing a service in the office to a patient that is likely to be noncovered, such as removing a benign mole, administering a tetanus vaccine without an injury, performing a cosmetic procedure such as a botulinum toxin injection, or performing an in-office lab test such as a cholesterol test prior to the approved time period. Physicians also order tests and studies that they themselves do not perform, such as laboratory tests or imaging tests, that may be medically unnecessary. In this instance, the physician may obtain the ABN for the performing entity, but it is the responsibility of the performing entity to ensure that the ABN was completed and presented properly, as outlined below. The same applies when a physician performs a procedure that is likely to be noncovered at a facility. For instance, if a surgeon is performing a cosmetic rhinoplasty at a hospital or ambulatory surgery center, the ABN can be completed by either the physician or the facility, but both are responsible for ensuring it was done properly.

Laboratories, both independent and hospital based, also commonly present ABNs to Medicare beneficiaries when a patient presents with an order for a laboratory test and the diagnosis is not covered based on the National Coverage Determination (NCD) for the test. There are 23 laboratory tests that have NCDs.[3] For example, blood counts are not covered for patients who are asymptomatic or who do not have conditions that could be expected

to result in hematological abnormalities. Medicare also covers many tests as part of the preventative care benefit.[4] These often have specific frequency limitations, such as cervical cancer screening with pap tests, which cannot be performed within the 23 months after the last exam in low-risk women with no prior abnormal tests. As noted above, although the test is being ordered by the provider, it is the obligation of the entity performing the test to ensure the ABN is completed properly.

Hospital outpatient departments also perform tests and procedures that are ordered by a provider but which are not performed by the provider, such as cardiac stress testing or radiology imaging studies. For example, Positron Emission Tomography (PET) scans are approved for specific indications as outlined in their respective NCDs.[5] To add to the complexity, some Medicare Administrative Contractors (MACs) have local coverage articles specifying the billing and coding requirements to be met in order for the service to be covered. Prior to performing the service, the provider must ensure that the test is being performed for an approved diagnosis. If not, they must either contact the provider and determine if additional clinical information is available to support the coverage of the test or provide the patient an ABN. If an ABN is provided, the patient should be given the opportunity to contact their provider and discuss the situation, as it is unlikely that the person presenting the ABN at the facility will have the clinical knowledge to adequately explain to the patient why the test is likely not to be covered by Medicare.

Nursing facilities also provide ABNs to patients. They generally do so in two situations. A patient in a Medicare Part A stay whose services are ending because they are no longer medically necessary but who would like to remain in the facility would be given a Skilled Nursing Facility (SNF) ABN.[6] For a patient in a nursing facility under Medicare Part B, an ABN would be given prior to providing any services to the patient that are not medically necessary.

Although infrequent, a hospice organization may provide an ABN to a beneficiary. This would occur if a patient who is not terminally ill requests hospice services (a scenario that is hard to envision), if a hospice patient requests a service that is not medically necessary, or if the hospice patient requests a level of care that is not medically necessary. For example, if a stable hospice patient requested to be admitted to inpatient hospice, an ABN may be provided.

Other providers such as durable medical equipment and therapy providers may also issue ABNs. In the case of therapy providers, the ABN is often triggered when the patient reaches the therapy cap.