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Complete Healthcare Compliance Manual 2024
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, therapists, 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 reduction of a service, or the termination 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. A main requirement is that it must be issued to a beneficiary with enough time prior to the service/procedure for the beneficiary to make an informed decision about whether or not to have the procedure/service. But it is inappropriate to produce an ABN for all Medicare beneficiaries receiving services for every procedure or office visit. Hence, having an effective ABN process is a compliance matter that requires implementing a reasonable process for a provider's communication of financial liabilities, appeal rights, and protections through notices to their patients.

Providers and suppliers use G modifiers to alert Medicare when they bill for services or items that they expect to be denied as either not "reasonable and necessary" (GA and GZ modifiers) or because they are not covered by Medicare (GY and GX modifiers). When an ABN is provided, the provider or supplier must indicate on the claim that there is a properly completed and signed ABN on file by attaching the -GA modifier to the claim.

Specifically, the -GA modifier is a code placed on the line item for the service when the claim is created telling 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 there can be situations where the provider will not be expecting payment from Medicare and will not be charging the patient. In this situation, the provider would attach modifier -GZ on the claim's appropriate line item(s). The GZ modifier indicates an ABN was not issued to the beneficiary and signifies that the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy.

When an ABN is properly presented, the service provided, and the claim submitted with the -GA modifier indicating the patient has accepted liability, the provider must still wait for the claim to be processed by the Medicare Administrative Contractor (MAC). In a 2013 audit report, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) determined that in 2011 Medicare paid 97.7% of claims that were submitted with the -GA modifier and 2.1% of claims submitted with the -GZ modifier.[2] That is, these claims should have been denied by the MAC. The OIG recommended that the Centers for Medicare & Medicaid Services (CMS) address the vulnerabilities discussed in the report. To this author's knowledge, there has been no further analyses of this. It is incumbent upon every provider to determine what action is appropriate when a payment from Medicare is received for a service where no payment was expected due to a lack of medical necessity or lack of coverage. Knowingly retaining such inappropriate reimbursements may put providers at overpayment risk and potential false claims act violations.

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.[3]

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 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, or the frequency of such tests may not be medically necessary. 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 likely to be noncovered at a facility. Multiple providers may be involved—for example when one provider delivers the technical component, and another delivers the same service's professional component, which is not an uncommon situation. 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. Furthermore, CMS advises that it will hold the "billing notifier" responsible for issuing the notice.[4]

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.. CMS has NCDs for many laboratory tests which can be found by using the Medicare Coverage Database search function.[5] 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. A very commonly performed but often non-covered test in the 2020s is serum vitamin D testing. This test is often performed to detect unrecognized vitamin D deficiency but is not covered by Medicare as a screening test per the Local Coverage Determinations published by the MACs.[6]

Medicare does provide coverage for many tests as part of the preventative care benefit.[7] 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 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.[8] To add to the complexity, some Medicare Administrative Contractors (MACs) have local coverage articles specifying the billing and coding requirements to be met for the service to be covered. Prior to performing the service, the provider must ensure 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 notices of non-coverage 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 Notice of Medicare Non-Coverage (NOMNC).[9] 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.

Podiatry services in nursing facilities are often rendered. For example, any service like removal of calluses or toenail trimming are routine and an ABN is not necessary. Treatment for mycotic nails is routine unless patient has a systemic condition, so an ABN is required if criteria not met.

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 (DME) 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.