Medicare Compliance Information

Advanced Beneficiary Notice (ABN)
Department of Health and Human Services (DHHS) Centers for Medicare and Medicaid Services (CMS) Program Memorandum AB-02-168
(http://www.cms.hhs.gov/transmittals/downloads/ab02168.pdf)

An ABN is a written notice a physician or supplier gives to a Medicare Beneficiary before services are furnished when the physician or supplier believes that Medicare probably, or certainly, will not pay for some or all of the services based on statutory exclusions, including:

- Medical reasonableness and necessity
- Research tests
- Wellness screening
- Testing without the presence of physical signs/symptoms (screening)
- Frequency limitations (examples: Pap and PSA testing have frequency limitations).

ABNs are designed for use with Medicare beneficiaries only, including those who are dually-eligible for Medicare and Medicaid. ABNs are not for use with patients who are not Medicare beneficiaries. The purpose of the ABN is to inform a Medicare beneficiary before he or she receives specified items or services that otherwise might be paid for, that Medicare probably will not pay for them on that particular occasion. The ABN also 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.

In addition, the ABN allows the beneficiary to better participate in his/her own health care treatment decisions by making informed consumer decisions. If the physician or supplier expects payment for the items or services to be denied by Medicare, the physician or supplier must advise the beneficiary before items or services are furnished. To be “personally and fully responsible for payment” means that the beneficiary will be liable to make payment “out-of-pocket,” through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or another Federal or non-Federal payment source. The physician or supplier must issue notices each time and as soon as they make the assessment that Medicare payment probably or certainly will not be made.

To be acceptable an ABN must:

- Be on the approved Form CMC-R-131 (see enclosed)
- Clearly identify the particular item or service
- State that the physician or supplier believes Medicare is likely (or certain) to deny payment for the particular item or service
- Give the physician’s or supplier’s reason(s) for their belief that Medicare is likely (or certain) to deny payment for the item or service

A physician or supplier should not give an ABN to a beneficiary unless the physician or supplier has some genuine doubt regarding the likelihood of Medicare payment. Giving ABNs for all claims or services (blanket ABNs) is not an acceptable practice. Notice must be given to a beneficiary based on a genuine judgment about the likelihood of Medicare payment for that individual’s claim.

A physician or supplier is prohibited from obtaining beneficiary signatures on blank ABNs and then completing the ABNs later. To be effective an ABN must be completed before delivery to the beneficiary.

Diagnosis Codes (ICD-9 Codes)

Medicare regulations (Program Memorandums B-03-045, B-03-046, AB-03-091) require the ordering physician to provide the laboratory with accurate and encounter specific ICD-9 codes when ordering laboratory testing. Medicare uses this information to determine if the testing is eligible for reimbursement. Medicare has instructed the laboratory to contact the ordering physician if this is not provided. A physician that does not provide this information on a regular basis is considered by Medicare to be in violation of Medicare regulations. The most current information from the Center of Medicare and Medicaid Services (CMS) regarding National Coverage Determinations (NCD) can be found on the CMS website at http://www.cms.hhs.gov/center/clinical.asp

Professional Courtesy

The office of the Inspector General (OIG) interprets a discount on laboratory testing for physicians, their office staff and family members as a potential kickback to the physician. For this reason, CHMC does not offer professional courtesy on laboratory services to physicians, their employees or their family members.

Testing Supplies

A laboratory may provide a physician with supplies that are DIRECTLY related to the testing that is submitted to the laboratory in amounts PROPORTIONAL to the volume of testing performed. Any supplies outside of these limits are considered a kickback to the physician and therefore fraud. Additionally, multi-purpose supplies outside of these limits supplied are considered a kickback. For example, a fax machine supplied by the laboratory for faxing results is considered a kickback because the client could use the fax machine for non-laboratory related purposes. Other items include latex gloves, lab coats, and medical waste disposal.