By **DEVON BERNARD**

Writing Valid ABNs

Learn the rules before asking patients to sign advanced beneficiary notices

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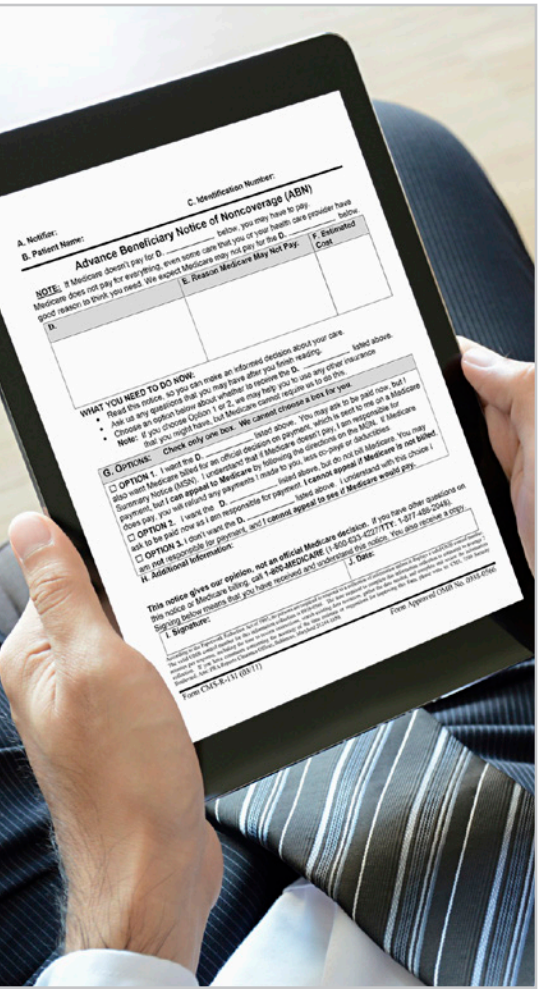


WITH MORE DENIALS OCCURRING on a regular basis because of increased audit activity, facilities are searching for ways to protect their investments and their bottom lines. Some are relying more heavily on advanced beneficiary notices (ABNs) to possibly shift financial liability to the patient in case a claim is denied due to medical necessity. But ABNs are not a cure-all, and having a patient sign an ABN form doesn't guarantee that you are protected.

For an ABN to be useful, it must be valid in the eyes of Medicare. If it is considered invalid, then you would be held financially liable for any claim denial due to medical necessity. This *Compliance Corner* article examines the ABN form and offers tips to help you fill out the ABN, deliver it, and issue it so that it will be considered a Medicare-compliant and valid ABN.

Preparing Valid and Proper Forms

There is only one valid ABN form for O&P services: the CMS-R-131 (03/11) form (see the lower left corner of the form to validate the form number). If your ABN does not contain this document number, your ABN is invalid.

Each ABN form also includes a disclaimer statement, which is found under the patient's signature box. The disclosure statement is required to be included on your ABN forms and cannot be removed.

Following is a section-by-section breakdown of the different parts of the ABN.

Section A: Notifier. This section indicates who is providing the ABN to the patient. To be considered valid, this section must include your company's name, address, and telephone number, and you also may include an email address or website address. Customization of the ABN to include your logo or multiple facility locations is acceptable as long as the form contains the required information (name, address, and telephone number).

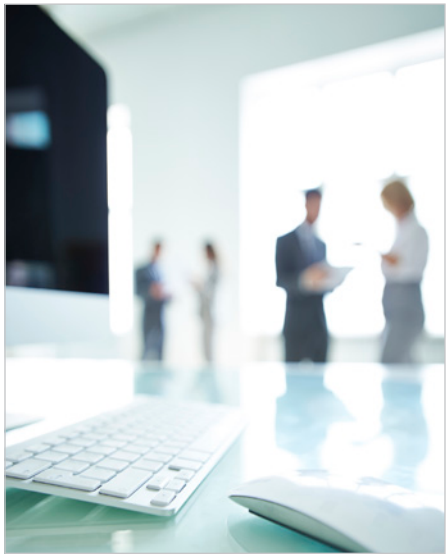
If you include multiple facility locations in the Notifier section, clearly mark the facility where the services are being provided so the patient can contact the correct location if he or she has any issues or questions. The key is to provide enough information so that the patient or his or her representative knows who provided the ABN and who will be providing the items/services, as well as how to contact you with questions or concerns.

Section B: Patient's Name. Include the patient's full name, and make sure it matches exactly the name printed on his or her Medicare ID card. If an ID card includes a middle initial, you should include the middle initial on the ABN form.

Although the ABN will not become invalid if you misspell the patient's name or if you forget to include a middle initial, it's important that you and the patient or

his or her representative recognize and understand that the name listed on the ABN is that of the patient in question.

Section C: Identification Number. This section is optional; if you choose not to use it, your ABN will not be considered invalid. This section is primarily used by you for record keeping or tracking purposes. The key to this section is that you do not use the patient's Social Security number or Medicare ID number as the identification number.



Section D: Title Unfilled. Here, list what item(s)/service(s) you believe will be denied. It's important to use language the patient can easily understand, so avoid listing only the Health Care Common Procedure Coding System code. Consider providing the manufacturer's name and model number, if available.

Once again, customization of this section of the ABN is acceptable in certain circumstances and will not invalidate the ABN. This section may be prefilled out to include the items you provide on a regular basis, and it is acceptable to use check boxes in this section as long as the item you are providing is clearly identified.

Section E: Reason Why Medicare Will Not Pay. Explain why you believe the items/services you are providing may be denied and why Medicare may not pay. Provide a detailed explanation in friendly terms; use everyday language and don't quote Medicare policy or use technical jargon. Provide a reason the patient can easily understand.

For the ABN to be valid, it must clearly identify the particular item or service being provided (Section D) as well as the specific reason why you believe Medicare will deny the item/service, so there must be at least one reason for the possible denial for each of the items mentioned in Section D, and the same reason can be used for multiple items. Be careful when listing or providing reasons. Simply listing a whole series of possible denials, without indicating which one may apply to your patient, could cause the ABN to be invalid. It is acceptable for you to provide multiple reasons, if multiple reasons apply.

Remember to be specific because if the item or service is denied for a reason that is different from what is stated on the ABN, then the ABN is not valid.

This section may be customized with information prefilled out, with check boxes to include some of the more common reasons you issue an ABN (for example, possible same/similar denials)—as long as the reason for possible denial is clearly identified.

Section F: Estimated Cost. You must provide a good faith estimate of the amount the patient may be liable for if/and when the claim is denied. You do not have to provide the exact amount; CMS and the durable medical equipment Medicare administrative contractors usually expect the estimate to be within $100, or 25 percent, of the actual costs, or whichever is greater.

Section G: Options. For the form to be valid, the patient must choose from one of the three "options" listed on the ABN form. You can't make the choice for the patient, so you may not provide the patient with a customized ABN form with options prechecked. However, if a patient requests that you select the box for them (perhaps because he or she is unable to mark the form), then you may do so.

Section H: Additional Information. This is another optional section, and your ABN will not be considered invalid if you don't put any information in this section. You may use this section to provide more detailed information about the reason for the denial (e.g., quoting policy) or any other information you feel the patient may need to know.

Sections I and J: Signature and Date. The patient must sign and date the form in these sections. If the patient cannot sign, you may request the signature of a patient representative (i.e., someone with power of attorney, spouse, adult child, etc.). This representative must have the best interest of the patient in mind and cannot have a financial interest in the claim. If someone other than the patient signs, you should document who signed and why the patient could not sign, and indicate on the ABN that the signature is that of a representative.

ABN Length

To be considered valid, the ABN cannot exceed one page. This does not mean you have to squeeze all of the information onto one page.

Instead, it means that the Sections A through J must appear on one page; in other words, you may not have your company's name and the items being delivered appear on page 1 and the patient's signature appear on page 3. Attachments are permitted, and you may include phrasing such as "See attached" in Section D, for example. If you are using attachments, there must be a clear and easy way to match the items being provided to the reason why an item will be denied and the amount the patient may be responsible for paying.

Valid Delivery Methods and Provision of ABNs

Deciding when an ABN should be provided or issued to a patient is the first step in ensuring that you are compliant with Medicare rules for liability protections and ABNs. The ABN may only be issued when you believe the item/service you are providing is normally covered under an established Medicare benefit, but you have a documented reason to believe that Medicare may deny the service due to medical necessity or coverage issues.

Providing an ABN to every single patient for every single item is considered by Medicare to be "blanket usage," which invalidates the ABNs you are providing. Medicare also considers generic and routine uses of ABNs to be invalid—for example, it is unacceptable to provide ABNs to patients when there is no specific reason to believe Medicare may not pay or deny a claim, or to simply state on the ABN that Medicare may pay.

Finally, for an ABN to be considered valid, it must be presented to the beneficiary far enough in advance of providing the item or service that the beneficiary has time to make an informed decision on whether to receive the service.

Providing an ABN in person is the ideal method of delivery. Be sure to provide it as early as possible to ensure the patient has time to review it and make an informed decision. If possible, it should not be provided at the time of delivery. If you must request that a patient sign an ABN at the time of delivery, document the time you provided the ABN to the patient and the time the patient signed the ABN.

When in-person delivery of the ABN is not possible, it is acceptable for you to use alternate methods such as mail (email or regular mail), fax, or direct telephone contact. If using one of these alternate methods, document in your records that you contacted the patient (or his or her representative), and wait for a response from the beneficiary (or his or her representative) to validate the delivery of the ABN.

To learn more about the proper use of an ABN, review Chapter 30 of the Medicare Claims Processing Manual located on the CMS website, *cms.hhs.gov/manuals/IOM*, or attend one of AOPA's coding and billing seminars. CP

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