Codify by AAPC

# Part B Insider (Multispecialty) Coding Alert

## Part B Mythbuster: Check Out These Top 5 ABN Myths

**These surprising CMS rules on ABN use are straight from Medicare policy.**

You've been issuing advanced beneficiary notices (ABNs) for years to cover your practice in instances when you think Medicare won't pay for a particular service, and you want to ensure that the beneficiary is liable for the service. However, even the most seasoned ABN pro may fall into the trap of one of these common myths. Read on to find out what the most common ABN myths are, and how you can avoid themas well as links to CMS citations for each rule.

Myth 1: You Must Ask Patients to Sign an ABN for Preventive Visits

It's a common scenario: Your Medicare patient wants more of a "physical" than what's included in the annual wellness visit, and asks you to perform a complete preventive medicine visit. You tell the patient she'll have to pay for the physical and she agrees, but you forget to ask her to sign an ABN, so you can't bill her for the service, right?

Wrong. "An ABN is not required for services that are statutorily excluded from coverage, such as preventive exams," CMS says in a Frequently Asked Question on the agency's website. "Practitioners should alert beneficiaries to financial liabilities and the voluntary ABN is one way of doing so," CMS continues.

Therefore, you can still bill the patient for the service without the signed ABN. Of course, many practices do have such patients sign the ABN in case there's ever a question of whether the patient actually agreed to pay for the service. However, it's legal to bill the patient without an ABN on file for statutorily excluded services.

**Source:** You can read this CMS Frequently Asked Question at https://questions.cms.gov/faq.php?id=5005&faqId=7481.

Myth 2: Labs Can't Use ABNs for Patients They've Never Seen Before

Most practices know that Medicare specifically prohibits the routine use of ABNs. This means that a practice who has a patient sign an ABN for each visit just to cover themselves ("in case" Medicare doesn't pay) cannot then bill the patient for every non-covered item. It is up to the practice to determine ahead of time which items may be denied, and then issue ABNs only in those circumstances.

This stance, however, can be difficult to follow for entities such as laboratories, which bill Medicare for services administered to patients they've never seen before. Therefore, CMS does have exceptions to the "routine use of ABNs" rule.

"For example, laboratories may routinely use ABNs because Medicare places frequency limitations on many laboratory services and laboratories may not be able to determine whether a beneficiary has already exceeded the limit for a test," the OIG writes in its May 3 report Medicare Payments for Part B Claims With G Modifiers.

**Source:** The OIG report can be read at http://go.usa.gov/Tv29.

Myth 3: You Can Double-Collect If Medicare Surprises You And Pays

***CPT® 2023 American Medical Association. All rights reserved.***

On occasion, you might administer a service that your MAC traditionally denies, so you ask the patient to sign an ABN before you submit the claimbut the carrier surprises you by reimbursing you for the service after all. Some practices may see this as a quick and easy way to make a little extra money by charging the patient anyway (or holding on to money that the patient already paid for the visit), thus doubling their income for one service. But this is absolutely inappropriate.

"If Medicare pays all or part of the claim for items or services previously paid by the beneficiary, or if Medicare finds you liable, you must refund the beneficiary the proper amount in a timely manner," CMS says on page 13 of the MLN Matters publication, "Advance Beneficiary Notice of Noncoverage." "Medicare considers refunds timely when made within 30 days after you get the Remittance Advice from Medicare or within 15 days after a determination on an appeal, if you or the beneficiary files an appeal."

Therefore, if your contractor pays for the service, don't bill the patient. And if you already collected from the patient, you must pay them back quickly.

**Source:** You can read the MLN Matters publication, "Advance Beneficiary Notice of Noncoverage" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf

Myth 4: You'll Be Able to Use an ABN to Avert PECOS Ordering/Referring Denials

As most practices are aware, CMS will soon begin denying claims for services ordered/referred by a practitioner who isn't in the PECOS system. The edits triggering these denials were supposed to kick in on May 1, but were delayed last week by CMS. However, if your practice isn't sweating this situation because you planned to just present ABNs to patients when you provide services referred by non-PECOS doctors, you can reconsider that logic.

"Claims from billing providers and suppliers that are denied because they failed the ordering/referring edit shall not expose a Medicare beneficiary to liability," CMS says in a Frequently Asked Question in its website. "Therefore, an advance beneficiary notice is not appropriate in this situation."

**Source:** You can read this FAQ in its entirety on the CMS website by visiting https://questions.cms.gov/faq.php?id=5005&faqId=8235.

Myth 5: You Need Separate ABNs for Each Day of A Treatment Course

If you're administering a service that you don't think Medicare will reimburse over the course of an extended time period, you needn't have the patient complete an ABN each time she presents for a step of the service. Instead, one ABN can do the trick.

"You may issue a single ABN to cover an extended course of treatment if the ABN identifies all items and services and the duration of the period of treatment for which you believe Medicare will not pay," CMS says on page 13 of its MLN Matters publication, "Advance Beneficiary Notice of Noncoverage."

If, however, the patient receives another item or service during that treatment course that you didn't cover on the ABN, you must issue a separate ABN, CMS adds. "A single ABN for an extended course of treatment remains valid for no more than one year," CMS says. "If the extended course of treatment continues after a year's duration, you must issue a new ABN."

**Source:** You can read the MLN Matters publication, "Advance Beneficiary Notice of Noncoverage" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN

*CPT® 2023 American Medical Association. All rights reserved.*

Codify by AAPC

006266.pdf.

CPT® 2023 American Medical Association. All rights reserved.