Health Information Compliance Alert

Part B Forms: You Must Use New ABN by Nov. 1, CMS Says

New form doesn't include major changes, but you are required to switch over to it.

It may seem like just yesterday that you switched over to the latest version of the ABN, which is a combined ABN/NEMB form -- but it's actually time again to upgrade to a newer version of the advance beneficiary notice.

The latest version of the ABN form CMS-R-193, with the release date of 3-20-11, is now available at www.cms.gov/BNI by clicking the "revised ABN" link, said CMS's **Donna Williamson** during a June 28 CMS Open Door Forum. Although the form doesn't include any substantial changes, mandatory use of the new version begins on Nov. 1, 2011.

A caller to the forum asked why the form was updated in the absence of substantial changes, because many practices find it cumbersome and expensive to switch over to new forms. CMS's **Stewart Streimer** replied that the current ABN form had an expiration date on it, and forms are customarily updated every three years based on provider comments.

Background on ABNs: Medicare only allows for a finite number of certain procedures per patient per time period. For example, Medicare covers an ob-gyn physical including a pelvic exam every two years for low-risk women. In some cases, you may not know whether a patient had a pelvic exam within the last two years, and if you perform one anyway, you could risk non-payment for that service. That's where the ABN comes into play. You can ask a patient to sign the ABN, which lets them know that Medicare may not cover their service, and that they will be responsible for payment if the claim is denied.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay for it. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare refuses to pay. Without a valid ABN, you cannot hold a Medicare patient responsible for the denied charges.

Know These Key ABN Facts

As your practice prepares to switch over to the updated ABN, keep these ABN essential truths in mind so you don't run afoul of CMS's coding rules.

Avoid "routine" ABNs: Some practices give patients ABNs for the majority of their services, to cover them "just in case" Medicare denies the service, but that constitutes an inappropriate use of the form. "Providers and suppliers must be sure that there is a reasonable basis for non-coverage associated with the issuance of each ABN," CMS says in its publication, "Advance Beneficiary Notice of Non-coverage (ABN)," available at www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf.

Know when forms are considered "voluntary to": In situations where you perform a service that Medicare statutorily excludes or never covers (such as cosmetic surgery or personal comfort items), you aren't required to issue an ABN to the patient, but you can do so.

Deliver the ABN properly: CMS defines an "effective" ABN delivery when you give the ABN to the beneficiary or his representative, and you meet the following criteria, CMS indicates:

- The ABN is delivered (preferably in person) and comprehended by a suitable recipient. If you don't deliver it in person and use an alternate method (such as fax, email, or mail), you must document the contact in the patient's records, and the patient must subsequently send a copy of the signed notice back to you.
- The approved, standardized ABN is completed.
- You offer the ABN far enough in advance of potentially non-covered services to give the patient time to consider all available options.

- You explain the ABN in its entirety and answer all related questions.
- The patient (or his representative) signs and dates the ABN and checks one of the option boxes.

Know how to complete the "estimated cost" field: One of the most puzzling aspects of an ABN is how to determine the estimated cost of a service. Although many practices struggle with this, CMS does offer some guidance.

You may not be able to predict the exact amount that the service will cost, but you must make a "good faith effort to insert a reasonable estimate," which should be within $100 or 25 percent of the actual costs, whichever is greater. For example, CMS notes, if you expect the estimated cost for a service to be about $250, you can enter "Between $150-$300" or "No more than $500" on the form. In addition, CMS notes, multiple services or items that are routinely grouped "can be bundled into a single cost estimate."