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THE ADVANCED BENEFICIARY NOTICE COMMONLY ASKED QUESTIONS

This guidance is for informational purposes only and was created by the American Academy of Audiology and the American Speech-Language-Hearing Association.

The Advanced Beneficiary Notice of Noncoverage (ABN) is a Medicare document that is used to notify Medicare beneficiaries of their potential financial responsibilities prior to the rendering of a service or the dispensing of an item. The current ABN form (CMS-R-131 effective March 2011) and its accompanying guidance can be found [here on the CMS website](#). This document is appropriate for Fee for Service Medicare Part B beneficiaries only.

Q. I noticed the ABN has several sections. What are they and what is to be placed in them?

A. As noted in the ABN directions, the following is to be included on the ABN form:

- Section D: The provider lists the item(s) or service(s) that they suspect may not be deemed medically necessary
- Section E: The provider lists the reason(s) why Medicare may not pay for the particular item(s) or service(s)
- Section F: The provider lists the usual and customary fee for the specific item or service. It is not necessary to list the Medicare allowed rate.
- Section G: The beneficiary must complete this section, selecting whether they
 - (1) Want to receive the specific item(s) or service(s) and want Medicare billed for an official decision on payment,
or
 - (2) Want to receive the items/services but do not want Medicare billed, or
 - (3) Do not want to receive the listed item/service
- Section H: Additional information or comments may be provided here, which may include the beneficiary's refusal to sign the ABN and a signature of a witness
- Section I and J: The beneficiary or their representative signs and dates the ABN

Q. What are some typical reasons why an item or service may not be covered?

A. The typical reasons may include but are not limited to the following:

- Item or service does not meet the definition of medical necessity
- Item or service is statutorily excluded or does not meet the definition of a Medicare benefit
- Unlisted item or service (no specific code exists for the item or service)
- Item or service is defined as not medically necessary by a local coverage determination (LCD).
- Item or service is routine
- Item or service is solely related to the purchase of a hearing aid

Q. Can the provider fill out the entire ABN form for the beneficiary's convenience?

A. The provider may complete the provider applicable portion of the ABN form; however, the beneficiary must complete the portion of the form indicating their choice of how the services should be billed to Medicare.

Q. When should I use an ABN?

- A. The ABN alerts the patient of their fiscal responsibility for non-covered services and has two roles:
- A **mandatory** notification that informs the beneficiary that the item or service **may not** meet the definition of medical necessity in this incidence of care
 - A **voluntary** notification of non-coverage that informs the beneficiary that the item or service is statutorily excluded (never covered) or **does not** meet the technical definition of a Medicare benefit.

Required Notification

Q. What does the mandatory ABN allow?

A. The use of the mandatory ABN allows the provider to notify the beneficiary that the item or service which is typically covered by Medicare may not be covered in this case. If Medicare denies payment for that item or service, the provider may collect payment directly from the beneficiary. This type of ABN must be completed before the item(s) or service(s) are provided.

Q. What are some examples where I would use a mandatory ABN?

A. Some common situations where the use of a mandatory ABN would be warranted:

- When the frequency of testing is occurring more often than the norm
- The audiologist has a physician order but there is evidence that medical necessity may have not been met
- A Local Coverage Determination (LCD) is in place and the provider is performing a procedure that has been identified as potentially being not medically necessary in this particular case.

Q. Just to be sure, should I give an ABN to every Medicare beneficiary?

A. Mandatory ABNs should never be used routinely (i.e. for every beneficiary or for the majority of beneficiaries). It should only be utilized when the specific need arises for its use for a particular patient procedure on a particular date of service. Issuing a mandatory ABN, or routinely using the -GA modifier for a service that is never covered, does not automatically transfer financial liability to the beneficiary, especially in the case of an improperly submitted claim.

Q. How do I alert Medicare that a mandatory ABN was issued to the patient?

A. If a mandatory ABN is completed and the beneficiary wants the claim submitted to Medicare for a coverage decision (they selected option 1 in section G), the provider should add the -GA modifier to the item(s) or service(s) on the CMS 1500 claim form that were listed on the ABN.

Clinical Examples for Required ABN Use

- A Medicare beneficiary has been diagnosed with a sudden, progressive sensorineural hearing loss and has been prescribed steroids. The ordering physician has requested that a hearing test be performed every three days during the course of the steroid treatment.
- A Medicare beneficiary is referred by an otolaryngologist, who has diagnosed her with Meniere's Disease. The patient had an attack in the last two days and the physician wants to document the possibility of an accompanying progressive hearing loss. However, the patient had an audiology assessment the week prior at another ENT/audiologist's office.

- Your Medicare Administrative Contractor has a Local Coverage Determination Policy (LCD) in effect that indicates CPT code 92557 (comprehensive audiometry) will not be paid if performed on the same date of service as CPT codes 92540 (basic vestibular evaluation) and 92543 (caloric vestibular test, each irrigation).

Voluntary Notification

Q. What is a voluntary ABN and what does the voluntary ABN allow?

A. The voluntary ABN was the result of the merger of the old Notice of Exclusions from the Medicare Benefits (NEMB) and the ABN forms in 2008. This new ABN then replaced the Notice of Non Coverage document that previously existed. Voluntary use of an ABN is not required in order to collect payment from a Medicare beneficiary. Its use is solely for beneficiary notification, information, and transparency.

Q. What are some examples where I would use a voluntary ABN?

A. Some common situations where a voluntary ABN may be useful are:

- Routine or annual audiology testing
- Hearing aids or testing for the sole purpose of obtaining a hearing aid
- Treatment services such as cerumen removal, canalith repositioning, tinnitus management, and aural rehabilitation
- Tinnitus maskers and devices
- Audiologic evaluations that were the result of solicitation (i.e. reminder cards, marketing events)
- Audiologic and/or vestibular testing completed by a student in the absence of 100% personal supervision by an audiologist or physician
- Audiologic testing that requires the skills of an audiologist or physician but was completed by a technician
- Screenings

Q. What if a voluntary ABN is completed and the beneficiary then decides they want the claim submitted to Medicare for a coverage decision (they selected option 1 in section G)?

A. The provider should add the -GY (item or service statutorily excluded or does not meet the definition of a Medicare benefit) and -GX (indicates that voluntary ABN has been issued) modifiers to the item(s) or service(s) that were listed on the ABN.

Q. How do I bill Medicare for services that are non-covered?

A. If the patient directs you to file the claim, then you must file a claim for a non-covered service with the GY and GX modifiers appended in box 24D of the CMS 1500 claim form.

Other Resources:

http://www.cms.gov/Medicare/Medicare-General Information/BNI/index.html?redirect=/BNI/02_ABN.asp

http://www.audiology.org/practice/reimbursement/medicare/Pages/ABNofNon_Coverage.aspx

<http://www.asha.org/Publications/leader/2010/101123/Medicare-Form-Addresses-Noncoverage-of-Services.htm>

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7821.pdf>

