



Helpful hints for filing

Medicare advance beneficiary notice (ABN)

The following information describes Medicare guidelines regarding the use of Advance Beneficiary Notices (ABNs) and should be used as a guide. For an item to be covered by Medicare, the following conditions apply: (1) item must be eligible for a defined Medicare benefit category; (2) item must be reasonable and necessary for the diagnosis or treatment of illness or

injury or to improve the functioning of a malformed body member; (3) the equipment is used in the patient's home; and (4) the item must meet all applicable Medicare statutory and regulatory requirements.¹ *The following information is to be used as a guide. For specific instructions, please reference your Supplier Manual or DME Medicare Administrative Contractor (MAC) provider helpline.*

Overview

When a beneficiary or physician requests an item and the supplier feels Medicare may not cover the item or an upgraded component of the item, the supplier may have the beneficiary sign an Advance Beneficiary Notice (ABN). The ABN informs a Medicare beneficiary, before the item is received, that Medicare may not cover or reimburse the full amount for that item. Consequently, the beneficiary can make an informed decision whether to accept the item, understanding that they may be taking on financial responsibility for all or an increased portion of the cost (beyond the 20% Medicare coinsurance). The ABN applies to both assigned and unassigned claims.

General guidelines for ABNs

As a general guideline, suppliers should not have every beneficiary sign an ABN for every item or service provided. ABNs should only be used in situations where there is a specific and identifiable reason to believe that Medicare will not pay for the item or service. The ABN allows the provider to bill the beneficiary in the following situations:

- If the physician orders an item for which the patient does not qualify

- If an item is requested by a beneficiary that does not meet the coverage guidelines
- If an item with an excess component is requested by the beneficiary

Some items are statutorily excluded from Medicare coverage and, therefore, an ABN is not required to charge the beneficiary, such as personal comfort items, orthopedic shoes and foot supplies (orthotics), and hearing aids.

¹Section 1862 (a)1(A) of Title XVIII of the Social Security Act.

ABNs for upgrades

Suppliers may use ABNs when providing upgrades. CMS defines an upgrade as an item that is more expensive because the item contains more components or features, or is greater in quantity than what the physician ordered. Items that are simply more expensive, or of “higher quality” than standard items, do not qualify as an upgrade.

The upgrade must be within the range of services that are appropriate for the beneficiary’s medical condition. ABNs may not be used to substitute an item or service that does not meet the intended medical purpose of the item originally ordered by the physician.

- An upgrade can occur within the same HCPCS code, or may be from one HCPCS code to another.
- If a beneficiary agrees to be financially liable by signing an ABN, the supplier may collect the difference between the charges for the upgraded item and the charges for the non-upgraded item from the beneficiary.

An ABN is not required if the supplier chooses to provide a free upgrade to the beneficiary. When providing a free upgrade, suppliers should not have the beneficiary sign an ABN, because the beneficiary will not be charged more than the normal deductible and copayment for the non-upgraded item.

ABNs for upgrades do not apply to physician-ordered items

CMS does not consider physician-ordered items under the upgrade guidelines. If a physician orders an item that the supplier believes to be more than what Medicare considers medically necessary, an ABN may be used. In this type of situation, it is treated as a waiver of liability for the full cost of the item. If a supplier renders a service to a patient which Medicare considers not medically necessary, the supplier should notify the patient in writing, before rendering the service, that Medicare will deny the claim and that the patient will be responsible for payment.

ABN documentation and billing requirements

On March 3, 2008, CMS implemented use of the revised ABN CMS-R-131 form. As of March 1, 2009, all providers and suppliers must use the new ABN CMS-R-131 form. Providers should explain the ABN form and upgrade process, when applicable, to the beneficiary prior to completing the ABN. The provider should discuss the items ordered, why Medicare may not pay for the item or upgrade, and the amount for which the beneficiary will be financially responsible.

The ABN form should be completed by the supplier and signed by the patient or person acting on the patient’s behalf. If the patient refuses to sign the ABN, a witness must sign and date the form, noting that the ABN was given to the patient but the patient refused to sign. The witness may be another employee of the supplier.

In the allocated fields of the ABN form, the supplier must specify:

- The **items or services for which the supplier expects Medicare will not pay**. These items or services must be described in sufficient detail so that the patient can understand precisely what items or services may not be covered.
- The **specific reason why the supplier expects Medicare to deny payment**. The reason(s) must be specific enough for the beneficiary to understand.

The ABN must explain in detail why the supplier feels that Medicare will not cover or reimburse the full amount for the device. It is not acceptable to simply state that the item is “not medically necessary.” The reason must be specific enough to allow the beneficiary to make an informed decision whether to pay for the item personally. Some examples of statements that may be acceptable to the DME MACs include:

- Medicare does not usually pay for this many treatments or services
- Medicare usually does not pay for this item/service
- Medicare does not pay for this because it is a treatment that has yet proven to be effective (experimental)
- Medicare does not pay for this many items/services within this period of time
- Medicare does not pay for such an extensive treatment
- Medicare does not pay for this equipment for the illness or condition stated

Claims for upgrades

Two lines should be listed on each claim for an upgrade. Suppliers will need to bill their submitted charges for the upgraded item on Line 1 and the full amount for the physician order on Line 2. Both line items are to appear on a single claim.

	Coding	Modifiers	Charge
Line 1	HCPCS code for the upgraded item provided to the beneficiary	If beneficiary signed ABN: "GA" waiver of liability on file (expected to be denied as not reasonable and necessary, ABN on file) If beneficiary did not sign ABN: "GZ" item or service not reasonable and necessary (expected to be denied, no ABN on file)	Supplier's charge for upgraded item
Line 2	HCPCS code for the item ordered by the physician	"GK" reasonable and necessary item or service associated with GA or GZ modifier <i>*If specified in DME MAC policy, a Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required for this item.</i>	Supplier's charge for item ordered by physician

If the upgrade is from one item to another within the same HCPCS code, this same HCPCS code will be listed on both lines, but with different charge amounts. The supplier must indicate the full charge for each item on the claim form, not the difference between the two.

The beneficiary will be responsible for the normal 20% coinsurance, and the difference between the Medicare-allowed payment for the standard item and the "reasonable" price of the upgraded item. "Reasonable" price is typically the suggested retail price.

- In box 19 of the claim form, or as an attachment to the claim, the supplier must list the upgrade features/components. If filing claims electronically, this information may be entered in the NTE segment/line note on the 837 electronic claim format.

Claims for free upgrades

When providing a free upgrade to a beneficiary, suppliers should report the appropriate HCPCS code for the non-upgraded item that the physician ordered. A "GL" modifier is attached to the HCPCS code for the physician-ordered item to indicate that this is an upgraded item at no additional charge. Suppliers may only charge for the non-upgraded item on the claim form.

	Coding	Modifiers	Charge
Line 1	HCPCS code for the non-upgraded item ordered by the physician	"GL" medically necessary upgrade provided instead of non-upgraded item, no charge, no ABN	Supplier's charge for non-upgraded item

In box 19 of the claim form, or as an attachment to the claim, the supplier must specify the make and model of the upgraded item that was provided and describe why this item is an upgrade. If filing claims electronically, this information may be entered in the NTE segment/line note on the 837 electronic claim format.

Claims for physician-ordered items

If a physician orders an item that the supplier feels will not be covered by Medicare and an ABN has been signed by the patient, the supplier may file a claim to Medicare with the appropriate HCPCS code for the physician-ordered item. Modifier "GA" should be indicated on the Medicare claim with the appropriate HCPCS code when it is filed to indicate that a waiver of liability is on file. Suppliers should indicate the charge for the physician-ordered item.

Refund requirements

If a supplier provides an item or service to a Medicare beneficiary which Medicare considers not medically necessary, the supplier should notify the beneficiary in writing, before providing the item or service, that Medicare will deny the claim and that the patient will be responsible for payment. Suppliers must make refunds of any amounts collected if the beneficiary was not properly notified of possible disallowed Medicare claims. Medicare provisions require beneficiaries be notified in advance and accept the additional financial responsibility prior to receiving the item or service. As outlined in the ABN Documentation and Billing Requirements section, Modifier–GA should be added to the applicable HCPCS code when the claim is filed to indicate “Waiver of liability on file.” These requirements apply to both assigned and unassigned claims.

If Medicare denies a claim that a supplier feels is medically necessary, it is the responsibility of the supplier to request that Medicare review the denied claim.

Note: Inclusion or exclusion of a code for a specific product or supply does not imply any health insurance coverage or reimbursement policy. All referenced information and codes were taken from HCPCS. Please refer to DMEPOS Supplier Manual for complete explanations.

This information should not be considered to be either legal or reimbursement advice. Given the rapid and constant change in public and private reimbursement, Philips Respironics cannot guarantee the accuracy or timeliness of this information and urges you to seek your own counsel and experts for guidance related to reimbursement, including coverage, coding and payment.

For more information from Philips Respironics

Reimbursement	Customer service	Website
Information & fee schedules Educational materials & questions (coding, coverage and payment)	1-800-345-6443; listen to the instructions and follow prompts to select the insurance reimbursement information option	www.philips.com/respironics

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