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TITLE: ABNs and Other Notices of Patient Potential Financial Liability

PURPOSE: To outline the use of the appropriate notice of potential financial liability for certain services provided to patients covered by Medicare, Medicaid, Tricare, and Commercial Insurers.

POLICY: This policy is intended to ensure that certain items and services provided by University of Vermont Medical Center (UVMHC) providers are reviewed for medical necessity and that patients receive advance notice of financial liability when an item or service may be non-covered. While UVMHC strives to provide only care that is considered reasonable and medically necessary, there are services that are not covered by third party payers in certain circumstances. The notice provided to the patient varies depending on their insurance coverage. There are four notices used at UVMHC. All notices must be scanned into the patient's medical record in a retrievable manner.

GENERAL INFORMATION: Information regarding coverage by various payers is set forth in Medicare National and Local Coverage Decisions (NCDs and LCDs), the Medicare and Medicaid manuals, periodic announcements and commercial insurer contracts and manuals. Notice of new or revised Medicare and Medicaid coverage rules will be forwarded to departments as needed by the Compliance and Privacy Department. Information regarding commercial insurance coverage is provided to departments by Contracting.

Clinical departments are responsible for ensuring a process is in place to determine whether items or services are medically necessary or covered by the patient's insurance policy for all procedures ordered or performed in their departments. If items or services are not considered medically necessary or otherwise not covered by the patient's insurance policy, the clinical department is responsible for ensuring a process is in place to provide the appropriate notice of potential financial responsibility **before a specimen is collected or the service is rendered.**

If the patient refuses to sign the notice of potential financial liability, and the patient still requests the service be performed, then two (2) staff members can document the refusal to sign on the notice and the patient can still be held financially liable. The notice must be filled out completely and must include additional documentation of the refusal to sign including the date the notice was reviewed with the patient and their refusal to sign, name of the person who refused to sign (name of patient or patient's representative), and the names of the two UVMHC staff members that witnessed the patient's refusal to sign the notice. Staff should inform the patient (or patient's representative) that they will be financially responsible for any items or services included on the notice which are likely to be denied by the insurance program due to lack of medical necessity.

Non-UVMHC physician offices (community providers) are responsible for determining whether items and services are medically necessary or covered by the patient's insurance for all procedures referred to UVMHC. If the items or services are not considered medically necessary and likely will not be covered, a copy of the appropriate waiver of financial responsibility should be provided with the requisition or order sent to UVMHC.

The performing department should have a process in place to confirm that the appropriate notice was obtained from the ordering provider. It is the responsibility of the performing department to obtain the appropriate notice in cases where the ordering provider's office failed to do so, and to place the appropriate modifiers on the claim when required.

The notices for each payer are attached and each is described below:

1. Medicare: Advance Beneficiary Notice of Non-Coverage (ABN)

Please see Section 5 for patients who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage)

The ABN is a standardized notice that must be given to a Medicare beneficiary when certain Medicare Part B **outpatient** items or services may not be paid for by Medicare¹. The ABN is not used for patients with a Managed Medicare plan i.e. Medicare HMO. The Commercial Advance Notice of Potential Non-Coverage must be used instead. The current, CMS-approved form R-131 (Exp. **06/30/23**) must be used and should have the UVMHC form number **032739** at the bottom (attached). An ABN must be issued when Medicare is expected to deny payment for an item or service because it is not reasonable and necessary under Medicare Program standards. For Medicare, UVMHC has an ABN flag built into Epic that notifies the ordering department when services that are subject to medical coverage policy are ordered and associated with a diagnosis code that is not covered. The flag gives the ordering department a chance to either associate a diagnosis code that is covered, as long as it is supported by documentation, or have a conversation with the patient to inform them of their financial responsibility and obtain an ABN.

The ABN allows the beneficiary to make an informed decision about whether to accept financial responsibility for those services if Medicare does not pay. The ABN serves as proof that the beneficiary was notified prior to receiving the service that Medicare might not pay and received an estimate of the amount they may need to pay. If an ABN is not issued or Medicare finds the ABN invalid in a situation requiring notice, UVMHC may not bill the beneficiary for the services, and may be financially liable if Medicare does not pay.

When a valid ABN is obtained, modifier GA (Waiver of liability statement on file) must be applied to the professional and hospital claims for the service for which the ABN was obtained. When an ABN is not obtained, or when the ABN is invalid, modifier GZ (Item or service expected to be denied as not reasonable and necessary) must be applied to the professional and hospital service for which the ABN should have been obtained.

Medicare does not require ABNs for “statutorily excluded” care, or services Medicare never covers. However, in these situations, a voluntary ABN may be issued. If an ABN is obtained for an item or service that is statutorily excluded from Medicare coverage, these services should include both the GY modifier (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) and the GX modifier (Notice of Liability Issued, Voluntary Under Payer Policy) on the line items on both hospital and physician claim forms.

Medicare prohibits the use of routine or blanket ABNs (i.e., where there is no reasonable expectation that the item or service will not be covered). When a service/test is subject to a frequency limitation, because all or virtually all beneficiaries may be at risk of having their claim denied, UVMHC may routinely give ABNs to beneficiaries in these instances only.

UVMHC should not seek to obtain an ABN from a beneficiary in a medical emergency or when he or she is under duress. ABN use in the emergency room may be appropriate in some cases for a medically stable beneficiary.

Every effort should be made to present the ABN to the patient in person. If that is not possible, a telephone discussion with the patient or representative, immediately followed by either a hand-delivered, mailed, or faxed notice is permitted. The contact must be documented in the Epic medical record. The patient must sign and retain the notice and return a copy of the signed notice to UVMHC to scan into the medical record. Keep a copy of the unsigned ABN on file while awaiting receipt of the signed ABN. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in the patient’s medical record and on the unsigned copy.

See attachment A of this policy for the steps to obtaining a valid ABN. Here is a link for additional information from CMS regarding the ABN: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf

2. Vermont and New York Medicaid: Notice of Financial Responsibility

Please see Section 5 for patients who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage)

The Notice of Financial Responsibility (attached) is used for Vermont and New York Medicaid beneficiaries when **outpatient or inpatient** services are provided that are not covered by those payers. The provider does not bill Medicaid for the non-covered items or services; the beneficiary must be billed directly. Medicaid requires providers to fully inform the patient that they will be financially

¹ For Inpatient services, hospitals must provide the appropriate Hospital-Issued Notice of Noncoverage (HINN) to patients prior to admission, at admission, or at any point during an inpatient stay if it is determined that the care being provided is not going to be covered because it is not medically necessary. See policy CMSW04 for information related to the HINN.

responsible for the item or service.² The provider is to give a copy of the notice to the beneficiary or representative, obtain a signature, and retain a copy in the beneficiary's medical record. Failure to give advance notice prevents the provider from billing the beneficiary. The form must include all of the following information:

1. Provider's name and Medicaid provider ID number
2. Beneficiary's name and signature (or signature of a parent, if beneficiary is a minor).
3. Description of service(s)
4. A clear statement that the provider is unwilling to accept Vermont Medicaid payment for the specific service(s) sought and if the beneficiary wants to get this service from this provider, the beneficiary or responsible adult must accept full financial responsibility
5. Date of signing

3. Tricare: Request for Non-Covered Services

Before delivering care, providers must notify TRICARE patients if services are not covered. The patient must agree in advance and in writing to receive and accept financial responsibility for non-covered services. The agreement must document the specific services, dates, and estimated costs. The UVMHC approved Request for Non-Covered Services form (attached) is used to notify Tricare beneficiaries if **outpatient or inpatient** items and services are not covered. Services that are expected to be denied by TRICARE as non-covered may still be submitted to Tricare; there are currently no modifiers that should be applied to the non-covered service indicating that the notice was obtained. If the beneficiary does not sign a Request for Non-Covered Services form, providers cannot bill the patient.³

The agreement must include all of the following information:

1. Description of service(s)
2. Date of Service
3. Estimated cost

In addition, providers must inform Tricare beneficiaries of the Tricare Hold Harmless Policy, which is included in the Request for Non-Covered Services form.

4. Commercial: Advance Notice of Potential Non-Coverage

The Advance Notice of Potential Non-Coverage (attached) is used to notify patients with commercial insurance coverage that an **outpatient or inpatient** item or service may be denied as experimental, investigational, or not medically necessary. The patient is acknowledging that they will be financially responsible for payment of the items or services in the event that their insurance policy does not pay. The notice must be given to the beneficiary prior to the service. Services that may be denied by the commercial insurance as non-covered may still be submitted to the insurance; there are currently no modifiers that should be applied to the non-covered service indicating that the notice was obtained.

5. Dually enrolled in both Medicare and Medicaid: Advance Beneficiary Notice of Non-Coverage (ABN)⁴

CMS has come out with special guidance for patients who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage). Aside from this special guidance, all other rules for a Medicare ABN in Section 1 must be followed.

Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted to Medicare for adjudication.

Strike through **Option Box 1** as provided below:

² Vermont Medicaid General Billing and Forms Manual, section 1.5 Notice That Vermont Medicaid Will Not Be Accepted page 10: <http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf>

³ TRICARE Provider Handbook East Region 2020, Noncovered Services, page 47: <https://docushare-web.apps.cf.humana.com/Marketing/docushare-app?file=3828890>

⁴ **Note:** These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances. More information on dual eligible beneficiaries may be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

☐ **OPTION 1.** I want the item or service listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

This guidance is required because the provider cannot bill the dually eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid. If Medicare denies a claim where an ABN was needed in order to transfer financial liability to the beneficiary, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:

- If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.
- If the beneficiary has full Medicaid coverage and Medicaid denies the claim, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

RELATED POLICIES:

The University of Vermont Medical Center Policy CMSW04 Notices of Non-Coverage

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Attachment A

Advance Beneficiary Notice – Procedure

Steps to obtaining a valid ABN:

1. UVMMC providers must use the UVMMC approved version (Form CMS-R-131 Exp. 06/30/23).
2. The following information must be completed on the ABN form before you present it to the patient to sign:
 - Patient's first name, middle initial if it appears on the beneficiary's Medicare card, and last name
 - Date of Birth
 - Medical record number (Lack of a medical record number on the ABN form does not invalidate the ABN.)
 - The specific item(s) or service(s) likely to be denied by Medicare.
 - You must list the general description of the items or services in terms that the patient will understand.
 - If more than one test is on the form and more than one reason, then it should be clearly indicated as to what reason matches what test.
 - The reason you believe Medicare is likely to deny coverage.
 - If no reason is indicated on the ABN as to why denial is likely to occur, then the ABN is invalid.
 - Estimated cost:
 - The beneficiary must be provided with an estimated cost to help them make an informed decision.
 - Use a good faith estimate for all the items and services likely to be denied. This includes both the facility and professional charges.
 - It is expected that the estimate will be within \$100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Examples of acceptable estimates include, but are not limited to, the following:
 - For a service that costs \$250:
 - "Between \$150 and \$300"
 - "No more than \$500"
 - Multiples items or services that routinely grouped can be bundled into a single-cost estimate.
3. After explaining the ABN to the patient, ask them to choose **Option 1, Option 2, or Option 3** by checking the appropriate box on the form. You may not choose the option for them.
4. Ask the beneficiary or authorized representative* to sign and date the form.
5. The ABN must be prepared with an original and at least one copy. The beneficiary is given his/her copy of the signed and dated ABN immediately, and one copy should be retained in the patient's EPIC record.

Medicare claims for which a valid ABN has been obtained must have the appropriate occurrence code/modifier.

For outpatient hospital claims enter:

- Occurrence code 32 with the date the ABN was signed; and
- GA modifier on HCPCS procedure line to which the ABN is applicable.

For professional claims enter:

1. GA modifier on HCPCS procedure code to which the ABN is applicable.

National Coverage Decisions (NCDs):

- i. **General:** <https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=BAAAAAAAAAAAAA>
- ii. **Laboratory specific NCDs:** <https://www.cms.gov/medicare/coverage/coverageegeninfo/labncdsid10.html>

Local Coverage Decisions (LCDs):

- **NGS Part A and Part B:**
[National Government Services Local Coverage Determinations](#)
- **DME MAC:** Noridian DME MAC Jurisdiction A
<https://med.noridianmedicare.com/web/jadme>



Dual Eligibility ABN of Medicaid Notice of TRICARE noncovered ABN of Noncoverage
Noncoverage UVMMC(Financial Responsibility services waiver form # 032739 UVMMC.pdf