How to Use the Medicare Advance Beneficiary Notice (ABN)

It is necessary for health care providers and suppliers to be aware of both current national and local Medicare coverage policies. These policies indicate which items/services will be considered reasonable, medically necessary, and appropriate. In most cases, the availability of this information (which is easily accessible) indicates that the health care provider knew, or should have known, that an otherwise covered item/service would be denied as not medically necessary this time.

When a provider properly uses the ABN form, they are protected from financial liability. An ABN must (mandatory) be given when Medicare is expected to deny payment on an otherwise covered service. (For chiropractic, this is ONLY the spinal CMT codes) The ABN gives effective notice to the beneficiary that Medicare will not likely pay for the service (CMT – maintenance care) rendered. Failure to provide the beneficiary with an ABN notice when one is required will make the provider liable for the amount of the service.

These are the characteristics of an acceptable ABN:

- Is on the approved FORM CMS-R-131
- All required sections are completed
- The notifier’s information is easily identified (name, address, etc.)
- It clearly describes the service
- Explains the reason Medicare is likely to deny payment
- Provides the estimated cost of the service
- Is signed and dated by the beneficiary

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. In a typical chiropractic office, this means that it must be delivered BEFORE the service is rendered. The option of whether to proceed with the service must be selected only by the patient or representative (who must also sign and date the form).

If the patient is unable to decide, it should be noted on the ABN, “Beneficiary refused to select an option.” Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations.

Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file. Some MAC carriers allow electronic copies. Check with your carrier to be sure. The ABN remains valid for a period of one year, or until another triggering event occurs. This means that if a patient moves from maintenance care back to active treatment, that ABN form is now deactivated, and when the patient moves to maintenance care again, a new ABN form would be signed, and would be valid for one year, or until another triggering event occurs.

In the event Medicare covers the services that were expected to be denied and those services have already been paid by the patient, a proper refund must be made to the patient. Refunds are considered prompt when made within 30 days of notice of denial from Medicare.