Policies of the University of North Texas Health Science Center	Chapter 14 – UNT Health
14.160 Advance Beneficiary Notice of Non-coverage	

Policy Statement

UNTHSC providers shall provide an advanced beneficiary notice of non-coverage (ABN) to Medicare patients before items or services are rendered when the provider believes Medicare is expected to deny payment, either entirely or in part, for the item or service because it is not reasonable and necessary under Medicare program standards.

Application of Policy

UNTHSC providers and staff

Definitions

1. Advance Beneficiary Notice of Non-coverage (ABN): ABN is a standardized notice provided to Medicare beneficiaries to allow them to make an informed decision about whether to receive services that they may be financially responsible for paying. ABNs apply only to Medicare beneficiaries enrolled in Medicare's fee-for-service option.

2. National/Local Coverage Determinations: indicates which items/services will be considered reasonable, medically necessary, and appropriate.

Procedures and Responsibilities

1. An ABN must be given when Medicare is expected to deny payment (entirely or in part) for the item or services because it is not reasonable and necessary. The ABN form must be given to the patient or the patient's representative before providing the services/items that may not be covered by Medicare.

   Responsible Party: UNTHSC providers and clinical staff

2. If a patient refuses to choose an option and/or refuses to sign the ABN, the provider should annotate the original copy of the ABN indicating the refusal to sign and list the witness(es) to the refusal on the notice. If a beneficiary refuses to sign a properly delivered ABN, the provider should consider not furnishing the item/service, unless the consequences (health and safety of the beneficiary) are such that this is not an option.

Responsible Party: UNTHSC providers and clinical staff

3. After the patient signs a properly issued ABN indicating his/her choice to receive the item/service and accept financial liability, the provider is permitted to bill the beneficiary for the care.

   Responsible Party: UNTHSC providers and clinical staff

4. If an ABN is not issued or is found to be an invalid notice when a notice is required, the provider is not permitted to bill the beneficiary for the services and the provider will have financial liability if Medicare does not pay.

   Responsible Party: UNTHSC providers and staff

5. UNTHSC providers and staff are to be aware of both National and Local Coverage Determinations to determine if an item/service will be covered. Local Coverage Determinations should be the primary resource. If there is no Local Coverage Determination for a particular item/service, then the National Coverage Determination should be referenced.

   Responsible Party: UNTHSC providers and clinical staff

6. ABNs are not to be used:

   a. To charge a patient for a component of a service when full payment is made through a bundled payment; or

   b. To transfer liability to the patient when items/services would otherwise be paid for by Medicare.

   Responsible Party: UNTHSC providers and clinical staff

7. An ABN should not be obtained from a beneficiary in a medical emergency or otherwise under great duress (i.e., when circumstances are compelling and coercive).

   Responsible Party: UNTHSC providers and clinical staff

8. Durable Medical Equipment suppliers must issue an ABN before providing the beneficiary with items/services if an advance coverage determination is required.

   Responsible Party: UNTHSC providers and staff

9. ABNs must not be issued on a routine basis where there is no reasonable basis for Medicare to not cover the item/service.

   Responsible Party: UNTHSC providers and staff

10. An ABN may be issued voluntarily to patients when the items/services are statutorily excluded or are never a Medicare benefit.

    Responsible Party: UNTHSC providers and staff

11. ABN delivery is effective when the notice is:

    a. Delivered (preferably in person) and comprehended by the patient or his representative;

    b. The ABN form has all the required blanks completed;

    c. Provided far enough in advance of potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options;

    d. Explained in its entirety and all questions related to the ABN are answered; and

    e. Signed and dated by the beneficiary or his representative after he has selected one option box on the notice.[1]

    Responsible Party: UNTHSC providers and staff

12. In circumstance when in-person delivery is not possible, an ABN may be delivered through the following means and in accordance with HIPAA policies, and the contact must be documented in the medical record:

    a. Telephone contact and the contact must be followed immediately by either a hand-delivered, mailed, e-mailed or faxed notice;

    b. Mail;

    c. Secure fax machine; or

    d. E-mail

    In the above situations, the provider must be in receipt of a signed ABN before providing the service and/or item.

    Responsible Party: UNTHSC providers and staff

13. UNTHSC personnel must ensure the patient or his representative signs and retains the notice and sends a copy of the signed notice to the provider when any of the delivery methods described above is used. Additionally, UNTHSC personnel must

---

[1] Please refer to the Advance Beneficiary Notice of Non-coverage job aide attached to this policy to properly complete the ABN notice.

keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the patient does not return a signed copy, UNTHSC staff must document the initial contact and subsequent attempts to obtain a signature in the medical record or on the notice.

Responsible Party: UNTHSC clinical staff

14. The patient and the provider must each retain one copy of the signed ABN.

Responsible Party: UNTHSC clinical staff

15. The signed ABN shall be scanned into the electronic medical record.

Responsible Party: UNTHSC staff

16. If after completing and signing the ABN the patient changes his mind:

    a. The provider should present the previously completed ABN to the patient and request that he annotate the original ABN. The annotation must include a clear indication of his new option selection along with his signature and date of annotation.

    b. In situations where the provider is unable to present the ABN to the patient in person, the provider may annotate the form to reflect the patient's new choice and immediately forward a copy of the annotated notice to the patient to sign, date, and return.

Responsible Party: UNTHSC providers and clinical staff

17. ABNs should be kept for five years from the date of care delivery. This includes those cases in which the patient declined the care, refused to choose an option, or refused to sign the notice.

Responsible Party: UNTHSC HIM manager

18. A single ABN may be issued to cover an extended course of treatment if the ABN identifies all items/services and the duration of the period of treatment for which the provider believes Medicare will not pay. If during the course of treatment an item/service is provided that is not listed on the ABN and may not be covered by Medicare, a separate ABN must be issued. A single ABN for an extended course of treatment is valid for no more than one year. If the extended course of treatment will continue after a year's duration, a new ABN must be issued.

Responsible Party: UNTHSC providers and clinical staff

19. Appropriate claims modifiers associated with ABN use must be used.

Responsible Party: UNTHSC providers, staff and Patient Financial Services

20. The ABN form must not exceed one page in length.

Responsible Party: UNTHSC providers and staff

References and Cross-references

Department of Health and Human Services; Center for Medicare & Medicaid Services: Advanced Beneficiary Notice of Non-Coverage Part A & Part B; Medicare Learning Network

Medicare Claims Processing Manual, Chapter 30 — Financial Liability Protections

Forms and Tools

Department of Health and Human Services; Center for Medicare & Medicaid Services: Advanced Beneficiary Notice of Non-Coverage Part A & Part B; Medicare Learning Network

ABN use and instructions found at: http://www.cms.gov/BNI/02_ABN.asp

14.223 Faxing Protected Health Information

ABN Forms:

- English and Spanish versions – Form CMS-R-131 (03/11)
- Gynecological Services ABN – English and Spanish versions – From CMS-R-131 (03/11)

Approved: May 29, 2012
Effective: May 29, 2012
Revised:

A. Notifier: UNT Health PO Box 99335 Fort Worth, TX 76199 Phone #: ( )
Provider Name & Address:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.** ____________ 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.
☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notificante: : UNT Health PO Box 99335 Fort Worth, TX 76199 Telefono #: ( )
Nombre del providor & direccion:
B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga **D.** ____________ a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados. Prevemos que Medicare no pagará **D.** ____________ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir D. ____________ mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

☐ **OPCIÓN 1.** Quiero **D.** ____________ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.

☐ **OPCIÓN 2.** Quiero **D.** ____________ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago.
No tengo derecho a apelar si no se le cobra a Medicare.

☐ **OPCIÓN 3.** No quiero **D.** ____________ mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notifier: **UNT Health PO Box 99335 Fort Worth, TX 76199** **Phone #: (   )**
Provider Name & Address:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
❑G0101-Cervical or vaginal cancer screening, pelvic & clinical breast exam.($93 for POS 03) ❑Q0091-Screening Pap smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory. ($100 for POS 03) ❑82270-Occult Blood ($18.00 for POS 03) ❑Other______________________________ ❑Other______________________________	❑May not be covered by Medicare per this service is only covered once every two years unless high risk. If high risk, covered once a year. ❑Medicare does not cover the diagnosis. ( ) ❑Non covered service by Medicare. ❑Other______________________________ ❑Other______________________________ ❑**Other**______________________________	❑**$93.00** ❑**$111.00** ❑**$100.00** ❑**$193.00** ❑**$118.00** ❑**$18.00** ❑**Other-** $______.____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **D.** ____________ 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.
☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notificante: UNT Health PO Box 99335 Fort Worth, TX 76199 Telefono #: ( )
Nombre del providor & direccion:
B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga **D.** ______________ a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados.
Prevemos que Medicare no pagará **D.** ______________ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado
❑**G0101**-Investigacion de cancer cervical o vaginal, examen clinico del pelvico y pecho. ($61 for POS 02) ❑**Q0091**-Borron de transferencia de Pap de la investigacion , obtencion, preparacion y transporte del boron de transferencia cervical o vaginal al laboratorio. ($50 for POS 02) ❑**Otro**______________________________ ❑**Otro**______________________________	❑Medicare no puede cubrir este servicio porque este servicio se cubierto solamente una vez cada dos anos a menos que sea de riesgo elevado. Si es de riesgo elevado, cubierto una vez al ano. ❑Medicare no cubre este diagnosis. ( ) ❑Medicare no cubre este servicio. ❑Otro______________________________ ❑**Otro**______________________________	❑**$61.00** ❑**$50.00** ❑**$111.00** ❑**Otro-** **$______.____** ❑**Otro-** $______.____

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir D. ______________ mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

☐ **OPCIÓN 1.** Quiero **D.** ______________ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.

☐ **OPCIÓN 2.** Quiero **D.** ______________ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago.
No tengo derecho a apelar si no se le cobra a Medicare.

☐ **OPCIÓN 3.** No quiero **D.** ______________ mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.