
Limitation of Liability

Advance Beneficiary Notice

October 2007

This training material was developed by the Upstate Medicare Division (UMD) for providers who furnish services to Medicare beneficiaries in the upstate New York region. It has been prepared as a tool to assist providers who bill the Medicare program, but it is not a legal document. This information was current at the time that it was developed, however, the official Medicare program provisions are contained in the relevant laws, regulations, and rulings. These provisions and any updates can be found on the UMD Web site, www.umd.nycpic.com, or on the Centers for Medicare & Medicaid Services (CMS) Web site, www.cms.hhs.gov. The ultimate responsibility for correct claim submission lies with the provider.



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Background

Providers who render services to Medicare beneficiaries, which are subsequently determined to be “not reasonable and necessary” under §1862(a)(1) of the Social Security Act, are required to refund any amount collected from the beneficiary. There are two circumstances in which you are not required to make a refund.

You are not required to make a refund when:

- You did not know, nor could you reasonably have been expected to know, that Medicare would not pay for the service.
- Prior to rendering the service, you notified the beneficiary in writing that Medicare would not pay for the service, and, after being so advised, the beneficiary agrees to pay for the service.

The purpose of the Advance Beneficiary Notice (ABN) is to protect Medicare beneficiaries from liability when they, in good faith, receive services from providers for which Medicare payment is denied on the basis that the services are excluded from coverage as “not reasonable and necessary for the diagnosis or treatment of an illness or injury.”

This provision discourages the rendering of services that are unnecessary or unreasonable and also ensures that where such services are provided, the beneficiary is given advance notice that Medicare is likely to deny payment for the particular service, the reasons why the physician believes payment is likely to be denied, and that the financial responsibility for the service lies with the beneficiary.

Evidence of Prior Knowledge

Your assertion that you did not know and could not reasonably have been expected to know that Medicare would not pay generally will be accepted unless controverted by other evidence. The Medicare program has established guidelines on the evidence which may be used for determining whether you knew or could reasonably have been expected to know, in a given case, that Medicare

would deny the service as “not reasonable and necessary.”

Examples of circumstances in which evidence would exist of your knowledge that Medicare would deny payment include:

- The Medicare carrier has provided general notice to the medical community either that Medicare does not pay for a particular service or that particular services are paid only under certain circumstances, e.g., an article in a newsletter or bulletin; and
- The carrier had previously given you individual notice that Medicare would deny payment for a type of service in all or similar circumstances, e.g., a message on your Provider Remittance or in correspondence.

Advance Beneficiary Notice

The Advance Beneficiary Notice – General Use (ABN-G) shall be used by providers, physicians, practitioners, and suppliers for all situations where Medicare payment is expected to be denied, including laboratory tests. The Advance Beneficiary Notice – Laboratory Use (ABN-L) is specifically for use when only laboratory services are being delivered.

You may access the Centers for Medicare & Medicaid Services (CMS) Web site to print the forms at www.cms.hhs.gov/BNI. For services furnished on or after January 1, 2003, physicians and suppliers must use these approved ABN forms.

Following are some examples of acceptable statements of reason for your belief that Medicare is likely to deny payment. The Medicare program uses such statements on its notices to beneficiaries of denial of payment on the basis that the services were “not reasonable and necessary.” You are free to use these or similar statements of reasons, as appropriate to the particular case.

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- Medicare usually does not pay for this many visits or treatments.
- Medicare usually does not pay for this service.
- Medicare usually pays for only one nursing home visit per month.
- Medicare usually does not pay for this shot.
- Medicare usually does not pay for this many shots.
- Medicare does not pay for this because it is a treatment that has yet to be proven effective.
- Medicare does not pay for this office visit unless it was needed because of an emergency.
- Medicare usually does not pay for like services by more than one doctor during the same period of time.
- Medicare usually does not pay for this many services within this period of time.
- Medicare usually does not pay for more than one visit a day.
- Medicare usually does not pay for such an extensive procedure.
- Medicare usually does not pay for like services by more than one doctor of the same specialty.
- Medicare usually does not pay for this equipment.
- Medicare usually does not pay for this lab test.

The requirement for advance notice is not satisfied by a signed statement by the beneficiary to the effect that, should Medicare deny payment under §1862(a)(1), the beneficiary agrees to pay for the service. Nor can routine notices to beneficiaries which do no more than state that Medicare denial of payment is possible, or that the physician never knows whether Medicare will deny payment, be

considered acceptable evidence of advance notice sufficient to set aside the refund requirements. Notices are not given to beneficiaries unless the physician has some genuine doubt regarding the likelihood of Medicare payment, as evidenced by his/her stated reasons. Giving notices for all claims or services is not an acceptable practice. A separate notice is required for each service rendered.

The Advance Beneficiary Notice must be:

- On the CMS approved ABN forms.
- Signed and dated prior to rendering the service.
- Used only when Medicare is likely to deny the service.
- Kept on record in your office.

Additional information on ABNs can be found in Internet-Only Manual (IOM), Pub. 100-04, Medicare Claims Processing Manual, Chapter 30, at www.cms.hhs.gov/Manuals/IOM/.

Limitation of Liability Modifiers

GA Waiver of Liability Statement on file. The patient has agreed to the service and is aware they are responsible for payment. In the case where the beneficiary refuses to sign the ABN, but insists on having the service rendered, please follow the guidelines. The beneficiary cannot properly refuse to sign the ABN at all and still demand the item or service. If a beneficiary refuses to sign a properly executed ABN, the physician or supplier should consider not furnishing the item or service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option. If the beneficiary refuses to sign the ABN, the physician or supplier should annotate the ABN, and have the annotation witnessed, indicating the circumstances and persons involved. If the beneficiary demands the service and refuses to pay, the physician or supplier should have a second person

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witness the provision of the ABN and the beneficiary's refusal to sign. They should both sign an annotation on the ABN attesting to having witnessed said provision and refusal. Where there is only one person on site, the second witness may be contacted by telephone to witness the beneficiary's refusal to sign the ABN by telephone and may sign the ABN annotation at a later time. The unused patient signature line on the ABN form may be used for such an annotation; writing in the margins of the form is also permissible. The physician or supplier should file as having given the ABN, with a GA modifier.

- GY** Item or service statutorily excluded or does not meet the definition of any Medicare benefit.
- GZ** Item or service expected to be denied as not reasonable and necessary.