

Advance beneficiary notice

W/P:

Page:

Location:

Auditor:

Audit Module:

Budget Hours:

Actual Hours:

Signature:

Objective: To ensure that the facility properly obtains advance beneficiary notices (ABN) from patients for Medicare non-covered services. Determine in your annual work plan how often audits should be conducted.

| | Date | W/P Ref |
|---|------|---------|
| <p>1. Policy review.</p> <ul style="list-style-type: none"> • Research Medicare’s policies on ABN use (revised instructions are in Transmittal R1587CP on the CMS Web site). • Compare the facility’s ABN policies to Medicare policies • Identify how physicians have been trained on ABN use <p>2. Review staff process for coverage determinations.</p> <ul style="list-style-type: none"> • Determine which staff members are responsible for coverage determination • Determine how staff identifies the proper ICD-9 and CPT codes. <p>3. Observe ABN use.</p> <ul style="list-style-type: none"> • Visit service areas to determine how they use ABNs • Interview managers of various departments to ensure that they are correctly interpreting ABN policies • Verify training by obtaining course materials and attendance sheets • Determine how the facility handles patients who refuse to sign an ABN • Facility’s use of translators with patients whose first language is not English • Identification of representatives for incompetent beneficiaries <p>4. Identify red flags. Watch for the following common problem areas:</p> <ul style="list-style-type: none"> • ABNs not being used at all • ABNs that do not specify the test or service or reasons that Medicare may not pay | | |

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| <ul style="list-style-type: none"> • Use of ABNs for non-Medicare patients or Medicare managed care patients • ABN use during emergencies—hospitals must not give ABNs to emergency room patients until after screening and stabilizing the patient <p>5. Choose a sample.</p> <ul style="list-style-type: none"> • Determine which tests or services to monitor • Review claims denials for inclusion in the sample • Select a random sample of a statistically valid number of claims. <p>6. Review medical and billing records.</p> <ul style="list-style-type: none"> • Determine whether the medical record documentation supports the diagnosis and procedure codes assigned • Review the use of the GA modifier and condition code 32. Do the following: <ul style="list-style-type: none"> • Verify that an ABN is on file • Identify whether the facility has attached the GA modifier to each procedure listed on the ABN <p>7. Verify ABN validity. Ensure that ABNs contain the following:</p> <ul style="list-style-type: none"> • Model language as provided by CMS in the ABN-approved form: CMS-R-131. • Specific information about the test or service that Medicare may not pay for <ul style="list-style-type: none"> • A specific reason why the facility believes Medicare may not pay for the test or service <p>Process for identification of good faith cost estimate with \$100 or 25% of the actual cost</p> <ul style="list-style-type: none"> • A signature by the patient or the patient’s legal representative • Make sure billing entity contact information appears on the form. <p>8. Review the use of the GA modifier and condition code 32. Do the following:</p> <ul style="list-style-type: none"> • Verify that an ABN is on file • Identify whether the facility has attached the GA modifier to each procedure listed on the ABN | | |
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Sources: Stacie Buck, RHIA, LHRM, president of HIM Associates, a consulting firm in North Palm Beach, FL; Brian Kozik, director of compliance and audit services for the North Shore Medical Center in Salem, MA; and Hank Vanderbeek, MPA, CIA, CFE, president of HAV Compliance Services, a consulting firm in Haverhill, MA; Kimberly Anderwood Hoy, Esq, Regulatory Specialist for HcPro, Inc. in Marblehead, MA.