SUBJECT: 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 (UVMCM) providers are reviewed for medical necessity and that patient's receive advance notice of financial liability when an item or service may be non-covered. While UVMCM 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 UVMCM. All notices must be scanned into the patient's PRISM record in a retrievable manner under the document type ABN/Notice of Potential Non-Coverage.

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 UVMCM 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-UVMCM 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 UVMCM. 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 clinical requisition and/or orders sent to UVMCM.

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 providers’ 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)

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 Medicare. The current, CMS-approved form R-131 (Exp. 03/2020) must be used and should have the UVMMC 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, UVMMC has a flag built in PRISM which notifies the ordering department when Laboratory or Cardiology services are ordered and the associated diagnosis code is not covered according to the applicable Medicare coverage policy. The flag gives the ordering department a chance to either associate a diagnosis code that is covered, 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, UVMMC 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, UVMMC may routinely give ABNs to beneficiaries in these instances only.

You 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 PRISM medical record. The patient must sign and retain the notice and return a copy of the signed notice to UVMMC 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](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf)

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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.

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 items or services; the beneficiary is billed. Medicaid requires providers to fully inform the patient that they will be financially responsible for the item or service. 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. When the beneficiary or responsible representative accepts financial responsibility, the claim cannot be submitted to Medicaid for processing.² 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) sought
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 should 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 if and will be financially responsible for the cost.³

The agreement must include all of the following information:

1. The specific services
2. Date of Service
3. Estimated costs

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

² Vermont DVHA Provider Manual, page 36:
³ TRICARE, North Region Provider Handbook, page 18:

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 medical 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 are expected to be denied by the Commercial insurance as non-covered should 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. If the beneficiary does not sign an Advance Notice of Potential Non-Coverage, the provider may be financially responsible for the cost.

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

REVIEWERS:
Lisa Goodrich, VP Medical Group Operations
Christina Oliver, VP Clinical Services
Rick Vincent, SVP, CFO
Carmone Austin, Network Director Contracting/Revenue Strategy
Michael Barewicz, Director of Professional Revenue
Jane Vizvarie, Director of Patient Financial Services
Shannon Lonergan, Director of Registration & Customer Service
Patricia Fisher, Medical Director Case Management & Medical Staff

APPROVING OFFICIAL’S NAME:
Jennifer Parks, Chief Compliance and Privacy Officer
Attachment A

Advance Beneficiary Notice – Procedure

Steps to obtaining a valid ABN:

1. UVMMC providers must use the UVMMC approved version (exp. 3/2020 or later).

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 PRISM 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):

  ii. Laboratory specific NCDs:

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
Advance Beneficiary Notice of Noncoverage (ABN)

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

<table>
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<tr>
<th>Item or Service:</th>
<th>Reason Medicare May Not Pay:</th>
<th>Estimated Cost:</th>
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<td>Medicare does not cover this item or service for your condition.</td>
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<td>Medicare does not cover this item or service more often than ______________.</td>
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<td></td>
<td>Medicare NEVER covers this item or service.</td>
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<td>Other: ______________</td>
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**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 item or service 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.

**OPTIONS:** Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the ______________ 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 ______________ 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 ______________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**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.

**Signature:**

**Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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.
Notice of Financial Responsibility to Medicaid Beneficiaries

VT Medicaid Provider # 0470003
NY Medicaid Provider # 00353851

Patient Name: ___________________________  MRN: ___________________________

Item or Service(s) being sought: ________________________________________________

CPT/HCPCS (if applicable): ___________________________  Estimated Cost: $ __________

The University of Vermont Medical Center is unwilling to bill or accept Medicaid payment for the above listed item(s) or service(s) because the service is not considered a covered Medicaid benefit. If you wish The University of Vermont Medical Center to provide the item or service you must accept full financial responsibility.

I understand and agree to be personally financially responsible for the item(s)/service(s) listed above and that I will be billed directly by The University of Vermont Medical Center. I also understand that The University of Vermont Medical Center will not bill Medicaid the item(s)/service(s).

Signature of beneficiary or legal representative: ______________________________________
(If legal representative, please note relationship.)

Date/Time: ___________________________

Witness: ___________________________  Date/Time: ___________________________

Make three copies of signed document and distribute as follows:
1) patient’s copy, 2) scan a copy into PRISM and 3) attach a copy for billing, if applicable
I am hereby requesting that the following services be provided to me by (Provider Name)

<table>
<thead>
<tr>
<th>Service(s) (List All)</th>
<th>Frequency Limitations</th>
<th>Proposed Date(s) of Services</th>
<th>Estimated Cost of Service(s)</th>
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In making this request, I acknowledge that these services are not a benefit of my health coverage under TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service.

I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, Inc./MHN Services.

Unless the decision to deny is overturned as a result of an appeal or dispute, I agree that I will be personally responsible for the payment IN FULL of the billed charges for these services.

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<tr>
<th>Sponsor Name</th>
<th>Patient Name (Print)</th>
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<th>Sponsor Social Security Number</th>
<th>Signature of Patient</th>
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TRICARE Hold Harmless Policy: A network provider may not require payment from the beneficiary for any excluded or excluded services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or inadmissible and has agreed in advance in writing to pay for the services.

Privacy Act Statement:
In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1196 et seq. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosures of information is voluntary, however, failure to provide the information may result in denial of benefits.
# Advance Notice of Potential Non-Coverage

**FOR PATIENTS WITH COMMERCIAL INSURANCE ONLY – NOT FOR PATIENTS WITH MEDICARE/MEDICAID/TRICARE**

**THIS SECTION IS TO BE COMPLETED BY OFFICE STAFF ONLY**

- **Patient Name / Medical Record Number (MRN)**
- **Medical Service Description / CPT Code Number(s)**
- **Treating Physician / Site of Service / Telephone Number**
- **Commercial Insurance Carrier / Plan Title or Number / Member ID Number**
- **Estimated Cost**

You have been scheduled to receive the medical service(s) specified above. Health insurance doesn't pay for everything, including some services your health care provider has good reason to think you need. The University of Vermont Medical Center believes your health insurance carrier might consider the above service(s) to be experimental, investigational, or not medically necessary, according to the terms of your insurance policy. **If your insurance carrier considers the above service(s) to be experimental, investigational, or not medically necessary, it will not pay benefits for the service, and you will be personally responsible for paying the bill.**

**WHAT YOU NEED TO DO NOW:**

1. Read this Notice very carefully so that you can make an informed decision about your health care.
2. Ask us any questions that you may have after you finish reading.
3. Choose one of the options by initialing in the box next to your selection.

- **OPTION 1:** I want the service(s) listed above even though I may be personally responsible for paying for them. I want my health insurer billed for an official decision on payment. I understand that if my insurer considers the service(s) to be experimental, investigational, or not medically necessary, and refuses payment for the service(s) in whole or in part, I am personally responsible for paying any unpaid portion of the bill. The University of Vermont Medical Center reserves its right to collect anticipated patient responsibility at the time of service.

- **OPTION 2:** I want the service(s) listed above, but do not bill my health insurer. I will be responsible for paying now, at the time of service, and I understand that by choosing this option, I cannot appeal or reverse my decision to self-pay for the service(s).

- **OPTION 3:** I don't want the service(s) listed above. I understand that with this choice I am not responsible for payment and I cannot appeal to see if my health insurer would pay.

I certify that I carefully read this Advance Notice of Potential Non-Coverage and fully understand its contents. I understand this Advance Notice of Potential Non-Coverage is legally binding and that my signature below verifies that I chose the option indicated above knowingly, freely and voluntarily.

<table>
<thead>
<tr>
<th>Patient Signature</th>
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<th>Witness Signature</th>
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**Print Patient Name**

**Print Witness Name / Employer and Title**