NATIONAL SEATING & MOBILITY

Advance Beneficiary Notice (ABN)

- ABNs are needed whenever it is suspected that Medicare will deny an item as not medically necessary, or the coverage criteria has not been met.
- ABNs are also required when it is expected that Medicare will deny an item due to same/similar equipment and patient requested upgrades.
- The ABN must be very specific and only secured in situations in which we are expecting a denial and should not be secured **"just in case"** of a denial.
- The ABN must outline each item that is expected to deny, the specific reason for the denial and the amount of the item(s) we are collecting from the client (Refer to NSM's Self-Pay Pricing Policy)
- The ABN must be signed/dated by the client or their Medicare authorized representative. A representative is an individual who may make health care and financial decisions on a beneficiary's behalf. (Guardian, Power of Attorney) If a representative signs, the reason the client cannot sign and the relationship to the client must be clearly document on the ABN form.
- NSM should complete sections A-F (and if applicable section H) prior to presenting the ABN to the beneficiary. The beneficiary must then select an option, sign, and date the ABN.
- Section H for the ABN can be used to document any additional information or other funding source expected denials and/or approvals as applicable or be left blank.
- Every effort should be made to collect a completed ABN prior to delivery, including Assuresign, email and USPS.
- If every effort has been made to collect a completed ABN prior to delivery and the client has requested to complete it at delivery, you must document the conversation in the work order notes verifying that the client understands the ABN, has been provided their options and will make a informed decision and complete the ABN at the time of delivery.
- If the ABN is needed for a denied/non-covered items that are to be paid by the client, the ABN must be collected prior to collecting payment from the client.
- ABNs are not required for Statutorily Excluded items or routinely non-covered items such as seat elevators or any HCPC A9270 unless required for secondary claim payment. We can still secure one as a best practice.

Advanced Beneficiary Notice (ABN) Common Verbiage for Section E. "Reason Medicare May Not Pay"

PAR Denial

- List specific reasons from the PAR Denial along with any of the below that specifically describes why Medicare will not pay for the item(s).

No RX/Order

- Anytime there is not a valid physician's order or RX on file, please add the verbiage "no order on file"

Group 2 POV or Group 4 PMD

- **If applicable** However, you have agreed to pay the difference in the amount of the Group 1 Scooter and the Group 2 Scooter **or** between the item which medical coverage criteria has been met and the item the client will receive.

Documentation that does not show Medicare coverage criteria has been met

- The documentation that was obtained does not meet Medicare's coverage criteria because of (X) Medicare will deny as not medically necessary.

- **If applicable for new base**, If the base denies, Medicare will also deny the accessories as not medically necessary.

Equipment the beneficiary requests, however coverage criteria has not been met

- Medical documentation does not document Medicare coverage criteria for this level of equipment has been meet. Therefore, you agree to pay the difference between the item which medical coverage criteria has been met and the item you receive.

Back-up/Reserve Equipment

- Medicare does not pay for backup or reserve equipment and will deny as non-covered or same and similar to your primary equipment. If the base denies, Medicare will deny the accessories as non-covered.

Community Use

- Medicare does not pay for community use equipment and will deny as not medically necessary/non-covered. If the base denies, Medicare will deny the accessories as non-covered/not medically necessary.

Same/Similar

- Since Medicare has paid for an item that is same/similar to this item within the last 5 years, Medicare will deny as same-similar/non-covered/not medically necessary.
- **If applicable**, If the base denies, Medicare will deny the accessories as non-covered/not medically necessary.

Denied Base Equipment

- Since the equipment being modified was denied by Medicare, these modifications/repairs will be denied as not medically necessary/non-covered. Medicare does not cover modification/repairs to equipment that they denied.

Equipment not n file with Medicare and there is no base justification

- Your equipment is not of file as payable by Medicare. Based on the fact there is no medical justification on file for the base and we were unable to obtain base justification, Medicare will deny as not medically necessary.

ICD10 Diagnosis Criteria Not Met

- Since you do not have a specific diagnosis as required per Medicare coverage criteria to receive this item, Medicare will deny not medically necessary/non-covered.

K0669- Cushion Not Verified/Coded by PDAC

- Since this cushion does not meet specific HCPC coding criteria as outlined by Medicare, Medicare will deny as non-covered/not medically necessary.

Transit Option/Transport Brackets

- Medicare does not pay for equipment to be used for transport, will deny as non-covered/not medically necessary.

Patient or Caregiver Convenience Items (lighting package, attendant wheel locks, etc.)

- These are considered convenience items and will deny as non-covered/not medically necessary

Patient Damage/Patient Abuse

- Since the damage was caused by the patient, coverage will not be considered. This is considered patient abuse and will not be covered by Medicare.

Non-Covered Electronics (E2377/E2313/E2311) due to Non-covered Upgrade such as Power Seat Elevate

- Since you do not have at least thee or more power seating functions that are considered medically necessary, Medicare will deny these electronics as not medically necessary.

Non-Covered Items (Power Elevate, Power Standing Feature, etc.)

- Medicare does not consider these items to be primarily medical in nature and will deny as non-covered.

Attendant Control when client can independently operate a PMD

- Medicare does not consider coverage for an attendant control when you can operate your equipment independently. This item is only covered in place of a beneficiary-operated drive control system when the beneficiary is unable to operate the wheelchair. Coverage criteria for Medicare has not been met and Medicare will deny as non-covered/not medically necessary.

Client wants to Bypass Medicare

- Since you have elected to receive your equipment prior to NSM receiving any medical justification, prescriptions, or required medical documentation, Medicare will deny as non-covered /not medically necessary.

Place of Service

- Medicare does not pay for equipment while residing in a nursing facility as equipment is only covered when intended for use in the home, which by Medicare explicitly does not include a skilled Nursing Facility as “home”. These items will deny as statutorily non-covered.