CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2782	**Date: September 6, 2013**
	Change Request 8404

SUBJECT: Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

I. SUMMARY OF CHANGES: This transmittal provides instructions for home health agency (HHA) use of the ABN as the replacement notice for the outgoing Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1. In addition, this transmittal includes ABN issuance guidelines for therapy services and therapy specific examples. Minor editorial changes were made to clarify existing manual instructions regarding ABN issuance.

EFFECTIVE DATE: December 9, 2013
IMPLEMENTATION DATE: December 9, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/ Table of Contents
R	30/ 50/ 50.1/ Introduction - General Information
R	30/ 50/ 50.3/ ABN Scope
R	30 /50/ 50.3.1/ Mandatory ABN Uses
R	30/ 50/ 50.4.1/ Issuers of ABNs (Notifiers)
R	30/ 50/ 50.4.3/ Representatives of Beneficiaries
R	30/ 50/ 50.6.1/ Proper Notice Documents
R	30/ 50/ 50.6.3/ Completing the ABN
R	30/ 50/ 50.6.5/ Other Considerations During ABN Completion
R	30/ 50/ 50.7.1/ Effective Delivery
R	30/50/ 50.7.2/ Options for Delivery Other than In Person
R	30/ 50/ 50.7.3/ Effects of Lack of Notification, Medicare Review and Claim Adjudication
R	30/ 50/ 50.13/ Collection of Funds and Refunds
R	30/ 50/ 50.14/ CMS Regional Office (RO) Referral Procedures
R	30/ 50/ 50.15.1/ Obligation to Bill Medicare
R	30/ 50/ 50.15.2/ Emergencies or Urgent Situations/ Ambulance Transport
R	30/ 50/ 50.15.3.1/ Special Issues Associated with the Advanced Beneficiary Notice (ABN) for Hospice Providers
R	30/ 50/ 50.15.3.2/ Special Issues Associated with the Advanced Beneficiary Notice (ABN) for CORFS
N	30/ 50/ 50.15.4/ Home Health Agency Use of the ABN
N	30/ 50/ 50.15.5/ Outpatient Therapy Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2782	Date: September 6, 2013	Change Request: 8404

SUBJECT: Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

EFFECTIVE DATE: December 9, 2013
IMPLEMENTATION DATE: December 9, 2013

I. GENERAL INFORMATION

A. Background: ABNs have been required to inform beneficiaries in Original Medicare about possible non-covered charges when limitation of liability applies. The Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296 is being discontinued, and home health agencies (HHAs) will now use the ABN for liability notification. This CR serves to provide instructions specific to HHA use of the ABN and will further clarify the current manual instructions on ABN use in Pub. 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50. Also included is ABN issuance guidance for therapy services.

B. Policy: Section 1879 of the Social Security Act (the Act) protects fee for service beneficiaries from payment liability in certain situations unless they are notified of their potential liability in advance.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8404.1	Contractors shall take any actions necessary to implement the attached instructions; primarily by assisting providers and suppliers in understanding their responsibilities and communicating the availability of the revised, clarified instructions.	X	X	X	X	X	X	X					
8404.2	Contractors shall update the ABN instructions from PUB. 100-04/Chapter 30/Section 50, currently on their websites with the revised ABN manual instructions found in this CR.	X	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility					
		A/B MAC	DME	FI	CAR	RHH	Other

		A	B	HHH	MAC		RIER	I	
8404.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	The ABN is an existing requirement executed by providers and suppliers. The release of these clarified manual instructions should have no impact on contractor workload beyond short term educational demands.

Section B: All other recommendations and supporting information: ATTACHMENTS (2)

1. ABN Form

2. ABN Form Instructions

V. CONTACTS

Pre-Implementation Contact(s): Evelyn Blaemire, 410-786-1803 or evelyn.blaemire@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

A. Notifier:

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.

Form Instructions

Advance Beneficiary Notice of Noncoverage (ABN)

OMB Approval Number: 0938-0566

Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. Home health agencies (HHAs) have used the HHABN Option Box 1 in the past to inform beneficiaries of liability. With the publication of these instructions, HHAs may now issue the ABN instead of the HHABN Option Box 1. In the near future, the HHABN will be discontinued and replaced with the ABN and a new change of care notice called the Home Health Change of Care Notice (HHCCN). The date for all HHAs to discontinue HHABN use will be published on the CMS website http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html and announced via Open Door Forums and Home Health Agency listservs.

All of the aforementioned physicians, suppliers, practitioners, and providers must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. (Note that although Medicare inpatient hospitals use other approved notices for this purpose, skilled nursing facilities (SNFs) must use the revised ABN for Part B items and services.) Since March 1, 2009, the ABN-G and ABN-L are no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131).

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. The revised ABN included in this package incorporates: suggestions for changes made by notifiers over the past 3 years of use, refinements made to similar liability notices in the same period based on consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. We have made additional changes based on suggestions received during the recent public comment period.

This version of the ABN continues to combine the general ABN (ABN-G) and the laboratory ABN (ABN-L) into a single notice, with an identical OMB form number. As combined, however, the new notice will capture the overall improvements incorporated into the revised ABN while still permitting pre-printing of the lab-specific key information and denial reasons used in the former ABN-L.
Also, note that while previously the ABN was only required for denial reasons recognized under section 1879 of the Act, the revised version of the ABN may also be used to provide voluntary notification of financial liability.

Instructions for completion of the form are set forth below. Once the new ABN approval process is completed, CMS will issue detailed instructions on the use of the ABN in Pub. 100-04 Medicare Claims Processing Manual, chapter 30, section 50. Related policy on billing and coding of claims, as well as coverage determinations, is found elsewhere in the CMS manual system or website (www.cms.hhs.gov).

Completing the Notice

OMB-approved ABNs are placed on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html . Notices placed on this site can be downloaded and should be used as is, as the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes.

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

> **Sections and Blanks:**
> There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into the blanks labeled (D) within the Option Box, Blank (G). The check boxes in the Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

A. Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

Blank (A) Notifier(s): Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for questions.

Blank (B) Patient Name: Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

Blank (C) Identification Number: Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

B. Body

Blank (D): The following descriptors may be used in the header of Blank (D):

- Item
- Service
- Laboratory test
- Test
- Procedure
- Care
- Equipment

- The notifier must list the specific items or services believed to be noncovered under the header of Blank (D).
- In the case of partial denials, notifiers must list in Blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous noncovered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.14.3 for additional information.
- General descriptions of specifically grouped supplies are permitted. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

Blank (E) Reason Medicare May Not Pay: In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. Three commonly used reasons for noncoverage are:

- "Medicare does not pay for this test for your condition."
- "Medicare does not pay for this test as often as this (denied as too frequent)."
- "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for noncoverage may be applied to multiple items in Blank (D).

Blank (F) Estimated Cost: Notifiers must complete Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially noncovered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D). In general, we would expect that the estimate should 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. Thus, examples of acceptable estimates would include, but not be limited to, the following:

<u>For a service that costs $250</u>:

Any dollar estimate equal to or greater than $150
"Between $150-300"
"No more than $500"

For a service that costs $500:

- Any dollar estimate equal to or greater than $375
- "Between $400-600"

- "No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

C. Options

Blank (G) Options: Blank (G) contains the following three options:

☐ **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.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. *See Ch. 30, §50.15.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare.*

Note: Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

☐ **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.**

This option allows the beneficiary to receive the noncovered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

☐ **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.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers

may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option".

D. Additional Information

Blank (H) Additional Information: Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable ;
- An additional dated witness signature; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

E. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

Blank (I) Signature: The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out "representative" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.

Blank (J) Date: The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statement in the footer of the notice is required to be included on the document.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

Table of Contents
(Rev 2782, Issued: 09-06-13)

50.15.4 - Home Health Agency Use of the ABN
50.15.5 – Outpatient Therapy Services

50.1 - Introduction - General Information

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Section 50 of the Medicare Claims Processing Manual establishes the standards for use by providers and suppliers (including laboratories) in implementing the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131. This section provides instructions regarding the notice issued by providers to beneficiaries in advance of providing what they believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30.

ABN - Quick Glance Guide[1]

Notice Name: Advance Beneficiary Notice of Noncoverage (ABN)
Notice Number: Form CMS-R-131
Issued by: Providers and suppliers of Medicare Part B items and services;
Hospice and Religious Non-medical HealthCare Institute (RNHCI) providing Medicare Part A items and services*; and home health agencies(HHAs) for Part A and Part B items and services*

Recipient: Original Medicare (fee for service) beneficiary
Additional Information:
The ABN, Form CMS-R-131 replaces the following notices:

- ABN-G
- ABN-L
- Notice of Exclusion of Medicare Benefits (NEMB)
- *Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296, Option Box 1 (effective 2013)*

Type of notice:	Must be issued:	Timing of notice:	Optional/Voluntary use:
Financial liability notice	• Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice, *HHA,* and RNHCI providers only) but may not be paid for in this particular case because it is not considered medically reasonable and necessary • Prior to providing custodial care • For hospice providers, prior to caring for a patient who is not terminally ill • For DME suppliers, additional situations requiring issuance are outlined in 50.3.1 • *For HHA providers, prior to providing care when the individual is not confined to the home or does not need intermittent skilled nursing care.*	Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.	Yes. Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit).

[1] *This is an abbreviated reference tool and is not meant to replace or supersede any of the directives contained in Section 50.*

50.3 - ABN Scope

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by providers and suppliers for items and services provided under Medicare Part B, including hospital outpatient services, and certain care provided under Part A (hospice and religious non-medical healthcare institutes only). Providers and suppliers who are not enrolled in Medicare cannot issue the ABN to beneficiaries.

Provider use of the ABN has expanded to include home health agency (HHA) issuance for Part A and Part B items and services. The ABN will replace the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1 issued by HHAs. The mandatory date for HHAs to use the ABN instead of the HHABN, Option Box 1 will be posted on the web link for home health notices found at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. Information specific to HHA use of the ABN has been added in §50.15.4. The guidelines for ABN use published in this section and the ABN form instructions apply to HHAs unless noted otherwise.

The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). The ABN is used to fulfill both mandatory and voluntary notice functions.

*T*he ABN replace*s* the following notices:

- ABN-G (CMS-R-131-G)
- ABN-L (CMS-R-131-L)
- NEMB (CMS-20007)
- *Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296, Option Box 1 (effective 2013)*

Skilled Nursing Facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), CMS Form 10055, is issued for Part A SNF items and services. Section 70 of this chapter contains information on SNFABN issuance.

50.3.1 - Mandatory ABN Uses

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

The following provisions necessitate delivery of the ABN:

- §1862(a)(1) of the Act (not reasonable and necessary);
- §1834(a)(17)(B) of the Act (violation of the prohibition on unsolicited telephone contacts);
- §1834(j)(1) of the Act (medical equipment and supplies supplier number requirements not met);
- §1834(a)(15) of the Act (medical equipment and/or supplies denied in advance);
- §1862(a)(9) of the Act (custodial care);

- §1879(g)(2) of the Act (hospice patient who is not terminally ill); *or*
- *§1879(g)(1) of the Act (home health services requirements are not met – not confined to the home or no need for intermittent skilled nursing care).*
- *§1833(g)(5) of the Act (when outpatient therapy services are in excess of therapy cap amounts and don't qualify for a therapy cap exception – effective January 1, 2013).*

When Medicare considers an item or service experimental (e.g., a "Research Use Only" or "Investigational Use Only" laboratory test), payment for the experimental item or service is denied under §1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

Expanded mandatory ABN use in 2011

The Patient Protection and Affordable Care Act, P.L. 111-148, §4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1)of the Act. Per §1862(a)(1)(P), Medicare covered personalized prevention plan services (as defined in section 1861(hhh)(1)) that are performed more frequently *than indicated per coverage guidelines* are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. The LOL provisions of §1879 apply to this new subparagraph; thus, providers must issue an ABN prior to providing a preventative service that is usually covered by Medicare but will not be covered in this instance because frequency limitations have been exceeded.

In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) when a noncontract supplier furnishes an item included in the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) for a Competitive Bidding Area (CBA). Although all other denial reasons triggering mandatory use of the ABN are found in §1879 of the Act, in this situation, §1847(b)(5)(D) of the Act permits use of the ABN with respect to these items and services.

50.4.1 - Issuers of ABNs (Notifiers)

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Entities who issue ABNs are collectively known as "**notifiers**". These entities can include physicians, practitioners, providers (including laboratories), and suppliers, and/or utilization review committees for the care provider. *In 2013, HHAs are added as ABN issuers.*

The notifier may direct an employee or a subcontractor to deliver an ABN. The billing entity will always be held responsible for effective delivery regardless of who gives the notice. When multiple entities are involved in rendering care, it is not necessary to give separate ABNs. Either party involved in the delivery of care can be the notifier when:

- There are separate "ordering" and "rendering" providers (e.g. a physician orders a lab test and an independent laboratory delivers the ordered tests);
- One provider delivers the "technical" and the other the "professional" component of the same service (e.g. a radiological test that an independent diagnostic testing facility renders and a physician interprets); or

- The entity that obtains the signature on the ABN is different from the entity that bills for services (e.g. when one laboratory refers a specimen to another laboratory which then bills Medicare for the test).

When the notifier is not the billing entity, the notifier must know how to direct the beneficiary who received the ABN to the billing entity for questions and should annotate the Additional Information section of the ABN with this information. It is permissible to enter the names of more than one entity in the header of the notice.

50.4.3 - Representatives of Beneficiaries

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Notifiers are responsible for determining who may act as a beneficiary's authorized representative for the purposes of ABN issuance under applicable State or other law. An individual who may make health care and financial decisions on a beneficiary's behalf (e.g. the beneficiary's legal guardian or someone appointed according to a properly executed "durable medical power of attorney") is an *authorized* representative. If the beneficiary has a known, legally authorized representative, the ABN must be issued to the existing representative. If a beneficiary does not have a representative and one is necessary, a representative may be appointed for purposes of receiving notice following CMS guidelines and as permitted by State and Local law. See §40.3.5 of this chapter for more detailed guidance on representatives.

When a representative is signing the ABN on behalf of a beneficiary, the ABN should be annotated to identify that the signature was penned by the "rep" or "representative". If the representative's signature is not clearly legible, the representative's name should be printed on the ABN.

50.6.1 - Proper Notice Documents

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

The ABN, Form CMS-R-131, is the Office of Management and Budget (OMB) approved standard notice. Failure to use this notice as mandated could result in the notice being invalidated and/or the notifier being held liable for the items or services in question.

The online replicable copies of the OMB approved ABN (CMS-R-131) and instructions for notice completion are available on the CMS website at:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

A. Language Choice

The ABN is available in English and Spanish under a dedicated link on the web page given above. Notifiers should choose the appropriate version of the ABN based on the language the beneficiary best understands. Insertions must be in English when the English language ABN is used. Similarly, when a Spanish language ABN is used, the notifier should make insertions on the notice in Spanish, if applicable. In addition, verbal assistance in other languages may be provided to assist beneficiaries in understanding the document. However, the printed document

is limited to the OMB-approved English and Spanish versions. Notifiers should document any types of translation assistance that are used in the "Additional Information" section of the notice.

B. Effective Versions

ABNs are effective as of the OMB approval date given at the bottom of each notice. The routine approval is for 3-year use. Notifiers are expected to exclusively use the current version of the ABN. Providers/suppliers must be attentive to the OMB approval date on the notice and seek instruction from the CMS website *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* on obtaining current versions of notices. CMS will allow a transition period for providers and suppliers to switch from using expiring notices to newly approved notices. The date of mandatory use of newly approved notices will be announced on the CMS website with the notice's release.

50.6.3 - Completing the ABN

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Step by step instructions for notice completion are posted along with the notice on the CMS website and can be downloaded via this link: *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html*

Notifiers must follow guidance provided in this section and the instructions posted on the CMS website to construct a valid notice.

50.6.5 - Other Considerations During ABN Completion

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Changes His/Her Mind

If after completing and signing the ABN, a beneficiary changes his/her mind, the notifier should present the previously completed ABN to the beneficiary and request that the beneficiary annotate the original ABN. The annotation must include a clear indication of his/her new option selection along with the beneficiary's signature and date of annotation. In situations where the notifier is unable to present the ABN to the beneficiary in person, the notifier may annotate the form to reflect the beneficiary's new choice and immediately forward a copy of the annotated notice to the beneficiary to sign, date, and return.

In both situations, a copy of the annotated ABN must be provided to the beneficiary as soon as possible. If a related claim has been filed, it should be revised or cancelled if necessary to reflect the beneficiary's new choice.

B. Beneficiary Refuses to Complete or Sign the Notice

If the beneficiary refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign *or choose an option* and may list witness(es) to the refusal on the notice although this is not required. If a

beneficiary refuses to sign a properly delivered ABN, the notifier should consider not furnishing the item/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.

In any case, the notifier must provide a copy of the annotated ABN to the beneficiary, and keep the original version of the annotated notice in the patient's file.

50.7.1 - Effective Delivery

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Delivery Requirements

ABN delivery is considered to be effective when the notice is:

1. Delivered by a suitable notifier to a capable recipient and comprehended by that recipient.

2. Provided using the correct OMB approved notice with all required blanks completed.

   Failure to use the correct notice may lead to the notifier being found liable since the burden of proof is on the notifier to show that knowledge was conveyed to the beneficiary according to CMS instructions.

3. Delivered to the beneficiary in person if possible.

4. Provided far enough in advance of delivering potentially noncovered items or services to allow sufficient time for the beneficiary to consider all available options.

5. Explained in its entirety, and all of the beneficiary's related questions are answered timely, accurately, and completely to the best of the notifier's ability.

   The notifier should direct the beneficiary to call 1-800-MEDICARE if the beneficiary has questions s/he cannot answer. If a Medicare contractor finds that the notifier refused to answer a beneficiary's inquiries or direct them to 1-800-MEDICARE, the notice delivery will be considered defective, and the notifier will be held financially liable for noncovered care.

6. Signed by the beneficiary or his/her representative.

B. Period of Effectiveness/ Repetitive or Continuous Noncovered Care

An ABN can remain effective for up to one year. Notifiers may give a beneficiary a single ABN describing an extended or repetitive course of noncovered treatment provided that the ABN lists all items and services that the notifier believes Medicare will not cover. If applicable, the ABN must also specify the duration of the period of treatment. If there is any change in care from what is described on the ABN within the 1-year period, a new ABN must be given. If during the course of treatment additional noncovered items or services are needed, the notifier must give the

beneficiary another ABN. There is a one year limit for using a single ABN for an extended course of treatment. A new ABN is required when the specified treatment extends beyond one year.

If a beneficiary is receiving repetitive non-covered care, but the provider or supplier failed to issue an ABN before the first or the first few episodes of care were provided, the ABN may be issued at any time during the course of treatment. However, if the ABN is issued after repetitive treatment has been initiated, the ABN cannot be retroactively dated or used to shift liability to the beneficiary for care that had been provided before ABN issuance. *In cases such as this, care that was provided before ABN delivery would be the financial responsibility of the supplier/provider.*

C. Incomplete ABNs

Allegations of improper or incomplete notices will be investigated by Medicare contractors. If the notifier is found to have given improper or incomplete written notice, the applicable Medicare contractor will not hold the beneficiary liable in the individual case.

D. Electronic Issuance of the ABN

Electronic issuance of ABNs is not prohibited. If a provider elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what s/he prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the signed ABN to keep for his/her own records. As stated earlier in §50.6.4, electronic retention of the signed ABN is permitted.

50.7.2 - Options for Delivery Other than In-Person

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

ABNs should be delivered in-person and prior to the delivery of medical care which is presumed to be noncovered. In circumstances when in-person delivery is not possible, notifiers may deliver an ABN through one of the following means:

- Direct telephone contact;
- Mail;
- Secure fax machine; or
- Internet e-mail

All methods of delivery require adherence to all statutory privacy requirements under HIPAA. The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery.

When delivery is not in-person, the notifier must verify that contact was made in his/her records. In order to be considered effective, the beneficiary should not dispute such contact. Telephone

contacts must be followed immediately by either a hand-delivered, mailed, emailed, or faxed notice. The beneficiary or representative must sign and retain the notice and send a copy of this signed notice to the notifier for retention in the patient's record.

The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the notifier must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself.

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability

A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. *See 50.13 for information on collection of funds.*

B. Provider Liability

A notifier will likely have financial liability for items or services if s/he knew or should have known that Medicare would not pay and fails to issue an ABN when required, or issues a defective ABN. In these cases, the notifier is precluded from collecting funds from the beneficiary and is required to make prompt refunds if funds were previously collected. Failure to issue a timely refund to the beneficiary may result in sanctions.

A notifier may be protected from financial liability when an ABN is required if s/he is able to demonstrate that s/he did not know or could not reasonably have been expected to know that Medicare would not make payment. However, issuance of a defective notice establishes the notifier's knowledge of potential noncoverage, and will not afford the notifier financial protection under the LOL or refund provisions.

HHAs: Please see 50.15.4 for additional information specific to HHA claim determinations and liability.

50.13 - Collection of Funds and Refunds

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Collection of Funds

A beneficiary's agreement to be responsible for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare that the beneficiary may have. The notifier may bill and collect funds from the beneficiary for noncovered items or services immediately after an ABN is signed, unless prohibited from collecting in advance of the Medicare payment determination by other applicable Medicare policy, State or local law. Regardless of whether they accept assignment or not, providers and suppliers are permitted to charge and collect the usual and customary fees; therefore, funds collected are not limited to the Medicare allowed amounts.

If Medicare ultimately denies payment of the related claim, the notifier retains the funds collected from the beneficiary *unless the claim decision finds the provider/supplier liable*. *When Medicare finds the provider/supplier liable or* if Medicare *or a secondary insurer* subsequently pays all or part of the claim for items or services previously paid by the beneficiary to the notifier, the notifier must refund the beneficiary the proper amount in a timely manner.

B. Refund Requirements Requiring Liability Notice

Under the Refund Requirements in §§1842(l) and 1879(h) of the Act, a beneficiary must receive a properly executed ABN so that he or she is "on notice" of liability. By signing the ABN, the beneficiary acknowledges that s/he understands the potential for liability and agrees to pay for the item or service described. The refund requirements requiring ABNs are:

1. Supplier claims under §1879(h) of the Act, citing three specific requirements when assignment is accepted:

    a. §1834(j)(1), when supplier number requirements for medical equipment and supplies are not met;
    b. §1834(a)(15), when medical equipment and/or supplies are denied in advance; or
    c. §1834(a)(17)(B), when there is a violation of the prohibition on unsolicited telephone contacts for medical equipment and supplies.

2. Physician claims under §1842(l) from non-participating physicians when assignment is not accepted for individual items and services that are denied on the basis of §1862(a)(1).

Physicians must make prompt refunds unless they could not have been expected to know that Medicare would not provide coverage or they notified the beneficiary in advance by issuing the ABN. Refunds are considered prompt when made within 30 days of notice of denial from Medicare or within 15 days after a determination on an appeal if an appeal is made.

50.14 - CMS Regional Office (RO) Referral Procedures

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Prior to submitting any materials to the RO, the Medicare contractor will contact the RO to determine how to proceed in referring a potential sanction case *for violation of refund*

requirements. When referring these types of cases to the region, the contractor should include the following:

A. Background of the Subject

The subject's business name, address, Medicare Identification Number, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment, supplies, or services.

B. Origin of the Case

A brief description of how the violations were discovered.

C. Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

D. Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiary and the supplier regarding the supplier's failure to make a refund. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and Health Insurance Claim Number;
- Claim Control Number;
- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;
- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Include any additional information that may be of value to the RO.

50.15.1 - Obligation to Bill Medicare

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Upon receipt of an ABN, beneficiaries always have the right to ask the notifer to submit a claim to Medicare for an official payment decision. A beneficiary must receive the item/service described in the ABN and choose Option 1 in order to request Medicare claim submission.

Providers/suppliers should refer to Publication 100-4, Chapter 1, Section 60 for instructions on submitting claims for statutorily noncovered items or services.

Note: Providers/suppliers will not violate mandatory claims submission rules under Section1848 of the Social Security Act when a claim is not submitted to Medicare at the beneficiary's request by their choice of Option 2 on the ABN.

50.15.2 - Emergencies or Urgent Situations/ Ambulance Transport

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. ABN issuance in emergency or urgent situations -

In general, a notifier may not issue an ABN to a beneficiary who has a medical emergency or is under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the ER may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

B. ABN issuance for ambulance transport -

Issuance of the ABN is mandatory *for ambulance transport services* if all of the following 3 criteria are met:

1. The service being provided is a Medicare covered ambulance benefit under §1861(s)(7) of the SSA and regulations under this section as stipulated in 42 CFR §410.40 -.41;

2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under § 1862(a)(1)(A) for the beneficiary on that particular occasion; and

3. The ambulance service is being provided in a non-emergency situation. (The patient is not under duress.)

Simplified, there are three questions to ask when determining if an ABN is required for an ambulance transport. If the answer to **all** of the following 3 questions is "yes", an ABN must be issued:

1. Is this service a covered ambulance benefit? AND
2. Will payment for part or all of this service be denied because it is not reasonable and necessary? AND
3. Is the patient stable and the transport non-emergent?

Example: A beneficiary requires ambulance transportation from her SNF to dialysis but insists on being transported to a new dialysis center 10 miles beyond the nearest dialysis facility.
Medicare covers this type of transport; however, since this particular transport is not to the nearest facility, it is not considered a covered Medicare benefit. Therefore, NO ABN is required. As a courtesy to the beneficiary, an ABN could be issued as a voluntary notice alerting her to the financial responsibility.

Example: A beneficiary requires non-emergent ground transport from a local hospital to the nearest tertiary hospital facility; however, his family wants him taken by air ambulance.

The ambulance service is a covered benefit, but the level of service (air transport) is not reasonable and necessary for this patient's condition. Therefore, an ABN MUST be issued prior to providing the service in order for the provider to shift liability to the beneficiary.

ABN issuance is mandatory only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. If an ambulance transport is statutorily excluded from coverage because it fails to meet Medicare's definition of the ambulance benefit, a voluntary ABN may be issued to notify the beneficiary of his/her financial liability as a courtesy.

50.15.3.1- Special Issues Associated with the ABN for Hospice Providers

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. General Use - Hospice

Hospice providers issue the ABN, Form CMS-R-131, according to the instructions given in this section. Mandatory use of the ABN is very limited for hospices. Hospice providers are responsible for providing the ABN when required as listed below for items and services billable to hospice. Hospices are not responsible for issuing an ABN when a hospice patient seeks care outside of the hospice's jurisdiction.
The three situations that would require issuance of the ABN by a hospice are:

- Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in §1879(g)(2) of the Act;
- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either §1862(a)(1)(A) or §1862(a)(1)(C); or
- The level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

Below are examples of scenarios that mandate ABN issuance and the accompanying denial reason that could be listed in Blank (E) on the ABN.

Example A:
Patient with chronic obstructive pulmonary disease and congestive heart failure is referred for hospice care; however, the hospice physician determines that the severity of the patient's diseases has recently improved with medical management, and the patient is not terminal.
Reason in Blank "E" on the ABN: "Medicare does not pay for hospice care when your illness is not considered terminal."

Example B:
A hospice patient's care was upgraded from Routine Home Care (RHC) to Continuous Home Care (CHC) during a period of crisis. The medical crisis improved and resolved so that CHC was no longer medically reasonable and necessary. The family requested that

CHC services be provided for two more days and were willing to pay out of pocket for the additional care. (The family did not want respite care services.)
Reason in Blank "E" on the ABN: "Medicare will not pay for this level of care when it is not medically reasonable and necessary."

Example C:
A hospice patient's family requests daily physician visits that are not medically reasonable and necessary for the patient's current condition.
Reason in Blank "E" on the ABN: "Medicare will not pay for physician visits that are not medically reasonable and necessary."

End of all Medicare covered hospice care –
When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is *going to be discharged* from hospice, the hospice *may be required to* issue the Notice of Medicare Noncoverage (NOMNC), CMS 10123 (see the "FFS ED Notices" link on the CMS website at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* for details). If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the noncovered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

B. Hospice Care Delivered by Non-Hospice Providers

It is the hospice's responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive inpatient hospice care in a hospital that is not under contract with the hospice. The hospice may delegate delivery of the ABN to the hospital in these cases.

C. When ABNs Are Not Required for Hospice Services

1. Revocations

Hospice beneficiaries or their representatives can revoke the hospice benefit. Revocations are not considered terminations under liability notice policy since the beneficiary is exercising his/her own freedom of choice. Therefore, no ABN is required.

2. Respite Care Beyond Five Consecutive Days

Respite care is limited to five consecutive days under the Act. When respite care exceeds five consecutive days, an ABN is not required since additional days of respite care are not part of the hospice benefit. CMS encourages hospice providers to give the ABN as a voluntary notice to inform patients of financial liability when more than five days of respite care will be provided.

3. Transfers

Beneficiaries are allowed one transfer to another hospice during a benefit period. However, subsequent transfers within the same benefit period are not permitted. In either case, an ABN is not required.

4. **Failure to Meet the Face to Face Requirement**
The ABN must not be issued when the face to face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face to face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill.

5. **Room and Board Costs for Nursing Facility Residents**
Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

50.15.3.2 - Special Issues Associated with the ABN for CORFs

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

Since Comprehensive Outpatient Rehabilitation Facility (CORF) services are billed under Part B, CORF providers must issue the ABN according to the instructions given in this section. The ABN is issued by CORFs before providing a service that is usually covered by Medicare but may not be paid for in a specific case because it is not medically reasonable and necessary.

When all Medicare covered CORF services *are going to end*, CORF's are required to issue a notice regarding the beneficiary's right to an expedited determination called a Notice of Medicare Noncoverage (NOMNC), CMS 10123. Please see the "FFS ED Notices" link on the CMS website at *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html* for these notification requirements. Upon termination of all CORF care, the ABN would be issued only if the beneficiary wants to continue receiving some or all services that will not be covered by Medicare because they are no longer considered medically reasonable and necessary. An ABN would not be issued if no further CORF services are provided.

50.15.4 - Home Health Agency use of the ABN

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. General Use - HHAs

The ABN replaces the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1. Background information on the HHABN and information pertaining to the Home Health Change of Care Notice (HHCCN), Form CMS-10280, which replaces the HHABN Option Box 2 and 3 formats, can be found in Section 60 of this chapter. Do not use the ABN in place of HHABN Option Box 2 or HHABN Option Box 3.

HHAs are required to issue an ABN to Original Medicare beneficiaries in specific situations where "limitation on liability" (LOL) protection is afforded under §1879 of the Act for items and/or services that the HHA believes Medicare will not cover (see Table 1 below). In these circumstances, if the beneficiary chooses to receive the items/services in question and Medicare does not cover the home care, HHAs may use the ABN to shift liability for the non-covered home care to the beneficiary.

ABNs are not used in managed care; however, when a beneficiary transitions to Medicare managed care from Original Medicare during a home health episode, ABN issuance is required when there are potential charges to the beneficiary that fall under the LOL protections. HHAs should contact their Regional Home Health Intermediary (RHHI) if they have questions on the ABN or related instructions, since RHHIs process home health claims for Original Medicare. The following chart summarizes the statutory provisions related to ABN issuance for LOL purposes:

Table 1.
Application of LOL for the Home Health Benefit

Citation from the Act	***Brief Description of Situation***	***Recommended Explanation for "Reason Medicare May Not Pay" section of ABN***
§1862(a)(1)(A)	*Care is not reasonable and necessary*	*Medicare does not pay for care that is not medically reasonable and necessary.*
§1862(a)(9)	*Custodial care is the only care delivered*	*Medicare does not usually pay for custodial care, except for some hospice services.*
§1879(g)(1)(A)	*Beneficiary is not homebound*	*Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit*
§1879(g)(1)(B)	*Beneficiary does not need skilled nursing care on an intermittent basis*	*Medicare requires part-time or intermittent need for skilled nursing care in order to cover services under the home health benefit*

B. Home Health Care Triggering Events

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Section 50.5 explains triggering events in general, and they are outlined specific to home health care below.

Table 2 - Triggering Events for ABN issuance by HHAs*

EVENT	***DESCRIPTION***
Initiation	*When an HHA expects that Medicare will not cover an item and/or service delivered under a planned course of treatment from the start of a spell of illness, OR before the delivery of a one-time item and/or service that Medicare is not expected to cover.*

Reduction	*When an HHA expects that Medicare coverage of an item or service will be reduced or stopped during a spell of illness while continuing others, including when one home health discipline ends but others continue.*
Termination	*When an HHA expects that Medicare coverage will end for all items and services in total.*

**ABN issuance is only required when the HHA is going to provide the beneficiary with the item or service that is being initiated, reduced, or terminated as described in the Table 2. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.*

1. HHA Initiations

Initiations occur at the start of home health care and may also occur when a service is added to an existing home health plan of care (POC). An ABN must be issued to the beneficiary prior to receiving care that is usually covered by Medicare, but in this particular instance, it is not covered or may not be covered by Medicare because:

- *the care is not medically reasonable and necessary,*
- *the beneficiary is not confined to his/her home (considered homebound),*
- *the beneficiary does not need skilled nursing care on an intermittent basis, or*
- *the beneficiary is receiving custodial care only.*

If the HHA believes that Medicare will not or may not pay for care for a reason other than one listed directly above, issuance of the ABN is not required.

An ABN is required at initiation only when there is potential for the beneficiary or his/her secondary insurance to incur a charge. The ABN informs the beneficiary of the potential charges and allows him/her to make a decision regarding whether or not s/he wants care that won't be paid for by Medicare. An ABN signed at initiation of home health care for items and/or services not covered by Medicare is effective for up to a year, as long as the items/services being given remain unchanged from those listed on the notice.

Example 1 – Initiation:

A beneficiary requires skilled nursing wound care 3 times weekly; however, she is not confined to the home. She wants the care done at her home by the HHA.

The ABN must be issued to this beneficiary before providing home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether or not to receive the non-covered care and accept the financial obligation.

Any one-time care that is provided and completed in a single encounter is considered an initiation in terms of triggering events and is subject to ABN issuance requirements if applicable. When an HHA performs an initial assessment of a beneficiary prior to admission but does not admit the beneficiary, an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, the HHA must provide notice to the beneficiary before performing and charging for this service.

Since Medicare has specific requirements for payment of home health services, there may be occasions where a payment requirement is not met, and therefore, the HHA expects that Medicare will not pay for the services. The HHA cannot use the ABN to transfer liability to the beneficiary when there is concern that a billing requirement may not be met. (For example, a home health agency can't issue an ABN at initiation of home care services in order to charge the beneficiary if the provider face to face encounter requirement is not met.)

2. Reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care, provided by the HHA and/or care that is part of the POC. If a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges, the HHA must issue the ABN prior to providing the noncovered items or services. Technically, this is an initiation of noncovered services following a reduction of services.

Example 2 - Reduction with subsequent initiation:

The beneficiary requires physical therapy (PT) for gait retraining 5 times per week for 2 weeks, then reduce to 3 times weekly for 2 weeks. After 2 weeks of PT, the beneficiary wants to continue therapy 5 times a week even though this amount of therapy is no longer medically reasonable and necessary. The HHA would issue an ABN to the beneficiary so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

3. Terminations

A termination is the cessation of all Medicare covered services provided by the HHA. If the patient wants to continue receiving care from the HHA that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services, an ABN must be issued to the beneficiary in order for the HHA to charge the beneficiary or secondary insurer. If the beneficiary won't be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Provider Non-Coverage, (NOMNC), CMS-10123. The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization (QIO) if they feel that termination of home health services is not appropriate. Detailed information and instructions for issuing the NOMNC can be found on

the CMS website under the link for "FFS ED Notices" at: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

If a beneficiary requests a QIO review upon receiving a NOMNC, the QIO will make a fast decision on whether covered services should end. If the QIO decides that Medicare covered care should end and the patient wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued to the beneficiary since this would be an initiation of non-covered care.

C. Effect of Other Insurers/Payers

If a beneficiary is eligible for both Original Medicare and Medicaid (dually eligible) or is covered by Original Medicare and another insurance program or payer, ABN requirements still apply. Other payers can include waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants.

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid but are not covered by Medicare for one of the reasons listed in Table 1, an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services. Some States have specific rules established regarding HHA completion of liability notices in situations where dual eligibles need to accept liability for Medicare noncovered care that will be covered by Medicaid. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the choice to bill Medicare. Medicaid has the authority to make this assertion under Title XIX of the Act, where Medicaid is recognized as the "payer of last resort", meaning other Federal programs like Medicare (Title XVIII) must pay in accordance with their own policies before Medicaid picks up any remaining charges.

Note: If there has been a State directive to select the third checkbox on the HHABN, HHAs must mark the first check box when issuing the ABN.

On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise.

Where there is no State specific directive, HHAs are permitted to instruct beneficiaries to select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. HHAs may add a statement in the "Additional Information" section to help a dual eligible better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your Medical Assistance plan will pay for this care."

HHAs may also use the "Additional Information" on the ABN to include agency specific information on secondary insurance claims or a blank line for the beneficiary to insert

secondary insurance information. Agencies can pre-print language in the "Additional Information" section of the notice.

D. HHA Exceptions to ABN Notification Requirements

ABN issuance is NOT required in the following HHA situations:

- *initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;*
- *care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance);*
- *telehealth monitoring used as an adjunct to regular covered HH care; or*
- *noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH prospective payment system (PPS) episode payment).*

E. ABN for Voluntary Notice by HHAs

HHAs may also use the ABN as a voluntary notice as described in Section 50.3.2.

> ***Example 3 - Voluntary ABN issuance by an HHA:***
>
> *A beneficiary is receiving home health services, and his physician orders telehealth monitoring as an adjunct to the regular home health visits. The HHA elects to issue the ABN before telehealth monitoring begins as a courtesy to the beneficiary and to prepare him for future billing statements. Per §1895(e) of the SSA, telehealth services are outside of the scope of HHA services covered by the prospective payment system. Thus, HHAs providing telehealth as an addition to covered Medicare services are not required to issue an ABN for the never covered telehealth services.*

F. Effect of Initial Payment Determinations on Liability

An ABN informs a beneficiary of his/her HHA's expectation with regard to Medicare coverage. If the care described on the ABN is provided, Medicare makes an actual payment determination on the items and/or services at issue when adjudicating the related claim. Such adjudications may uphold the provider's expectation, in which case the beneficiary will remain liable for payment if agreeing to accept this liability based on a valid ABN. However, adjudication may not conform to the provider's expectation, in which case the decision made on the claim supersedes the expectation given on the ABN. That is, Medicare may cover and pay for care despite the HHA's expectation, or deny the claims and find the provider liable. In such cases, if the HHA collected funds from the beneficiary, the HHA must promptly refund the appropriate amount to the beneficiary.

G. Use of abbreviations

HHAs were instructed to avoid using abbreviations when using the HHABN. When completing the ABN, HHAs must avoid using abbreviations in the body of the notice unless the abbreviation is already spelled out elsewhere. For example, an abbreviation such as "PT" that can have

multiple meanings in a home health setting (part-time, physical therapy, prothrombin time) should be spelled out at least once on the ABN next to the abbreviation of the word(s). When this is done, the abbreviation can be used again on the notice. ABNs containing abbreviations that are not defined in this manner on the notice may be invalidated by contractors.

H. Cost Estimate

HHAs should follow the ABN form instruction guidelines for providing cost estimates for items or services. The cost estimate must be a good faith estimate based on agency charges and the expected frequency and duration of each service. Cost estimates per visit or per number of visits weekly are acceptable. A difference in the cost estimate and actual cost will not automatically invalidate the ABN. The cost estimate must give the beneficiary an idea of what his/her out of pocket costs might be if s/he chooses to receive the care listed on the ABN.

> ***Cost estimate examples:***
> *$440 for 4 weekly nursing visits in 1/13.*
>
> *$260 for 3 physical therapy visits 1/3-1/7/13.*
>
> *$50 for spare right arm splint.*

When more than one item and/or service is at issue, the HHA must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate.

50.15.5 - Outpatient Therapy Services

(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. American Taxpayer Relief Act (ATRA) of 2012 (PL 112-240, January 3, 2013) and Outpatient Therapy Services

Section 603 (c) of the ATRA amended §1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable. ***Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable.*** *ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.*

B. Mandatory ABN issuance for therapy services

Therapists are required to issue the ABN to beneficiaries prior to providing therapy that is not medically reasonable and necessary regardless of the therapy cap. Statutory changes (described in the section above) mandate ABN issuance when therapy services that aren't medically reasonable and necessary exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that won't be covered by Medicare because the services aren't medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether or not to get the services and accept financial responsibility for them.

Example 1 – Therapy cap is not met - ABN Mandatory
Mr. X has been receiving physical therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the plan of care (POC). The total amount applied to his therapy cap this year is $780. Mr. X requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that won't be covered by Medicare because they are no longer medically necessary.

Example 2 – Therapy cap has been met - ABN Mandatory
Ms. Z has recently been receiving physical therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. Ms. Z. requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

Sample wording for ABN completion in either Example 1 or 2:
1st column of ABN table labeled "D". (Remove "D" and all other lettering on the ABN prior to issuance and insert "Services" in all blanks labeled "D".)
"Physical therapy services two times per week for three weeks."

Under column labeled "Reason Medicare May Not Pay":
"You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary."

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Example 3 – Therapy cap met - No ABN required
Mr. A has been receiving PT three times a week and has not met his PT goals. Mr. A has met his therapy cap of $1900, but additional PT above the cap is medically reasonable and necessary. Since Mr. A qualifies for a therapy cap exception, his continued therapy above the cap will be covered by Medicare. When the therapist submits claims for the necessary therapy that exceeds the cap amount, the –KX modifier is used to attest that

therapy beyond the cap amount is medically reasonable and necessary. In this example, an ABN is not issued to Mr. A. since the ABN is only issued for therapy above the cap that is not medically reasonable and necessary.

Providers/suppliers must not issue the ABN to all beneficiaries who receive services that exceed the cap amount.

C. Voluntary ABN iss`uance for therapy services

With the aforementioned ATRA changes to liability protections for therapy services, a provider/supplier will seldom encounter situations for using a voluntary ABN or an optional notification for non-covered therapy services. (See 50.3.2 for information on voluntary ABN issuance.)

An example of therapy services that are never covered by Medicare are physical therapy services rendered by a chiropractor. So, a chiropractor offering physical therapy services as allowed by his/her state's scope of practice could issue a voluntary ABN to the beneficiary.

D. ABN issuance for services above the therapy threshold

Therapy threshold amounts are greater than therapy cap amounts. Since the ATRA amendment of §1833(g)(5) of the Act provides limitation of liability protections for therapy services above the cap, therapy services above the threshold are affected. Prior to this statutory amendment, providers weren't required to issue an ABN when providing services in excess of the threshold, and if Medicare denied a claim for services above the threshold, the beneficiary could be held financially liable. Now, ABN issuance is required in order to transfer liability to the beneficiary for therapy services above the threshold that are not medically reasonable and necessary. In some cases, an ABN issued for therapy services above the cap will be effective for therapy above the threshold. When the beneficiary nears the annual threshold, a step-wise approach can help determine if ABN issuance is required.

Step 1: Was an ABN already issued for therapy above the cap?

a. Yes – ABN issued, services above the threshold listed
If the beneficiary has already received an ABN for therapy above the cap listing the therapy services to be provided in excess of the threshold, the ABN requirement has been met. No additional beneficiary notification is needed.

b. Yes – ABN issued, services above the threshold not listed
If the beneficiary has already received an ABN for therapy above the cap and the ABN doesn't include the therapy services to be provided in excess of the threshold, the provider must issue a new ABN listing the services that won't be covered.

Example: *Mr. Jones requires both PT and SLP services.*
He reached the cap amount for PT-SLP services, and PT goals were met. However, Mr. Jones requested continued PT services that were not medically necessary; so, an ABN for continued PT services was issued per CMS guidelines.

Mr. Jones had not met SLP goals when he reached the cap amount for PT-SLP services. SLP services above the cap were medically reasonable and necessary and covered by the Medicare therapy exceptions process. He met SLP goals just as he reached the threshold for PT-SLP services. He has requested continued SLP services that aren't medically necessary. A separate ABN for the SLP services must be issued.

c. No – ABN never issued.

An ABN was never issued for therapy services because the beneficiary received therapy above the cap amount that was medically reasonable and necessary and covered as a Medicare therapy exception.
Go to Step 2.

Step 2: Are therapy services above the threshold medically reasonable and necessary?

a. Yes

When the provider believes that therapy services above the threshold are medically reasonable and necessary, an ABN should not be issued. Go to Step 3.

b. No

At any point, when the provider believes that therapy services won't be covered by Medicare because they aren't medically reasonable and necessary, an ABN must be issued.