mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Medicare Advance Written Notices of Non-coverage

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

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What's Changed?

Note: No substantive content updates.

An advance written notice of non-coverage helps Medicare Fee-for-Service (FFS) patients choose whether to get items and services Medicare usually covers but may not pay for because they're not medically necessary or are considered custodial care. Communicate these financial liabilities and appeal rights and protections through notices to your patients. If you don't provide your patients with the required written notices, you may be financially liable if we deny payment.

Throughout this booklet, **you** refers to the health care provider or supplier.

Notifiers are entities who issue ABNs and can include physicians, practitioners, health care providers (including labs), suppliers, and utilization review committees for the care provider.

Types of Advance Written Notices of Non-coverage

We use these notices:

Advance Beneficiary Notice of Non-coverage (ABN) (CMS-R-131) — All health care providers and suppliers must issue an ABN when they expect a payment denial that transfers financial liability to the patient. This includes:

- **Part B (outpatient)** items and services from independent labs, skilled nursing facilities (SNFs), and home health agencies (HHAs)
- **Part A (inpatient)** items and services from hospice providers, HHAs, and religious non-medical health care institutions (RNHCIs)

Find detailed instructions on how to complete an ABN in the Advance Beneficiary Notice of Non-coverage Tutorial.

Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) (CMS-10055) — SNFs must issue a SNF ABN to transfer financial liability to the patient before providing a Part A item or service that we usually pay for but may not because it's not medically necessary or is custodial care.

Hospital-Issued Notices of Non-coverage (HINN) — Hospitals must issue a HINN before or at admission, or during an inpatient stay if they determine the patient's care isn't covered because it's:

- Not medically necessary
- Not delivered in the most appropriate setting
- Custodial care

Sections 220 and 240 of the Medicare Claims Processing Manual, Chapter 30 have more HINN information.

Hospitals issue 4 different HINNs:

1. **HINN 1 — Pre-admission/Admission HINN:** Use before an entirely non-covered stay
2. **HINN 10 — Notice of Hospital Requested Review (HRR):** Use for FFS and Medicare Advantage Program (Part C) patients when requesting a Quality Improvement Organization discharge decision review without a provider agreement
3. **HINN 11 — Non-covered Service(s) During Covered Stay:** Use for non-covered items and services during an otherwise covered stay
4. **HINN 12 — Non-covered Continued Stay:** Use with the Hospital Discharge Appeal Notices to inform patients of their potential non-covered continued stay charges

Beneficiary Notices Initiative (BNI) has copies of the HINNs.

The Medicare Outpatient Observation Notice (MOON) (CMS-10611) informs patients when they're an outpatient getting observation services and aren't a hospital or CAH inpatient. Section 400 of the Medicare Claims Processing Manual, Chapter 30 has more information.

Issuing an Advance Written Notice of Non-coverage

When to Issue a Notice

Advance written notices of non-coverage apply to patients who have Medicare FFS coverage. To transfer financial liability to the patient, issue an advance written notice of non-coverage:

- When a Medicare item or service isn't reasonable or necessary under Program standards, including care that's:
  - Not indicated for the diagnosis, treatment of illness, injury, or to improve the functioning of a malformed body member
  - Experimental, investigational, or considered research only
  - More than the number of services allowed in a specific period for that diagnosis
- When providing custodial care
- When outpatient therapy services exceed therapy threshold amounts
- For hospice providers, before caring for a patient who isn't terminally ill:
  - Specific items or services billed separately from the hospice per diem payment (for example, physician services) that aren't reasonable or necessary
  - Level of hospice care isn't reasonable or medically necessary
- For HHA providers, before caring for a patient who isn't confined to the home or doesn't need intermittent SNF care
- Before providing a preventive service we usually cover, but won't cover when services exceed frequency limits

- For DMEPOS suppliers, before providing a Medicare item or service we cover because the:
  - Provider accepted prohibited unsolicited phone contacts
  - Supplier hasn't met supplier number requirements
  - Non-contract supplier provides an item listed in a competitive bidding area
  - Patient wants the item or service before the advance coverage determination

Non-Contract DMEPOS Suppliers

An ABN is valid if a patient understands what the notice means. An exception applies when patients have no financial liability to a non-contract supplier of an item from the Competitive Bidding Program unless they sign an ABN indicating Medicare won't pay for the item because they got it from a non-contracted supplier and they agree to accept financial liability.

Services must meet specific medical necessity requirements in the statute, regulations, guidance, and criteria defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) (if any exist for the service reported). Every service you bill must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

NCDs or LCDs may limit coverage. NCDs limit specific Medicare service, procedure, or technology coverage on a national basis. HHS determines reasonable and necessary NCDs. Medicare Administrative Contractors (MACs) may develop an LCD to further define an NCD or if there's no specific NCD. This coverage decision gives guidance to the public and medical community within a specific geographic area. In most cases, this information's availability indicates you knew, or should've known, we would deny the item or service as not medically necessary.

Issuing a Notice as a Courtesy

You don't need to notify the patient before you provide an item or service we never cover or that isn't a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the patient about their financial liability. Issuing the notice voluntarily doesn't affect financial liability, and the patient isn't required to check an option box or sign and date the notice. The Items & Services Not Covered Under Medicare booklet has more information about non-covered services.

Events Prompting a Notice

These triggering events may prompt an advance written notice of non-coverage:

- Initiations
- Reductions
- Terminations

Initiations

Initiations happen at the beginning of a new patient encounter, start of a plan of care, or when treatment begins. If you believe at initiation that we won't cover certain items or services because they're not reasonable and necessary, issue the notice before the patient gets the non-covered care to transfer financial liability.

Reductions

Reductions happen when a component of care decreases (for example, frequency or service duration). Don't issue the notice every time there's a care reduction. If a reduction occurs and the patient wants to continue getting care that's no longer considered medically reasonable or necessary, issue the notice before the patient gets the non-covered care to transfer financial liability.

Terminations

Terminations stop all or certain items or services. If the patient wants to continue getting care no longer considered medically reasonable or necessary, issue the notice before the patient gets the non-covered care to transfer financial liability.

Issuing a Notice When Multiple Entities Provide Care

When multiple entities provide care, we don't require separate advance written notices of non-coverage. Any notifier involved in delivering care can issue the notice when:

- There are separate ordering and delivering providers (for example, a provider orders a lab test, and an independent lab delivers it)
- A provider delivers the technical component, and another delivers the same service's professional component (for example, a radiology test from an independent diagnostic testing facility, and another provider interprets the results)
- The entity that gets the signature on the notice isn't the same entity billing the service (for example, a lab refers a specimen to another lab, and the second lab bills us)

In these situations, you may enter more than 1 notifier in the form's header, space **A. Notifier**, if the patient can clearly identify who to contact with billing questions.

We hold the **billing notifier** responsible for issuing the notice.

Prohibitions & Frequency Limits

Routine Notice Prohibition

There's no reason to issue an advance written notice of non-coverage on a routine basis, except for:

- Experimental items and services
- Items and services with frequency coverage limitations
- Medical equipment and supplies denied because the supplier had no supplier number, or the supplier made an unsolicited phone contact
- Medically unnecessary services that are always denied

Other Prohibitions

You can't issue an advance written notice of non-coverage to:

- Shift liability and bill the patient for services denied due to a Medically Unlikely Edit
- Compel or force patients in a medical emergency or under great duress
  - Using an advance written notice of non-coverage in the emergency room or during ambulance transports may be appropriate in some cases (for example, a patient who's medically stable and not under duress)
- Charge a patient for part of a service we fully pay through a bundled payment
- Transfer liability to the patient when we would otherwise pay for the items and services

Frequency Limits

Some Medicare-covered services have frequency limits. We pay for only a certain amount of a specific item or service in each diagnosis period. If you believe an item or service may exceed frequency limits, issue the notice before providing it to the patient.

If you don't know how many times the patient got a service within a specific period, get this information from them or other providers involved in their care. Find your MAC's website or check eligibility to determine if a patient met the frequency limits from another provider during the calendar year.

The Medicare Preventive Services educational tool has more information on Medicare-covered services that have frequency limits.

Extended Treatment

You may issue a single notice to cover extended treatment if it lists all items and services and the duration of treatment when you believe we won't pay. If the patient gets an item or service during the treatment that you didn't list on the notice and we may not cover it, issue a separate notice.

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Repetitive or Continuous Non-covered Care

An advance written notice of non-coverage remains effective after delivery if there's no change in:

- Care described on the original notice
- Patient's health status
- Medicare coverage guidelines for the items or services in question (for example, updates or changes to the policy of an item or service)

Note: If any bullets above change during treatment, issue a new notice.

For repetitive or continuous items or services, you may issue the patient another notice after 1 year for subsequent treatment of the non-covered condition. This isn't required unless any conditions above apply.

You may give a patient a single notice describing an extended or repetitive non-covered treatment course if it lists all items and services you believe we won't cover. If applicable, it must also specify the treatment duration.

If a patient is getting repetitive non-covered care but you failed to issue a notice before providing the first episodes of care, you may issue one at any time during treatment. However, if you issued the notice after initiating repetitive treatment, it can't be retroactively dated or used to shift liability to the patient for care provided before you issued it. In these cases, care provided before the notice's delivery is the health care provider's or supplier's financial responsibility.

Completing an Advance Written Notice of Non-coverage

An advance written notice of non-coverage should be:

- Issued (preferably in person) and understood by the patient or their representative.
- Completed on the approved, standardized notice format (when applicable), with all required blanks completed. It can't exceed 1 page. You may include attachments listing additional items and services. If you use attachment sheets, they must clearly match the items or services in question with cost estimates and the reason you expect a denial. The patient should be able to read it. We permit limited advance written notice of non-coverage customization, like pre-printing information in certain blanks.
- Issued far enough in advance for potentially non-covered items or services so the patient can consider available options.
- Explained in its entirety, with you answering all notice-related questions.
- Signed and dated by the patient or their representative after they select an option. If you issue the notice electronically, offer the patient a paper copy and keep a copy for your records (whether signed on paper or electronically). If you maintain electronic medical records, you may scan the signed hard copy.

- Kept for 5 years from the date-of-care delivery when no other requirements under state law apply. We require you to keep all notice records, including when the patient declined care, refused an option, or refused to sign the notice.

If you can't issue the notice in person, you may issue it via phone, email, mail, or fax (according to HIPAA policy). The patient shouldn't dispute the contact. Document the contact in the patient's records and keep the unsigned notice copy on file while you wait for the signed notice.

You must follow phone contacts immediately with a hand-delivered, mailed, emailed, or faxed notice. The patient or the patient's representative must sign and keep the notice and send you a signed copy for their medical record. If the patient fails to return a signed copy, document the initial contact and subsequent attempts to get a patient's signature.

When Patients Change Their Minds

If a patient changes their mind after completing and signing the notice, ask them to add explanatory notes to their notice. They must sign and date the notes and clearly indicate their new selection. If you can't provide the notice in person, you may add explanatory notes to the form that show the patient's new selection and immediately forward a copy to the patient to sign, date, and return. Provide them with a copy of the revised notice as soon as possible.

Patient Refuses to Choose an Option or Sign

If the patient or their representative refuses to choose an option or sign the notice, add notes to the original copy indicating their refusal. You may list any refusal witnesses, but it's not required. If a patient refuses to sign a properly issued notice, consider not providing the item or service unless the consequences prevent it (health and safety of the patient or civil liability in case of harm).

Collecting Patient Payment

Once you issue an advance written notice of non-coverage and properly notify the patient that we may not cover the item or service, and they sign the notice, you may seek payment from them. If we pay for all or part of the item or service claim and the patient also pays, you must refund them the proper amount in a timely manner. We consider refunds timely within 30 days after you get the remittance advice or within 15 days after an appeal determination (if you or the patient file an appeal).

Note: We don't allow SNFs to collect Part A services payment until the MAC makes a claim payment decision. Specific dually eligible billing limitations apply, including for Qualified Medicare Beneficiaries.

Financial Liability

If you don't issue a required notice or your MAC finds the notice invalid and you knew, or should've known, we won't pay for a usually covered item or service, we may hold you financially liable. You can't collect payment from the patient. If you previously collected the patient's payment, refund the proper amount in a timely manner.

Claim Reporting Modifiers

Using Modifiers for ABN Claim Reporting

Modifier	When to Use Modifier
GA **Waiver of Liability Statement Issued, as Required by Payer Policy**	Report when you issue a mandatory ABN for a service as required and keep it on file. You don't need to submit a copy of the ABN, but you must make it available upon request. Use the GA modifier when both covered and non-covered services appear on an ABN-related claim.
GX **Notice of Liability Issued, Voluntary Under Payer Policy**	Report when you issue a voluntary ABN for a service we never cover because it's statutorily excluded or isn't a Medicare benefit. Use this modifier with modifier GY.
GY **Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit**	Report Medicare statutorily excludes the item or service, or the item or service doesn't meet the definition of a Medicare benefit. Use this modifier with modifier GX.
GZ **Item or Service Expected to Be Denied as Not Reasonable and Necessary**	Report when you expect we'll deny payment for the item or service because it's not medically necessary and you didn't issue an ABN.
GK **Reasonable and Necessary Item/ Service Associated with a GA or GZ modifier**	Report when upgrading a piece of equipment. If you have an ABN, bill with GA. If you don't have an ABN, bill with GZ.
GL **Medically Unnecessary Upgrade Provided Instead of Non-Upgraded Item, No Charge, No ABN**	Report when you provide an upgraded item, but don't charge us or the patient for the non-upgraded item, and you didn't issue an ABN.

Section 60.4.2 of the Medicare Claims Processing Manual, Chapter 1 has more ABN modifier information.

When Not to Use an Advance Written Notice of Non-coverage

Don’t use an advance written notice of non-coverage for items and services you provide under Medicare Part C or Part D.

You don’t need to notify the patient before you provide items or services that aren’t a benefit or never covered.

Section 20.2.1 of the Medicare Claims Processing Manual, Chapter 30 lists Medicare non-covered items and services.

Resources

Email Your ABN Questions

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