

Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

Table of Contents *(Rev. 2878, 02-21-14)*

50 - Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

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 Guide¹

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	<ul style="list-style-type: none"> • 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).

50.2 - General Statutory Authority - Financial Liability Protection Provisions (FLP) of Title XVIII (Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The Financial Liability Protection provisions (FLP) of the Social Security Act (the Act) protect beneficiaries, health care providers and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The FLP provisions include:

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

- Limitation On Liability (LOL) under §1879(a)-(g) of the Act;
- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l) of the Act; and
- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act.

Additional information on the FLP provisions can be found in Sections 10 and 20 of this chapter.

50.2.1 - Applicability to Limitation On Liability (LOL)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The Limitation On Liability (LOL) protections of §1879 of the Act apply only when a provider believes that a Medicare covered item or service may be denied in a particular instance because it is not reasonable and necessary under §1862(a)(1) of the Act or because the item or service constitutes custodial care under §1862(a)(9) of the Act. §1879 of the Act requires a provider to notify a beneficiary in advance when s/he believes that items or services will likely be denied either as not reasonable and necessary or as constituting custodial care. If such notice (in the form of an ABN or as otherwise noted in §40.2) is not given, providers may not shift financial liability to beneficiaries for these items or services if Medicare denies the claim. Beneficiaries are afforded LOL protection when items or services are denied for reasons listed in §50.3.1.

50.2.2 - Compliance with Limitation On Liability Provisions

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A healthcare provider/supplier (herein also referred to as a “notifier”) who fails to comply with the ABN instructions risks financial liability and/or sanctions. LOL provisions shall apply as required by law, regulations, rulings and program instructions. Additionally, when authorized by law and regulations, sanctions under the Conditions of Participation (COPs) may be imposed.

The Medicare contractor will hold any provider who either failed to give notice when required or gave defective notice financially liable. A notifier who can demonstrate that s/he did not know and could not reasonably have been expected to know that Medicare would not make payment will not be held financially liable for failing to give notice. However, a notifier who gave defective notice may not claim that s/he did not know or could not reasonably have been expected to know that Medicare would not make payment as the issuance of the notice (albeit defective) is clear evidence of knowledge. See §50.12 for Refund Requirements.

50.3 - ABN Scope

(Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

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). *With the exception of DME POS suppliers (see Section 50.10), 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.

The ABN replaces 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.

50.3.2 - Voluntary ABN Uses

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or most care that fails to meet a technical benefit requirement (i.e. lacks required certification). However, the ABN can be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in §1861 of the Social Security Act;
- Care that is explicitly excluded from coverage under §1862 of the Social Security Act. Examples include:
 - Services for which there is no legal obligation to pay;
 - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
 - Services required as a result of war;
 - Personal comfort items;
 - Routine eye care;
 - Dental care; and
 - Routine foot care.

The voluntary ABN serves as a courtesy to the beneficiary in forewarning him/her of impending financial obligation. When an ABN is used as a voluntary notice, the beneficiary should not be asked to choose an option box or sign the notice. The provider or supplier is not required to adhere to the issuance guidelines for the mandatory notice (as set forth below) when using the ABN for voluntary notification.

NOTE: Certain DME items/services that fail to meet a technical requirement may require an ABN as outlined in the mandatory use section above.

50.4 - Issuance of the ABN

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

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.

50.4.2.-Recipients of the ABN

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers are required to give an ABN to a FFS Medicare beneficiary or his/her representative before providing him/her with a Medicare covered item or service that may not be covered in this particular instance or before providing custodial care. Recipients of ABNs include beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). A notifier’s inability to give notice to a beneficiary or his/her representative does not allow the notifier to shift financial liability to the beneficiary. Note: See §§40.3.4.6 and 50.6.5.B in this chapter for information on beneficiary refusals.

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.

50.5 - ABN Triggering Events

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers are required to issue ABNs when an item or service is expected to be denied based on one of the provisions in §50.3.1. This may occur at any one of three points during a course of treatment which are initiation, reduction, and termination, also known as “triggering events”.

A. Initiations

An initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. If a notifier believes that certain otherwise covered items or services will be noncovered (e.g. not reasonable and necessary) at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.

Example: Mrs. S. asks her physician for an EKG because her sister was recently diagnosed with atrial fibrillation. Mrs. S. has no diagnosis that warrants medical necessity of an EKG but insists on having an EKG even if she has to pay out of pocket for it. The physician's office personnel issue an ABN to Mrs. S. before the EKG is done.

B. Reductions

A reduction occurs when there is a decrease in a component of care (i.e. frequency, duration, etc.). The ABN is not issued every time an item or service is reduced. But, if a reduction occurs and the beneficiary wants to receive care that is no longer considered medically reasonable and necessary, the ABN must be issued prior to delivery of this noncovered care.

Example: Mr. T, is receiving outpatient physical therapy five days a week, and after meeting several goals, therapy is reduced to three days per week. Mr. T wants to achieve a higher level of proficiency in performing goal related activities and wants to continue with therapy 5 days a week. He is willing to take financial responsibility for the costs of the 2 days of therapy per week that are no longer medically reasonable and necessary. An ABN would be issued prior to providing the additional days of therapy weekly.

C. Terminations

A termination is the discontinuation of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue receiving care that is no longer medically reasonable and necessary.

Example: Ms. X has been receiving covered outpatient speech therapy services, has met her treatment goals, and has been given speech exercises to do at home that do not require therapist intervention. Ms. X wants her speech therapist to continue to work with

her even though continued therapy is not medically reasonable or necessary. Ms. X is issued an ABN prior to her speech therapist resuming therapy that is no longer considered medically reasonable and necessary.

50.6 - ABN Standards

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

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.

50.6.2 - General Notice Preparation Requirements

(Rev. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

The following are the general instructions that notifiers must follow in preparing an ABN for mandatory use:

A. Number of Copies: A minimum of two copies, including the original, must be made so the beneficiary and notifier each have one. The notifier should retain the original whenever possible.

B. Reproduction: Notifiers may reproduce the ABN by using self-carbonizing paper, photocopying, digitized technology, or another appropriate method. All reproductions must conform to applicable form and manual instructions.

C. Length and Size of Page: The ABN form must not exceed one page in length; however, attachments are permitted for listing additional items and services. If attachments are used, they must allow for clear matching of the items or services in question with the reason and cost estimate information. The ABN is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page.

D. Contrast of Paper and Print: A visually high-contrast combination of dark ink on a pale background must be used. Do not use reversed print (i.e. white print on black paper), or block-shaded (highlighted) text.

E. Font: To the extent practicable, the fonts as they appear in the ABN downloaded from the CMS web site should be used. Any changes in the font type must be based solely on limitations of the notifier's software and/or hardware. In such cases, notifiers should use alternative fonts that are easily readable, such as Arial, Arial Narrow, Times New Roman, and Courier. Font style and formatting must be maintained regardless of font type used.

Any other changes to the font, such as italics, embossing, bold, etc., should not be used since they can make the ABN more difficult to read. The font size generally should be 12 point. Titles should be 14-16 point, but insertions in blanks of the ABN can be as small as 10 point if needed.

Information inserted by notifiers in the blank spaces on the ABN may be typed or legibly hand-written.

F. Customization: Notifiers are permitted to do some customization of ABNs, such as pre-printing information in certain blanks to promote efficiency and to ensure clarity for beneficiaries. Notifiers may develop multiple versions of the ABN specialized to common treatment scenarios, using the required language and general formatting of the ABN. Blanks (G)-(I) must be completed by the beneficiary or his/her representative when the ABN is issued and may **never** be pre-filled. Lettering of the blanks (A-J) should be removed prior to issuance of an ABN.

If pre-printed information is used to describe items/services and/or common reasons for noncoverage, the notifier must clearly indicate on the ABN which portions of the pre-printed information are applicable to the beneficiary. For example, pre-printed items or

services that are inapplicable may be crossed out, or applicable items/services may be checked off.

Providers who pre-print a menu of items or services may wish to list a cost estimate alongside each item or service. For example, notifiers may merge the items/service section (Blank D) with the estimated cost section (Blank F) as long as the beneficiary can clearly identify the services and related costs that may not be covered by Medicare.

G. Modification: The ABN may not be modified except as specifically allowed by these instructions.

Notifiers must exercise caution before adding any customizations beyond these guidelines, since changing ABNs too much could result in invalid notice and provider liability for noncovered charges. Validity judgments are generally made by Medicare contractors, usually when reviewing ABN-related claims; however, any complaints received may be investigated by contractors and/or CMS central or regional offices.

An example of an approved customization of the ABN which can be used by providers of laboratory services ([Sample Lab ABN](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html)) is available for download
<http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

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.

50.6.4 – Retention Requirements

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The ABN must be prepared with an original and at least one copy. The beneficiary is given his/her copy of the signed and dated ABN immediately, and the notifier should retain the original ABN in the beneficiary's record. In certain situations, such as delivery by fax, the notifier may not have access to the original document upon signing. Retention of a copy of the signed document would be acceptable in specific cases such as this.

In a case where the notifier that gives an ABN is not the entity that ultimately bills Medicare for the item or service (e.g. when a physician issues an ABN, draws a test specimen, and sends it to a laboratory for testing), the notifier must give a copy of the signed ABN to the billing entity. The copy provided must be legible and may be a carbon, fax, electronically scanned, or photo reproduction copy.

Applicable retention periods for the ABN are discussed in Chapter 1 of this manual, §110. In general, it is 5 years from discharge/completion of delivery of care when there are no other applicable requirements under State law. Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice. Electronic retention of the signed paper document is acceptable. Notifiers may scan the signed paper or “wet” version of the ABN for electronic medical record retention and if desired, give the paper copy to the beneficiary.

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 - ABN Delivery Requirements

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

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.

50.7.3.1 - Using ABNs for Medical Equipment and Supplies Claims When Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts) Are Expected (Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(a)(18) or §1879(h)(3) of the Act (unassigned and assigned claims, respectively), an ABN must clearly identify the particular item or service and state that the supplier expects that Medicare will deny payment for that particular medical equipment or supplies because the supplier violated the prohibition on unsolicited telephone contacts. The supplier must obtain a signed ABN before furnishing the item to the beneficiary. Since it is the unsolicited telephone contact which is prohibited by law, giving advance beneficiary notice by telephone does not qualify as notice and is not permissible. Telephone notice may not be used in this case.

The contractor will not accept any telephone ABN as effective notice to the beneficiary. Since giving or mailing a written ABN and obtaining the beneficiary's agreement to pay before telephoning is equivalent to obtaining the beneficiary's written permission for the supplier to telephone under §1834(a)(17)(A)(i) of the Act, a supplier has little to gain from using the ABN process instead of simply seeking the beneficiary's written permission to contact him or her. If a supplier does use a written ABN prior to calling, the beneficiary's agreement to pay is essential under the Refund Requirements in order for the supplier to collect from the beneficiary. Medicare denial of payment because of the prohibition on unsolicited telephone contacts applies to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally. Therefore, the usual restriction on routine notices to all beneficiaries does not apply in this case. (See §40.3.6.4.D, "Routine ABN Prohibition Exceptions.")

50.7.3.2 - ABNs for Medical Equipment and Supplies Claims Denied Under §1834(j)(1) of the Act (Because the Supplier Did Not Meet Supplier Number Requirements) (Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(j)(4)(A) and §1879(h)(1) of the Act (unassigned and assigned claims, respectively) for medical equipment and supplies for which payment will be denied due to failure to meet supplier number requirements under §1834(j)(1) of the Act, the ABN must state that Medicare will deny payment for any medical equipment or supplies because the supplier does not have a supplier number. The ABN must convey to the beneficiary the certainty of denial, so that the beneficiary can make an informed consumer decision whether to receive the medical equipment or supplies and pay for it out of pocket. The following is acceptable language for the ABN-G "Because:" box: "Medicare will pay for items furnished to you by a supplier of medical equipment and supplies only if the supplier has a Medicare supplier number. Payment for such items furnished to you by a supplier which does not have a supplier number is prohibited under the Medicare law. We do not have a Medicare supplier number, therefore, Medicare will not pay for any medical equipment and supplies which we furnish to you." It is particularly important that the beneficiary's signed agreement to pay should be dated by the beneficiary because, in this type of denial, any proper written advance notice with the beneficiary's signed agreement to pay shall be effective for any medical equipment or supplies purchased or rented from the same supplier within the one year following the date of the beneficiary's signed agreement to pay. This exception relieves the supplier, which has duly notified a beneficiary of its lack of a supplier number and the fact that Medicare will not pay, from the necessity of obtaining a signed agreement from the beneficiary every time the beneficiary does business with the supplier.

Exception to ABN Requirement

A supplier which can show that it did not know and could not reasonably have been expected to know that a customer was a Medicare beneficiary, or that a customer was making a purchase for a Medicare beneficiary, can seek protection under the LOL provision, §1879 of the Act, or, in the case of unassigned claims, under the applicable RR

provision, §1834(j)(4) of the Act. If the supplier can show that a person who is not a Medicare beneficiary made a purchase on behalf of a person who is a Medicare beneficiary and did not apprise the supplier of the fact that the purchase was being made on behalf of a Medicare beneficiary, the supplier may be protected. If the supplier can show that a Medicare beneficiary who made a purchase did not identify himself or herself as a Medicare beneficiary and that the person's age or appearance was such that the supplier could not reasonably have been expected to know or surmise that the person was a Medicare beneficiary, the supplier may be protected. These protections are meant for an honest supplier in the rare case where a Medicare beneficiary who is relatively youthful, healthy and able in appearance does not identify himself or herself as a beneficiary and the supplier understandably does not surmise that he or she might be a Medicare beneficiary. If the beneficiary disputes the supplier's allegation and conclusive proof of the allegation is not presented, the supplier's allegation may not be accepted. If the involved Medicare beneficiary is found to be obviously aged and/or disabled, such that any adult person working for a supplier would reasonably surmise that he or she could be a Medicare beneficiary, the supplier's allegation may not be accepted. If the beneficiary purchased an item which would strongly suggest to any reasonable adult person working for a supplier that the beneficiary is aged and/or disabled, the supplier's allegation may not be accepted. If a supplier can show that a customer, who is a Medicare beneficiary or was making a purchase for a Medicare beneficiary and did not identify him/herself accordingly to the supplier, was on notice of the necessity to so self-identify, the beneficiary may be held liable under §1879 or §1834(j)(4) of the Act, in which case the supplier could collect from the beneficiary. Given the possible difficulty of showing conclusively that it did not know and could not reasonably have been expected to know that a customer was a Medicare beneficiary, or that a customer was making a purchase for a Medicare beneficiary, a supplier would be well advised to consider using signage, giving public notice alerting customers that they need to inform the supplier if they are a Medicare beneficiary or are making a purchase for a Medicare beneficiary. If a supplier which does not have a supplier number provides adequate public notice to a Medicare beneficiary before medical equipment or supplies are furnished, e.g., by means of clearly visible signs, and if the adequacy of such public notice is not disputed by the beneficiary, the supplier can qualify for waiver of the Refund Requirements. Such public notices must be such that Medicare beneficiaries:

1. Are virtually certain to see them before purchasing or renting Medicare-covered medical equipment or supplies from the supplier (that is, they are posted in places where they are most likely to be seen by the target audience), and
2. May reasonably be expected to be able to read them and understand them.

Therefore, such public notices must be readily visible, in easily readable plain language, in large print, and would have to be provided in the language(s) commonly used in the locality. The following is acceptable language for the public notice:

Notice to Medicare Beneficiaries. Medicare will pay for medical equipment and supplies only if a supplier has a Medicare supplier number. We do not have a Medicare supplier

number. Medicare will not pay for any medical equipment and supplies we sell or rent to you. You will be personally and fully responsible for payment.

Do not hold any beneficiary who cannot read any such public notice of a supplier to be properly notified in advance by the supplier that Medicare will not pay. If a supplier alleges that it provided adequate public notice to Medicare beneficiaries but a beneficiary disputes the allegation, in the absence of conclusive evidence in favor of the supplier, do not hold the beneficiary to be properly notified in advance by the supplier that Medicare will not pay; hold the supplier liable. The RR provision that the beneficiary must agree to pay for the item or service makes the use of signage without an ABN a risk for the supplier. It would be in a supplier's best interest to issue ABNs advising beneficiaries that they will have to pay for supplies and to post public notices in its store(s) which inform beneficiaries of the fact that it is not a Medicare enrolled supplier, and that claims for supplies purchased from that supplier will be denied payment by Medicare.

Medicare denial of payment on the basis of a supplier's lack of a supplier number applies to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally. Therefore, the usual restriction on routine notices to all beneficiaries does not apply in this case. (See §40.3.6.4.D, "Routine ABN Prohibition Exceptions.") Given the potential for beneficiary disputes over suppliers' public notice efforts to result in supplier liability, all suppliers which do not have supplier numbers would be very well advised to provide the standard written ABN to all Medicare beneficiaries, obtaining their signed agreement. The use of written notices in conjunction with public notices will provide maximum protection to suppliers as well as more surely providing proper advance notice to beneficiaries so that they can make informed consumer decisions.

50.7.3.3 - ABNs for Medical Equipment and Supplies Claims Denied in Advance Under §1834(a)(15) of the Act - Prior Authorization Procedures **(Rev. 1, 10-01-03)**

To qualify for waiver of the Refund Requirements under §1834(j)(4)(B) and §1879(h)(2) of the Act (unassigned and assigned claims, respectively) for medical equipment and supplies for which payment is denied in advance under §1834(a)(15) of the Act, the ABN-G must clearly identify the particular item of medical equipment and supplies and must state in the "Because:" box either: "Medicare has denied payment in advance and we expect that Medicare will continue to deny payment." or "Medicare requires that we request an advance determination of coverage of this medical equipment and/or supplies. We have not requested an advance determination, so we expect that Medicare will deny payment." as applicable. Denial of payment in advance under §1834(a)(15) of the Act refers both to cases in which the supplier requested an advance determination and you determined that the item would not be covered, and to cases in which the supplier failed to request an advance determination when such a request is mandatory. (See §150.5.2, "Knowledge Standards for §1834(a)(15) Denials.")

50.8 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Notifiers must give an ABN before a beneficiary receives a Medicare covered item containing upgrade components that are not medically reasonable and necessary and not paid for by the supplier. For example, an ABN must be issued when a notifier expects that Medicare will not pay for additional parts or features of a usually covered item because those parts and/or features are not medically reasonable and necessary. DME upgrades involve situations in which the upgraded item or component has a different Health Insurance Common Procedure Coding System (HCPCS) code than the item that will be covered by Medicare. Please refer to Chapter 20, Section 120 in this manual for information on billing procedures for ABN upgrades.

ABNs cannot be used to charge beneficiaries for premium quality services described as “excess components.” Similarly, ABNs cannot be used to shift liability for an item or service that is described on the ABN as being “better” or “higher quality” on an ABN but do not exceed the HCPCS code description.

50.9 - ABNs for Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A refund is required under §1834(a)(18) or §1879(h)(3) of the Act for both assigned and unassigned claims unless prior to furnishing the item, a valid ABN was issued notifying the beneficiary of potential nonpayment because the supplier violated the prohibition against unsolicited telephone contacts. The supplier must obtain a signed ABN before furnishing the item to the beneficiary.

Giving advance beneficiary notice by telephone does not qualify as notice in this case and is not permissible. The supplier must either hand deliver or mail a written ABN and obtain the beneficiary’s signature prior to making the unsolicited telephone contact.

Since unsolicited telephone contacts are expressly prohibited by statute, there is presumption of supplier knowledge of this provision. To rebut this presumption, the supplier must submit convincing evidence showing ignorance of the prohibition. A previous denial of a claim for any item furnished by a particular supplier on the basis of this prohibition is considered actual notice to that supplier. Such a denial shall be construed as actual knowledge on all future claims.

50.10 - ABNs for Claims Denied Under §1834(j)(1) of the Act (Supplier Did Not Meet Supplier Number Requirements)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

Sections 1834(j)(4)(A) and 1879(h)(1) of the Act require issuance of a valid ABN notifying the beneficiary of potential nonpayment because a supplier did not meet the

supplier number requirement. These provisions apply to both assigned and unassigned claims.

Suppliers without a Medicare supplier number have the option of giving public notice to beneficiaries regarding their Medicare status in lieu of issuing individual ABNs to all Medicare beneficiaries. The supplier can qualify for a waiver of the refund requirements if adequate public notice is given to beneficiaries informing them of the supplier's failure to meet Medicare's supplier number requirements as long as the adequacy of such public notice is not disputed by the beneficiary. An example of adequate public notice would include clearly visible signs posted at the supplier's place of business. If a supplier only conducts business via the internet, a clearly visible notice on the supplier's internet business site is acceptable as long as such notice is also available in printed materials, such as a supplier's catalog. These public notices must be readily visible, in easily readable plain language, in large print, and must be provided in the language(s) commonly used in the locality.

In the event that the beneficiary disputes receipt of public notice, there is a presumption that the supplier did not properly notify the beneficiary unless the supplier can provide evidence to the contrary. Medicare contractors will not hold a beneficiary who cannot read any such public notice liable.

If a supplier can show that s/he did not know that a purchase was being made either by or for a Medicare beneficiary, s/he may seek protection from the refund requirements under §1834(j)(4) of the Act.

Medicare contractors presume that suppliers know that a supplier number is required in order for Medicare to make payment. Thus, a supplier would have to submit evidence to the contrary to rebut this presumption. However, this presumption is not rebuttable if a supplier has previously received a claim denial §1834(j)(1).

50.11 - ABNs for Claims Denied in Advance Under §1834(a)(15) of the Act (When a Request for an Advance Determination of Coverage Is Mandatory)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

50.11.1 - Situations In Which Advance Coverage Determinations Are Mandatory

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A request for an advance determination of coverage of medical equipment and supplies is mandatory under §1834(a)(15)(C)(i) & (ii) of the Act when:

- The item is listed by the Secretary as being subject to unnecessary utilization in your contractor's service area under §1834(a)(15)(A); or

- The supplier is listed by the Secretary under §1834(a)(15)(B) of the Act as a supplier who has submitted a substantial number of claims, which have been denied as not medically reasonable and necessary under §1862(a)(1) of the Act or the Secretary has identified a pattern of over utilization.

In cases in which an advance coverage determination is mandatory, an ABN must be issued to the beneficiary prior to furnishing the item. If the advance coverage determination has not been received, or if the determination is that Medicare will not pay for the care, an ABN is required prior to furnishing the requested item.

50.11.2 - Situations In Which Advance Coverage Determinations Are Optional

(Rev. 1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

A request for an advance determination of coverage of medical equipment and supplies is optional under §1834(a)(15)(C)(iii) of the Act when the item is customized and either the patient or the supplier requests an advance determination. In cases where an advance coverage determination is optional and the beneficiary requests such a determination, an ABN must be furnished prior to furnishing the requested item.

Every supplier is expected to know whether or not an advance coverage determination is required for Medicare payment. The presumption of that supplier's knowledge becomes non-rebuttable after a single denial under §1834(a)(15) of a claim by a particular supplier.

50.12 - ABNs for items listed in a DMEPOS Competitive Bidding Program

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

§1862 (a)(17) excludes Medicare payment for Competitive Bidding Program (CBP) items/ services that are provided by a non-contract supplier in a Competitive Bidding Area (CBA) except in special circumstances. A non-contracted supplier is permitted to provide a beneficiary with an item or service listed in the CBP when the supplier properly issues an ABN prior to delivery of the item or service per 42 CFR §414.408(e)(3)(ii). In order for the ABN to be considered valid when issued under these circumstances, the reason that Medicare may not pay must be clearly and fully explained on the ABN that is signed by the beneficiary.

Sample wording for the "Reason Medicare May Not Pay" blank of the ABN:
 Since we are not a contracted supplier, Medicare will not pay for this item. If you get this item from a contracted supplier such as ABC Medical Supplies, Medicare will pay for it.

To be a valid ABN, the beneficiary must understand the meaning of the notice. Suppliers must explain to the beneficiary that Medicare will pay for the item if it is obtained from a different supplier in the area. While some suppliers may be reluctant to direct beneficiaries to a specific contracted supplier, the non-contracted supplier should at least

direct the beneficiary to 1-800 –MEDICARE to find a local contracted supplier at the beneficiary’s request.

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(1) 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.

50.13.1 - Physicians' Services Refund Requirements

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

The physicians' services refund requirement provision, found in §1842(l) of the Act as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1986, requires timely refunds for certain services. When a reduction in payment, not a full denial, occurs, the physician must refund to the beneficiary amounts collected which exceed the Medicare payment for the less extensive item or service. These refund requirements apply to both participating and non-participating physicians.

When the beneficiary signs an ABN agreeing to accept responsibility for payment before services are delivered, the collected funds can be retained. A refund is not required if the physician did not know and could not reasonably have been expected to know that Medicare would not pay for the services because they were not reasonable and necessary.

The Medicare contractor must notify the beneficiary in any case in which the physician requests review of the denial or reduction in payment or asserts that a refund is not required.

50.13.2 - DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

All suppliers who sell or rent medical equipment and supplies to Medicare beneficiaries are subject to the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act, whether accepting assignment or not. Medical equipment and supplies are defined in the following statutes applicable to this section:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act;
- Home dialysis supplies and equipment, as described in §1861(s)(2)(F) of the Act;
- Immunosuppressive drugs, as described in §1861(s)(2)(J) of the Act;
- Therapeutic shoes for diabetics, as described in §1861(s)(12) of the Act;

- Oral drugs prescribed for use as an anticancer therapeutic agent, as described in §1861(s)(2)(Q) of the Act;
- Self-administered erythropoietin, as described in §1861(s)(2)(P) of the Act; and
- Other items as determined by the Secretary.

If a proper ABN is not issued prior to the receipt of one of the preceding items and the above provisions apply, the beneficiary has no financial responsibility. The refund provisions of the Act apply to both assigned and unassigned claims.

50.13.3 - Time Limits and Penalties for Physicians and Suppliers in Making Refunds

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

A required refund must be made within specified time limits:

- The refund must be made to the beneficiary within 30 days after the date the physician/supplier receives the remittance advice (RA) if the physician/supplier does not request review of an initial full or partial denial; or
- The refund must be made to the beneficiary within 15 days after the date the physician/supplier receives the notice of the review determination if the physician/supplier requests review within 30 days of receipt of the notice of the initial determination.

Physicians/suppliers who knowingly and willfully fail to make a refund where required within these time limits may be subject to civil money penalties and/or exclusion from the Medicare program.

The beneficiary should contact the contractor or CMS when a physician/supplier fails to make a timely refund. If the contractor determines that a physician/supplier failed to make a refund, it will contact the physician/supplier in person or by telephone to discuss the facts of the case. The contractor will attempt to determine why the required refund has not been made and will explain the legal requirements. The contractor will determine whether referral to the Office of Inspector General (OIG) or CMS is appropriate and will make appropriate referrals to the OIG if necessary. The OIG or CMS may impose civil money penalties, assessments, and sanctions if he or she fails to make the required refund. The contractor will retain a detailed written report of contact.

50.13.4 - Supplier's Right to Recover Resalable Items for Which Refund Has Been Made

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

If the Medicare contractor denies Part B payment for an item of medical equipment or supplies on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, and the beneficiary is relieved of liability for payment for that item under §1834(a)(18) of the Act, the effect of the denial, subject to State law, cancels the contract

for the sale or rental of the item. If the item is resalable or re-rentable, the supplier is permitted to repossess the item. Suppliers are strongly discouraged from recovering items which are consumable or not fit for resale or re-rental.

If a supplier makes proper refund under §1834(a)(18) of the Act, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resalable or re-rentable. When the contract of sale or rental is cancelled on the basis described above, the supplier may enter into a new sale or rental transaction with the beneficiary as long as the beneficiary has been informed of their liability. If the circumstances which preclude payment for the item have been removed (e.g. the supplier has now obtained a supplier number when that supplier did not have one before), the supplier may submit to the Medicare contractor a new claim based on the resale or re-rental of the item to the beneficiary. If payment is still precluded, the supplier can issue an ABN.

Under the capped-rental method, if the Medicare contractor determines that the supplier is obligated to make a refund, the supplier must repay Medicare those rental payments that the supplier has received for the item. However, the Medicare beneficiary must return the item to the supplier.

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 - Special Considerations

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

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 notifier 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 Section 1848 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 - Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF)

(Rev. 2480, Issued: 06-01-12, Effective: 09-04-12, Implementation: 09-04-12)

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. 2878, Issued: 02-14-14 Effective: 05-15-14 Implementation: 05-15-14)

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.

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.)

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. *When issuing ABNs to dual eligibles, HHAs are permitted to direct the beneficiary to select a particular option box on the notice to facilitate coverage by the other payer. This is an exception to the usual ABN issuance guidelines prohibiting the notifier from selecting one of the options for the beneficiary.* When a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer, HHAs *should* instruct beneficiaries to select Option 1 on the ABN. 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.

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. *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. In the past, some States directed HHAs to select the third checkbox on the HHABN to indicate the*

choice to bill Medicare. On the ABN, the first check box under the “Options” section indicates the choice to bill Medicare and is similar to the third checkbox on the outgoing HHABN. Note: If there has been a State directive to submit a Medicare claim for a denial, HHAs must mark the first check box when issuing the ABN.

HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise. *The appropriate option selection for dual eligibles will vary depending on the State’s Medicaid directive. If the HHA’s State Medicaid office does NOT want a claim filed with Medicare prior to filing a claim with Medicaid, the HHA should direct the beneficiary to choose Option 2. When Option 2 is chosen based on State guidance, but the HHA is aware that the State sometimes asks for a Medicare claim submission at a later time, the HHA must add a statement in the “Additional Information” box such as “Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan.”*

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 issuance 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.