DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – Medicare is denying an increasing number of claims, because providers are not identifying, nor sending to, the correct primary payer prior to claims submission. Medicare would like to remind providers, physicians, and suppliers that they have the responsibility to bill correctly and to ensure claims are submitted to the appropriate primary payer. Please refer to the "Medicare Secondary Payer (MSP) Manual," Chapters 1, 3 and 5, and MLN Matters® Article SE1217 for additional guidance.

MLN Matters® Number: MM7821

Related Change Request (CR) #: CR 7821

Related CR Release Date: June 1, 2012

Effective Date: September 4, 2012

Related CR Transmittal #: R2480CP

Implementation Date: September 4, 2012

Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, Updated Manual Instructions

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers that submit claims to Medicare Contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to beneficiaries enrolled in Original Medicare.

What You Need to Know

This article is based on Change Request (CR) 7821 which clarifies the currently published instructions on Advance Beneficiary Notice of Noncoverage (ABN) use in the "Medicare Claims Processing Manual" (Chapter 30, Section 50). Make sure that your billing staff is aware of these ABN policy updates and clarifications that are summarized in this article.

Background

ABNs are issued by providers and suppliers to inform beneficiaries in Original Medicare about possible charges for items or services that are not covered by Medicare. Issuance of the ABN is required in certain situations when limitation of liability (LOL) applies. You may review that information in the Social Security Act (Section 1879; see http://www.ssa.gov/OP_Home/ssact/title18/1879.htm). In 2008 CMS revised the notice and its instructions to streamline and simplify the notice process.

Change Request (CR) 7821 revises the current manual instructions on ABN use in the "Medicare Claims Processing Manual", Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)). The revised Chapter 30, Section 50 is included as an attachment to CR7821. The last page of this article contains a "Quick Glance Guide" from the revised manual section, that may help you and your staff comply with ABN issuance requirements.

Key Points from the Updated Chapter 30 Section 50

General Information

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, formerly the "Advance Beneficiary Notice."

Since March 1, 2009, the ABN-G (general) and ABN-L (laboratory) are no longer valid notices and have been replaced with the ABN.

ABN Scope

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).

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.

Skilled Nursing Facilities (SNFs) issue the ABN for Part B services only. The Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form 10055, is issued for Part A SNF items and services.

Home Health Agencies (HHAs) do not issue the ABN. HHAs issue the Home Health Advance Beneficiary Notice of Noncoverage (HHABN), Form CMS-R-296.

Mandatory ABN Uses

The following provisions of the Social Security Act necessitate delivery of the ABN:

- Section1862(a)(1) of the Social Security Act (not reasonable and necessary); http://www.ssa.gov/OP_Home/ssact/title18/1862.htm;
- Section 1834(a)(17)(B) of the Social Security Act (violation of the prohibition on unsolicited telephone contacts); http://www.ssa.gov/OP_Home/ssact/title18/1834.htm ;
- Section 1834(j)(1) of the Social Security Act (medical equipment and supplies supplier number requirements not met),
- Section 1834(a)(15) of the Social Security Act (medical equipment and/or supplies denied in advance),
- Section 1862(a)(9) of the Social Security Act (custodial care); (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm),
- Section 1879(g)(2) of the Social Security Act (hospice patient who is not terminally ill); see http://www.ssa.gov/OP_Home/ssact/title18/1879.htm on the Internet.

Expanded Mandatory ABN use in 2011

In addition, delivery of an ABN is mandatory under 42 CFR §414.408(e)(3)(ii) (http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl t) 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) unless the beneficiary has signed an ABN. Although all other denial reasons triggering mandatory use of the ABN are found in Section 1879 of the Social Security Act, in this situation, Section 1847(b)(5)(D) (http://www.ssa.gov/OP_Home/ssact/title18/1847.htm) of the Social Security Act permits use of the ABN with respect to these items and services.

The Affordable Care Act, P.L. 111-148, section 4103(d)(1)(C) added a new subparagraph (P) to 1862(a)(1) of the Act. Per section 1862(a)(1)(P), Medicare covered personalized prevention plan services (as defined in section 1861(hhh)(1)) that are performed more frequently than covered 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 limitation of liability (LOL) provisions of section1879 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.

Voluntary ABN Uses

ABN issuance is 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.

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.

ABN Triggering Events

Notifiers are required to issue the ABN when an item or service is expected to be denied based on one of the provisions in the Mandatory Use section above. 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.

Completing the ABN

The ABN and step by step instructions for notice completion are posted on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html on the CMS website. Notifiers must follow the instructions posted on the CMS website to construct a valid notice.

Retention Requirements

Retention periods for the ABN are five 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.

Clarification of 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. The limit for use of a single ABN for an extended course of treatment is one year. 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.

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. Electronic retention of the signed ABN is permitted.

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

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.

ABNs for Items Listed in a DMEPOS Competitive Bidding Program

The Social Security Act (Section 1862 (a)(17)(http://www.ssa.gov/OP_Home/ssact/title18/1862.htm) 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) (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl). 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.

Emergencies or Urgent Situations/ Ambulance Transport

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 Emergency Room (ER) may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.

Issuance of the ABN is mandatory if all of the following 3 criteria are met:

1. The service being provided is a Medicare covered ambulance benefit under Section1861(s)(7) of the Social Security Act (http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) and regulations under this section as stipulated in 42 CFR 410.40 -.41 (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr414_main_02.tpl);
2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under Section 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 Skilled Nursing Facility (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.

Special Issues Associated with the ABN for Hospice Providers

General Use - Hospice

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 Section1879(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 Section1862(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 Section1862(a)(1)(A) or 1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

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 discharged from hospice, the hospice must 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?redirect=/BNI/ 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.

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.

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. However, in this situation, the hospice would be required to issue a Notice of Medicare Noncoverage (NOMNC), CMS 10123, before the end of all covered care. (See the "FFS ED Notices" link on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/BNI/ for details.)

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.

Special Issues Associated with the ABN for CORFs

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 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?redirect=/BNI/ 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.

Additional Information

The official instruction, CR 7821, issued to your Medicare Carrier, FI, RHHI, DME MAC, or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2480CP.pdf on the CMS website.

If you have any questions, please contact your carrier, FI, RHHI, DME MAC, or A/B MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS

website. The ABN and instructions can be downloaded from http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website.

ABN - Quick Glance Guide[1]

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

Type of notice:	Must be issued:	Timing of notice:	Optional/Voluntary
Financial liability notice	• Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice 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 Chapter 50.3.1 of the "Medicare Claims Processing Manual."	Prior to delivery of the item or service in question. Provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.	Yes. Prior to providing an item or service that is never covered by Medicare (not a Medicare benefit).

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