



**News Flash** - The July 2008 version of the *Evaluation & Management Services Guide*, which provides evaluation and management services information about medical record documentation, International Classification of Diseases and Current Procedural Terminology codes, and key elements of service, is now available on the Centers for Medicare & Medicaid Services Medicare Learning Network at [http://www.cms.hhs.gov/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf) on the CMS website.

MLN Matters Number: MM6136 Revised

Related Change Request (CR) #: 6136

Related CR Release Date: September 5, 2008

Effective Date: March 3, 2008

Related CR Transmittal #: R1587CP

Implementation Date: March 1, 2009

**Note:** This article was revised on February 11, 2011, to add a reference to MLN Matters® article MM6988 available at <http://www.cms.gov/MLNMattersArticles/downloads/MM6988.pdf> on the CMS website. MM6988 directs contractors to request, as part of the Additional Documentation Requests (ADRs), required ABNs when performing a complex medical record review on all claims. All other information remains unchanged.

## Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage

### Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

### What You Need to Know

CR 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN); which combines the general Advance Beneficiary Notice (ABN-G) and laboratory Advance Beneficiary Notice (ABN-L) into a single form, with form number (CMS R-131).

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

You should be aware that beginning March 3, 2008 and prior to March 1, 2009, your contractors will accept either the current ABN-G and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification.**

Make sure that your billing staffs are aware of these ABN form changes.

## Background

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Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious non-medical health care institutions paid under Part A; were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The *Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR6136 is the updated Chapter 30 and the Web address for viewing CR6136 is contained in the "Additional Information" section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious non-medical healthcare institutions only) and Part B. It may not be 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).
2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

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*Note: Once the revised SNFABN is implemented, Skilled Nursing Facilities must use the revised SNFABN for all items and services billed to Part A and Part B.*

3. The following situations require by statute that an ABN be issued:
  - Care is not reasonable and necessary;
  - There was a violation of the prohibition on unsolicited telephone contacts;
  - Medical equipment and supplies supplier number requirements not met;
  - Medical equipment and/or supplies denied in advance;
  - Custodial care; and
  - A hospice patient who is not terminally ill.
4. In the following situations ABN use is voluntary  
ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).  
Additionally, the ABN can also 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 Section 1861 of the Social Security Act;
  - Care that is explicitly excluded from coverage under Section 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 physicals (except the initial preventive physical or "Welcome to Medicare" physical examination) and most screening tests;
    - Routine eye care;
    - Dental care; and
    - Routine foot care.
5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as "**notifiers**". Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

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Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three “**triggering events**” during a course of treatment (initiation, reduction, and termination).

Notifiers must give an ABN to “**recipients**” (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers’ inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient’s record and undisputed by the beneficiary.

*Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN Preparation Requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and Comprehensive Outpatient Rehabilitation Facility (CORF).

## Additional Information

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You can find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf> on the CMS website. There you will find the updated *Medicare Claims Processing Manual* Chapter 30(Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

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

Additional information on the revised ABN and other limitation of liability notices can be found on the Beneficiary Notice Initiatives website at <http://www.cms.hhs.gov/bni> on the CMS website. Questions regarding the revised ABN can be emailed to the [RevisedABN\\_ODF@cms.hhs.gov](mailto:RevisedABN_ODF@cms.hhs.gov) email resource address.

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