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PRINT-FRIENDLY VERSION

MEDICARE ADVANCE WRITTEN NOTICES OF NONCOVERAGE

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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TYPES OF ADVANCE WRITTEN NOTICES OF NONCOVERAGE

An advance written notice of noncoverage is a way for a Fee-For-Service (FFS) beneficiary to make an informed decision about items and services that are usually covered by Medicare but may not be expected to be paid in a specific instance for certain reasons, such as lack of medical necessity. These Centers for Medicare & Medicaid Services notices are approved for this purpose:

- **Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131,** is issued by all health care providers and suppliers when Medicare payment is expected to be denied, including:
  - Independent laboratories, Skilled Nursing Facilities (SNFs), and home health agencies (HHAs) providing Medicare Part B (outpatient) items and services
  - Hospice providers, HHAs, and Religious Nonmedical Health Care Institutions rendering Part A items and services

The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If the beneficiary does not get written notice when it is required, he or she may not be held financially liable if Medicare denies payment, and the provider or supplier may be financially liable if Medicare does not pay.

- **Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055,** is issued by SNFs before providing a Part A item or service to a FFS beneficiary that is usually paid by Medicare, but may not be paid in this particular instance because it is not medically reasonable and necessary or it is custodial care. SNFs may issue either the SNFABN or one of the five SNF Denial Letters as the liability notice for Part A items and services that are usually paid by Medicare, but may not be paid in this particular instance.

- **Hospital-Issued Notice of Noncoverage (HINN)** is issued by hospitals prior to admission, at admission, or at any point during an inpatient stay if hospitals determine that the care the beneficiary is receiving, or is about to receive, is not covered because it is:
  - Not medically necessary
  - Not delivered in the most appropriate setting
  - Custodial in nature

  The four HINNs hospitals issue are:
  - Preadmission/Admission HINN, also known as HINN 1–Use prior to an entirely non-covered stay
  - Notice of Hospital Requested Review (HRR), also known as HINN 10–Use for FFS and Medicare Advantage Program (Part C) beneficiaries when requesting Quality Improvement Organization review of a discharge decision without physician concurrence
  - HINN 11–Use for non-covered items and services provided during an otherwise covered stay
  - HINN 12–Use with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay
- **Home Health Change of Care Notice (HHCCN), Form CMS-10280,** is issued by HHAs to notify a FFS beneficiary who is receiving home health care benefits about plan of care (POC) changes. The beneficiary must receive written notification before HHAs may reduce or terminate an item and/or service.

ISSUING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

When You Must Issue an Advance Written Notice of Noncoverage

You must issue an advance written notice of noncoverage:

- When an item or service is not considered reasonable and necessary under Medicare Program standards. Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:
  - Experimental and investigational or considered “research only”
  - Not indicated for diagnosis and/or treatment in this case
  - Not considered safe and effective
  - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is furnished
- When outpatient therapy services exceed therapy cap amounts **and** do not qualify for a therapy cap exception
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)

- Before furnishing an item or service that will not be paid by Medicare because (durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers):
  - The provider violated the prohibition against unsolicited telephone contacts
  - The supplier has not met supplier number requirements
  - The supplier is a non-contract supplier furnishing an item listed in a competitive bidding area
  - Medicare requires an advance coverage determination, and the beneficiary wants the item or service before the advance coverage determination is made

NON-CONTRACT DMEPOS SUPPLIERS

For an ABN to be valid, beneficiaries must understand the meaning of the notice. Where an exception applies, beneficiaries have no financial liability to a non-contract supplier furnishing an item included in the Competitive Bidding Program unless they sign an ABN indicating that Medicare will not pay for the item because it was received from a non-contract supplier and they agree to accept financial liability. For more information about non-contract DMEPOS supplier requirements, refer to The DMEPOS Competitive Bidding Program Non-Contract Supplier.

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

Limited coverage may result from NCDs or LCDs. NCDs set forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis. NCDs are a reasonable and necessary determination made by the Secretary of the Department of Health & Human Services. To further define an NCD or in the absence of a specific NCD, Medicare Administrative Contractors (MACs) may develop an LCD, which is a coverage decision made at their own discretion to provide guidance to the public and the medical community within a specified geographic area. In most cases, the availability of this information indicates you knew, or should have known, Medicare would deny the item or service as not medically necessary.

When You May Voluntarily Issue an Advance Written Notice of Noncoverage

You are not required to notify the beneficiary before you furnish an item or service that Medicare never covers or is not a Medicare benefit. You may, however, choose to issue a voluntary advance written notice of noncoverage or a similar notice as a courtesy to alert the beneficiary about his or her forthcoming financial liability. When you issue the advance written notice of noncoverage as a voluntary notice, it has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. For more information about non-covered services, refer to Items and Services Not Covered Under Medicare.

Three Events That Prompt Issuance of an Advance Written Notice of Noncoverage

These three "triggering events" may prompt issuance of an advance written notice of noncoverage:

- Initiations
- Reductions
- Terminations

Initiations

Initiations occur at the beginning of a new patient encounter, start of a POC, or beginning of treatment. If you believe at initiation that Medicare will not cover certain otherwise covered items or services because they are not reasonable and necessary, you must issue an advance written notice of noncoverage prior to the beneficiary receiving the non-covered care.

Reductions

Reductions occur when a component of care decreases (for example, frequency or duration of a service). An advance written notice of noncoverage should not be issued every time there is a reduction in care. If a reduction occurs and the beneficiary wants to continue to receive the care that is no longer considered medically reasonable and necessary, you must issue an advance written notice prior to furnishing non-covered care.

For the HHCCN, reductions to the POC may occur when an HHA reduces or stops items and/or services during a spell of illness while continuing others, including when one home health discipline ends but others continue.

Terminations

Terminations are the discontinuation of all or only certain items or services. If services are being terminated and the beneficiary wants to continue receiving care that is no longer considered medically reasonable and necessary, you must issue an advance written notice of noncoverage prior to furnishing non-covered care.

For the HHCCN, terminations to the POC may occur when an HHA ends delivery of all services.

Issuing an Advance Written Notice of Noncoverage When Multiple Entities Render Care

When multiple entities render care, Medicare does not require you to issue separate advance written notices of noncoverage. Any party involved in the delivery of care can issue the advance written notice of noncoverage when:

- There are separate ordering and rendering providers (for example, a physician orders a laboratory test and an independent laboratory delivers the ordered test)
- One health care provider delivers the technical component and another provider delivers the professional component of the same service (for example, a radiological test that an independent diagnostic testing facility renders and a physician interprets)
- The entity that obtains the signature on the advance written notice of noncoverage is not the same entity that bills for the service (for example, one laboratory refers a specimen to another laboratory and the second laboratory then bills Medicare for the test)

In these situations, you may enter the names of more than one entity in the header of the advance written notice of noncoverage as long as the beneficiary can clearly identify whom to contact for billing questions.

Note: Regardless of who issues the advance written notice of noncoverage, Medicare holds the billing entity responsible for effective issuance.

PROHIBITIONS AND FREQUENCY LIMITS

Routine Notice Prohibition

You may not issue an advance written notice of noncoverage on a routine basis or when there is no reasonable basis to expect that Medicare may not cover the item or service. You must ensure a reasonable basis exists for noncoverage associated with the issuance of each advance written notice of noncoverage. Some exceptions to the routine notice prohibition include:

- Experimental items and services
- Items and services with frequency limitations for coverage
- Medical equipment and supplies denied because the supplier had no supplier number or the supplier made an unsolicited telephone contact
- Services always denied for medical necessity

Other Prohibitions

You cannot issue an advance written notice of noncoverage to:

- Shift liability and bill the beneficiary for the services denied due to a Medically Unlikely Edit (MUE).
- A beneficiary in a medical emergency or under great duress (compelling or coercive circumstances). Advance written notice of noncoverage use in the emergency room or during ambulance transports may be appropriate in some cases for a medically stable beneficiary who is not under duress.
- Charge a beneficiary for a component of a service when Medicare makes full payment through a bundled payment.
- Transfer liability to the beneficiary when Medicare would otherwise pay for items and services.

Frequency Limits

Some Medicare-covered services are subject to frequency limits, which means that Medicare will pay for only a certain quantity of a specific item or service in a given time period for a particular diagnosis. If you believe an item or service may exceed frequency limits, you must issue an advance written notice of noncoverage before you furnish the item or service to the beneficiary.

If you do not know the number of times the beneficiary got a service within a specific timeframe, you may get this information from the beneficiary or other providers involved in his or her care. You may also contact your MAC or use the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) (270/271) to determine if a Medicare beneficiary met the frequency limits from another provider during the calendar year.

Extended Course of Treatment

You may issue a single advance written notice of noncoverage to cover an extended course of treatment if it lists all items and services and the duration of treatment for which you believe Medicare will not pay. If the beneficiary receives an item or service during the course of treatment that you did not list on the advance written notice of noncoverage and Medicare may not cover it, you must issue a separate advance written notice of noncoverage. A single advance written notice of noncoverage for an extended course of treatment is valid for no longer than 1 year. If the extended course of treatment continues after 1 year, you must issue a new advance written notice of noncoverage.

COMPLETING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

An advance written notice of noncoverage should be:

- Issued (preferably in person) to and comprehended by the Medicare beneficiary or his or her representative for the purpose of giving notice under applicable State or other law.
- Completed on the approved, standardized notice format, with all required blanks completed. It cannot exceed one page in length. You may include attachments that list additional items and services. If you use attachment sheets, they must allow for clear matching of the items or services

in question with the reason a denial is expected and cost estimate information. You must use a visually high-contrast combination of dark ink on a pale background, and the print should be readable to the beneficiary. Medicare permits limited customization of the advance written notice of noncoverage, such as preprinting information in certain blanks.

- Issued far enough in advance of potentially non-covered items or services to allow sufficient time for the beneficiary to consider available options.
- Explained in its entirety with all questions related to the advance written notice of noncoverage answered.
- Signed and dated by the beneficiary or his or her representative after he or she selects one option box. If you issue the advance written notice of noncoverage on an electronic screen, you must ask the beneficiary if he or she prefers a paper version and issue a paper notice if he or she prefers such. You should retain a copy and give the beneficiary a paper copy (whether the advance written notice of noncoverage is signed on paper or electronically). If you maintain Electronic Medical Records, you may scan the signed hard copy for retention.
- Kept for 5 years from the date-of-care delivery when no other requirements under State law apply. Medicare requires you to keep a record of the advance written notice of noncoverage in all cases, including when the beneficiary declined the care, refused to choose an option, or refused to sign the advance written notice of noncoverage.

If you are not able to issue the advance written notice of noncoverage in person, you may issue it via direct telephone, email, mail, or secure fax machine (according to HIPAA policy). The beneficiary should not dispute the contact. You should document the contact in the beneficiary's records and keep a copy of the unsigned advance written notice of noncoverage on file while you are waiting for the signed notice. Telephone contacts must be immediately followed by either a hand-delivered, mailed, emailed, or faxed advance written notice of noncoverage. The beneficiary or the beneficiary's representative must sign and retain the advance written notice of noncoverage and send a copy of the signed notice to you for retention in the beneficiary's record. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in the beneficiary's records or on the advance written notice of noncoverage.

For detailed instructions on completing an ABN, refer to Advance Beneficiary Notice of Noncoverage Interactive Tutorial.

When the Beneficiary Changes His or Her Mind

After completing and signing the advance written notice of noncoverage, if the beneficiary changes his or her mind, you should present the completed notice to the beneficiary and request that he or she annotate it. The annotation must be signed and dated and include a clear indication of his or her new option selection. If you cannot present the advance written notice of noncoverage to the beneficiary in person, you 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. You must provide a copy of the annotated advance written notice of noncoverage to the beneficiary as soon as possible.

When the Beneficiary Refuses to Choose an Option or Sign the Advance Written Notice of Noncoverage

If the beneficiary or the beneficiary's representative refuses to choose an option or refuses to sign the advance written notice of noncoverage, you should annotate the original copy of the notice indicating the refusal to choose an option or sign the notice. You may list any witnesses to the refusal on the advance written notice of noncoverage, although a witness is not required. If a beneficiary refuses to sign a properly issued advance written notice of noncoverage, you should consider not furnishing the item or service unless the consequences (health and safety of the beneficiary or civil liability in case of harm) prevent this option.

COLLECTING PAYMENT FROM THE BENEFICIARY

When an advance written notice of noncoverage is required, if you properly notify the beneficiary that the item or service may not be covered and he or she signs the notice, you may seek payment from him or her. If Medicare pays all or part of the claim for items or services previously paid by the beneficiary, you must refund the beneficiary the proper amount in a timely manner. Refunds are considered timely when they are made within 30 days after you receive the Remittance Advice from Medicare or within 15 days after a determination on an appeal if you or the beneficiary file an appeal.

Note: SNFs are not permitted to collect money for Part A services until Medicare makes an official payment decision on the claim.

FINANCIAL LIABILITY

When an advance written notice of noncoverage is required and you do not issue a notice or Medicare finds that the advance written notice of noncoverage is invalid and you knew, or should have known, that Medicare would not pay for a usually covered item or service, you may be financially liable if Medicare does not pay. You cannot collect funds from the beneficiary. If you previously collected payment from the beneficiary, you must refund the beneficiary the proper amount in a timely manner.

CLAIM REPORTING MODIFIERS ASSOCIATED WITH THE ABN

Claim Reporting Modifiers Associated with the ABN

Modifier	When to Use the Modifier
GA **Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case**	Report when you issue a mandatory ABN for a service as required and it is on file. You do not need to submit a copy of the ABN, but you must have it available on request.
GX **Notice of Liability Issued, Voluntary Under Payer Policy**	Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.
GY **Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit**	Report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.
GZ **Item or Service Expected to Be Denied as Not Reasonable and Necessary**	Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

WHEN YOU SHOULD NOT USE AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

You should not use an advance written notice of noncoverage for items and services you furnish under the Medicare Advantage Program (Part C) or the Prescription Drug Benefit (Part D). You are not required to notify the beneficiary before you furnish items or services that are not a Medicare benefit or that Medicare never covers such as:

- Services for which there is no legal obligation to pay
- Services authorized or paid by a government entity other than Medicare (this exclusion does not include services paid by Medicaid on behalf of dual-eligibles)
- Services required as a result of war
- Personal comfort items such as radios and televisions
- Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses
- Hearing aids

RESOURCES

Medicare Advance Written Notices of Noncoverage Resources

For More Information About…	Resource
Forms and Instructions, Rules, and Financial Liability Protections	Email Your Questions Beneficiary Notices Initiative (BNI) Chapter 1, Section 60.4.1 of the Medicare Claims Processing Manual (Publication 100-04) Chapter 30 of the Medicare Claims Processing Manual (Publication 100-04)
Medicare Coverage	CMS.gov/Medicare-Coverage-Database CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html CMS.gov/Medicare/Coverage/CoverageGenInfo
HETS	CMS.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp
HHCCN Form Instructions	CMS.gov/Medicare/Medicare-General-Information/BNI/Downloads/HHCCN-Form-Instructions.pdf
DME Supplier Requirements	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
MUEs	CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html
Contact Your Medicare Administrative Contractor with Questions	CMS.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Medicare Information for Beneficiaries	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Advance Beneficiary Notice of Noncoverage (ABN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish.zip
Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/CMS10055.zip
SNF Denial Letters	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/SNF-DENIAL-LETTERS.pdf
Hospital-Issued Notice of Noncoverage (HINN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/HINNs.zip
Home Health Change of Care Notice (HHCCN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/HHCCN-Forms-English-and-Spanish.zip
The DMEPOS Competitive Bidding Program Non-Contract Supplier	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243505.html
Items and Services Not Covered Under Medicare	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1253078.html
Advance Beneficiary Notice of Noncoverage Interactive Tutorial	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909183.html
Email Your Questions	RevisedABN_ODF@cms.hhs.gov
Beneficiary Notices Initiative (BNI)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI
Chapter 1, Section 60.4.1 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf#page=169
Chapter 30 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf