CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2878	**Date: February 14, 2014**
	Change Request 8597

SUBJECT: Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

I. SUMMARY OF CHANGES: This transmittal provides removal of language that was erroneously included in the September 6, 2013 issuance of CR 8404, Transmittal 2782, Sections 50.3 and 50.6.2 of Chapter 30 in the Medicare Claims Processing Manual. It also provides revised and clarified manual instructions in Section 50.15.4 regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

EFFECTIVE DATE: MAY 15, 2014
IMPLEMENTATION DATE: MAY 15, 2014
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/ 50/ 50.3/ ABN Scope
R	30/ 50/ 50.6.2/ General Notice Preparation Requirements
R	30/ 50/ 50.15.4/ Home Health Agency Use of the ABN

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2878	Date: February 14, 2014	Change Request: 8597

SUBJECT: Correction CR - Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131

EFFECTIVE DATE: MAY 15, 2014
IMPLEMENTATION DATE: MAY 15, 2014

I. GENERAL INFORMATION

A. Background: This transmittal provides removal of language that was erroneously included in the September 6, 2013 issuance of CR 8404, Transmittal 2782, in Sections 50.3 and 50.6.2 of Chapter 30 in the Medicare Claims Processing Manual. It also provides revised and clarified manual instructions in Section 50.15.4 regarding home health agency issuance of the Advance Beneficiary Notice of Noncoverage (ABN) to dual eligible beneficiaries.

B. Policy: Section 1879 of the Social Security Act (the Act) protects fee for service beneficiaries from payment liability in certain situations unless they are notified of their potential liability in advance.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
8597.1	Contractors shall take any actions necessary to implement the attached instructions; primarily by assisting providers and suppliers in understanding their responsibilities and communicating the availability of the revised, clarified instructions.	X	X	X	X					
8597.2	Contractors shall update the ABN instructions from PUB. 100-04/Chapter 30/Section 50, currently on their websites with the revised ABN manual instructions found in this CR.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8597.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Evelyn Blaemire, 410-786-1803 or evelyn.blaemire@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

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.

50.6.2 - 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) is available for download* *http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html* .

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.

*ABN		
	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.

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.

1. 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.)

2. 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. W*hen 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.