

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MEDICARE ADVANCE BENEFICIARY NOTICES



TABLE OF CONTENTS

TYPES OF ABNS	1
PROHIBITIONS AND FREQUENCY LIMITS	4
COMPLETING THE ABN	5
COLLECTING PAYMENT FROM THE BENEFICIARY	6
FINANCIAL LIABILITY AND THE ABN	6
CLAIM REPORTING MODIFIERS	7
RESOURCES	8

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This booklet provides the following information on Medicare's Advance Beneficiary Notices (ABNs):

- ❖ Types of ABNs;
- ❖ Prohibitions and frequency limits;
- ❖ Completing the ABN;
- ❖ Collecting payment from the beneficiary;
- ❖ Financial liability and the ABN;
- ❖ Claim reporting modifiers; and
- ❖ Resources.

TYPES OF ABNs

The ABN is a written notice you must issue to a Fee-For-Service beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity. The following CMS notices are approved for this purpose:

- ❖ Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131;
- ❖ Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055; and
- ❖ Hospital-Issued Notice of Noncoverage (HINN).

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 you may be financially liable if Medicare does not pay. The ABN is used for Medicare Part B (outpatient) and Part A (limited to hospice, Home Health Agencies, and Religious Nonmedical Health Care Institutions only) items and services. You must issue the ABN when:

- ❖ You believe Medicare may not pay for an item or service;
- ❖ Medicare usually covers the item or service; and
- ❖ Medicare is expected to deny payment for the item or service because it is not medically reasonable and necessary for this beneficiary in this case or for one of the reasons listed in the “When You Must Issue an ABN” section below.

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 billed, 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 United States (U.S.) 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 located 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.

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; or
- ❖ More than the number of services Medicare allows in a specific period for the corresponding diagnosis.

When You Must Issue an ABN

You must issue an ABN when you expect Medicare may deny payment for an item or service because:

- ❖ It is not considered reasonable and necessary under Medicare Program standards;
- ❖ The care is considered custodial;
- ❖ Outpatient therapy services are in excess of therapy cap amounts **and** do not qualify for a therapy cap exception;
- ❖ A beneficiary is not terminally ill (for hospice providers only); or



- ❖ A beneficiary is not homebound or there is no need for intermittent skilled nursing care (for home health services only).

Additional mandatory requirements apply to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. An ABN must be issued before DMEPOS suppliers furnish a beneficiary with an item or service that will not be paid for by Medicare because:

- ❖ 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; or
- ❖ 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

To be a valid ABN, the beneficiary must understand the meaning of the notice. Non-contract DMEPOS suppliers must explain to the beneficiary that Medicare will pay for the item if it is obtained from a different supplier in the area.

For more information about non-contract DMEPOS supplier requirements, refer to the Medicare Learning Network® (MLN) publication titled “The DMEPOS Competitive Bidding Program Non-Contract Supplier” located at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243505.html> on the CMS website.



When You May Voluntarily Issue an ABN

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 ABN or a similar notice as a courtesy to alert the beneficiary about his or her forthcoming financial liability. When you issue the ABN 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 noncovered services, refer to the MLN publication titled “Items and

Services That Are Not Covered Under the Medicare Program” located at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf> on the CMS website.

Three Events That Prompt Issuance of an ABN

The following three triggering events may prompt you to issue an ABN:

- ❖ Initiations;
- ❖ Reductions; and
- ❖ Terminations.

Each triggering event is described in more detail below.

Initiations

An initiation occurs at the beginning of a new patient encounter, start of a plan of care, 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 ABN prior to the beneficiary receiving the noncovered care.

Reductions

A reduction occurs when a component of care decreases (for example, frequency or duration of a service). An ABN 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 ABN prior to furnishing noncovered care.

Terminations

A termination is 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 ABN prior to furnishing noncovered care.

Issuing an ABN When Multiple Entities Render Care

When multiple entities render care, Medicare does not require you to issue separate ABNs. Any party involved in the delivery of care can issue the ABN 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); or
- ❖ The entity that obtains the signature on the ABN 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 ABN as long as the beneficiary can clearly identify whom to contact for billing questions.

Note: Regardless of who issues the ABN, Medicare holds the billing entity responsible for effective issuance.

PROHIBITIONS AND FREQUENCY LIMITS

Routine Notice Prohibition

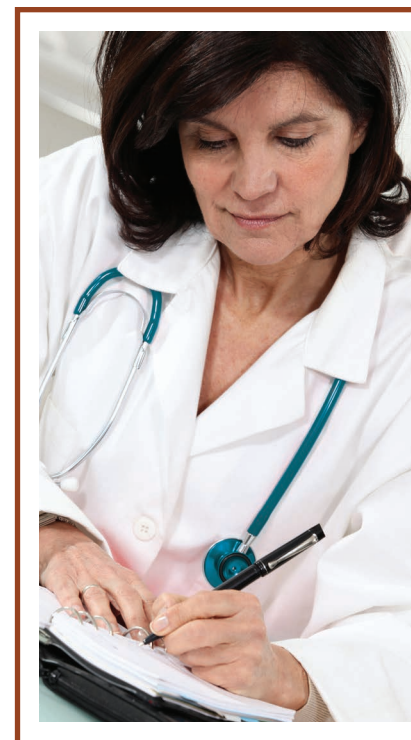
You may not issue an ABN on a routine basis or when there is no reasonable basis to expect that Medicare may not cover the item or service. You must ensure a reasonable basis exists for noncoverage associated with the issuance of each ABN. Some exceptions to the routine notice prohibition include:

- ❖ 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; or
- ❖ Services that are always denied for medical necessity.

Other Prohibitions

You cannot issue an ABN 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). ABN 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; or
- ❖ 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 ABN 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 be able to 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 ABN to cover an extended course of treatment if the ABN 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 ABN and Medicare may not cover it, you must issue a separate ABN. A single ABN 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 ABN.

COMPLETING THE ABN

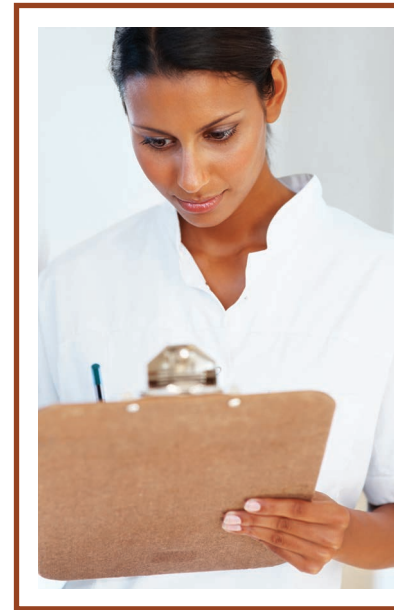
The ABN should be:

- ❖ 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, such as preprinting information in certain blanks of the ABN;

- ❖ Issued far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options;
- ❖ Explained in its entirety with all questions related to the ABN answered;
- ❖ Signed and dated by the beneficiary or his or her representative after he or she selects one option box. If you issue the ABN on an electronic screen, you must ask the beneficiary if he or she prefers a paper version and issue a paper ABN if he or she prefers such. You should retain a copy and give the beneficiary a paper copy (whether the ABN is signed on paper or electronically). If you maintain Electronic Medical Records, you may scan the signed hard copy for retention; and
- ❖ 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 ABN in all cases, including when the beneficiary declined the care, refused to choose an option, or refused to sign the ABN.

If you are not able to issue the ABN 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 ABN on file while you are waiting for the signed ABN. Telephone contacts must be immediately followed by either a hand-delivered, mailed,



emailed, or faxed ABN. The beneficiary or the beneficiary's representative must sign and retain the ABN and send a copy of the signed ABN 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 ABN.

For detailed instructions on completing an ABN, refer to the MLN publication titled "Advance Beneficiary Notice of Noncoverage Interactive Tutorial" located at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909183.html> on the CMS website.

When the Beneficiary Changes His or Her Mind

After completing and signing the ABN, if the beneficiary changes his or her mind, you should present the completed ABN to the beneficiary and request 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 ABN 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 ABN to the beneficiary to sign, date, and return. You must provide a copy of the annotated ABN to the beneficiary as soon as possible.

When the Beneficiary Refuses to Choose an Option or Sign the ABN

If the beneficiary refuses to choose an option or sign the ABN, you should annotate the original copy of the ABN indicating the

refusal to choose an option or sign the ABN. You may list any witnesses to the refusal on the ABN, although a witness is not required. If a beneficiary refuses to sign a properly issued ABN, 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 ABN is required, if you properly notify the beneficiary that the item or service may not be covered and he or she signs the ABN, 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.

FINANCIAL LIABILITY AND THE ABN

When an ABN is required and you do not issue an ABN or Medicare finds that the ABN 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

The chart below provides the claim reporting modifiers associated with ABN use.

Claim Reporting Modifiers

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.

RESOURCES

The chart below provides resource information for the ABN.

ABN Resources

For More Information About...	Resource
ABN Forms and Instructions, Rules, and Financial Liability Protections	ABN Questions RevisedABN_ODF@cms.hhs.gov General Information https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website “Medicare Claims Processing Manual” (Publication 100-04), Chapter 1, Section 60.4.1, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf and Chapter 30, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf on the CMS website
Medicare Coverage	https://www.cms.gov/Medicare-Coverage-Database on the CMS website https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html on the CMS website https://www.cms.gov/Medicare/Coverage/CoverageGenInfo on the CMS website
HETS	https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp on the CMS website
DME Supplier Requirements	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf on the CMS website
MUEs	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html on the CMS website

ABN Resources (cont.)

For More Information About...	Resource
Medicare Administrative Contractor Contact Information	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website
All Available MLN Products	“ MLN Catalog ” on the CMS website
Provider-Specific Medicare Information	MLN publication titled “ MLN Guided Pathways: Provider Specific Medicare Resources ” on the CMS website
Medicare Information for Beneficiaries	https://www.medicare.gov on the CMS website



The Medicare Learning Network® Disclaimers are available at <http://go.cms.gov/Disclaimer-MLN-Product> on the CMS website.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Check out CMS on:

