DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

Note: This article was revised on April 8, 2014, to add a link to MM8597 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8597.pdf), which removed language that was erroneously included in CR8404 and in the "Medicare Claims Processing Manual," Chapter 30, Sections 50.3 and 50.6.2. It also provides clarified manual instructions regarding home health agency issuance of the ABN to dual eligible beneficiaries. All other information is unchanged.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 8404 which provides: 1) instructions for Home Health Agency (HHA) use of the Advance Beneficiary Notice of Noncoverage (ABN) to replace the outgoing Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1; 2) ABN issuance guidelines for therapy services and therapy specific examples; and 3) minor editorial changes to clarify existing manual instructions regarding ABN issuance.

Home health agencies and therapy providers should make sure that their health care and billing staff are aware of these ABN policy changes. All other providers should note that there have been no substantive changes to the ABN form or general instructions for issuance and can reference MM7821 (available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7821.pdf**) for general ABN information.

Background

Section 1879 of the Social Security Act (the Act) protects Fee-For-Service (FFS) beneficiaries from payment liability (in certain situations) unless the beneficiary is given advance notice of his/her potential liability. The ABN informs beneficiaries about such possible non-covered charges and fulfills this notification requirement when Limitation of Liability (LOL) applies.

The Centers for Medicare & Medicaid Services (CMS) is expanding use of the ABN to include issuance by home health agency (HHA) providers 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 that is currently used by HHAs. The mandatory date for all HHAs to begin use of the ABN and discontinue use of the HHABN will be posted at **http://cms.gov/Medicare/Medicare-General-Information/BNI/HHABN.html** on the CMS website. The guidelines for ABN use published in Chapter 30, Section 50 of the "Medicare Claims Processing Manual" and the ABN form instructions apply to HHAs unless otherwise noted.

Key Points from the Updated Chapter 30 Section 50

HHA Use of ABN – General Use

HHAs are required to issue an ABN to Original Medicare beneficiaries in specific situations where “Limitation on Liability” (LOL) protection is afforded under Section 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 projections. HHAs should contact their 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
Statutory Provisions Related to ABN Issuance for LOL purposes

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
Section 1862(a)(1)(A)	Care is not reasonable and necessary	Medicare does not pay for care that is not medically reasonable and necessary.
Section 1862(a)(9)	Custodial care is the only care delivered	Medicare does not usually pay for custodial care, except for some hospice services.
Section 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
Section 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

If one of the above situations applies and the beneficiary chooses to receive the home care items/services that may not be covered by Medicare, HHAs must issue the ABN to the beneficiary to notify him/her of potential financial responsibility. In addition, when Medicare considers an item or service experimental (e.g., a "Research Use Only" or "Investigational Use Only" laboratory test), payment for the experimental item or service is denied under Section 1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN.

HHA Triggering Events

HHAs may be required to provide an ABN to an Original Medicare beneficiary when a triggering event occurs. Table 2, below, outlines triggering events specific to HHAs.

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.
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.

*ABN 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 this Table. If the beneficiary does not want the item or service that is being initiated, reduced, or terminated, no ABN is required.

- **HHA Initiations**

The HHA must issue a beneficiary an ABN prior to delivering care that is usually covered by Medicare, but in this particular instance, the item or service may not be or is not covered by Medicare because:

- The care is not medically reasonable and necessary;
- The beneficiary is not confined to his/her home (is not considered homebound);
- The beneficiary does not need skilled nursing care on an intermittent basis; or
- The beneficiary is receiving custodial care only.

Note: If the HHA believes that Medicare will not (or may not) pay for care for a reason other than ones listed directly above, issuance of the ABN is not required.

INITIATION EXAMPLE: 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 HHA must issue the ABN to this beneficiary before providing the home care that will not be paid for by Medicare. This allows the beneficiary to make an informed decision on whether to receive the non-covered care, and to accept the financial obligation.

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.

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 a beneficiary's initial assessment prior to admission but does not admit him/her; an ABN is not required if there is no charge for the assessment. However, if an HHA charges for an assessment, it 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 in which 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 cannot 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.)

- **HHA Reductions**

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care that an HHA provides and/or that is part of the Plan of Care (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 item or service and will 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).

REDUCTION WITH SUBSEQUENT INITIATION EXAMPLE: A 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 so that he understands the situation and can consent to financial responsibility for the PT not covered by Medicare.

- **HHA Terminations**

A termination is the cessation of all HHA-provided Medicare covered services. If a beneficiary wants to continue receiving home health care that will not be covered by Medicare for any of the statutory reasons listed in Table 1 and a physician orders the services; the HHA must issue the beneficiary an ABN in order to charge the beneficiary or a secondary insurer. If the beneficiary will not 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** on the CMS website.

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 beneficiary wishes to continue receiving care from the HHA even though Medicare will not pay, an ABN must be issued since this would be an initiation of non-covered care.

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 (such as waiver programs, Office on Aging funds, community agencies (e.g., Easter Seals) or grants), ABN requirements still apply.

For example, when a beneficiary is a dual eligible and receives home health services that are covered only under Medicaid, but are not covered by Medicare for one of the reasons listed in Table 1; an ABN must be issued at the initiation of this care to inform the beneficiary that Medicare will likely deny the services.

Some States have specific rules regarding HHA completion of liability notices in situations where dual eligible beneficiaries need to accept liability for Medicare noncovered care that Medicaid will cover. 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 assumes any remaining charges).

On the ABN, the first check box under the "Options" section indicates the choice to bill Medicare and is equivalent to the third checkbox on the outgoing HHABN. HHAs serving dual eligibles should comply with existing HHABN State policy within their jurisdiction as applicable to the ABN unless the State instructs otherwise.

Note: If a State has issued a directive to select the third checkbox on the HHABN, HHAs must mark **the first check box** when issuing the ABN.

Where there is no State specific directive, HHAs are permitted to instruct beneficiaries to select Option 1 on the ABN when a Medicare claim denial is necessary to facilitate payment by Medicaid or a secondary insurer. 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 to 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.

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).

Other HHA ABN Guidance

1. ABN for Voluntary Notice by HHAs

HHAs may use the voluntary ABN, as a courtesy, to alert beneficiaries of impending financial obligation for items and services that are never covered by Medicare as described in the "Medicare Claims Processing Manual," Chapter 30 (Financial Liability Protections), Section 50.3.2 (Voluntary ABN Uses).

2. 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 actually provided, Medicare makes a 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 claim 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.

3. Use of abbreviations

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.

4. 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.

Outpatient Therapy Services Use of the ABN

Section 603(c) of the American Taxpayer Relief Act (ATRA) amended Section 1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.

Prior to the ATRA amendment, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable.

Now, with this ATRA amendment to the Act, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

Therapists are required to issue an ABN to beneficiaries before providing them therapy that is not medically reasonable and necessary, regardless of the therapy cap. Statutory changes (mentioned above) mandate ABN issuance when therapy services are not medically reasonable and necessary and exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that will not be covered by Medicare because the services are not medically

necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether to obtain the services and accept financial responsibility for them.

THERAPY CAP IS NOT MET - ABN MANDATORY EXAMPLE: A beneficiary has been receiving Physical Therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the Plan of Care (POC). The total amount applied to his therapy cap this year is $780. He requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that will not be covered by Medicare because they are no longer medically necessary.

THERAPY CAP HAS BEEN MET - ABN MANDATORY EXAMPLE: A beneficiary has recently been receiving Physical Therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. She requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary.

In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.

Additional Information

The official instruction, CR8404, issued to your Medicare contractor regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf** on the CMS website. The revised portions of the "Medicare Claims Processing Manual" are a part of CR8404.

You may want to review MM8403 (**http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8403.pdf**) which alerted HH providers that effective December 9, 2013, HHABN Form CMS-R-296 will be discontinued and HHCCN will replace the HHABN option boxes 2 and 3. HHABN option box 1 will be replaced by the ABN of Noncoverage (CMS-R-131).

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.