Medicare Claims Processing Manual

Chapter 30 - Financial Liability Protections

Table of Contents

Crosswalk to Old Manuals

10 - Financial Liability Protections (FLP) Provisions of Title XVIII

20 - Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed

20.1 - Coverage Denials to Which the Limitation on Liability Applies

20.1.1 - Statutory Basis

20.1.2 - Dependent Services

20.1.3 - Partial Denials Based on Reasonable and Necessary Levels of Care

20.2 - Denials for Which the Limitation On Liability Provision Does Not Apply

20.2.1 - Categorical Denials

20.2.2 - Technical Denials

30 - Determining Liability for Disallowed Claims Under §1879

30.1 - Determining Beneficiary's Liability

30.1.1 - Beneficiary Determined to Be Liable - Right to Appeal

30.1.2 - Beneficiary Determined to Be Without Liability

30.2 - Determining Provider, Practitioner, or Supplier Liability

30.2.1 - General

30.2.2 - Provider/Practitioner/Supplier is Determined to Be Liable - Right to Appeal

30.2.3 - Provider/Practitioner/Supplier Determined to Be Without Liability

40 - Determining Knowledge for FLP Purposes

40.1 - Determining Whether Provider, Practitioner, or Supplier Had Knowledge of Noncoverage of Services

40.1.1 - Criteria for Determining Practitioner and Other Supplier Knowledge

40.1.2 - Criteria for Determining Provider Knowledge

40.1.3 - Acceptable Standards of Practice

40.1.4 - Fraud, Abuse, Patently Unnecessary Items and Services

40.2 - Determining Whether Beneficiary Had Knowledge of Noncoverage of Services

40.2.1 - Beneficiary Knowledge Standards

40.2.2 - Written Notice as Evidence of Knowledge

40.2.3 - Sources of Written Notice

40.2.4 - Other Evidence of Knowledge

40.3 - Advance Beneficiary Notice Standards

40.3.1 - Proper Notice Documents

40.3.1.1 - Readability Requirements

40.3.1.2 - Specificity, Delivery, and Receipt

40.3.1.3 - Defective Notice

40.3.2 – Qualified Notifiers

40.3.3 - Timeliness

40.3.4 - Effective Delivery

40.3.4.1 - Basic Delivery Requirements

40.3.4.2 - Telephone Notice

40.3.4.3 - Capable Recipient

40.3.4.4 - Responsiveness to Inquiries

40.3.4.5 - Identification of Notifier

40.3.4.6 - Dealing With Beneficiary Refusals

40.3.5 - Authorized Representatives

40.3.6 - Routine Notice Prohibition

40.3.6.1 - Generic ABNs

40.3.6.2 - Blanket ABNs

40.3.6.3 - Signed Blank ABNs

40.3.6.4 - Routine ABN Prohibition Exceptions

40.3.7 - Standards for Situations Where the Beneficiary is in a Medical Emergency or Is Otherwise Under Great Duress

40.3.7.1 - Emergency Medical Treatment and Active Labor Act (EMTALA) Situations

40.3.7.2 - Other Situations

40.3.8 - Reason for Predicting Denial

50 - Form CMS-R-131 Advance Beneficiary Notice (ABN)

50.1 - Basic Requirements for ABNs
50.1.1 - Approved Standard Forms
50.1.2 - User-Customizable Sections
50.1.3 - Where to Obtain the ABN Forms
50.1.4 - OMB Burden Notice for CMS-R-131
50.2 - When and to Whom an ABN Should Be Given
50.2.1 - Likelihood or Certainty of Denial
50.2.2 - Situations in Which ABN Is Not Given
50.2.2.1 - Non-Qualifying Categorical Exclusions
50.2.2.2 - Non-Qualifying Technical Exclusions
50.2.2.3 - When Services Will Not Be Furnished
50.2.2.4 - M+C Enrollees and Non-Medicare Patients
50.2.3 - Qualifying Categorical Exclusions
50.2.4 - Qualifying Technical Exclusions
50.2.5 - Routine ABNs
50.2.6 - Qualified Recipients
50.3 - Delivery of the ABN
50.3.1 - Timely Delivery
50.4 - Choosing the ABN Form to Use
50.5 - Form Instructions for ABN-G and ABN-L (Form CMS-R-131)
50.5.1. - Format of Insertions on ABN
50.5.2 - Guidelines for Customizing the ABN Header
50.5.3 - Patient Name Line
50.5.4 - Medicare Health Insurance Claim Number (HICN) Line
50.5.5 - ABN-G Customizable Boxes
50.5.6 - ABN-L Customizable Boxes
50.5.7 - Estimated Cost Line
50.5.8 - Prohibition of Pre-Selection of an Option on ABNs
50.5.9 - Date and Signature
50.6 - Signature Requirements
50.6.1 - Who May Sign an ABN
50.6.2 - Disputed Signature
50.6.3 - Retention of Signed and Dated Copies of ABNs

50.7 - Special Rules

50.7.1 - Exception for Repetitive Notices

50.7.2 - ABNs for Claims Affected by the Physicians' Services Refund Requirement

50.7.3 - ABNs for Claims Affected by the Medical Equipment and Supplies Refund Requirement

50.7.3.1 - Using ABNs for Medical Equipment and Supplies Claims When Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts) Are Expected

50.7.3.2 - ABNs for Medical Equipment and Supplies Claims Denied Under §1834(j)(1) of the Act (Because the Supplier Did Not Meet Supplier Number Requirements)

50.7.3.3 - ABNs for Medical Equipment and Supplies Claims Denied in Advance Under §1834(a)(15) of the Act - Prior Authorization Procedures

50.7.3.4 - ABNs for Unassigned Claims for Medical Equipment and Supplies Which Are Denied on the Basis of §1862(a)(1) of the Act, as Not Reasonable and Necessary

50.7.4 - ABN Standards for Partial Denials on the Basis of Medical Necessity

50.7.5 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

50.7.6 - ABN Standards for Services in Skilled Nursing Facilities (SNFs)

50.7.7 - Effect of Furnishing ABNs and Collection From Beneficiary

50.7.7.1 - Providing a Proper ABN

50.7.7.2 - Provider's Exposure to Financial Liability

50.7.7.3 - Financial Liability Resulting for Providing a Defective ABN

50.7.7.4 - Collection From Liable Beneficiary

50.7.7.5 - Receiving ABNs From Different Entities

50.7.7.6 - ABNs and Bundled Payment

50.7.7.7 - Health Insurance Portability and Accountability Act of 1996 (HIPAA) Sanctions and the Use of ABNs

50.7.8 - Laboratory Issues with ABNs

50.8 - Instructions for Fiscal Intermediaries and Providers on Advance Beneficiary Notice (ABN) Standards for Items and Services for Which

Institutional Part B Claims Will Be Processed by Fiscal Intermediaries and on Limits on Beneficiary Liability for Medical Equipment and Supplies

50.8.1 - Incorporation by Reference of §50.1-§50.7

50.8.2 - ABNs for Medical and Other Health Services Furnished by a Home Health Agency (HHA) Under Part B

50.8.3 - ABNs for Part B Services Furnished in a Skilled Nursing Facility (SNF)

50.9 - Instructions for Regional Home Health Intermediaries (RHHIs) and Hospices on Advance Beneficiary Notice (ABN) Standards for Certain Hospice Claims

50.9.1 - Incorporation by Reference of §50.1-§50.7

50.9.2 - Denial Situations that Call for ABNs

50.9.3 - Acceptable ABN Language

60 - Form CMS-R-296 Home Health Advance Beneficiary Notice (HHABN)

60.1 - Basic Requirements for HHABNs

60.1.1 - Approved Standard Forms

60.1.2 - User-Customizable Section

60.1.3 - Where to Obtain the HHABN Forms

60.1.4 - OMB Burden Notice for Form CMS-R-296

60.2 - When and to Whom an HHABN Should Be Given

60.2.1 - Expectation of Denial

60.2.2 - Situations In Which HHABN Is Not Given

60.2.2.1 - Categorical Exclusions

60.2.2.2 - Technical Exclusions

60.2.2.3 - Services Not Under HHA PPS

60.2.2.4 - When Home Health Care Services Will Not Be Furnished

60.2.2.5 - M+C Enrollees and Non-Medicare Patients

60.2.3 - Situations in Which HHABN Should Be Given

60.2.3.1 - Triggering Events

60.2.3.2 - Dual-Eligibles

60.2.3.3 - Medicare as Sole Payer

60.2.4 - Routine HHABN Prohibition

60.2.5 - To Whom an HHABN Should Be Given

60.3 - Delivery of HHABNs
60.3.1 - Delivery Must Meet Advance Beneficiary Notice Standards
60.3.2 - HHABN Specific Delivery Issues
60.3.3 - Timely Delivery
60.3.4 - Actual Receipt of Notice Required
60.3.5 - Understandability and Comprehensibility of Notice
60.4 - Form Instructions for the HHABN (Form CMS-R-296)
60.4.1 - General Rules
60.4.2 - Header of HHABN
60.4.3 - Body of HHABN
60.4.4 - Option Boxes
60.5 - Signature Requirements for HHABN
60.6 - Special Rules for HHABNs
60.6.1 - Reissuance of the HHABN
60.6.2 - Acceptance or Rejection of HHABN
60.6.3 - Effect of HHABN on Beneficiary
60.6.4 - Financial Liability
60.6.5 - Limitation on Liability
60.6.6 - Home Care Not Ordered by Physicians
60.6.7 - Regulatory Requirements
60.6.8 - Standards
60.6.9 - Effect of Furnishing HHABNs and Collection From Beneficiary
60.6.9.1 - Effective Notice
60.6.9.2 - Defective Notice
60.6.9.3 - Collection From Beneficiary
60.6.9.4 - Unbundling Prohibition
70 - Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
70.1 - Basic Requirements for SNFABNs
70.1.1 - Approved Model Form
70.1.2 - User-Customizable Section
70.1.3 - Where to Obtain the SNFABN Form
70.2 - When and to Whom a SNFABN Should Be Given
70.2.1 - When and to Whom a SNFABN Should Be Given

70.2.2 - Situations inWhich SNFABN Is Not Given

70.2.2.1 - Categorical Exclusions

70.2.2.2 - Technical Exclusions

70.2.2.3 - Services Not Under SNF PPS

70.2.2.4 - When Extended Care Items or Services Will Not Be Furnished

70.2.2.5 - M+C Enrollees and Non-Medicare Patients

70.2.3 - Situations in Which SNFABN Should Be Given

70.2.3.1 - Triggering Events

70.2.3.2 - Dual-Eligibles

70.2.3.3 - Medicare as Sole Payer

70.2.4 - Routine SNFABN Prohibition

70.2.5 - To Whom a SNFABN Should Be Given

70.3 - Delivery of SNFABNs

70.3.1 - Delivery Must Meet Advance Beneficiary Notice Standards

70.3.2 - SNFABN Specific Delivery Issues

70.3.3 - Timely Delivery

70.3.4 - Actual Receipt of Notice Required

70.3.5 - Understandability and Comprehensibility of Notice

70.4 - Form Instructions for the SNFABN (Form CMS-10055)

70.4.1 - General Rules

70.4.1.1 - Delivery of SNFABN When Based on Statutory Exclusion

70.4.1.2 - Guidelines for Replicating the SNFABN Form

70.4.1.3 - Modification of the SNFABN Form

70.4.2 - Header of SNFABN

70.4.2.1 - Customization of CMS-10055 SNFABN Header

70.4.2.2 - Guidelines for Customizing the SNFABN Header

70.4.3 - Body of SNFABN

70.4.3.1 - Entering the Required Date(s) on the CMS-10055 SNFABN

70.4.3.2 - Specifications Required for the “Items or Services” Section of the SNFABN

70.4.3.3 - Specifications Required for the “Because” Section of the SNFABN

70.4.3.4 - Answering Inquiries About the SNFABN Notification

70.4.3.5 - Providing Cost Estimation(s) for Items or Services on the SNFABN

70.4.3.6 - Providing Non-Medicare Insurance Information on the SNFABN

70.4.3.7 - Providing Contractor Information on the SNFABN

70.4.3.8 - Required Guidelines in Preparation for Submitting Medicare Claims

70.4.3.9 - Providing Appropriate Recipient Name on the SNFABN

70.4.3.10 - Providing the Medicare Health Insurance Claim Number on the SNFABN

70.4.3.11 - Providing Date of Signature on the SNFABN

70.4.4 - Option Boxes

70.4.4.1 - Selecting an Option on the SNFABN

70.4.4.2 - Prohibition of Pre-Selection of an Option on the SNFABN

70.4.4.3 - Effect of Beneficiary’s Option Selection

70.4.5 - Proper Denial Paragraphs

70.5 - Signature Requirements for SNFABN

70.6 - Special Rules for SNFABNs

70.6.1 - Effect of Furnishing SNFABNs and Collection From Beneficiary

70.6.1.1 - Effective Notice

70.6.1.2 - Defective Notice

70.6.1.3 - Collection From Beneficiary

70.6.1.4 - Unbundling Prohibition

70.6.2 - Reissuance of the SNFABN

70.6.3 - Acceptance or Rejection of SNFABN

70.6.4 - Effect of SNFABN on Beneficiary

70.6.5 - Financial Liability

70.6.6 - Limitation on Liability

70.6.7 - Extended Care Items or Services Not Ordered by Physicians

70.6.8 - Regulatory Requirements

70.6.9 - Standards

70.6.9.1 - Establishing When Beneficiary Is On Notice of Noncoverage

70.6.9.2 - Source of Beneficiary Notification

70.6.9.3 - Determining the Notification Date for the Denial Paragraph

70.6.9.4 - Requesting a Medicare Decision

80 - Hospital ABNs (Hospital-Issued Notices of Noncoverage - HINN)

80.1 - When and to Whom a Hospital ABN Should Be Given

80.1.1 - Admission or Preadmission Hospital ABNs

80.1.2 - Continued Stay Hospital ABNs

80.1.2.1 - Attending Physician Concurs

80.1.2.2 - Attending Physician Does Not Concur

80.1.2.3 - Advance Continued Stay Hospital ABN

80.1.3 - Combined Notices in Swing-Bed Situations

80.1.4 - Continued Stay Hospital ABN in Swing Beds Treated as SNF Beds

80.1.5 - Delivery of Hospital ABN

80.1.6 - Qualified Recipients of Hospital ABNs

80.2 - Issuing the Appropriate Hospital ABN

80.3 - Hospital ABNs (HINNs)

80.3.1 – Hospital ABN Content Standards

80.3.2 - Hospital ABNs Model Language

80.3.3 - Hospital ABN Header Text

80.3.4 - Hospital ABN End Text

80.3.5 – Messages for Body of Hospital ABNs 1-9

80.3.5.1 - Hospital ABN 1 Message - Admission or Preadmission

80.3.5.2 - Hospital ABN 2 Message - Continued Stay (Attending Physician Concurs)

80.3.5.3 - Hospital ABN 3 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes From Acute to NF Level of Care)

80.3.5.4 - Hospital ABN 4 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes From Acute to SNF Level of Care)

80.3.5.5 - Hospital ABN 5 Message - Continued Stay (QIO Concurs)

80.3.5.6 - Hospital ABN 6 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes From Acute to NF Level of Care)

80.3.5.7 - Hospital ABN 7 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes From Acute to SNF Level of Care)

80.3.5.8 - Hospital ABN 8 Message - Continued Stay - Swing Bed Only (Patient Changes From SNF to NF or Custodial Care)

80.3.5.9 - Hospital ABN 9 Message - Direct Preadmission/Admission to NF Swing Bed

80.3.6 - Hospital ABN 10 Message - Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization

80.4 - Signature Requirements

80.4.1 - Acknowledgment of Receipt

80.4.2 - Beneficiary Signature Refusal

80.4.3 - Signature Requirements Under Special Circumstances

80.5 - QIO Review Authority for Hospital ABNs

80.6 - QIO Monitoring of Hospital ABNs

80.6.1 - Ongoing Monitoring

80.6.2 - Inappropriate Hospital ABN

80.7 - Notices in Investigational/Experimental Procedures Situations

80.8 - Beneficiary Liability

80.8.1 - Preadmission Hospital ABNs

80.8.2 - Admission Hospital ABNs

80.8.2.1 - Hospital ABN Issued On the Day of Admission

80.8.2.2 - Hospital ABN Issued After the Day of Admission

80.8.3 - Continued Stay Hospital ABNs

80.8.3.1 - For Hospital ABNs Issued With the Concurrence of the Attending Physician

80.8.3.2 - For Hospital ABNs Issued With the Concurrence of the QIO, or With the Concurrence of the Attending Physician

80.8.4 - Grace Days

80.9 - Provider Liability

80.10 - Right to a Reconsideration

80.10.1 - QIO Disagrees With the Hospital’s Determination

80.10.2 - QIO Agrees With the Hospital’s Determination

90 - Form CMS-20007 - Notices of Exclusions From Medicare Benefits (NEMBs)

90.1 - General Rules

90.1.1 - Using NEMBs With Categorical Denials

90.1.2 - Using NEMBsWith Technical Denials

90.1.3 - Readability and Understandability

90.1.4 - Modification of the Form CMS-20007

90.1.5 - Using the Standard Form CMS-20007

90.2 - Header

90.2.1 - Options for Header

90.2.2 - Customizing the Header

90.3 - Explanation Box

90.4 - Check-Off Boxes

90.5 - Footer

100 - Indemnification Procedures for Claims Falling Within the Limitation on Liability Provision

100.1 - Contractor and Social Security Office (SSO) Responsibility in Indemnification Claims

100.2 - Conditions for Indemnification

100.3 - Development and Documentation of Indemnification Requests

100.3.1 - Proof of Payment

100.4 - Beneficiary Requests Indemnification, but Had No Financial Interest in the Claim

100.5 - Questionable Indemnification Requests Procedure

100.6 - Determining the Amount of Indemnification

100.7 - Notifying the Provider, Practitioner, or Supplier

100.8 - Making Payment Under Indemnification

100.9 - Limitation on Liability Determination Does Not Affect Medicare Exclusion

100.10 - Exhibits

Exhibit 1 - Letter to Provider

Exhibit 2 - Letter to Beneficiary Who Requests Indemnification

Exhibit 3 - Letter to Someone Other Than Beneficiary Who Requests Indemnification

Exhibit 4 - Letter to Practitioner or Supplier (Noninstitutional Services)

Exhibit 5 - Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)

Exhibit 6 - Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services)

Exhibit 7 - Statement of Claimant or Other Person

110 - Contractor Instructions for Application of Limitation On Liability

110.1 - Payment Under Limitation on Liability

110.2 - When to Make Limitation on Liability Decisions

110.3 - Preparation of Denial Notices

110.4 - Bill Processing

110.5 - Contractor Review of ABNs

110.5.1 - General Rules

110.5.2 - Situations in Which Contractor Review of ABNs is Indicated.

110.5.3 - Other Reasons for Contractor Request for Copies of ABNs

120 - Carrier Specific Instructions for Application of Limitation on Liability

120.1 - Documentation of Notices Regarding Coverage

120.2 - Availability of Coverage Notices to Operating Personnel

120.3 - Applicability of Limitation on Liability Provision to Claims for Outpatient Physical Therapy Services Furnished by Clinics

120.4 - Limitation on Liability Notices to Beneficiaries From Carriers

120.5 - Carrier Reviews in Assignment Cases Conducted at the Request of Either the Beneficiary or the Assignee

120.5.1 - Guide Paragraphs for Carriers to Use Where §1879 Is Applicable at Review Level

130 - Intermediary Specific Instructions for Application of Limitation on Liability

130.1 - Applicability of the Limitation on Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B

130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services

130.1.2 - Determining Provider Liability in Claims for Ancillary and Outpatient Services

130.2 - Prior Hospitalization and Transfer Requirements for SNF Coverage as Related to Limitation on Liability

130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds

130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

140 - Physician Refund Requirements (RR) Provision for Nonassigned Claims for Physicians Services Under §1842(l) - Instructions for Carriers and Physicians

140.1 - Services Furnished Before October 1, 1987

140.2 - Services Furnished Beginning October 1, 1987

140.3 - Time Limits for Making Refunds

140.4 - Situations Where a Refund Is Not Required

140.5 - Appeal Rights

140.6 - Processing Initial Denials

140.6.1 - Initial Beneficiary Notices

140.6.2 - Initial Physician Notices

140.7 - Processing Beneficiary Requests for Review

140.8 - Processing Physician Requests for Review

140.8.1 - Review of the Denial or Reduction in Payment

140.8.2 - Beneficiary Given ABN and Agreed to Pay

140.8.3 - Physician Knowledge

140.9 - Guide Paragraphs for Inclusion in Review Determination

140.10 - Physician Fails to Make Refund

140.11 - OIG Referral Procedures

140.12 - Imposition of Sanctions

150 - DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) - Instructions for Carriers and Suppliers

150.1 - Definition of Medical Equipment and Supplies

150.1.1 - Unassigned Claims Denied on the Basis of the Prohibition on Unsolicited Telephone Contacts

150.1.2 - Unassigned Claims Denied on the Basis of Not Being Reasonable and Necessary

150.1.3 - Unassigned Claims Denied on the Basis of Failure of the Supplier to Meet Supplier Number Requirements

150.1.4 - Assigned Claims Denied on the Basis of the Prohibition on Unsolicited Telephone Contacts

150.1.5 - Assigned Claims Denied on the Basis of Failure of the Supplier to Meet Supplier Number Requirements

150.1.6 - Assigned Claims Denied on the Basis of Not Being Reasonable and Necessary

150.2 - Items and Services Furnished on an Unassigned Basis on or After January 1, 1995

150.3 - Items and Services Furnished On an Assigned Basis On or After January 1, 1995

150.4 - Time Limits for Making Refunds

150.5 - Supplier Knowledge Standards for Waiver of Refund Requirement

150.5.1 - Knowledge Standards for §1862(a)(1) Denials

150.5.2 - Knowledge Standards for §1834(a)(15) Denials

150.5.2.1 - Denial of Payment in Advance

150.5.2.2 - When a Request for an Advance Determination of Coverage Is Mandatory

150.5.2.3 – When a Request for an Advance Determination of Coverage Is Optional

150.5.2.4 - Presumption for Constructive Notice

150.5.2.5 - Presumption When Advance Determination was Requested

150.5.2.6 - Presumption for Listed Overutilized Items

150.5.2.7 - Presumption for Listed Suppliers

150.5.2.8 - Presumption for Medical Necessity

150.5.2.9 - Presumption About Beneficiary Knowledge

150.5.3 - Knowledge Standards for §1834(a)(17)(B) Denials

150.5.4 - Knowledge Standards for §1834(j)(1) Denials

150.5.5 - Additional Knowledge Standards for All Medical Equipment and Supplies Denials

150.6 - Advance Beneficiary Notice Standards for Waiver of Refund Requirement

150.7 - Appeal Rights

150.8 - Processing Initial Denials

150.9 - Processing Beneficiary Requests for Review

150.10 - Processing Supplier Requests for Review

150.10.1 - Review of the Denial of Payment

150.10.2 - Beneficiary Given Advance Beneficiary Notice and Agreed to Pay

150.10.3 - Supplier Knowledge

150.11 - Guide Paragraphs for Inclusion in Review Determination

150.12 - Supplier Fails to Make Refund

150.13 - CMS Regional Office (RO) Referral Procedures

150.14 - Imposition of Sanctions

150.15 - Supplier’s Right to Recover Resaleable Items for Which Refund Has Been Made

10 - Financial Liability Protections (FLP) Provisions of Title XVIII

(Rev. 1, 10-01-03)

The financial liability protections (FLP) provisions of the Social Security Act (the Act) protect beneficiaries and health care providers (physicians, practitioners, suppliers, and providers) under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The FLP provisions include:

- Limitation On Liability (LOL) under §1879(a)-(g) of the Act.
- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l) of the Act.
- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act.

The FLP provisions apply to individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B), but are not applicable to Medicare M+C (Part C) enrollees nor to non-Medicare enrollees. The Advance Beneficiary Notices (ABNs) proper to the FLP provisions are to be used solely for individuals enrolled in the Medicare FFS program and are not to be used for Medicare M+C enrollees nor for non-Medicare enrollees.

The FLP provisions apply very specifically, on the basis of the statutory provision under which a particular denial occurs as well as other criteria described in this Chapter 30. The manner in which the FLP provisions apply varies by whether or not the claim is assigned or non-assigned, under Part A or Part B, and the statutory basis for denial of the claim. Following are frequently asked questions (FAQs) about differences between the Limitation On Liability and Refund Requirements provisions. More specific guidance follows later in this Chapter.

Q.1. What are the main differences between "Limitation On Liability" (LOL) and the "Refund Requirements" (RR)?

A.1. LOL and RR are both financial liability provisions of the Medicare law. LOL is provided under §1879(a)-(g) of the Act for all Part A services and all assigned claims for Part B services. RR is provided under §1879(h) of the Act for assigned claims for medical equipment and supplies. RR is also provided for unassigned claims for medical equipment and supplies under §§1834(a)(18) and 1834(j)(4) of the Act and for unassigned claims for physicians' services under §1842(l) of the Act. LOL provides for program payment for denied claims in certain circumstances, and for beneficiary indemnification in certain circumstances. RR does not provide for either program payment or indemnification, but does provide that physicians and suppliers, if held liable under RR provisions, must make refunds to beneficiaries of any amounts collected.

Q.2. Is there some difference in the significance of the beneficiary's signature on an Advance Beneficiary Notice (ABN) depending on whether LOL or RR applies?

A.2. Yes. In order for a beneficiary to be held liable under RR, that is, under §§1834(a)(18), 1834(j)(4), 1842(l), or 1879(h) of the Act, it is necessary that the beneficiary sign the ABN. All the RR provisions require, not only that the beneficiary be notified, but also that the beneficiary agree to pay in order for the beneficiary to be held liable. Thus, an unsigned ABN cannot be used to shift liability to a beneficiary when RR applies. Under LOL, a beneficiary signature is not an absolute requirement. The LOL provision requires only that the beneficiary be properly notified; there is no explicit requirement for an agreement to pay. Therefore, these instructions provide for the situation in which a beneficiary receives an ABN, refuses to sign it, but still demands to receive the services specified on the ABN. In that case, the provider, physician, practitioner, or supplier can annotate the form, with the signature of a witness, that the beneficiary received notice but refused to sign the form, and can submit the claim with an indication that an ABN was given.

Q.3. The ABN forms indicate that, if Medicare denies payment, the beneficiary agrees to be personally and fully responsible for payment and to pay personally, either out of pocket or through any other insurance that the beneficiary has. Why is that, if LOL does not require the beneficiary to agree to make payment?

A.3. The LOL provisions require only that the beneficiary be notified (i.e., agreement to pay is not a requirement); nevertheless, since the beneficiary's signature on an ABN indicating receipt can, and very likely will, result in his or her financial liability under the LOL provisions, the approved ABN form includes agreement to pay language in all cases, as a matter of full disclosure. Consumer testing indicated that beneficiaries appreciated this information and considered it important and necessary for making an informed consumer decision. Furthermore, not including this information on ABNs given in LOL applicable situations could easily mislead beneficiaries to think that they have a third option, i.e., to receive the services and not accept liability; which is not a genuine option under LOL. Under LOL, a beneficiary who is properly notified and who receives a service which is subsequently denied payment for the reasons cited on the ABN can be held liable, whether or not the beneficiary agreed to make payment. This fact is a significant difference between LOL and RR.

20 - Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed

(Rev. 1, 10-01-03)

A3-3431, B3-7300.1

Section 1879(a)-(g) of the Act provides financial relief to beneficiaries, providers, practitioners, physicians, and other suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision."

The basic purpose of this provision is to protect beneficiaries and other claimants from liability in denial cases under certain conditions when services they received are found to be excluded from coverage for one of the reasons specified in §20.1.

Medicare payment under the limitation on liability provision is dependent upon two primary factors. First, the claims for the services or items furnished must have been denied for one of the reasons specified in §20.1. The second factor in determining if Medicare payment is made under the limitation on liability provision is whether the beneficiary and/or the provider, practitioner, physician, or other supplier knew or could reasonably have been expected to know that the items or services (for which Medicare payment was denied on one of the bases specified in §20.1) were not covered. A determination of whether the protection under the limitation on liability provision can be afforded for a denied claim is made as a result of a prepayment medical review or a post-payment audit review. Unfavorable determinations may be appealed.

Where items or services are denied for one of the reasons specified in §20.1, and the other conditions described above are met, the Medicare program makes payment when neither the beneficiary nor the provider, practitioner, or supplier knew, and could not reasonably be expected to have known, that the items or services were not covered. When the beneficiary did not have such knowledge, but the provider, practitioner, or supplier knew, or could have been expected to know, of the exclusion of the items or services, the liability for the charges for the denied items or services rests with the provider, practitioner or supplier. When the beneficiary knew or could have been reasonably expected to know that the items or services were not covered, the liability for the charges rests with the beneficiary, i.e., the beneficiary is responsible for making payment to the provider, practitioner or supplier.

The limitation on liability provision requires the contractor to identify each claim for items or services denied for one of the reasons specified in §20.1. Such denials are processed in the normal manner except that a special message is entered on the notice to the beneficiary and/or provider, practitioner or supplier. Remittance Advices (RA) to providers, practitioners, or suppliers indicate which items or services were denied for one of the reasons specified in §20.1 in a message included in the RA.

In some cases, the provider, practitioner, or supplier may submit a copy of an advance beneficiary notice (ABN) that satisfies the applicable requirements in §50 - §90, inclusive or may annotate the claim to show that such ABN was given. The contractor should not make an automatic finding that the service is denied for one of the reasons specified in §20.1 merely because an acceptable ABN has been submitted. The fact that there is an acceptable ABN must in no way prejudice the contractor determination as to whether there is or is not sufficient evidence to justify a denial for one of the reasons specified in §20.1.

20.1 - Coverage Denials to Which the Limitation on Liability Applies

(Rev. 1, 10-01-03)

B3-7300.2, B3-7300.3, CMS Rulings (No. 95-1, 96-2, 96-3, 97-1)

20.1.1 - Statutory Basis

(Rev. 1, 10-01-03)

A coverage determination for an item or service must be made **before** there can be a decision with respect to whether Medicare payment may be made under the limitation on liability provision. Medical review entities, acting for the Secretary, are authorized to make the coverage determinations. These entities include fiscal intermediaries (FIs), carriers, and Quality Improvement Organizations (QIOs). In CMS Ruling 95-1 and hereafter in these instructions, these entities are referred to collectively as Medicare contractors. These entities must act in accordance with the Medicare statutes, regulations, national coverage instructions, accepted standards of medical practice, and CMS Rulings when making coverage determinations.

The claims payment and beneficiary indemnification provisions (§§1879(a) and (b)) of the limitation on liability provision are applicable only to claims for beneficiary items or services submitted by providers, or by suppliers (which includes physicians or other practitioners, or an entity other than a provider that furnishes health care services under Medicare) that have taken assignment, and only to claims for services, not otherwise statutorily excluded, that are denied on the basis of §§1862(a)(1), 1862(a)(9), 1879(e), or 1879(g) of the Act, which, under current law, include the following:

- Services and items found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (§1862(a)(1)(A) of the Act);

- Pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration, furnished to an individual at high or intermediate risk of contracting hepatitis B, that are not reasonable and necessary for the prevention of illness (§1862(a)(1)(B) of the Act);

- Services and items that, in the case of hospice care, are not reasonable and necessary for the palliation or management of terminal illness (§1862(a)(1)(C) of the Act);

- Clinical care services and items furnished with the concurrence of the Secretary and, with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, that are not reasonable and necessary to carry out the purposes of §1886(e)(6) of the Act (which concerns identification of medically appropriate patterns of health resources use) (§1862(a)(1)(D) of the Act);

- Services and items that, in the case of research conducted pursuant to §1142 of the Act, are not reasonable and necessary to carry out the purposes of that section (which concerns research on outcomes of health care services and procedures) (§1862(a)(1)(E) of the Act);

- Screening mammography that is performed more frequently than is covered under §1834(c)(2) of the Act or that is not conducted by a facility described in §1834(c)(1)(B) of the Act and screening pap smears and screening pelvic exams performed more frequently than is provided for under §1861(nn) of the Act (§1862(a)(1)(F) of the Act);

- Screening for glaucoma, which is performed more frequently than is provided under §1861(uu);

- Prostate cancer screening tests (as defined in §1861(oo)), which are performed more frequently than is covered under such section;

- Colorectal cancer screening tests, which are performed more frequently than is covered under §1834(d);

- The frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;

- Custodial care (§1862(a)(9) of the Act);

- Inpatient hospital services or extended care services if payment is denied solely because of an unintentional, inadvertent, or erroneous action that resulted in the beneficiary's transfer from a certified bed (one that does not meet the requirements of §1861(e) or (j) of the Act) in a skilled nursing facility (SNF) or hospital (§1879(e) of the Act);

- Home health services determined to be noncovered because the beneficiary was not "homebound" or did not require "intermittent" skilled nursing care (as required by §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act) on or after July 1, 1987, and before December 31, 1995 (§1879(g)(1) of the Act); and.

- Hospice care determined to be noncovered because the beneficiary was not "terminally ill" (as required by §1861(dd)(3)(A) of the Act), as referenced by §1879(g)(2) of the Act since BBA 1997.

20.1.2 - Dependent Services

(Rev. 1, 10-01-03)

When it is determined that Medicare payment will be made under the limitation on liability provision for claims for items or services that were denied for one of the reasons specified in §20.1.1, the payment determination includes claims for any dependent services that are denied as an indirect result of these denials. This longstanding CMS

policy is based on the fact that the cause for denial of payment for the qualifying service is the primary cause for denial of the dependent services. For example, where a particular qualifying service is denied as not reasonable and necessary under §1862(a)(1) of the Act, lack of medical necessity is the underlying reason for the denial of the dependent services. Therefore, if the limitation on liability protection applies to the denial of the qualifying service, it will also apply to the dependent service.

For example, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, home health aide services can be covered only if a beneficiary needs intermittent skilled nursing care. When coverage is denied for intermittent skilled nursing services (the qualifying primary services) under §1862(a)(1) or (9) of the Act, home health aide services (the dependent services) likewise are not covered. In such cases, if Medicare payment is made under the limitation on liability provision for the primary services, it would be made for the dependent services as well, provided the services are otherwise covered (that is, all other conditions for payment of the dependent services are met including a physician's certification of the need for the dependent services and proof that the services are reasonable and necessary).

20.1.3 - Partial Denials Based on Reasonable and Necessary Levels of Care

(Rev. 1, 10-01-03)

The limitation on liability protection may also be applicable if a reduction in the level of payment occurs because the furnished services or items are at a level higher than was reasonable and necessary to meet the needs of the patient. This is because Medicare payment for the difference between reasonable and necessary services and items and those actually furnished is denied on the basis of §1862(a)(1)(A) of the Act as not reasonable and necessary. For example, if it is determined that the level of care furnished by a hospice (such as continuous home care) was not reasonable and necessary under §1862(a)(1)(A) because the care could have been given at a lower level (such as routine home care), Medicare payment under the limitation on liability provision may be made for the difference in reimbursement between the denied continuous home care and the approved routine home care if both the beneficiary and provider did not know, or could not reasonably have been expected to know, that payment would not be made for the higher level of care.

The limitation on liability protection may also be applicable if the contractor reduces the level of payment on the basis of §1862(a)(1) of the Act, that is, when partially denying a more extensive service or item on the basis that it is not reasonable and necessary, even though Medicare pays for a less extensive service or item. A case in which the level of payment is reduced because a component of the service or item is in excess of the beneficiary's medical needs is a medical necessity partial denial of that unnecessary component of the covered item or service. "Excess component" means an item, feature, or service, and/or the extent of, number of, duration of, or expense for an item, feature, or service, which is in addition to, or is more extensive and/or more expensive than, the item or service which is reasonable and necessary under Medicare's coverage requirements.

For example, a deluxe or aesthetic feature of an upgraded item of medical equipment is an "excess component." Charge increases on the basis of purported premium quality services are not considered to be "excess components" since that would constitute circumvention of payment limits and applicable charging limits (e.g., limiting charges in the case of unassigned claims for physicians' services and fee schedule amounts in the case of assigned claims). The "excess component" definition for partial denials, with respect to an item, feature, or service that is "more expensive" refers to increased charges attributable to furnishing something that is clearly more extensive, that is, more in number, more frequent, for a longer period of time, or with added features; it does not suffice to claim that an item or service is "better" or "higher quality."

20.2 - Denials for Which the Limitation On Liability Provision Does Not Apply

(Rev. 1, 10-01-03)

CMS Ruling 95-1, PM AB-02-168 Part I

Medicare payment under the limitation on liability provision cannot be made when Medicare coverage is denied on any basis other than one of the provisions of the law specified in §20.1.1. (See the Medicare Financial Management Manual, Chapter 3, concerning liability for overpayments arising from other causes.) There are certain claims, however, that may appear to involve a question of medical necessity, as described in §1862(a)(1) of the Act, but the actual Medicare payment denial is based on a statutory provision other than §1862(a)(1). Under these circumstances, Medicare payment under the limitation on liability provision cannot be made because the denial is not based on one of the statutory provisions specified in §20.1.1.

Section 1879(a) of the Act provides that Medicare payment will be made under the limitation on liability provision "when a determination is made that, by reason of §1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g) of the Act, payment may not be made under Part A or Part B" and the conditions described in §1879(a)(2) are met. The statute thus explicitly restricts the application of the limitation on liability provision to cases that are decided on one of the statutory grounds we have specified in §20.1.1. In so providing, the Congress recognized that the issue of medical necessity of a service or item need never be reached if it were determined that the service or item would not otherwise be covered under the statute.

For example, when a Part B claim is submitted for ambulance services, the first step in processing the claim is to determine whether the services meet the requirements of §1861(s)(7) of the Act (that is, to ascertain that other methods of transportation are contraindicated) and, therefore, may be covered services under the Medicare statute. If other methods of transportation are contraindicated (and all other regulatory criteria met), only then must the Medicare contractor determine if the ambulance services are "reasonable and necessary" under §1862(a)(1). If other methods of transportation are not contraindicated, there is no reason for the Medicare contractor to make a medical

necessity determination under §1862(a)(1) because the services have already been determined to be not otherwise covered under the Medicare statute.

Therefore, when items or services are denied for any reason other than one of the specific statutory bases for denial specified in §20.1.1, limitation on liability cannot be applied.

20.2.1 - Categorical Denials

(Rev. 1, 10-01-03)

Examples of circumstances in which Medicare payment under the limitation on liability provision cannot be made because the actual Medicare payment denial is based on a statutory provision other than §1862(a)(1) include, but are not limited to, the following categorical exclusions under §1862(a)(2)-(8) and (10)-(21) of the Act:

Personal comfort items (§1862(a)(6)).

- Routine physicals and most tests for screening (§1862(a)(7)).
- Most shots (vaccinations) (§1862(a)(7)).
- Routine eye care, most eyeglasses and examinations (§1862(a)(7)).
- Hearing aids and hearing examinations (§1862(a)(7)).
- Cosmetic surgery (§1862(a)(10)).
- Orthopedic shoes and foot supports (orthotics) (§1862(a)(8)).
- Dental care and dentures (in most cases) (§1862(a)(12)).
- Routine foot care and flat foot care (§1862(a)(13)).
- Services under a physician’s private contract (§1862(a)(19)).
- Services paid for by a governmental entity that is not Medicare (§1862(a)(3)).
- Health care received outside of the U. S. not covered by Medicare (§1862(a)(4)).
- Services by immediate relatives (§1862(a)(11)).
- Services required as a result of war (§1862(a)(5)).
- Services for which there is no legal obligation to pay (§1862(a)(2)).
- Home health services furnished under a plan of care, if the agency does not submit the claim (§1862(a)(21)).

- Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997 (§1862(a)(16)).

- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need) (§1862(a)(17)).

- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangement with the hospital (§1862(a)(14)).

- Items and services furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility, unless they are furnished under arrangements by the skilled nursing facility (§1862(a)(18)).

- Services of an assistant at surgery without prior approval from the peer review organization (§1862(a)(15)).

- Outpatient occupational and physical therapy services furnished incident to a physician's services (§1862(a)(20)).

NOTE: Refer to §1862(a) of the Act for a more complete listing than above.

20.2.2 - Technical Denials

(Rev. 1, 10-01-03)

Examples of circumstances in which Medicare is expected to deny payment for an item or service which may be a Medicare benefit but for which the coverage requirements are not met, include, but are not limited to, the following technical denials:

- Payment for the additional cost of a private room in a hospital or SNF is denied when the privacy accommodations are not required for medical reasons. Medicare payment for the additional cost is denied on the basis of §1861(v)(2) of the Act.

- Payment for a dressing is denied because it does not meet the definition for "surgical dressings" in §1861(s)(5) of the Act. Accordingly, Medicare payment is denied on the basis of §1861(s)(5) of the Act.

- Payment for SNF stays not preceded by the required 3-day hospital stay.

- Payment for SNF stay because the beneficiary did not meet the requirement for transfer to a SNF and for receiving covered services within 30 days after discharge from the hospital and because the special requirements for extension of the 30 days were not met.

- Payment for home health services because they were not ordered on a plan of treatment or subsequent amendment.

- Payment for any form of parenteral and enteral nutrition therapy because the beneficiary did not qualify for the prosthetic device benefit under §1861(s)(8) of the Act.

- Payment for items that do not meet the definition of durable medical equipment (§1861(n)). Such items can never be covered even though in an individual case they may seem medically necessary because of the patient's condition.

- Payment for a medically unreasonable or unnecessary item or service that is also barred because of failure to meet a condition of payment required by regulations, as in the following examples:

    a. Drugs and biologicals which are usually self-administered by the patient (§1861(s)(2)(A)&(B));

    b. Ambulance services denied because transportation by other means is not contraindicated or because regulatory criteria specified in 42 CFR 410.40, such as those relating to destination or nearest appropriate facility, are not met. In such circumstances, Medicare payment is denied on the basis of §1861(s)(7) of the Act. (See the Medicare Benefit Policy Manual, Chapter 10).

    (**NOTE:** The limitation on liability provision could apply, however, where payment for ambulance services was fully or partially denied as unreasonable, as in the following examples. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation. A level of care downgrade, e.g., from Advance Life Support (ALS)-2 to ALS-1, or from ALS to Basic Life Support, when the transport at the lower level of care is a covered transport. A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary's home. A transport of a skilled nursing facility patient to a hospital or to another SNF for a service that can be performed more economically in the first SNF.)

    c. Other items or services that must be denied under 42 CFR 410.12 through 410.105 of the Medicare regulations.

    A reduction in allowed charges results from the contractor's determination that the claim does not meet the reasonable charge criteria, since the authority for reasonable charge reductions is found in §1842. However, when the contractor determines that a claim is to be allowed as a lesser service, the partial denial is based on a decision that the greater service is not reasonable and necessary per §1862(a)(1) and therefore, limitation on liability can apply.

30 - Determining Liability for Disallowed Claims Under §1879

(Rev. 1, 10-01-03)

A3-3432, B3-7300.4

See §20 for the criteria that must be met before the FI or carrier (hereafter referred to collectively as "contractor") considers limitation on liability as discussed in the following subsections.

Ordinarily a finding is made that the beneficiary did not know nor could reasonably have been expected to know that the items or services were not covered by Medicare, unless there is evidence as discussed in §40.2. The procedures for determining whether the provider knew or could reasonably have been expected to know of the noncoverage of services are discussed in §40.1.

30.1 - Determining Beneficiary's Liability

(Rev. 1, 10-01-03)

A3-3432.1, CMS Ruling 95-1, PM AB-02-168

The contractor presumes that the beneficiary did not know that services are not covered **unless** the evidence indicates that written notice was given to the beneficiary. In some cases, the beneficiary may have been given notice in a recent previous claim that a type of care is not covered. More commonly, as indicated above, the provider, practitioner, or supplier gives an ABN to the beneficiary that a particular stay or course of treatment is not covered or that coverage ended at a particular time. (See §40.2 regarding when a beneficiary is on notice of noncoverage.) On any claim to which limitation on liability applies, the beneficiary liability determination is to be made first by the contractor, followed (as may be necessary) by the provider, practitioner, or supplier liability determination.

30.1.1 - Beneficiary Determined to Be Liable - Right to Appeal

(Rev. 1, 10-01-03)

Under §1879(c) of the Act and 42 CFR 411.404, the beneficiary is held to be liable when it is determined that he or she had prior knowledge that Medicare payment for the service or item would be denied or could reasonably have been expected to have had such knowledge. The most likely reason to find that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay is where, before the item or service was furnished, the provider, practitioner, or supplier notified the beneficiary by properly delivering the approved Advance Beneficiary Notice (ABN), of the certainty or likelihood that Medicare would not pay for the specific service. In these instances, the contractor determines that the beneficiary is liable and the beneficiary is held responsible for expenses incurred for services or items for which Medicare payment is denied, regardless of whether the provider, practitioner, or other supplier had knowledge. The

Medicare program makes no payment to the beneficiary, provider, practitioner, or other supplier. However, the beneficiary can appeal both the coverage issue, and the contractor's determination of beneficiary liability for the cost of the noncovered care. (See Chapter 29, "Appeals of Claim Decisions.") In a case where a beneficiary received an ABN and, upon initial determination, the claim was paid as covered, that original ABN cannot be used as evidence of knowledge to hold the beneficiary liable in a later case relating to a similar or reasonably comparable service in which the same reason for denial applies, since the original ABN was belied by the favorable payment decision.

30.1.2 - Beneficiary Determined to Be Without Liability

(Rev. 1, 10-01-03)

In deciding whether the beneficiary or his/her authorized representative knew, or could reasonably have been expected to know, that payment would not be made for items or services s/he received, the beneficiary's allegation that s/he did not know, in the absence of evidence to the contrary, will be acceptable evidence for LOL purposes. Unless evidence indicates that the beneficiary knew or had reason to know that the items or services received were noncovered, the contractor presumes that the beneficiary did not know that the services are not covered. Under §1879(a)(2) of the Act and the accompanying regulations at 42 CFR 411.400(a)(2), the Medicare program must make payment when the provider, practitioner, or other supplier did not know and could not reasonably have been expected to know that the services or items would be denied. In these instances, the usual deductible and coinsurance amounts apply. The number of days or visits paid for under the limitation on liability provision is charged to the beneficiary's utilization record. Medicare payment may also be made under §1154(a)(2)(B) of the Act and 42 CFR 411.400(b)(2) for a 1-day "grace period" after the date of notice to the provider or to the beneficiary, whichever is earlier, if additional time is needed to arrange for post-discharge care. If it is determined thereafter by a QIO or the Medicare contractor that even more time is required in order to arrange post-discharge care, 1 additional "grace period" day is paid. Initial approval of 2 or more "grace period" days is not permitted. The "grace period" is applicable only if circumstances would have permitted Medicare program payment under §1879(a)(1) and (2) of the Act and 42 CFR 411.400(b)(2), that is, protection under the limitation on liability provision was afforded both to the beneficiary and the provider;

Unless the provider is found to be liable for the items for which the beneficiary was not held liable:

- All days or HHA visits for which the beneficiary received the benefit of limitation on liability (regardless of whether Medicare payment is made) are charged to the beneficiary's utilization record of hospice and SNF days and HHA visits, as though covered under Medicare; and

- Such days and visits are shown as having been used on CMS' notice to the beneficiary.

Under §1879(b) of the Act and 42 CFR 411.402, Medicare does not make payment when it is determined that the provider, practitioner, or other supplier had prior knowledge that Medicare would deny payment for services or items or could reasonably have been expected to have had this knowledge. In these instances, the beneficiary is not responsible for paying the deductible and coinsurance charges related to the denied claim and the beneficiary's Medicare utilization record is not charged for the services and items furnished, effective for all services or items furnished on or after January 1, 1988.

30.2 - Determining Provider, Practitioner, or Supplier Liability

(Rev. 1, 10-01-03)

A3-3432.2, CMS Ruling 95-1

30.2.1 - General

(Rev. 1, 10-01-03)

The contractor holds the provider, practitioner, or supplier liable for noncovered services if it is determined that the provider:

- Had actual knowledge of the noncoverage of services in a particular case, or
- Could reasonably have been expected to have such knowledge.

However, it does not hold a provider, practitioner, or supplier liable under §1879 where the provider, practitioner, or supplier indicates on the claim (via Occurrence Code 32 for FI claims, and via use of the HCPCS code modifier "GA" on carrier claims) that they have given the beneficiary, before furnishing the items or services, an ABN. In such a case, the contractor holds the beneficiary, not the provider, practitioner, or supplier, liable for the denied charges.

30.2.2 - Provider/Practitioner/Supplier is Determined to Be Liable - Right to Appeal

(Rev. 1, 10-01-03)

A provider, practitioner, or supplier that is determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary may appeal such a decision by the contractor under certain conditions. If a beneficiary is partially liable for the noncovered items or services, the contractor must first establish that the beneficiary will not exercise his/her appeal rights. (See Chapter 29, "Appeals of Claims Decisions.") If the beneficiary chooses not to appeal, the provider, practitioner, or supplier has the right to appeal both the coverage and limitation on liability decisions. However, a provider, practitioner, or supplier does not have a right to appeal when neither the beneficiary nor the provider is liable, e.g., when the entire noncovered portion of the stay is paid under §1879.

NOTE: Under §1879(b) of the Act and 42 CFR 411.402 et seq., if the provider, practitioner, or other supplier is considered to be liable and requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of the beneficiary's expenses, the Medicare program indemnifies the beneficiary or other person(s) for any amounts paid by the beneficiary. This includes any deductible or coinsurance charges paid by or on behalf of the beneficiary. Further, these indemnification payments are considered an overpayment to the provider, practitioner, or other supplier. The limitation on liability provision applies to third party payers, including liability insurers. Therefore, a provider, practitioner, or supplier that the contractor determines liable may not seek payment from a third party payer without being subject to recovery action that could occur if it sought payment from the beneficiary.

30.2.3 - Provider/Practitioner/Supplier Determined to Be Without Liability

(Rev. 1, 10-01-03)

If the contractor determines that neither the provider, practitioner, or supplier nor the beneficiary knew or had reason to know that the services provided the beneficiary were not covered, the Medicare program will accept liability and make payment. (See §110.1.)

40 - Determining Knowledge for FLP Purposes

(Rev. 1, 10-01-03)

CMS Ruling 95-1

The proper application of all the financial liability protections (FLP) provisions requires determinations about beneficiaries' knowledge (or lack of knowledge), before items and/or services were furnished, that Medicare was certain or likely to deny payment for the items or services. For the protection under the Limitation On Liability (LOL) provision or any Refund Requirements (RR) provision to be afforded, lack of prior knowledge that Medicare payment for the item or service would be denied must first be established. Two determinations must be made to establish knowledge: first, whether and when the beneficiary knew or should have known that Medicare payment for the item or service would be denied (see §40.2), and, second, whether and when the provider, practitioner, or other supplier knew or should have known that Medicare payment for the item or service would likely be denied (see §40.1). The principles for determining knowledge described in §§40.1 and 40.2 apply, unless otherwise explicitly specified, to determinations of knowledge with respect to denials under these FLP provisions:

- Limitation On Liability (LOL) under §1879(a)-(g);
- Refund Requirements (RR) for Non-assigned Claims for Physicians Services under §1842(l); and

- Refund Requirements (RR) for Assigned and Non-assigned Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h).

40.1 - Determining Whether Provider, Practitioner, or Supplier Had Knowledge of Noncoverage of Services

(Rev. 1, 10-01-03)

CMS Ruling 95-1, A3-3439, A3-3440

The Medicare contractors determine, based on the information they maintain and/or disseminate to a particular provider, practitioner or other supplier, whether the provider, practitioner or other supplier actually had prior knowledge that services or items would likely be denied or whether knowledge reasonably could have been expected. The determination of actual or expected knowledge is based on all the relevant facts pertaining to each particular denial. In accordance with regulations at 42 CFR 411.406, evidence that the provider, practitioner, or other supplier did, in fact, know or should have known that Medicare would not pay for a service or item includes:

- A Medicare contractor's prior written notice to the provider, practitioner, or other supplier of Medicare denial of payment for similar or reasonably comparable services or items;

- Medicare's general notices to the medical community of Medicare payment denial of services and items under all or certain circumstances (such notices include, but are not limited to, manual instructions, bulletins, carriers' written guides, and directives); and

- Provision of the services and items was inconsistent with acceptable standards of practice in the local medical community (refer to §40.1.3 and §40.1.4).

If any of the circumstances described above exists, a provider, practitioner or other supplier is held to have knowledge.

40.1.1 - Criteria for Determining Practitioner and Other Supplier Knowledge

(Rev. 1, 10-01-03)

The practitioner or other supplier, at the initial determination, is presumed to have had the requisite knowledge of likely Medicare denial of payment for denied services or items and, thereby, to be liable, with one exception. If a practitioner or other supplier gives the beneficiary proper written advance beneficiary notice that Medicare will likely deny payment for the service or item to be furnished, and so documents the claim, the beneficiary is held liable for the denied services or items at the initial determination. Such a notice constitutes proof that both the beneficiary and the practitioner or other supplier had prior knowledge that Medicare payment would be denied for the service or item in

question. When both the beneficiary and the practitioner or other supplier are found to have had the requisite knowledge of likely Medicare denial, the beneficiary is held liable. The issue of whether the practitioner or other supplier is liable arises only when the beneficiary has already been found not liable.

If the practitioner or other supplier cannot show that the beneficiary received proper written advance beneficiary notice, the practitioner or other supplier will be presumed to have knowledge (and, thereby, liability) unless he/she/it can prove that he/she/it did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service or item. If the practitioner or other supplier can make such a convincing showing, the contractor will find that the practitioner or other supplier did not have the requisite knowledge.

40.1.2 - Criteria for Determining Provider Knowledge

(Rev. 1, 10-01-03)

A provider is always considered to have prior knowledge, and no Medicare payment will be made to any provider for any claim, if previous notification was given or if for any other reason the provider clearly should have known that the claim would be denied. Criteria for determining whether a provider had knowledge or should have had knowledge that services or items would be denied are in regulations at 42 CFR 411.406, which cites various forms and methods of notification that provide sufficient evidence that the provider knew or should have known that the services or items would be denied. Such notices are sufficient notice for all subsequent claims involving that same service or item under similar or reasonably comparable conditions. In general, notification often is provided by one of the following sources:

- The provider's utilization review committee informed the provider in writing that the services were not covered;

- The provider previously submitted a no-payment claim (i.e., a *pro forma* filing in which no payment is sought, rather, only a formal payment denial determination is requested), or submitted a claim for Medicare payment only at the request of the beneficiary;

- The provider issued a written advance beneficiary notice of the likelihood of Medicare payment denial for a service or item to the beneficiary;

- Medicare has issued manuals, bulletins, memoranda, etc., advising providers of the noncoverage of a particular service or category of services. All participating providers are issued instructions that discuss and define coverage and noncoverage of specified services under Medicare. For example, instructions in the Medicare Benefit Policy Manual define covered care and provide examples of unskilled services that Medicare does not cover;

- A Medicare contractor previously issued a written notice to the provider that Medicare payment for a particular service or item is denied. This also includes notification of Quality Improvement Organization (QIO) screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by the QIO. Instructions for application of limitation on liability to QIO determinations are in the QIO Manual;

- The provider was previously notified by telephone and/or in writing that care is not covered or that covered care has ended; or

- A general bulletin or newsletter was issued to providers advising that a specific service or item is not considered reasonable and necessary.

The provider is accountable for information contained in the patient's medical records, such as the patient's medical chart, attending physicians' notes, or similar records, since these are provider records. Where it is clear and obvious from review of a particular medical record that the patient received only noncovered services described in the Medicare Benefit Policy Manual, the provider is held to have knowledge of noncoverage. Clear-cut decisions as to noncovered care may not be possible in some cases since patients may, for example, require a combination of skilled and unskilled services during a SNF stay or when receiving services at home. Evidence based upon medical records, such as that described in the following list, clearly indicates knowledge that Medicare payment for services or items would be denied and the date of such knowledge:

- A physician clearly indicated in the patient's medical record that the patient no longer needed the services or the level of care provided;

- The physician indicated the patient could be discharged;

- The attending physician refused to certify or recertify the patient's need for a particular level of care covered by Medicare because he/she determined that the patient does not require a covered level of care; or

- The contractor requested additional medical evidence after a certain number of days to determine whether continued coverage is warranted. However, the provider did not submit the evidence within the stipulated time.

EXAMPLE: Based on an admission notice and medical information, it was conditionally projected that SNF coverage was likely to extend for 12 days. The SNF must submit additional evidence of coverage within the 12 days. If the SNF failed to do so, its liability can be waived only through the 12th day of the stay, if the contractor later determined the services were not covered under §1862(a)(l) or (9). The contractor follows the established procedure for requesting additional evidence needed in a particular case to permit a decision on coverage. Where the beneficiary is still an inpatient at the SNF, the contractor advises the SNF that the additional information must be submitted (i.e., postmarked), within five workdays of a telephone request, or if a telephone request is not feasible, postmarked within seven workdays of the date of a written request. If this requirement is

met, the SNF is protected from liability under the limitation on liability provision through the date the contractor made the coverage determination based on the requested additional evidence and notified the SNF. If the evidence is not submitted within the required five to seven days, the SNF is protected from liability only through the date the additional evidence was requested.

40.1.3 - Acceptable Standards of Practice

(Rev. 1, 10-01-03)

In situations in which services or items furnished do not meet locally acceptable standards of practice, the provider, practitioner, or other supplier is considered to have known that Medicare payment for the services or items would be denied. Providers, practitioners, and other suppliers are always responsible for knowing locally acceptable standards of practice; their local licensure is premised on the assumption that they have such knowledge. Medicare payment to providers, practitioners, or other suppliers is premised on the presumption that they have such knowledge, as evidenced by their licensure. No other evidence of knowledge of local medical standards of practice is necessary. Medicare contractors, in determining what "acceptable standards of practice" exist within the local medical community, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association." By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine.

40.1.4 - Fraud, Abuse, Patently Unnecessary Items and Services

(Rev. 1, 10-01-03)

Generally, the protection under the financial liability protections provisions (LOL and RR) cannot be afforded to providers, practitioners, or other suppliers if a formal finding of fraud or abuse has been made with regard to a provider's, practitioner's, or other supplier's billing practices. In cases in which a formal finding of fraud or abuse is made, an immediate finding of liability for the provider, practitioner, or other supplier results. The contractor makes an immediate finding of liability, not only in fraud and abuse, but also in other situations where a provider, practitioner, or other supplier furnishes and claims payment for services that are so patently unnecessary that all providers, practitioners, and other suppliers could reasonably be expected to know that they are not covered. Generally, this would be the case where abuse has been identified in a particular claim. Abuse exists when a provider, practitioner, or other supplier furnishes services that are inconsistent with accepted sound medical practices, are clearly not

within the concept of reasonable and necessary as defined by law or regulations, and, if paid for, would result in an unnecessary financial loss to the program.

40.2 - Determining Whether Beneficiary Had Knowledge of Noncoverage of Services

(Rev. 1, 10-01-03)

CMS Ruling 95-1, A3-3439.1, B3-7300.5

40.2.1 - Beneficiary Knowledge Standards

(Rev. 1, 10-01-03)

Beneficiary knowledge standards vary between the §1879 LOL provision and the two Refund Requirements, for physician services and for medical equipment and supplies.

Limitation On Liability - §1879(a)(2) of the Act requires that the beneficiary "did not know, and could not reasonably have been expected to know, that payment would not be made* * *," for items or services that are excluded from coverage for one of the reasons specified in §20.1, in order for the LOL protection to be afforded. This includes knowledge based on written notice having been provided to the beneficiary, as well as any other means from which it is determined that the beneficiary knew, or should have known, that payment would not be made.

Physician Refund Requirement - §1842(l)(1)(C)(ii) requires that "before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service," that is, for physician services that are denied because they were not reasonable and necessary under §1862(a)(1) of the Act, in order for the refund requirement protection to be afforded.

Medical Equipment and Supplies Refund Requirement - §1834(a)(18)(A)(ii) [which is incorporated by reference into §1834(j)(4) and §1879(h)] requires that "before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item," that is, for medical equipment and supplies denied on the basis of §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or §1862(a)(1) of the Act, in order for the refund requirement protection to be afforded.

In both Refund Requirement cases, the beneficiary's knowledge must be evidenced by a signed advance beneficiary notice and agreement to pay personally in case of a denial.

40.2.2 - Written Notice as Evidence of Knowledge

(Rev. 1, 10-01-03)

The CMS regulations at 42 CFR 411.404 provide one basis for determining beneficiary knowledge that payment would not be made for items or services that are excluded from

coverage. These regulations provide that a beneficiary will be considered to know, **based on written notice**, that services or items were excluded from coverage. Under these regulations, there is a presumption that he or she knew, or could reasonably have been expected to know, that Medicare payment for a service or item would be denied if advance written notice has been given either to the beneficiary or to someone acting on his or her behalf that the items or services were not covered.

In accordance with 42 CFR 411.404, a written notice of Medicare denial of payment must contain sufficient information to enable the beneficiary to understand the basis for the denial. Such notice constitutes sufficient documentation to show that the beneficiary had prior knowledge of the likelihood of denial of that claim, and of future claims filed by, or on behalf of, the beneficiary that involve that same or a similar item or service. In addition, a written notice of Medicare denial of payment from a Medicare contractor for a recent previous claim for a particular service or item received by the beneficiary serves as prior written notice for future claims filed by or on behalf of the beneficiary that involve that same or a similar service or item. A notice that a beneficiary received within the twelve months before the claims denial at issue may be considered as evidence of prior knowledge with respect to such same or similar service or item that is denied payment by Medicare for the same reason in both the earlier and the later cases.

40.2.3 - Sources of Written Notice

(Rev. 1, 10-01-03)

Generally, the required written notice of the certainty or likelihood of Medicare payment denial must be furnished to the beneficiary (or to the beneficiary's authorized representative) by:

- A provider, practitioner, or other supplier before the service or item was furnished;
- The provider, after the Medicare contractor, during the course of the patient's stay, advised the provider that covered care had ceased;
- A provider utilization review committee that, on admission or during the patient's stay, advised that the patient no longer required covered care; or
- The Medicare contractor.

40.2.4 - Other Evidence of Knowledge

(Rev. 1, 10-01-03)

While 42 CFR 411.404 provides criteria for beneficiary knowledge **based on written notice,** §1879(a)(2) of the Act specifies only that **knowledge** must not exist in order to apply the limitation on liability protection. If it is clear and obvious that a beneficiary in fact did know, prior to receiving a service or item, that Medicare payment for that service or item would be denied, the administrative presumption favorable to the beneficiary

referred to in 42 CFR 411.404, is rebutted. For example, if the beneficiary admits that he or she had prior knowledge that payment for a service or item would be denied, no further evidence is required; the absence of a written notice is moot.

The failure of any provider, practitioner, or other supplier to furnish to a beneficiary proper advance notice of the likelihood of denial is not sufficient to afford the beneficiary the protection of the limitation on liability provision if the contractor has proof that the beneficiary, nonetheless, had the requisite knowledge that the service would be denied. In any case in which the contractor has such evidence of prior knowledge on the beneficiary's part, the beneficiary must be held liable under the limitation on liability provision.

40.3 - Advance Beneficiary Notice Standards

(Rev. 1, 10-01-03)

PM AB-02-168

The purpose of the ABN is to inform a Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for, that Medicare certainly or probably will not pay for them on that particular occasion. The ABN, also, allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which he or she may have to pay out of pocket or through other insurance. In addition, the ABN allows the beneficiary to better participate in his/her own health care treatment decisions by making informed consumer decisions. If the provider, practitioner, or supplier expects payment for the items or services to be denied by Medicare, the provider, practitioner, or supplier must advise the beneficiary before items or services are furnished that, in its opinion, the beneficiary will be personally and fully responsible for payment. To be "personally and fully responsible for payment" means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other Federal or non-Federal payment source. The provider, practitioner, or supplier must issue an ABN each time, and as soon as, it makes the assessment that Medicare payment certainly or probably will not be made. A provider, practitioner, or supplier (that is, a qualified notifier as defined in §40.3.2), shall notify a beneficiary by means of timely (as defined in §40.3.3) and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Any Advance Beneficiary Notice (ABN) must meet the following notice standards in order to be acceptable as evidence of the beneficiary's knowledge for the purposes of the FLP provisions, LOL and RR, except as otherwise explicitly specified. A notification which does not meet the following ABN standards may be ruled defective and may not serve to protect the interests of the notifier (provider, practitioner, or supplier). Any requirement to furnish a notice to a beneficiary is not met by delivery of a defective notice.

40.3.1 - Proper Notice Documents

(Rev. 1, 10-01-03)

When, for a particular purpose, an approved standard form (e.g., Form CMS-R-131, Form CMS-R-296) exists, it constitutes the proper notice document. Notices not using a mandatory standard notice form may be ruled defective. In the absence of such a standard form, approved model notice language constitutes the proper notice document. A notifier's unapproved modification of either a standard form or model notice language may render that notice defective.

40.3.1.1 - Readability Requirements

(Rev. 1, 10-01-03)

Both the originals and copies of ABNs must meet the following conditions to facilitate beneficiary understanding:

- Do not use italics, nor any font that is difficult to read, nor reversed print (e.g., white on black). Examples of easily readable fonts include, but are not limited to, Arial, Arial Narrow, Times Roman, Courier. On standard forms, the published fonts may not be changed to any other font;
- Use at least a 12 point font size;
- Use a visually high-contrast combination of dark ink on a pale background.
- Do not block-shade ("highlight") notice text; and
- Insertions in forms' blanks, if any, must be typed, printed, or legibly handwritten.

40.3.1.2 - Specificity, Delivery, and Receipt

(Rev. 1, 10-01-03)

An ABN must:

- Be written in lay language;
- Cite the particular items or services for which payment will be or is likely to be denied;
- Cite the notifier's reasons for believing Medicare payment will be or is likely to be denied. (See §40.3.8);
- Be delivered by a qualified notifier to the beneficiary (or to the beneficiary's authorized representative), before those items or services were furnished; and

- Be received by, and its contents must be comprehended by, the beneficiary (or authorized representative).

40.3.1.3 - Defective Notice

(Rev. 1, 10-01-03)

An ABN is not acceptable evidence if:

- The notice is unreadable, illegible, or otherwise incomprehensible, or the individual beneficiary (or authorized representative) is incapable of understanding the notice due to the particular circumstances (even if others may understand);

- The notice is given during any emergency, or the beneficiary is under great duress, or the beneficiary (or authorized representative) is, in any way, coerced or misled by the notifier, by the contents of the notice, and/or by the manner of delivery of the notice. (See §40.3.7);

- The notifier routinely gives this notice to all beneficiaries for whom the notifier furnishes items or services. (See §40.3.6);

- The notice is no more than a statement to the effect that there is a possibility that Medicare may not pay for the items or services. (See §40.3.6); or

- The notice was delivered to the beneficiary (or authorized representative) more than one year before the items or services are furnished.

    NOTE: A previously furnished ABN is acceptable evidence of notice for current items or services if the previous ABN cites similar or reasonably comparable items or services for which denial is expected on the same basis in both the earlier and the later cases. A written denial (on the same basis in both the earlier and the later cases) of payment from a Medicare contractor for a claim for the same or similar items or services received by the beneficiary not more than one year previously is acceptable evidence of notice for current items or services.

40.3.2 – Qualified Notifiers

(Rev. 1, 10-01-03)

An ABN must be delivered to the beneficiary (or authorized representative) by a qualified notifier such that the beneficiary (or authorized representative) may have confidence in and rely upon the accuracy and credibility of the notice. A QIO, intermediary, or carrier, group or committee responsible for utilization review for the provider that furnished the services, or provider, practitioner, or supplier that furnished or ordered the items and/or services (including their staff and employees) is a qualified notifier for delivery of ABNs for the purposes of the limitation on liability provision and the refund requirements provisions. In this section, when explaining the “notifier’s” liability risks, etc., it is generally the provider, practitioner, or supplier that furnished or ordered the items and/or services to which reference is made.

40.3.3 - Timeliness

(Rev. 1, 10-01-03)

A beneficiary must be notified far enough in advance of an event about which a decision must be made by the beneficiary (e.g., receiving a medical service) so that the beneficiary can make a rational, informed consumer decision without undue pressure. Last minute notification can be coercive, and a coercive notice is a defective notice. ABN delivery should take place before a procedure is initiated and before physical preparation of the patient (e.g., disrobing, placement in or attachment of diagnostic or treatment equipment) begins. This standard does not constitute a blanket prohibition on delivery of notice after a beneficiary has entered an examination room, a draw station, a sales room, etc., and is ready to receive services or items. If a situation arises during an encounter when a notifier sees a need for a previously unforeseen service and expects that Medicare will not pay for it, delivery of a notice is permissible, provided that the beneficiary is capable of receiving notice and has a meaningful opportunity to act on it (e.g., the beneficiary is not under general anesthesia). Where it is foreseeable that the need for service for which Medicare likely would not pay may arise during the course of an encounter, and the beneficiary is either certain or likely not to be capable of receiving notice during the initial service (e.g., the beneficiary will be under anesthesia), it is permissible to give notice before any service is initiated.

40.3.4 - Effective Delivery

(Rev. 1, 10-01-03)

Delivery of a notice occurs when the beneficiary (or authorized representative) both has received the notice and can comprehend its contents.

40.3.4.1 - Basic Delivery Requirements

(Rev. 1, 10-01-03)

The notifier should hand-deliver the ABN to the beneficiary or authorized representative. (Where hand-delivery is impossible, e.g., in furnishing items and services by telephone order, mail order, over the internet, etc., ABNs still need to be executed in advance of furnishing the item or service, e.g., by mail, fax, using an online form, etc.) Delivery is the notifier's responsibility. The contractor will consider delivery of an ABN by a notifier's staff or employees to be delivery by the notifier. If the beneficiary alleges non-receipt of notice and the notifier cannot show that notice was received by the beneficiary, the contractor will not find that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay; i.e., it will hold the notifier liable and the beneficiary not liable. The ABN must be prepared with an original and at least one copy. The notifier must retain the original and give the copy to the beneficiary or authorized representative. (In a case where the notifier that gives an ABN is not the entity which ultimately bills Medicare for the item or service, e.g., when a physician draws a test specimen and sends it to a laboratory for testing, the notifier should give a copy of the signed ABN to the entity which ultimately bills Medicare.) The copy is given to the

beneficiary immediately after the beneficiary signs it. Legible duplicates (carbons, etc.), fax copies, electronically scanned copies, or photocopies will suffice. This is a fraud and abuse prevention measure. If a beneficiary is not given a copy of the ABN and if the beneficiary later alleges that the ABN presented to the contractor by the notifier is different in any material respect from the ABN he/she signed, the contractor will give credence to the beneficiary's allegations.

40.3.4.2 - Telephone Notice

(Rev. 1, 10-01-03)

The contractor will not consider a telephone notice to a beneficiary, or authorized representative, to be sufficient evidence of proper notice for limiting any potential liability, unless the content of the telephone contact can be verified and is not disputed by the beneficiary. If a telephone notice was followed up immediately with a mailed notice or a personal visit at which written notice was delivered in person and the beneficiary signed the written notice accepting responsibility for payment, the contractor will accept the time of the telephone notice as the time of ABN delivery.

40.3.4.3 - Capable Recipient

(Rev. 1, 10-01-03)

The contractor will not consider delivery of a notice to be properly done unless the beneficiary, or authorized representative, was able to comprehend the notice (i.e., they were capable of receiving notice). A comatose person, a confused person (e.g., someone who is experiencing confusion due to senility, dementia, Alzheimer's disease), a legally incompetent person, a person under great duress (for example, in a medical emergency) is not able to understand and act on his/her rights, therefore necessitating the presence of an authorized representative for purposes of notice. A person who does not read the language in which the notice is written, a person who is not able to read at all or who is functionally illiterate to read any notice, a blind person or otherwise visually impaired person who cannot see the words on the printed page, or a deaf person who cannot hear an oral notice being given by phone, or could not ask questions about the printed word without aid of a translator, is a person for whom receipt of the usual written notice in English may not constitute having received notice at all (this is not an exclusive list). This may be remedied when an authorized representative has no such barrier to receiving notice. However, in the absence of an authorized representative, the notifier must take other steps to overcome the difficulty of notification. These may include providing notice in the language of the beneficiary (or authorized representative), in Braille, in extra large print, or by getting an interpreter to translate the notice, in accordance with the needs of the beneficiary or authorized representative to act in an informed manner. If the beneficiary was not capable of receiving the notice, the contractor will hold that the beneficiary did not receive proper notice, hold that the beneficiary is not liable, and will hold the notifier liable.

40.3.4.4 - Responsiveness to Inquiries

(Rev. 1, 10-01-03)

The contractor will hold that a beneficiary did not receive proper notice in any case where it finds that the notifier refused to answer inquiries from a beneficiary, or authorized representative, who requested further information and/or assistance in understanding and responding to the notice, including the basis for its assessment that items or services may not be covered.

40.3.4.5 - Identification of Notifier

(Rev. 1, 10-01-03)

In the case of an ABN on which the notifier's identifying information in the header of the ABN form identifies the entity or person that obtained the ABN, rather than the entity or person that is billing for the services (e.g., when one laboratory refers a specimen to another laboratory which then bills Medicare for the test; when a physician executes an ABN with his or her own identifying information in the header in conjunction with ordering a laboratory test for which the testing laboratory will submit the claim to Medicare), the contractor will consider the ABN form to be valid so long as it was otherwise properly executed.

40.3.4.6 - Dealing With Beneficiary Refusals

(Rev. 1, 10-01-03)

A beneficiary (or authorized representative) who has been given an ABN may decide to receive the item or service. In this case, the beneficiary should indicate that he/she is willing to be personally and fully responsible for payment. When a beneficiary decides to decline an item or service, he/she should so indicate. The beneficiary cannot properly refuse to sign the ABN at all and still demand the item or service. If a beneficiary refuses to sign a properly executed ABN, the notifier should consider not furnishing the item or service, unless the consequences (health and safety of the patient, or civil liability in case of harm) are such that this is not an option. Additionally, the notifier may annotate the ABN, and have the annotation witnessed, indicating the circumstances and persons involved.

A. In the case of claims to which Limitation on Liability protections under §1879 of the Act apply, if the notifier does furnish the item or service, the beneficiary's signature is meant to attest to receipt of the ABN; it has "agreement to pay" language so that it is absolutely clear to the beneficiary what the implications for him or her are. Once the beneficiary has read a properly executed ABN, he or she is "on notice"; that is, the beneficiary "knew, or could reasonably have been expected to know, that payment could not be made." The beneficiary has two legitimate choices: (a) To obtain the service and be prepared to pay out of pocket, that is, personally or by any other insurance coverage, or (b) Not to obtain the service. If the beneficiary demands the

service and refuses to pay, the notifier should have a second person witness the provision of the ABN and the beneficiary's refusal to sign. They should both sign an annotation on the ABN attesting to having witnessed said provision and refusal. Where there is only one person on site (e.g., in a "draw station"), the second witness may be contacted by telephone to witness the beneficiary's refusal to sign the ABN by telephone and may sign the ABN annotation at a later time. An unused patient signature line on the ABN form may be used for such an annotation; writing in the margins of the form is also permissible. The notifier should file its claim as having given the ABN. The beneficiary will be held liable per §1879(c) of the Act in case of a denial.

B. In the case of claims to which Refund Requirement protections under §§1834(a)(18), 1834(j)(4), 1842(l), or §1879(h) of the Act apply, if the physician or supplier does furnish the item or service, the beneficiary's signature is meant to attest both to receipt of the ABN and to the beneficiary's agreement to pay. The beneficiary both must receive a properly executed ABN so that he or she is "on notice" (that is, the beneficiary "knew, or could reasonably have been expected to know, that payment could not be made") **and** must agree to pay. The beneficiary has the same two legitimate choices: (a) To obtain the service and be prepared to pay out of pocket, that is, personally or by any other insurance coverage, or (b) Not to obtain the service. If the beneficiary demands the service and refuses to pay (will not sign or else marks out the agreement to pay language), the physician or supplier must take into account the fact that it will not be able to collect from the beneficiary in deciding whether or not to furnish the items or services. Although there would be little point in having a second person witness the provision of the ABN and the beneficiary's refusal to agree to pay (because the requirement that the beneficiary agree to pay still would not be fulfilled), the physician or supplier may annotate the ABN, as described above. The physician or supplier, if the items or services are furnished despite the beneficiary's refusal to pay, should file the claim as not having obtained a signed ABN, since it was not completed properly by the beneficiary. The contractor will not hold the beneficiary liable per §§1834(a)(18), 1834(j)(4), 1842(l), or §1879(h) of the Act in case of a denial and will hold the physician or supplier liable.

C. In either case, the beneficiary who does receive an item or service, of course, always has the right to a Medicare determination and the claim must be filed with Medicare.

40.3.5 - Authorized Representatives

(Rev. 1, 10-01-03)

An authorized representative is a person who is acting on the beneficiary's behalf and in the beneficiary's best interests, and who does not have a conflict of interests with the beneficiary, when the beneficiary is temporarily or permanently unable to act for himself or herself. A notifier's inability to give notice to a beneficiary directly or through an authorized representative does not allow the notifier to shift liability to the beneficiary.

An individual authorized under state law to make health care decisions, e.g., a legally appointed representative or guardian of the beneficiary (if, for example, the beneficiary

has been legally declared incompetent by a court), or an individual exercising explicit legal authority on the beneficiary's behalf (e.g., in accordance with a properly executed "durable medical power of attorney" statement or similar document), may be the authorized representative of the beneficiary with respect to receiving notice.

An authorized representative should have the beneficiary's best interests at heart and should be reasonably expected to act in a manner which is protective of the person and the rights of the beneficiary. In the absence of some more compelling consideration, the order of priority of authorized representatives is:

A. The spouse, unless legally separated.

B. An adult child.

C. A parent.

D. An adult sibling.

E. A close friend (defined as "an adult who has exhibited special care and concern for the patient, who is familiar with the patient's personal values, and who is reasonably available").

An authorized representative should have no relevant conflict of interests with the beneficiary. A notifier (including the notifier's employees) that has a conflicting interest (such as shifting financial liability to the beneficiary) is not qualified to be an authorized representative.

A person (typically, a family member or close friend) whom the beneficiary has indicated may act for him or her, but who has not been named in any legally binding document conveying such a role to that person may be an authorized representative. In states which have health care consent statutes providing for health care decision-making by surrogates on behalf of patients who lack advance directives and guardians, reliance upon individuals appointed or designated under such statutes to act as authorized representatives is permissible, as may be necessary.

In case of necessity, a disinterested third party, such as a public guardianship agency, may be an authorized representative, e.g., where the beneficiary's inability to act has arisen suddenly (e.g., a medical emergency, a traumatic accident, an emotionally traumatic incident, disabling drug interaction, stroke, etc.), and there is no one who can be genuinely considered to be the beneficiary's choice as his or her authorized representative.

40.3.6 - Routine Notice Prohibition

(Rev. 1, 10-01-03)

In general, the "routine" use of ABNs is not effective. By "routine" use, CMS means giving ABNs to beneficiaries where there is no specific, identifiable reason to believe Medicare will not pay. Notifiers should not give ABNs to beneficiaries unless the

notifier has some genuine doubt that Medicare will make payment as evidenced by their stated reasons. Giving routine notices for all claims or services is not an acceptable practice. If the contractor identifies a pattern of routine notices in situations where such notices clearly are not effective, it will write to the notifier and remind it of these standards. In general, routinely given ABNs are defective notices and will not protect the notifier from liability. However, ABNs may be routinely given to beneficiaries when all or virtually all beneficiaries may be at risk of having their claims denied. §40.3.6.4 specifies circumstances in which ABNs may be routinely given.

40.3.6.1 - Generic ABNs

(Rev. 1, 10-01-03)

"Generic ABNs" are routine ABNs to beneficiaries which do no more than state that Medicare denial of payment **is possible**, or that the notifier never knows whether Medicare will deny payment. Such "generic ABNs" are not considered to be acceptable evidence of advance beneficiary notice. The ABN must specify the service and a genuine reason that denial by Medicare is expected. ABN standards likewise are not satisfied by a generic document that is little more than a signed statement by the beneficiary to the effect that, should Medicare deny payment for anything, the beneficiary agrees to pay for the service. "Generic ABNs" are defective notices and will not protect the notifier from liability.

40.3.6.2 - Blanket ABNs

(Rev. 1, 10-01-03)

A notifier should not give an ABN to a beneficiary unless the notifier has some genuine doubt regarding the likelihood of Medicare payment as evidenced by its stated reasons. Giving ABNs for all claims or items or services (i.e., "blanket ABNs") is not an acceptable practice. Notice must be given to a beneficiary on the basis of a genuine judgment about the likelihood of Medicare payment for that individual's claim.

40.3.6.3 - Signed Blank ABNs

(Rev. 1, 10-01-03)

A notifier is prohibited from obtaining beneficiary signatures on blank ABNs and then completing the ABNs later. An ABN, to be effective, must be completed before delivery to the beneficiary. The contractor will hold any ABN that was blank when it was signed to be defective notice that will not protect the notifier from liability.

40.3.6.4 - Routine ABN Prohibition Exceptions

(Rev. 1, 10-01-03)

ABNs may be routinely given to beneficiaries and considered to be effective notices which will protect notifiers in the following exceptional circumstances:

A. Services Which Are Always Denied for Medical Necessity - In any case where a national coverage decision provides that a particular service is never covered, under any circumstances, as not reasonable and necessary under §1862(a)(1) of the Act (e.g., at present, all acupuncture services by physicians are denied as not reasonable and necessary), an ABN that gives as the reason for expecting denial that: "Medicare never pays for this item/service" may be routinely given to beneficiaries, and no claim need be submitted to Medicare. If the beneficiary demands that a claim be submitted to Medicare, the notifier should submit the claim as a demand bill.

B. Experimental Items and Services - When any item or service which Medicare considers to be experimental (e.g., "Research Use Only" and "Investigational Use Only" laboratory tests) is to be furnished, since all such services are denied as not reasonable and necessary under §1862(a)(1) of the Act because they are not proven safe and effective, the beneficiary may be given an ABN that gives as the reason for expecting denial that: "Medicare does not pay for services which it considers to be experimental or for research use." Alternative, more specific, language with respect to Medicare coverage for clinical trials may be substituted as necessary as the ABN's reason for expecting denial.

C. Frequency Limited Items and Services - When any item or service is to be furnished for which Medicare has established a statutory or regulatory frequency limitation on coverage, or a frequency limitation on coverage on the basis of a national coverage decision or on the basis of the contractor's local medical review policy (LMRP), because all or virtually all beneficiaries may be at risk of having their claims denied in those circumstances, the notifier may routinely give ABNs to beneficiaries. In any such routine ABN, the notifier must state the frequency limitation as the ABN's reason for expecting denial (e.g., "Medicare does not pay for this item or service more often than **frequency limit**").

D. Medical Equipment and Supplies Denied Because the Supplier Had No Supplier Number or the Supplier Made an Unsolicited Telephone Contact - Given that Medicare denials of payment under §1834(j)(1) of the Act on the basis of a supplier's lack of a supplier number, and under §1834(a)(17)(B) of the Act, the prohibition on unsolicited telephone contacts, apply to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally, the usual prohibition on provision of routine notices to all beneficiaries does not apply in these cases.

NOTE: A routine ABN, like any other ABN, is effective only for the reason for expecting denial that is specified on the ABN. Such a routine ABN will not be effective notice, that is, will not shift liability to the beneficiary, in the case of any Medicare denial of the claim for any reason other than that specified on the ABN.

40.3.7 - Standards for Situations Where the Beneficiary is in a Medical Emergency or Is Otherwise Under Great Duress

(Rev. 1, 10-01-03)

An ABN should not be obtained from a beneficiary in a medical emergency or otherwise under great duress (i.e., when circumstances are compelling and coercive) since that individual cannot be expected to make a reasoned informed consumer decision. In genuine emergencies, the beneficiary/victim and his or her family/friends (authorized representative) are under great duress, by the emergency circumstances, to sign anything in order to obtain help. On the other hand, there is a risk that beneficiaries might actually forego needed emergency services if faced with a financial burden which they believe they cannot bear. A requirement for delivery of a notice is that the beneficiary, or authorized representative, must be able to comprehend the notice, i.e., they must be capable of receiving notice (see §40.3.4.3). A person under great duress is not able to understand and act on his or her rights. If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held liable where the LOL or RR provisions apply, and the notifier may be held liable.

40.3.7.1 - Emergency Medical Treatment and Active Labor Act (EMTALA) Situations

(Rev. 1, 10-01-03)

An ABN should not be given to a beneficiary in any case in which EMTALA (§1876 of the Act) applies, until the hospital has met its obligations under EMTALA, which includes completion of a medical screening examination (MSE) to determine the presence or absence of an emergency medical condition, or until an emergency medical condition has been stabilized. The CMS published this policy in the November 10, 1999 OIG/HCFA Special Advisory Bulletin on the Patient Anti-Dumping Statute: “A hospital would violate the patient anti-dumping statute if it delayed a medical screening examination or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature. The best practice would be for a hospital not to give financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual’s agreement to pay for services before the individual is stabilized. This is because the circumstances surrounding the need for such services, and the individual’s limited information about his or her medical condition, may not permit an individual to make a rational, informed consumer decision.” This policy applies in any case in which EMTALA applies, not only to EMTALA cases seen in emergency rooms (ERs). Giving ABNs to beneficiaries under great duress is not permitted, regardless of the particular treatment setting or location. Even when a beneficiary does not appear to have a life threatening condition, rather, he or she is seeking primary care services at an ER, an ABN

should not be given to the beneficiary in any case in which EMTALA applies until the hospital has met its obligations under EMTALA. An ABN that is otherwise appropriate may be given to a Medicare beneficiary who is seen in the ER after completion of an MSE, but an ABN should not be given unless there is a genuine reason to expect that Medicare will deny payment for the services because giving routine "blanket" ABNs to beneficiaries is not permitted (see §40.3.6.2). There always must be a reason for expecting that Medicare will deny payment for the services furnished to the individual beneficiary on a specific occasion, and that reason must appear on the ABN. EMTALA does not prohibit asking payment questions entirely, rather, only doing so before screening/stabilization. After screening/stabilization, EMTALA no longer applies and ABNs may be given, when otherwise appropriate, to beneficiaries who come to emergency care settings after they have received a medical screening examination and are stabilized.

40.3.7.2 - Other Situations

(Rev. 1, 10-01-03)

A provider, practitioner, or supplier may not shift liability to a beneficiary under great duress by giving an ABN to the beneficiary. ABNs given to any individual who is under great duress cannot be considered to be proper notice. It is inconsistent with the purpose of advance beneficiary notice, which is to facilitate an informed consumer decision by a beneficiary whether or not to receive an item or service and pay for it out-of-pocket, to attempt to obtain beneficiaries' signatures on ABNs during medical emergencies and other compelling, coercive circumstances where a rational, informed consumer decision cannot reasonably be made. For that reason, providers, practitioners, and suppliers may not use ABNs to shift financial liability to beneficiaries in emergency care situations. Ambulance companies may not give ABNs to beneficiaries or their authorized representatives in any emergency transport because such beneficiaries are under great duress. Skilled nursing facilities may not give ABNs in the case of "middle-of-the-night" emergencies or in any other emergency circumstances, since the beneficiary clearly cannot make an informed consumer decision. The contractor will consider any ABN given in any kind of coercive circumstances, including medical emergencies, to be defective. In all such coercive situations, the contractor will find that the beneficiary did not know and could not reasonably have been expected to know that Medicare would not make payment. The contractor will determine the provider's, practitioner's, or supplier's liability by the appropriate knowledge standards which are used in cases where ABNs are not given and beneficiary agreements to pay are not obtained. This policy regarding duress applies in any case in which a beneficiary is under great duress and cannot make an informed consumer decision. This is the basis for the "last moment delivery" policy that a beneficiary must be notified well enough in advance of receiving a medical service so that the beneficiary can make a rational, informed consumer decision. In any case of such "last moment delivery" of an ABN, the delivery may not be considered timely and the beneficiary may not be held liable.

40.3.8 - Reason for Predicting Denial

(Rev. 1, 10-01-03)

Statements of reasons for predicting Medicare denial of payment at a level of detail similar to the approved "Medical Necessity" messages for MSNs are acceptable for ABN purposes. Simply stating "medically unnecessary" or the equivalent is not an acceptable reason, insofar as it does not at all explain why the physician or supplier believes the items or services will be denied as not reasonable and necessary. To be acceptable, the ABN must give the beneficiary a reasonable idea of why the notifier is predicting the likelihood of Medicare denial so that the beneficiary can make an informed consumer decision whether or not to receive the service and pay for it personally. Listing several reasons which apply in different situations without indicating which reason is applicable in the beneficiary's particular situation generally is not an acceptable practice, and such an ABN may be defective and may not protect the notifier from liability. However, if more than one reason for denial could apply (e.g., exceeding a frequency limit and "same day" duplication; cases where the reason for denial could depend upon the result of a test; etc.), the contractor will not invalidate an ABN on the basis of citing more than one reason for denial.

50 - Form CMS-R-131 Advance Beneficiary Notice (ABN)

(Rev. 1, 10-01-03)

PM AB-02-168 Part I

50.1 - Basic Requirements for ABNs

(Rev. 1, 10-01-03)

An ABN is a written notice a physician or supplier gives to a Medicare beneficiary before items or services are furnished when the physician or supplier believes that Medicare probably or certainly will not pay for some or all of the items or services on the basis of one of the following statutory exclusions.

- §1862(a)(1) of the Act, for example:
    - Medical reasonableness and necessity;
    - Mammography;
    - Pap smear;
    - Pelvic exam;
    - Glaucoma;
    - Prostate cancer; and

- Colorectal cancer screening tests.

- §1834(a)(17)(B) of the Act, violation of the prohibition on unsolicited telephone contacts for medical equipment and supplies;

- §1834(j)(1) of the Act, medical equipment and supplies supplier number requirements not met; and

- §1834(a)(15) of the Act, medical equipment and/or supplies is denied in advance.

The only other applicable bases of denial for which ABNs are applicable, i.e.,

- §1862(a)(9) of the Act, custodial care;

- §1879(g)(1) of the Act, homebound and intermittent denials for home health care; and

- §1879(g)(2) of the Act, hospice patient is not terminally ill,

are unlikely to apply in a Part B situation. (See §50.8 and §50.9 regarding use of Form CMS-R-131 ABNs for Part B items and services furnished by institutional providers and/or processed by fiscal intermediaries and for hospice services.)

50.1.1 - Approved Standard Forms

(Rev. 1, 10-01-03)

ABN-G and ABN-L (viz., OMB Approval No. 0938-0566, Form Nos. Form CMS-R-131-G and Form CMS-R-131-L, each with English and Spanish versions) are the OMB-approved ABNs for use with Part B items and services. They satisfy the requirements under both LOL and RR for advance beneficiary notice and the beneficiary's agreement to pay. The use of any other ABNs or modified ABNs may be ineffective in protecting users from liability. The ABN-G and the ABN-L must be prepared with an original and at least one patient copy. For services furnished on or after January 1, 2003, physicians and suppliers must use these approved ABN forms. The ABN-G may be used for all situations, including laboratory tests. The ABN-L may be used for physician-ordered laboratory tests. Laboratories are permitted to reproduce the ABN on the back of their laboratory test requisition forms. Users may produce ABNs using self-carboning paper and other methods of producing copies, including photocopying, printing, and electronic generation, but they must conform to the OMB-approved standard form design.

50.1.2 - User-Customizable Sections

(Rev. 1, 10-01-03)

Users are permitted to customize the header, the "Items or Services" and "Because" box areas on the Form CMS-R-131-G, and the header, the reasons, and tests 3-column box

areas on the Form CMS-R-131-L. The box containing three columns for laboratory tests and reasons for expecting denial on the ABN-L is customizable by the physician or supplier, except that the captions (reasons) for the left and center columns may not be revised while the right column (experimental and research use exclusion) may be revised or deleted at the discretion of the physician or supplier. The contractor will not invalidate an ABN solely on the basis that the user included in a customizable area some item(s) of information (e.g., information about the ABN's implications for the beneficiary's other insurers) which is/are not explicitly required by these instructions. The specified box areas are customizable and are scalable (that is, they may be lengthened). The ABN is designed as a letter-size form; nevertheless, it may be expanded to a legal size form by a user, to allow increasing the size of the customizable box areas, to suit the user's particular needs. In any case, the ABN must be only one page in length and may be modified only in the specified user-customizable sections. The standard sections of the forms (those sections which are not specified as user-customizable) may not be modified in any respect; they must be identical to the replicable PDF forms. The use of improperly modified ABNs may be ineffective in protecting users from liability.

50.1.3 - Where to Obtain the ABN Forms

(Rev. 1, 10-01-03)

The online replicable copies of Form CMS-R-131 forms in PDF format are available online:

- English Advance Beneficiary Notice [ABN] (CMS-R-131-G) for general use.

  http://cms.hhs.gov/medicare/bni/CMSR131G_June2002.pdf

- Spanish ABN (CMS-R-131-G) for general use.

  http://cms.hhs.gov/medicare/bni/CMSR131G_Spanish_June2002.pdf

- English ABN (CMS-R-131-L) for laboratory tests.

  http://cms.hhs.gov/medicare/bni/CMSR131L_June2002.pdf

- Spanish ABN (CMS-R-131-L) for laboratory tests.

  http://cms.hhs.gov/medicare/bni/CMSR131L_Spanish_June2002.pdf

See also the online ABN resources at the CMS Beneficiary Notices Initiative Web page at http://www.cms.hhs.gov/medicare/bni/ and at CMS' Medlearn ABN Quick Reference Guide Web page at http://www.cms.hhs.gov/medlearn/refabn.asp

50.1.4 - OMB Burden Notice for CMS-R-131

(Rev. 1, 10-01-03)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average five minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If there are any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare & Medicaid Services
Attn: Reports Clearance Officer
7500 Security Boulevard
C5-14-03
Baltimore, Maryland 21244-1850.

50.2 - When and to Whom an ABN Should Be Given

(Rev. 1, 10-01-03)

50.2.1 - Likelihood or Certainty of Denial

(Rev. 1, 10-01-03)

Whether an ABN should be given in a particular instance depends on the user's (that is, the provider's**,** physician's, practitioner's, or supplier's) expectation of Medicare payment or denial.

- If the user expects Medicare to pay, an ABN should **not** be given.
- If the user "never knows whether or not Medicare will pay," an ABN should **not** be given.
- If the user expects Medicare to deny payment, the next question is: "On what basis is denial expected?"

50.2.2 - Situations in Which ABN Is Not Given

(Rev. 1, 10-01-03)

ABNs should not be given in situations where they are not appropriate.

50.2.2.1 - Non-Qualifying Categorical Exclusions

(Rev. 1, 10-01-03)

With the exception of the "not reasonable or necessary" ("medical necessity") categorical exclusion under §1862(a)(1), if the item or service is not a Medicare benefit (e.g., routine physicals and tests in the absence of signs and symptoms, routine foot care, dental care), a Form CMS-R-131 ABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

50.2.2.2 - Non-Qualifying Technical Exclusions

(Rev. 1, 10-01-03)

With the exception of the qualifying technical exclusions, viz., the three qualifying medical equipment and supplies exclusions (§1834(a)(17)(B), violation of the prohibition on unsolicited telephone contacts; §1834(j)(1), supplier number requirements not met; and §1834(a)(15), denied in advance) and the exclusion for a hospice patient who is not terminally ill (§1879(g)(2)), if Medicare is expected to deny payment for an item or service which is a Medicare benefit because it does not meet a technical benefit requirement (e.g., lack of required certification, ambulance service where other forms of transportation were not contraindicated), a Form CMS-R-131 ABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

50.2.2.3 - When Services Will Not Be Furnished

(Rev. 1, 10-01-03)

The ABN is not to be given in circumstances in which the provider, practitioner or supplier will not furnish services. (This rule is not applicable in the situation where the beneficiary elects to receive services but refuses to sign the ABN attesting to being personally and fully responsible for payment, in which case, the provider, practitioner or supplier may then consider not furnishing the specified services (see §40.3.4.6)). An ABN is evidence of beneficiary knowledge about the likelihood of Medicare denial, for the purpose of determining financial liability for expenses incurred for services furnished to a beneficiary and for which Medicare does not pay. The ABN states "The purpose of this form is to help you make an informed choice about whether or not you want to receive these [items or services/laboratory tests], knowing that you might have to pay for them yourself." and §50.2.3 specifies that ABNs are to be given with respect to services furnished to a beneficiary for which denial is expected. For a provider, practitioner or supplier to give a beneficiary an ABN and then refuse to furnish services even though the beneficiary elects to receive services by selecting Option 1, is tantamount to the prohibited practice (see §50.5.8) of the provider, practitioner or supplier pre-selecting Option 2 (not to receive services) on an ABN.

50.2.2.4 - M+C Enrollees and Non-Medicare Patients

(Rev. 1, 10-01-03)

The ABN is not to be used for Medicare M+C (Part C) enrollees nor for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B).

50.2.3 - Qualifying Categorical Exclusions

(Rev. 1, 10-01-03)

If Medicare is expected to deny payment (entirely or in part) for the item or service that the provider, practitioner or supplier furnishes to a beneficiary because it is not reasonable and necessary under Medicare program standards (viz., "medical necessity denials" under §1862(a)(1) of the Act), the ABN-G or the ABN-L, as appropriate, should be given (this is applicable to all assigned Part B items and services, and to unassigned physicians' services and medical equipment and supplies). Certain screening tests (mammography, pap smear, pelvic exam, glaucoma, prostate cancer, colorectal cancer) have frequency limits under §1862(a)(1) of the Act, therefore, §1842(l) and §1879(a)-(c) of the Act apply and ABNs should be given when Medicare denial of payment for frequency is expected for any of these tests.

50.2.4 - Qualifying Technical Exclusions

(Rev. 1, 10-01-03)

If Medicare is expected to deny payment for medical equipment and supplies because it is not covered:

(i) under §1834(a)(17)(B) of the Act, violation of the prohibition on unsolicited telephone contacts;

(ii) under §1834(j)(1) of the Act, supplier number requirements not met; or

(iii) under §1834(a)(15) of the Act, failure to obtain advance determination of coverage,

then an ABN should be given (this is applicable to both assigned and unassigned medical equipment and supplies).

50.2.5 - Routine ABNs

(Rev. 1, 10-01-03)

A user will not be held to have violated the prohibition on routine ABNs solely on the basis of the number of ABNs which the user gives to beneficiaries, when those ABNs are justified by the user having a genuine reason to give an ABN. Some users (e.g., a

physician furnishing acupuncture services) may give ABNs to most or all of their Medicare patients without violating the routine ABNs prohibition. (See §40.3.6.4, **"**Routine ABN Prohibition Exceptions.")

50.2.6 - Qualified Recipients

(Rev. 1, 10-01-03)

An ABN may be given to a Medicare beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Ultimately, if a situation arises in which a beneficiary simply cannot receive an ABN and notice cannot be given to an authorized representative, the beneficiary is protected by not having received an ABN. A user's inability to give notice to a beneficiary directly or through an authorized representative does not allow the user to shift liability to the beneficiary.

50.3 - Delivery of the ABN

(Rev. 1, 10-01-03)

A provider, practitioner, or supplier (that is, a qualified notifier as defined in §40.3.2), shall notify a beneficiary by means of timely and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative. Delivery of an ABN occurs when the beneficiary or authorized representative (i.e., the person acting on the beneficiary's behalf) both has received the notice and can comprehend its contents. All notices must include an explanation written in lay language of the user's reason for believing the items or services will be denied payment. ABNs must meet the standards in §40.3, "Advance Beneficiary Notice Standards."

50.3.1 - Timely Delivery

(Rev. 1, 10-01-03)

In a case where a physician draws a test specimen and sends it to a laboratory for testing, and did not give the beneficiary an ABN, the laboratory may contact the beneficiary and give him/her an ABN without violating the timely delivery rule, so long as testing of the specimen has not begun. If a beneficiary alleges she/he was coerced into accepting medical items or services by receiving the ABN at the last moment, the Medicare contractor will investigate the facts. If the user is found to have clearly and obviously violated this timely delivery rule, the contractor will hold that the notice was not properly delivered in advance of furnishing the item or service and that the beneficiary therefore is not liable. (See timeliness standards in §40.3.3.)

50.4 - Choosing the ABN Form to Use

(Rev. 1, 10-01-03)

For items and/or services furnished on or after January 1, 2003, users must use the OMB-approved ABNs (ABN-G and ABN-L, Form CMS-R-131) for use with Part B items and services. Any other ABN form shall be considered to be defective notice. The ABN-G may be used for all situations, including laboratory tests, by all users. The ABN-L may be used for laboratory tests, by any user furnishing laboratory tests.

50.5 - Form Instructions for ABN-G and ABN-L (Form CMS-R-131)

(Rev. 1, 10-01-03)

50.5.1. - Format of Insertions on ABN

(Rev. 1, 10-01-03)

The user must ensure that the readability of the ABN facilitates beneficiary understanding. No insertion into the blanks and boxes of the ABN, if typed or printed, should use italics nor any font that is difficult to read. An Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. If insertions are handwritten, they must be legible. In all cases, both the originals and copies of ABNs must be legible and high-contrast. When Spanish language ABNs are used, the user should make insertions on the form in Spanish to the best of their ability. If this is impossible, the user needs to take other steps as necessary to ensure that the beneficiary understands the notice.

50.5.2 - Guidelines for Customizing the ABN Header

(Rev. 1, 10-01-03)

The ABN's header should have the identifying information of the billing entity. If the billing entity is a group practice, then the group practice may have its identifying information in the header. It may be prudent for each member of a group practice to also include their name in the header, but it is not required. A laboratory should put its own identifying information in the header where a client physician is delivering the ABN form to a beneficiary on behalf of the laboratory. ABNs included on laboratory requisition forms should have the identifying information of the laboratory in the header, not the client physician's information, even when stocks of the ABNs are provided to client physicians for their use in ordering tests. Users put their name, address, and telephone number at the top of the notice header; and may elect to include their logo (if any). Within these general rules, a notice header may be customized by the user.

50.5.3 - Patient Name Line

(Rev. 1, 10-01-03)

The user enters the name of the patient, not substituting the name of an authorized representative.

50.5.4 - Medicare Health Insurance Claim Number (HICN) Line

(Rev. 1, 10-01-03)

The user enters the patient's Medicare HICN. An ABN will not be invalidated solely for the lack of a Medicare HICN unless the beneficiary recipient of an ABN alleges that the ABN was signed by someone else of the same name and the Medicare contractor cannot resolve the matter with certainty.

50.5.5 - ABN-G Customizable Boxes

(Rev. 1, 10-01-03)

ABN-G Customizable Boxes

In the section of the ABN-G beginning "We expect that Medicare will not pay for the item(s) or service(s) …," in the first box "Items or Services:", the user specifies the health care items or services for which he/she/it expects Medicare will not pay. The items or services at issue must be described in sufficient detail so that the patient can understand what items or services may not be furnished. HCPCS codes by themselves are not acceptable as descriptions. The use on the ABN of a list of the items and/or services which the particular user frequently furnishes, with check-off boxes or some similar method of identifying the particular items or services for which denial is predicted, is an acceptable practice. Listing several items and/or services without indicating which is/are applicable in the beneficiary's particular situation is not an acceptable practice and such an ABN is defective and will not protect the user from liability. In the second box "Because:" the users give the reason why they expect Medicare to deny payment. The reason(s) must be sufficiently specific to allow the patient to understand the basis for the expectation that Medicare will deny payment. The use of lists of reasons for denial which the particular physician or supplier has found are frequently applicable, with check-off boxes or some similar method of indicating the selection of the reason(s), is an acceptable practice. For example, the three reasons included on the ABN-L form may be used, with slight modification, on the ABN-G form: "Medicare does not pay for this item or service for your condition"; "Medicare does not pay for this item or service more often than frequency limit"; and "Medicare does not pay for services which it considers to be experimental or for research use". See §50.7.3.4 with respect to citing the lack of a Certificate of Medical Need (CMN) as a reason for expecting a medical necessity denial. Users may customize these two boxes for their own use.

50.5.6 - ABN-L Customizable Boxes

(Rev. 1, 10-01-03)

ABN-L Customizable Boxes

In the section of the ABN-L beginning "Medicare probably will not pay …," users specify the laboratory tests for which they expect Medicare will not pay in the customizable boxes. The laboratory tests at issue must be described in sufficient detail so that the patient can understand what laboratory tests may not be furnished. The use of standard laboratory test descriptions is permitted. HCPCS codes by themselves are not acceptable as descriptions. ABN-L has been designed with three columns with the specific reasons for expected denial captioning these columns. Users enter or preprint laboratory tests in these three columns; the use of check off boxes is permitted. This format allows the user to customize the ABN-L with a preprinted list of tests linked to the captioned reasons for denial. The boxes containing three columns for laboratory tests and reasons for expecting denial on the ABN-L may be customized by the user, except that the captions (reasons) for the left and center columns may not be revised while the right column (experimental and research use exclusion) may be revised or deleted at the discretion of the user. Use of the right column to specify the frequency and/or duration of a standing order is permissible. Use of a fourth category, "Other:" is permissible.

50.5.7 - Estimated Cost Line

(Rev. 1, 10-01-03)

The user may provide the patient with an estimated cost of the items and/or services. The patient may ask about the cost and jot down an amount in this space. Users should respond to such inquiries to the best of their ability. The lack of an amount on this line, or an amount which is different from the final actual cost, does not invalidate the ABN; an ABN will not be considered to be defective on that basis. In the case of an ABN which includes multiple items and/or services, it is permissible for the user to give estimated amounts for the individual items and/or services rather than an aggregate estimate of costs. Amounts may be provided either with the description of items and services or on the "Estimated Cost" line.

50.5.8 - Prohibition of Pre-Selection of an Option on ABNs

(Rev. 1, 10-01-03)

The patient must personally select an option. The user must not pre-select either option. Pre-selection is prohibited and will invalidate the ABN. The Medicare contractor will not accept as evidence of beneficiary notice any ABN on which the user has pre-selected an option.

50.5.9 - Date and Signature

(Rev. 1, 10-01-03)

In the "Date" blank, the patient, or his or her authorized representative, should enter the date on which he or she signed the ABN. If the date is filled in by the user and the beneficiary or his or her authorized representative does not dispute the date, that date is acceptable. ABNs will not be invalidated simply because the date is typed or printed. In the "Signature of patient …" blank, the patient, or person acting on his or her behalf, must sign his or her name.

50.6 - Signature Requirements

(Rev. 1, 10-01-03)

50.6.1 - Who May Sign an ABN

(Rev. 1, 10-01-03)

The beneficiary himself or herself may sign an ABN. In the case of a beneficiary who is incapable or incompetent, his or her authorized representative (as defined in §40.3.5) may sign.

50.6.2 - Disputed Signature

(Rev. 1, 10-01-03)

If the beneficiary's (or authorized representative's) signature is absent from an ABN, in case of a dispute as to the beneficiary's (or authorized representative's) receipt of the ABN, the Medicare contractor will give credence to the beneficiary's (or authorized representative's) allegations regarding the ABN.

50.6.3 - Retention of Signed and Dated Copies of ABNs

(Rev. 1, 10-01-03)

The user must obtain the signed and dated ABN from the beneficiary, either in person or, where this is not possible, via return mail from the beneficiary or authorized representative acting on the beneficiary's behalf as soon as possible after the ABN has been signed and dated. The beneficiary retains the patient's copy of the signed and dated ABN and returns the original. The user retains the original ABN. These copies will be relevant in case of any future appeal. Users are not required to routinely submit copies of all ABNs to their Medicare contractor but must submit copies upon request of the contractor.

50.7 - Special Rules

(Rev. 1, 10-01-03)

50.7.1 - Exception for Repetitive Notices

(Rev. 1, 10-01-03)

A single ABN covering an extended course of treatment is acceptable provided the ABN identifies all items and services for which the physician or supplier believes Medicare will not pay. If, as the extended course of treatment progresses, additional items or services are to be furnished for which the physician or supplier believes Medicare will not pay, the physician or supplier must separately notify the patient in writing (i.e., give the beneficiary another ABN) that Medicare is not likely to pay for the additional items or services and obtain the beneficiary's signature on the ABN. Items or services (e.g., laboratory tests) provided on a regularly scheduled basis under a "standing order" may be considered, for these beneficiary notice purposes only, as an extended course of treatment; and a single ABN may suffice (e.g., for all the tests furnished the beneficiary which are contemplated by that order), as described above, with a new ABN being required only when additional items or services, which are not specified by the initial course of treatment ABN and for which noncoverage is expected, are to be furnished to the beneficiary. When an ABN is to be given for a "standing order" the physician or supplier must specify in the "Items or Services:" box of the ABN-G, or in the appropriate column of the customizable box beginning "Medicare probably will not pay …" on the ABN-L, the pertinent facts (e.g., frequency and duration) of the standing order. One year is the limit for use of a single ABN for an extended course of treatment; if the course of treatment extends beyond one year, a new ABN is required for the remainder of the course of treatment. An ABN, once signed by the beneficiary, may not be modified or revised. When a beneficiary must be notified of new information, a new ABN must be given.

50.7.2 - ABNs for Claims Affected by the Physicians' Services Refund Requirement

(Rev. 1, 10-01-03)

Under §1842(1) of the Act, the prohibition against billing for unassigned physician services which are denied on the basis of §1862(a)(1) of the Act as not reasonable and necessary, the physicians' services Refund Requirement provision, a refund is required under certain circumstances, unless a proper ABN-G was given the beneficiary and the beneficiary agreed to pay. (See §140 for instructions on determining situations where a refund under §1842(1) of the Act is required.)

50.7.3 - ABNs for Claims Affected by the Medical Equipment and Supplies Refund Requirement

(Rev. 1, 10-01-03)

Under §1834(a)(18)(A)(ii) of the Act, a refund is not required of the supplier if, before the medical equipment or supplies were furnished, the beneficiary was informed by the supplier that Medicare would not pay for the specific item or service and, after receiving such an advance beneficiary notice, the beneficiary agreed to pay for the item or service. The Refund Requirement provisions of §1834(a)(18) of the Act are incorporated by reference in §§1834(j)(4) and 1879(h) of the Act, which are also limits on beneficiaries' liability for denied claims (unassigned and assigned, respectively) for medical equipment and supplies. (See §150 for the medical equipment and supplies Refund Requirement instructions.)

50.7.3.1 - Using ABNs for Medical Equipment and Supplies Claims When Denials Under §1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts) Are Expected

(Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(a)(18) or §1879(h)(3) of the Act (unassigned and assigned claims, respectively), an ABN must clearly identify the particular item or service and state that the supplier expects that Medicare will deny payment for that particular medical equipment or supplies because the supplier violated the prohibition on unsolicited telephone contacts. The supplier must obtain a signed ABN before furnishing the item to the beneficiary. Since it is the unsolicited telephone contact which is prohibited by law, giving advance beneficiary notice by telephone does not qualify as notice and is not permissible. Telephone notice may not be used in this case. The contractor will not accept any telephone ABN as effective notice to the beneficiary. Since giving or mailing a written ABN and obtaining the beneficiary's agreement to pay before telephoning is equivalent to obtaining the beneficiary's written permission for the supplier to telephone under §1834(a)(17)(A)(i) of the Act, a supplier has little to gain from using the ABN process instead of simply seeking the beneficiary's written permission to contact him or her. If a supplier does use a written ABN prior to calling, the beneficiary's agreement to pay is essential under the Refund Requirements in order for the supplier to collect from the beneficiary. Medicare denial of payment because of the prohibition on unsolicited telephone contacts applies to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally. Therefore, the usual restriction on routine notices to all beneficiaries does not apply in this case. (See §40.3.6.4.D, "Routine ABN Prohibition Exceptions.")

50.7.3.2 - ABNs for Medical Equipment and Supplies Claims Denied Under §1834(j)(1) of the Act (Because the Supplier Did Not Meet Supplier Number Requirements)

(Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(j)(4)(A) and §1879(h)(1) of the Act (unassigned and assigned claims, respectively) for medical equipment and supplies for which payment will be denied due to failure to meet supplier number requirements under §1834(j)(1) of the Act, the ABN must state that Medicare will deny payment for any medical equipment or supplies because the supplier does not have a supplier number. The ABN must convey to the beneficiary the certainty of denial, so that the beneficiary can make an informed consumer decision whether to receive the medical equipment or supplies and pay for it out of pocket. The following is acceptable language for the ABN-G "Because:" box: "Medicare will pay for items furnished to you by a supplier of medical equipment and supplies only if the supplier has a Medicare supplier number. Payment for such items furnished to you by a supplier which does not have a supplier number is prohibited under the Medicare law. We do not have a Medicare supplier number, therefore, Medicare will not pay for any medical equipment and supplies which we furnish to you." It is particularly important that the beneficiary's signed agreement to pay should be dated by the beneficiary because, in this type of denial, any proper written advance notice with the beneficiary's signed agreement to pay shall be effective for any medical equipment or supplies purchased or rented from the same supplier within the one year following the date of the beneficiary's signed agreement to pay. This exception relieves the supplier, which has duly notified a beneficiary of its lack of a supplier number and the fact that Medicare will not pay, from the necessity of obtaining a signed agreement from the beneficiary every time the beneficiary does business with the supplier.

Exception to ABN Requirement

A supplier which can show that it did not know and could not reasonably have been expected to know that a customer was a Medicare beneficiary, or that a customer was making a purchase for a Medicare beneficiary, can seek protection under the LOL provision, §1879 of the Act, or, in the case of unassigned claims, under the applicable RR provision, §1834(j)(4) of the Act. If the supplier can show that a person who is not a Medicare beneficiary made a purchase on behalf of a person who is a Medicare beneficiary and did not apprise the supplier of the fact that the purchase was being made on behalf of a Medicare beneficiary, the supplier may be protected. If the supplier can show that a Medicare beneficiary who made a purchase did not identify himself or herself as a Medicare beneficiary and that the person's age or appearance was such that the supplier could not reasonably have been expected to know or surmise that the person was a Medicare beneficiary, the supplier may be protected. These protections are meant for an honest supplier in the rare case where a Medicare beneficiary who is relatively youthful, healthy and able in appearance does not identify himself or herself as a beneficiary and the supplier understandably does not surmise that he or she might be a

Medicare beneficiary. If the beneficiary disputes the supplier's allegation and conclusive proof of the allegation is not presented, the supplier's allegation may not be accepted. If the involved Medicare beneficiary is found to be obviously aged and/or disabled, such that any adult person working for a supplier would reasonably surmise that he or she could be a Medicare beneficiary, the supplier's allegation may not be accepted. If the beneficiary purchased an item which would strongly suggest to any reasonable adult person working for a supplier that the beneficiary is aged and/or disabled, the supplier's allegation may not be accepted. If a supplier can show that a customer, who is a Medicare beneficiary or was making a purchase for a Medicare beneficiary and did not identify him/herself accordingly to the supplier, was on notice of the necessity to so self-identify, the beneficiary may be held liable under §1879 or §1834(j)(4) of the Act, in which case the supplier could collect from the beneficiary. Given the possible difficulty of showing conclusively that it did not know and could not reasonably have been expected to know that a customer was a Medicare beneficiary, or that a customer was making a purchase for a Medicare beneficiary, a supplier would be well advised to consider using signage, giving public notice alerting customers that they need to inform the supplier if they are a Medicare beneficiary or are making a purchase for a Medicare beneficiary. If a supplier which does not have a supplier number provides adequate public notice to a Medicare beneficiary before medical equipment or supplies are furnished, e.g., by means of clearly visible signs, and if the adequacy of such public notice is not disputed by the beneficiary, the supplier can qualify for waiver of the Refund Requirements. Such public notices must be such that Medicare beneficiaries:

1. Are virtually certain to see them before purchasing or renting Medicare-covered medical equipment or supplies from the supplier (that is, they are posted in places where they are most likely to be seen by the target audience), and

2. May reasonably be expected to be able to read them and understand them.

Therefore, such public notices must be readily visible, in easily readable plain language, in large print, and would have to be provided in the language(s) commonly used in the locality. The following is acceptable language for the public notice:

Notice to Medicare Beneficiaries. Medicare will pay for medical equipment and supplies only if a supplier has a Medicare supplier number. We do not have a Medicare supplier number. Medicare will not pay for any medical equipment and supplies we sell or rent to you. You will be personally and fully responsible for payment.

Do not hold any beneficiary who cannot read any such public notice of a supplier to be properly notified in advance by the supplier that Medicare will not pay. If a supplier alleges that it provided adequate public notice to Medicare beneficiaries but a beneficiary disputes the allegation, in the absence of conclusive evidence in favor of the supplier, do not hold the beneficiary to be properly notified in advance by the supplier that Medicare will not pay; hold the supplier liable. The RR provision that the beneficiary must agree to pay for the item or service makes the use of signage without an ABN a risk for the supplier. It would be in a supplier's best interest to issue ABNs advising beneficiaries that they will have to pay for supplies and to post public notices in its store(s) which

inform beneficiaries of the fact that it is not a Medicare enrolled supplier, and that claims for supplies purchased from that supplier will be denied payment by Medicare.

Medicare denial of payment on the basis of a supplier's lack of a supplier number applies to all varieties of medical equipment and supplies and to all Medicare beneficiaries equally. Therefore, the usual restriction on routine notices to all beneficiaries does not apply in this case. (See §40.3.6.4.D, "Routine ABN Prohibition Exceptions.") Given the potential for beneficiary disputes over suppliers' public notice efforts to result in supplier liability, all suppliers which do not have supplier numbers would be very well advised to provide the standard written ABN to all Medicare beneficiaries, obtaining their signed agreement. The use of written notices in conjunction with public notices will provide maximum protection to suppliers as well as more surely providing proper advance notice to beneficiaries so that they can make informed consumer decisions.

50.7.3.3 - ABNs for Medical Equipment and Supplies Claims Denied in Advance Under §1834(a)(15) of the Act - Prior Authorization Procedures

(Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(j)(4)(B) and §1879(h)(2) of the Act (unassigned and assigned claims, respectively) for medical equipment and supplies for which payment is denied in advance under §1834(a)(15) of the Act, the ABN-G must clearly identify the particular item of medical equipment and supplies and must state in the "Because:" box either: "Medicare has denied payment in advance and we expect that Medicare will continue to deny payment." or "Medicare requires that we request an advance determination of coverage of this medical equipment and/or supplies. We have not requested an advance determination, so we expect that Medicare will deny payment." as applicable. Denial of payment in advance under §1834(a)(15) of the Act refers both to cases in which the supplier requested an advance determination and you determined that the item would not be covered, and to cases in which the supplier failed to request an advance determination when such a request is mandatory. (See §150.5.2, "Knowledge Standards for §1834(a)(15) Denials.")

50.7.3.4 - ABNs for Unassigned Claims for Medical Equipment and Supplies Which Are Denied on the Basis of §1862(a)(1) of the Act, as Not Reasonable and Necessary

(Rev. 1, 10-01-03)

To qualify for waiver of the Refund Requirements under §1834(j)(4)(C) of the Act, the ABN-G must clearly identify the particular item of medical equipment and supplies for which the supplier believes that Medicare will deny payment and must annotate in the "Because:" box the supplier's reason(s) it believes Medicare will deny payment.

The lack of a Certificate of Medical Necessity (CMN) for a particular Durable Medical Equipment (DME) item is an acceptable reason for expecting denial of a claim and would

satisfy the requirements of what would constitute an acceptable notice; e.g., “Medicare cannot pay for this item because the doctor did not complete the certificate of medical need.” Where a physician has been asked to render a CMN and refuses to do so, then the failure of a supplier to obtain a CMN would result in the claim being denied for medical necessity purposes. Giving an ABN is neither the first nor the only supplier action called for in this situation. While a supplier may ultimately give an ABN to a beneficiary, that is by no means the only responsibility of the supplier in this situation. The supplier first must make a good faith effort to obtain a CMN from the physician on a timely basis; this responsibility must not be simply shifted to beneficiaries through routinely giving ABNs. If the supplier’s genuine efforts to obtain a CMN fail, then the supplier advising the beneficiary, in conjunction with giving an ABN, to request his or her physician to provide a CMN, would be a prudent practice.

50.7.4 - ABN Standards for Partial Denials on the Basis of Medical Necessity

(Rev. 1, 10-01-03)

Physicians and suppliers may give an ABN when they expect Medicare to reduce the level of payment on the basis of §1862(a)(1) of the Act, that is, when they expect a partial denial of a more extensive service or item on the basis that it is not reasonable and necessary under §1862(a)(1) of the Act, even though Medicare pays for a less extensive service or item. A case in which Medicare reduces the level of payment because a component of the service or item is in excess of the beneficiary’s medical needs is a medical necessity partial denial of that unnecessary component of the covered item or service. “Excess component” means an item, feature, or service, and/or the extent of, number of, duration of, or expense for an item, feature, or service, which is in addition to, or is more extensive and/or more expensive than, the item or service which is reasonable and necessary under Medicare’s coverage requirements. The ABN given in the case of an expected partial denial must clearly identify, in the “Items or Services:” box, the excess component(s) of the item or service for which denial is expected (it is the part of the item or service that is expected to be denied that is the subject of the ABN, not the part that is expected to be paid) and must state in the “Because:” box the reason that Medicare is expected to deny payment for the specified excess component(s). Medicare will not accept charge increases on the basis of purported premium quality services as “excess components” since that would constitute circumvention of payment limits and applicable charging limits (e.g., limiting charges in the case of unassigned claims for physicians’ services and fee schedule amounts in the case of assigned claims). For example, a physician cannot charge extra amounts over Medicare payment limits for a service on the basis that his or her service is a “higher quality” than the same service furnished by other physicians and shift liability for that extra amount to a beneficiary who receives that service by obtaining the beneficiary’s agreement to pay on an ABN. The “excess component” definition for partial denials, with respect to an item, feature, or service that is “more expensive” refers to increased charges attributable to furnishing something that is clearly more extensive, that is, more in number, more frequent, for a longer period of time, or with added features. It does not suffice to claim that an item or service is “better” or “higher quality.”

50.7.5 - ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(Rev. 1, 10-01-03)

When upgraded DMEPOS is to be furnished and the physician or supplier expects Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, an ABN-G should first be delivered to the beneficiary and the signature of the beneficiary, agreeing to be personally and fully responsible for payment, should be obtained. The ABN should specify, in the "Items or Services:" box, the excess component(s) for which denial is expected (it is the upgrade features that are expected to be denied that are the subject of the ABN, not the standard items/services for which payment is expected) and must state in the "Because:" box the reason that Medicare is expected to deny payment for the specified excess component(s) related to the upgrade. Statements of reasons for predicting Medicare denial of payment at a level of detail similar to those in Chapter 21, "Medicare Summary Notices," are acceptable for ABN purposes, for example, "Your condition does not support the need for the special features of this equipment." An "upgrade," for purposes of these instructions, is synonymous with an "excess component," as defined in §50.7.4. For example, a deluxe or aesthetic feature of an upgraded item of medical equipment is an "excess component." ABNs may not be used for substitution of a dissimilar item or service that is not both medically appropriate for the beneficiary's medical condition and consistent with the attending physician's original order for the item or service, e.g., ABNs may not be used for substitution of a wheelchair when a cane was prescribed, nor for a hospital bed when a wheelchair was prescribed. Any cost estimate provided on the ABN-G must relate to the extra expense for the upgrade features, over and above the Medicare allowable amount for the standard item or service, not to the total cost of the item or service. Following are frequently asked questions (FAQs) about DMEPOS upgrades.

Q.1. What is a DMEPOS upgrade using an ABN?

A.1. A DMEPOS upgrade is the furnishing of an item that includes an "excess component," e.g., deluxe or aesthetic features of equipment. "Excess component" means an item, feature, and/or the extent of, number of, duration of, or expense for an item or feature, which is in addition to, or is more extensive and/or more expensive than, the item which is medically necessary under Medicare coverage requirements. When upgraded DMEPOS is to be furnished and the supplier expects a Medicare reduction in payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, an ABN should first be delivered to the beneficiary and the signature of the beneficiary, agreeing to be personally and fully responsible for payment for those additional expenses, should be obtained. Using an ABN to upgrade DMEPOS is clearly for features or options that are above and beyond medical necessity. Using ABNs to attempt to resolve coding and pricing issues is inappropriate.

Q.2. May an ABN be used to charge a beneficiary an additional amount for an item merely on the basis that the item is "higher quality"?

A.2. ABN's may not be used to charge beneficiaries more for "higher quality" items when there is not a distinguishable excess component of the items. Such charge increases on the basis of purported premium quality items would constitute circumvention of payment limits and applicable Medicare charge limits. An excess component, with respect to items that are more expensive, refers to increased charges attributable to furnishing something that is clearly more extensive, that is, more in number, more frequent, for a longer period of time, or with added features. A deluxe or aesthetic feature of an upgraded item is an excess component. It does not suffice merely to claim that an item is "better" or "higher quality."

Q.3. May an ABN be used to substitute a dissimilar item for the item that the attending physician ordered for the beneficiary and to obtain Medicare payment for the ordered item?

A.3. No. ABNs may not be used for substitution of a dissimilar item with Medicare payment for the ordered item. A "dissimilar item" is a substantially different item that is not both medically appropriate for the beneficiary's medical condition and consistent with the physician's original order. For example, ABNs may not be used for substitution of a wheelchair when a cane was prescribed, nor for a hospital bed when a wheelchair was prescribed, because canes, wheelchairs, and hospital beds are dissimilar items, substantially different from one another. On the other hand, ABNs may be used for substitution of similar items, e.g., substitution of a wheelchair with additional features when a wheelchair without those features was prescribed, and substitution of a hospital bed with additional features when a hospital bed without those features was prescribed. If a beneficiary wants substitution of a dissimilar item, an ABN to the beneficiary must specify that the full cost of the dissimilar item furnished will be at the beneficiary's own expense.

Q.4. What is the supplier's responsibility when using an ABN to allow a beneficiary to upgrade from an item which is medically necessary to an item which is not at all medically necessary (e.g., from a manual wheelchair to a power wheelchair when the ordering physician does not want the beneficiary to use a power wheelchair)?

A.4. In the special case where a beneficiary wants to upgrade to an item and the supplier is aware that the ordering physician wants the beneficiary to use the item ordered for clinical reasons (e.g., the physician would consider the upgraded item to be unsafe for that beneficiary), the entire upgraded item would not be medically necessary and Medicare would make no payment for it. If a supplier has such a case and the beneficiary signs an ABN which specifies that the full cost of the upgraded item will be at the beneficiary's own expense, the supplier should advise the beneficiary to contact his/her physician to notify the physician that s/he upgraded the equipment. In cases where there is no such medical objection from the physician, a beneficiary could upgrade from a manual wheelchair to a power

wheelchair, being made responsible to pay the difference in cost between the two by an ABN.

Q.5. How will upgrades in different payment categories be handled?

A.5. The claim for an upgraded item will be processed based on the payment methodology of the category of the medically necessary non-upgraded item. Using an ABN to furnish an upgraded item to a beneficiary, with the beneficiary being personally responsible for payment for the difference between the costs for the standard and the upgraded items, does not change the coverage or payment statutory provisions, rules, and instructions for the particular benefit involved; they continue to apply as if the standard item had been provided.

Q.6. What must a supplier specify in the "Items or Services:" and "Because:" boxes of form CMS-R-131-G, and enter in the "Estimated Cost:" blank of form CMS-R-131-G, in order to properly charge a beneficiary an additional amount for an upgraded item?

A.6. The supplier must specify in the "Items or Services:" box the excess component(s) for which denial is expected. NOTE: It is the upgrade features that are expected to be denied, the excess components, that are the subject of the ABN, not the standard item for which payment is expected. The supplier should not specify the entire piece of equipment in the "Items or Services:" box when using the ABN for an upgrade. Likewise, the supplier must specify in the "Because:" box the reason that Medicare is expected to deny payment for the specified excess components related to the upgrade. The supplier should enter in the "Estimated Cost:" blank of the ABN-G the extra expense for the specified excess components, over and above the Medicare allowable amount for the standard item, not the total cost of the upgraded item. It is this extra expense for which a beneficiary who signs an ABN may agree to be responsible for payment if Medicare denies payment.

EXAMPLE

A patient's physician ordered a manual wheelchair but the patient wants to upgrade to a motorized wheelchair. The supplier should specify in the "Items or Services:" box the excess component - in this case, that is the motorized feature. The supplier should not specify the entire item (e.g., "motorized wheelchair"). The supplier should specify in the "Because:" box the reason that Medicare is expected to deny payment for the motorized feature, for example, "Your condition does not support the need for the motorized feature of this equipment." The supplier should enter the cost estimate for the amount attributable to the motorized feature, over and above the Medicare allowable amount for the manual wheelchair.

Q.7. A piece of equipment has an upgrade which is a particular feature that the supplier believes to be an excess component. The beneficiary's physician's order for the piece of equipment did specify this particular feature. May a beneficiary be charged

an additional amount for equipment with this particular feature by executing an ABN?

A.7. Yes. Even though the physician ordered equipment with that feature, a supplier which believes that the feature is an excess component for which Medicare payment may be denied may give an ABN for that feature. Because a partial denial of Medicare payment for the piece of equipment with that feature is expected, an ABN may be used to charge the beneficiary an additional amount for that feature. Where a supplier does not have a genuine reason to expect Medicare denial, physician-ordered features should be provided without additional charge.

Q.8. A piece of equipment has an upgrade which is a particular feature that is an excess component. The beneficiary's physician's order for the piece of equipment did not specify this particular feature. May a beneficiary be charged an additional amount for equipment with that particular feature by executing an ABN?

A.8. Yes. Because the feature is an excess component which the physician did not order, a beneficiary who is willing to personally purchase that feature may do so by signing an ABN which specifies that feature, the reason for expecting denial by Medicare (e.g., "Your condition does not support the need for the special features of this equipment" or "Medicare will not pay for a [specify the feature] on this piece of equipment for your condition"), and the extra cost to the beneficiary for that feature.

Q.9. A beneficiary's physician ordered a particular piece of equipment but the beneficiary wishes to obtain an upgraded piece of similar equipment with an additional feature (or features), which is defined by a different HCPCS code than the ordered equipment. May a beneficiary be charged an additional amount for the upgraded equipment by executing an ABN?

A.9. Yes. The similar, but upgraded, equipment has an additional feature that is not medically necessary for the individual because the physician did not order equipment with that feature. That feature, therefore, is an excess component for which no additional payment may be made by Medicare under the fee schedule for the particular piece of equipment that the physician ordered. A beneficiary who is willing to personally purchase that feature may do so by signing an ABN which specifies that feature, the reason for expecting denial by Medicare, and the extra cost to the beneficiary for that feature.

Q.10. A beneficiary's physician ordered a particular piece of equipment but the beneficiary wishes to obtain a dissimilar piece of equipment, which is defined by a different HCPCS code, which is more expensive than the ordered equipment. (For example, the physician ordered a walker, but the beneficiary wants to purchase a wheelchair.) May a beneficiary be charged an additional amount for the dissimilar equipment by executing an ABN which specified the difference in cost between the items?

A.10. No. ABNs may not be used for substitution of a dissimilar item. In the example given, Medicare would pay nothing towards the wheelchair. If the supplier obtained the beneficiary's signature on an ABN which specified that Medicare would not pay at all for the wheelchair and specified the full cost of the wheelchair to the beneficiary, the beneficiary could obtain the wheelchair at his/her own expense.

50.7.6 - ABN Standards for Services in Skilled Nursing Facilities (SNFs)

(Rev. 1, 10-01-03)

Skilled nursing facilities may not give ABNs to beneficiaries in the case of "middle-of-the-night" emergencies, since the beneficiary is under duress and clearly cannot make an informed consumer decision. Authorized representatives for beneficiaries who are residents in SNFs are unlikely to be readily available for such emergencies and, depending upon the closeness of their personal relationship with the beneficiaries, may also be under duress in a medical emergency. SNF staff may not sign ABNs for beneficiaries as their authorized representatives. If there is an item or service which may predictably be needed in such emergency situations, the SNF, or the physician or supplier that will furnish such an item or service to a beneficiary in the SNF, can give an ABN for a standing order for that item or service to the beneficiary, or to the authorized representative as appropriate, well in advance, when she or he is not in an emergency situation, in order to authorize furnishing the item or service when the need does arise (see §50.7.1 regarding standing orders). The effectiveness of such an ABN cannot extend beyond one year; at the end of a year, another ABN would need to be given. This procedure may be used for other, non-emergency items and services which are foreseeable, e.g., an ABN for a standing order for laboratory tests when the collection of samples may be at a time when the authorized representative is unlikely to be available, or the beneficiary may be at reduced capacity (e.g., the beneficiary will be awakened during the night). SNFs need to plan for the provision of ABNs given the particular needs of their resident population. A SNF which does not plan ahead may find itself in a situation where delivery of an ABN is not possible, in which case liability cannot be shifted to the beneficiary.

50.7.7 - Effect of Furnishing ABNs and Collection From Beneficiary

(Rev. 1, 10-01-03)

50.7.7.1 - Providing a Proper ABN

(Rev. 1, 10-01-03)

When ABNs are properly used by physicians and suppliers, the ABNs also protect them from liability under the several statutory provisions which limit beneficiaries' liability. A beneficiary who has been given a proper written ABN, before an item or service was furnished, giving notice of the likelihood (or certainty) that Medicare would not pay for the specific item or service and of the reason therefore and who, after being so informed,

has agreed to pay the physician or supplier for the item or service, will be held liable. That is, that beneficiary will be found to have known in advance that Medicare would not pay, and the physician or supplier will be free to bill and collect the related charges from the beneficiary. A beneficiary who has been given such a proper ABN and who, after being so informed, refused to sign the ABN at all but demanded and received the item or service, may be held liable under LOL but not under RR.

50.7.7.2 - Provider's Exposure to Financial Liability

(Rev. 1, 10-01-03)

Failure to meet the ABN standards and procedures will expose a physician or supplier to the risk of potential financial liability for denied items or services in cases where, in the absence of a proper ABN, the beneficiary would be held not to have known, nor to reasonably have been expected to have known, that his/her claims for the denied items and services he/she received were likely to be denied by Medicare. A physician or supplier held liable for such denied charges will be precluded from collecting from the beneficiary and may be required to make refunds to the beneficiary, or face possible sanctions for failure to do so. If the contractor suspects that a physician or supplier is not furnishing ABNs with the intent to induce or coerce referrals for other items and/or services paid for by Medicare whereby anti-kickback statutes could be implicated, or if it suspects that a physician or supplier is doing so for any fraudulent, abusive, or otherwise illegal purposes, it will refer the case to the CMS regional office. In the case of a physician or supplier that does not obtain an ABN, when giving an ABN would have been appropriate, because the physician or supplier had no opportunity to do so (e.g., when a laboratory receives a specimen for testing, does not see the patient, and the specimen's testing is time-sensitive, such that the patient cannot be contacted about an ABN before the test is performed), the contractor will not consider the physician's or supplier's failure to obtain an ABN under such circumstances as indicative of fraud or abuse on that sole basis.

50.7.7.3 - Financial Liability Resulting for Providing a Defective ABN

(Rev. 1, 10-01-03)

A physician or supplier who supplies a defective ABN (one which does not meet the standards in §40.3) will not be protected from liability. A beneficiary who received a defective ABN should not be liable and the physician or supplier who/which gave the defective ABN should be held liable. Certain ABN standards may vary on the basis of the particular type of denial (e.g., as not reasonable and necessary, as violating the prohibition on unsolicited telephone contacts) and on the basis of whether the claim is assigned or unassigned.

50.7.7.4 - Collection From Liable Beneficiary

(Rev. 1, 10-01-03)

When an ABN was properly executed and given timely to a beneficiary (who, if RR applies, agreed to pay in the event of denial by Medicare) and, in fact, Medicare denies payment on the related claim (whether assigned or unassigned), the physician or supplier may bill and collect from the beneficiary for that service. Medicare does not limit the amount which the physician or supplier, participating or nonparticipating, may collect from the beneficiary in such a situation. Medicare charge limits do not apply to either assigned or unassigned claims when collection from the beneficiary is permitted on the basis of an ABN. A beneficiary's agreement to "be personally and fully responsible for payment" means that the beneficiary agrees to pay out-of-pocket or through any other insurance that the beneficiary may have, e.g., through employer group health plan coverage, Medicaid or other Federal or non-Federal payment source.

50.7.7.5 - Receiving ABNs From Different Entities

(Rev. 1, 10-01-03)

When an ABN was given to a beneficiary for a service for which Medicare pays in more than one part to different entities, e.g., for a radiological test with a technical component and a professional component, if the specification of the service on the ABN reasonably includes both components, that ABN, from either party, will serve as evidence of knowledge for LOL and RR. It is not necessary that both parties to the service give separate ABNs. If the beneficiary asks for a cost estimate, the estimate should include both parts of the service.

50.7.7.6 - ABNs and Bundled Payment

(Rev. 1, 10-01-03)

ABNs may not be used to shift liability to a beneficiary in the case of services or items for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be liable for payment for the service or item because bundled payment is made by Medicare. Using an ABN to collect from a beneficiary where full payment is made on a bundled basis would constitute double billing. An ABN may be used to shift liability to a beneficiary in the case of services or items for which partial payment is bundled into other payments; that is, where part of the cost is not included in the bundled payment made by Medicare.

50.7.7.7 - Health Insurance Portability and Accountability Act of 1996 (HIPAA) Sanctions and the Use of ABNs

(Rev. 1, 10-01-03)

Section 231(e)(4) of HIPAA adds to the Social Security Act a new §1128A(a)(1)(E) which provides for civil monetary penalties when claims are submitted "for a pattern of medical or other items or services that a person knows or should know are not medically necessary." This HIPAA sanction provision and the ABN provisions are not related and should not be confused with one another, but also are not mutually exclusive. Concerns have been raised by the physician and supplier communities that the use of ABNs could be construed by CMS or another agency pursuing enforcement activities as documenting such a pattern of medically unnecessary care. You may assure physicians and suppliers inquiring about this matter that the use of ABNs will not run them afoul of the HIPAA sanctions. The HIPAA sanctions are meant to deal with fraudulent claims for patently unnecessary medical care. The LOL and RR ABN provisions are meant to deal with giving beneficiaries proper advance notice of the likelihood of Medicare denial of payment for medical care that may be medically unnecessary, under Medicare coverage standards, for the individual beneficiary on a specific occasion. These are entirely different provisions and should not be confused, as indicated in the Conference Report accompanying HIPAA §231 ("the conferees intend that a penalty will be imposed on presentation of a claim that is false or fraudulent. No sanction is intended for providers who simply inform beneficiaries that a particular service is not covered by Medicare. Moreover, nothing in this section is intended to supersede the limitation on liability provisions established under Section 1879 of the Social Security Act.") The use of ABNs, in and of itself, is not evidence of any HIPAA sanctionable violation. At the same time, the use of an ABN does not provide any protection against the HIPAA sanctions to any physician, supplier or provider that does file a fraudulent claim. Do not hold any beneficiary who received an ABN in the case of a fraudulent claim to be properly notified under either LOL or RR; do hold the physician or supplier liable in such a case.

50.7.8 - Laboratory Issues with ABNs

(Rev. 1, 10-01-03)

Laboratories may use either the form ABN-G or ABN-L for laboratory tests. Following are some frequently asked questions (FAQs) about particular laboratory issues with ABNs.

Q.1. A physician orders a laboratory test, and the laboratory does both the specimen collection and laboratory test/processing. Is the laboratory or physician responsible for executing the ABN?

A.1. Because the laboratory has the risk of financial liability in the case of a denial, it is the laboratory's responsibility to execute the ABN. The physician may execute the ABN but it is not a requirement. If the physician had executed an ABN, the laboratory need not repeat it.

Q.2. A physician orders a laboratory test; the specimen collection is done in the physician office, and is sent to the laboratory for processing. Is the laboratory or physician responsible for executing the ABN?

A.2. Whether the physician or the laboratory collects the specimen, it is still the laboratory's responsibility to execute the ABN because the laboratory has the risk of financial liability in the case of a denial. However, physicians are encouraged to execute ABNs in these situations, since the physician has the better opportunity to give notice.

Q.3. If a physician is "not responsible" to execute an ABN when a laboratory will bill Medicare for the test, why does Medicare encourage the physician to execute an ABN in these situations?

A.3. By "not responsible" is meant that the physician is "not required by law" to execute an ABN for a test for which payment to the laboratory is likely to be denied. Nevertheless, a physician endeavoring to provide the best care to patients may wish to deliver an ABN in such a case. In this situation, the physician has immediate contact with the patient during the office visit or specimen collection, and is thus in the best position to have a meaningful dialogue with her/him regarding the choices to be made in going forward with the test or declining it. By delivering the ABN, the physician also is working in partnership with the laboratory that serves the practice (since the laboratory may not even encounter the patient), and this will help the laboratory to remain financially solvent and available to the patients of the practice. While Medicare does not mandate this partnering between physicians and their affiliated laboratories, it is certainly encouraged by Medicare. The best practice in this situation is for the patient to receive any necessary ABN at the physician's office.

Q.4. If the physician does not execute the ABN, what recourse does the laboratory have?

A.4. The laboratory may contact the beneficiary in order to execute an ABN in person or by telephone (with immediate mail notice follow up). If the beneficiary: (i) cannot be reached, or (ii) refuses to sign an ABN or (iii) initially agrees via telephone and then refuses to sign, the laboratory has two options. The laboratory may either perform the test with the likelihood that it may not be able to collect from the beneficiary, or may choose not to perform the test (this may be a State law violation in some States).

Q.5. In the scenarios in **Q.4**, if the beneficiary does not sign an ABN, what is the financial liability of the laboratory when it must perform the test?

A.5. In scenario (i), since the beneficiary was not reached before the test was performed, the beneficiary cannot be collected from; the laboratory is financially liable. In scenario (ii), since the beneficiary was given an ABN in person but refused to sign, the beneficiary will be held financially liable in case of a denial. (The laboratory should keep the following documentation in its files at the time the beneficiary

refuses to sign as evidence that the beneficiary was notified of possible denial should he/she later appeal on the basis an ABN was not given: A signed document by two laboratory personnel witnessing the provision of the ABN and the beneficiary's refusal to sign. Where there is only one person on site (e.g., in a “draw station”), the second witness may be immediately contacted by telephone to witness the beneficiary's refusal to sign the ABN and may sign the note for the file at a later time.) In scenario (iii), since the beneficiary was contacted by telephone and agreed to sign the ABN but later refused to sign, the beneficiary is not liable because disputed telephone notice is not acceptable; the laboratory will be financially liable. It is possible that, on appeal, an ALJ may determine that the beneficiary is liable under the Limitation On Liability provision if the ALJ finds some evidence that the beneficiary was advised of possible denial to be convincing.

Q.6. Many times the fee schedule is not available. How can a cost estimate be made and how would this affect the beneficiary in terms of liability if actual costs were substantially higher than what was estimated on the ABN?

A.6. The physician should estimate cost as she or he would if a private pay patient asked for cost information. If she or he is unable to give even a reasonable estimate, then the consequences are the same as with any other patient - namely, due to the inability to provide an estimate, the patient might decide to decline the service. For a grossly underestimated cost estimate and the beneficiary refuses to pay the bill, the beneficiary's liability may be up to an ALJ or a court. Medicare does not require a physician to provide an estimated cost of the service, but Medicare does suggest that he/she provide one so that the beneficiary has sufficient information to make an informed decision about whether he/she wishes to receive the service.

50.8 - Instructions for Fiscal Intermediaries and Providers on Advance Beneficiary Notice (ABN) Standards for Items and Services for Which Institutional Part B Claims Will Be Processed by Fiscal Intermediaries and on Limits on Beneficiary Liability for Medical Equipment and Supplies

(Rev. 1, 10-01-03)

PM AB-02-168 Part III

50.8.1 - Incorporation by Reference of §50.1-§50.7

(Rev. 1, 10-01-03)

A. Physicians, suppliers, and providers, and the fiscal intermediaries processing their claims, must follow the general requirements for CMS-R-131 ABNs as they are enunciated in §50.1-§50.7 and, as applicable, the general requirements for implementing limits on beneficiary liability for medical equipment and supplies (the DMEPOS Refund Requirements) as they are enunciated in §150.

B. These instructions on the use of ABNs apply to all claims for Part B items and services furnished by institutional providers and/or processed by fiscal intermediaries (inclusive of, e.g., Part B claims submitted by a physician or other supplier for processing by a fiscal intermediary, Part B claims for medical and other health services furnished by an HHA, Part B claims for certain items and services when furnished by a participating SNF (either directly or under arrangements) to an inpatient of the SNF, if payment for these services cannot be made under Part A). Providers must utilize Form CMS-R-131 ABN procedures for these Part B items and services furnished to Medicare beneficiaries, including dually-eligible (e.g., Medicare and Medicaid) beneficiaries. They must not give Hospital ABNs Hospital Issued Notices of Noncoverage, NONCs/HINNs) to beneficiaries for Part B items and services. They must not give any type of Medicare ABNs to patients who are not Medicare beneficiaries.

50.8.2 - ABNs for Medical and Other Health Services Furnished by a Home Health Agency (HHA) Under Part B

(Rev. 1, 10-01-03)

Part B of Medicare is designed to supplement the basic Part A coverage. In addition to providing coverage for unlimited home health visits in a calendar year, Part B provides coverage for certain “medical and other health services.” Reimbursement may be made to an HHA that furnishes, either directly or under arrangements with others, certain medical and other health services. The instructions in §50.1-§50.7 and §150 are applicable with respect to Part B claims for medical and other health services furnished by an HHA.

50.8.3 - ABNs for Part B Services Furnished in a Skilled Nursing Facility (SNF)

(Rev. 1, 10-01-03)

Insofar as payment may be made under Part B for certain items and services when furnished by a participating SNF (either directly or under arrangements) to an inpatient of the SNF, if payment for these services cannot be made under Part A (e.g., the beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Part A in his/her current spell of illness or was determined to be receiving a noncovered level of care, or the 3-day prior hospitalization or the transfer requirement is not met), the instructions in §50.1 - §50.7 and §150 are applicable with respect to such Part B claims.

50.9 - Instructions for Regional Home Health Intermediaries (RHHIs) and Hospices on Advance Beneficiary Notice (ABN) Standards for Certain Hospice Claims

(Rev. 1, 10-01-03)

PM AB-02-168 Part IV

50.9.1 - Incorporation by Reference of §50.1-§50.7

(Rev. 1, 10-01-03)

Hospices and Regional Home Health Intermediaries (RHHIs) processing hospice claims must follow the general requirements for ABNs as they are enunciated in §50.1-§50.7. Insofar as those requirements are specifically applicable to two types of potential hospice claims denials, hospices and RHHIs must follow the instructions in §50.9.

50.9.2 - Denial Situations that Call for ABNs

(Rev. 1, 10-01-03)

There are two situations in which hospice services may be denied, for which an ABN is appropriate:

A. Due to ineligibility (the beneficiary is not "terminally ill" within the statutory definition in §1861(dd)(3)(A) of the Act, per §1879(g)(2) of the Act); and

B. Because a level of care is determined inappropriate for the hospice patient (under §1862(a)(1) of the Act).

50.9.3 - Acceptable ABN Language

(Rev. 1, 10-01-03)

Hospices are required to give an ABN to Medicare beneficiaries when the hospice believes that Medicare will deny payment on one of the bases listed in §50.9.2. When preparing such an ABN, the hospice must use the following approved language for filling in the "Items or Services" and "Because" boxes on the Form CMS-R-131-G form, as follows:

A - Ineligibility:

Box 1: Item or Services: "The Medicare hospice benefit."

Box 2: Because: "We have determined that you are not eligible under Medicare rules for certification as having a terminal prognosis as defined in the law."

B - Level of Care:

Box 1: Item or Services: “The hospice General Inpatient Care level of care.” OR “the hospice Continuous Home Care level of care.”

Box 2: Because: “We have determined that you do not require this level of service.”

60 - Form CMS-R-296 Home Health Advance Beneficiary Notice (HHABN)

(Rev. 1, 10-01-03)

PM A-03-024, PM A-03-025

Following are the standards for use by Home Health Agencies (HHAs) in implementing the Home Health Advance Beneficiary Notice (HHABN) requirements. This section provides instructions, consistent with the home health prospective payment process, regarding the notices that HHAs must provide to home health beneficiaries in advance of furnishing what HHAs believe to be noncovered care or of reducing or terminating ongoing care. HHAs must also meet the ABN Standards in §40.3 in completing and delivering HHABNs.

60.1 - Basic Requirements for HHABNs

(Rev. 1, 10-01-03)

An HHABN is a written notice given by an HHA to a Medicare beneficiary before home health care is furnished, reduced, or terminated when the HHA believes that Medicare will not pay for some or all of the home health care that it furnishes and that a physician ordered on the basis of one of the following statutory exclusions:

The patient does not need intermittent skilled nursing care - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B].

The patient is not confined to the home - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B].

The service may be denied as “not reasonable or necessary” (“medical necessity”) - §1862(a)(1).

The service may be denied as “custodial care” - §1862(a)(9).

NOTE: The terminology “Medicare will not pay” is used here and in the HHABN because it is a concept understandable to beneficiaries. A Medicare official determination in favor of the beneficiary will not necessarily result in **additional** Medicare payments being made under HHA PPS.

60.1.1 - Approved Standard Forms

(Rev. 1, 10-01-03)

HHABNs (viz., OMB Approval No. 0938-0781, Forms CMS-R-296, English and Spanish versions) are the OMB-approved ABNs for use with HHA PPS services. They satisfy the requirements under LOL for advance beneficiary notice and the beneficiary's agreement to pay. The use of any other ABNs or modified HHABNs may be ineffective in protecting users from liability. The HHABN must be prepared with an original and at least one patient copy. For services furnished on or after January 1, 2004, HHAs must use these approved HHABN forms. HHAs may produce HHABNs using self-carboning paper and other methods of producing copies, including photocopying, printing, and electronic generation, but they must conform to the OMB-approved standard form design.

60.1.2 - User-Customizable Section

(Rev. 1, 10-01-03)

Users (HHAs) are permitted to customize the header on the Form CMS-R-296. The RHHI will not invalidate an HHABN solely on the basis that the HHA included in the customizable header some item(s) of information (e.g., information about the HHABN's implications for the beneficiary's other insurers) which is/are not explicitly required by these instructions. The HHABN is designed as a letter-size form; nevertheless, it may be expanded to a legal size form by a user, to allow increasing the size of the customizable header, to suit the user's particular needs. In any case, the HHABN must be only one page in length and may be modified only in the specified user-customizable section. The standard sections of the forms (those sections which are not specified as user-customizable) may not be modified in any respect; they must be identical to the replicable PDF forms. The use of improperly modified HHABNs may be ineffective in protecting users from liability.

60.1.3 - Where to Obtain the HHABN Forms

(Rev. 1, 10-01-03)

The online replicable copies of CMS-R-296 forms in PDF format are available online:

- English Home Health Advance Beneficiary Notice [HHABN] (CMS-R-296). http://cms.hhs.gov/medicare/bni/CMSR296_JUNE2002.pdf

- Spanish Home Health Advance Beneficiary Notice [HHABN] (CMS-R-296). http://cms.hhs.gov/medicare/bni/CMSR296_SPANISH_JUNE2002.pdf

See also the online HHABN resources at the CMS Beneficiary Notices Initiative Web page at http://www.cms.hhs.gov/medicare/bni/ and at CMS' Medlearn HHABN Quick Reference Guide Web page at http://www.cms.hhs.gov/medlearn/refhhabn.asp.

60.1.4 - OMB Burden Notice for Form CMS-R-296

(Rev. 1, 10-01-03)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0781. The time required to complete this information collection is estimated to average six minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:

Centers for Medicare & Medicaid Services
Attn: Reports Clearance Officer
C5-14-03
7500 Security Boulevard
Baltimore, Maryland 21244-1850.

60.2 - When and to Whom an HHABN Should Be Given

(Rev. 1, 10-01-03)

60.2.1 - Expectation of Denial

(Rev. 1, 10-01-03)

Whether an HHABN should be given in a particular instance depends on the HHA's expectation of Medicare payment or denial for services that it furnishes.

If the HHA expects Medicare to pay, an HHABN should **not** be given.

If the HHA "never knows whether or not Medicare will pay," an HHABN should **not** be given.

If the HHA expects Medicare to deny payment, the next question is: "On what basis is denial expected?"

60.2.2 - Situations In Which HHABN Is Not Given

(Rev. 1, 10-01-03)

HHAs are not to give patients HHABNs in situations where they are not appropriate.

60.2.2.1 - Categorical Exclusions

(Rev. 1, 10-01-03)

With the exception of the two qualifying categorical exclusions, viz., the "not reasonable or necessary" ("medical necessity") exclusion under §1862(a)(1) and the "custodial care" exclusion under §1862(a)(9), if the item or service is not a Medicare benefit (e.g., personal comfort items excluded under §1862(a)(6)), an HHABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

60.2.2.2 - Technical Exclusions

(Rev. 1, 10-01-03)

With the exception of the two qualifying technical exclusions, viz., the homebound and intermittent exclusions under §1814(a)(2)(C) and §1835(a)(2)(A), if Medicare is expected to deny payment for an item or service which is a Medicare benefit because it does not meet a technical benefit requirement (e.g., services not ordered by a physician), an HHABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

60.2.2.3 - Services Not Under HHA PPS

(Rev. 1, 10-01-03)

HHABNs are for use with home health care and are not required for services provided outside of the home. If Medicare is expected to deny payment for Part B covered medical and other health services which the HHA furnishes, either directly or under arrangements with others, an HHABN should not be given. For Part B services furnished on an outpatient basis, a Form CMS-R-131 ABN may be used, if appropriate. (See §50.8.2, "Form CMS-R-131 ABNs.")

60.2.2.4 - When Home Health Care Services Will Not Be Furnished

(Rev. 1, 10-01-03)

The HHABN is not to be given in circumstances in which the HHA will not furnish services. (This rule is not applicable in the situation where the beneficiary elects to receive services but refuses to sign the HHABN attesting to being personally and fully responsible for payment, in which case, the HHA may then consider not furnishing the specified services (see §40.3.4.6).) An HHABN is evidence of beneficiary knowledge about the likelihood of Medicare denial, for the purpose of determining financial liability for expenses incurred for services furnished to a beneficiary and for which Medicare does not pay. The HHABN states "You can get these services if you think you need them" and §60.2.3 specifies that HHABNs are to be given with respect to services furnished to a beneficiary for which denial is expected. For an HHA to give a beneficiary an HHABN and then refuse to furnish services even though the beneficiary elects to receive services

by selecting either Option A or Option B, is tantamount to the prohibited practice (see §60.4.4.2) of the HHA pre-selecting Option C (not to receive services) on an HHABN.

60.2.2.5 - M+C Enrollees and Non-Medicare Patients

(Rev. 1, 10-01-03)

The HHABN is not to be used for Medicare M+C (Part C) enrollees nor for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B).

60.2.3 - Situations in Which HHABN Should Be Given

(Rev. 1, 10-01-03)

If Medicare is expected to deny payment (entirely or in part) on the basis of one of the exclusions listed in §60.1 for items or services that the HHA furnishes to a beneficiary, an HHABN should be given to the beneficiary.

60.2.3.1 - Triggering Events

(Rev. 1, 10-01-03)

HHAs are required to give an HHABN to Medicare beneficiaries (including dual eligible) when the HHA believes that Medicare will not continue to pay for some or all of the home health care a physician has ordered for the beneficiary. Because of the belief that Medicare will not pay for the services ordered by the physician, the HHA is either going to deny, reduce, or terminate services to the beneficiary unless the beneficiary agrees to be personally and fully responsible for payment for such services. (Note: An HHABN is not given when the HHA is unwilling to furnish services even if the beneficiary is willing to agree to be personally and fully responsible for payment for such services. See §60.2.2.4.) The HHA must give the Medicare beneficiary an HHABN before reducing or terminating home health care that the beneficiary already is receiving, and that Medicare has been paying for, if the physician's order for such care would still continue care, but the HHA expects payment for the home health services will be denied by Medicare. An HHABN is required when an HHA determines that Medicare is not likely to pay for otherwise covered home health care services that a physician has ordered. HHAs must give an HHABN whenever a triggering event occurs. (A triggering event is defined as one of three changes to services: initiation, reduction, or termination.) The following circumstances constitute the three triggering events for an HHABN:

A - Initiation of Services

In the situation in which an HHA advises a beneficiary that it will not accept the beneficiary as a Medicare patient because it expects that Medicare will not pay for the services that a physician has ordered, the HHA must provide an HHABN to the beneficiary before it furnishes home health services to the beneficiary.

B - Reduction of Services

In the situation in which an HHA proposes to reduce a beneficiary's home health services because it expects that Medicare will not pay for a subset of home health services, or for any services at the current level and/or frequency of care that a physician has ordered, the HHA must provide an HHABN to the beneficiary before it reduces services to the beneficiary.

C - Termination of Services

In the situation in which an HHA proposes to stop furnishing all home health services to a beneficiary, because it expects that Medicare will not continue to pay for the services that a physician has ordered, the HHA must provide an HHABN to the beneficiary before it terminates such home health services.

60.2.3.2 - Dual-Eligibles

(Rev. 1, 10-01-03)

If the patient is a Medicare-Medicaid dual-eligible and a triggering event occurs, the HHA needs to give the patient (or authorized representative) an HHABN.

60.2.3.3 - Medicare as Sole Payer

(Rev. 1, 10-01-03)

When the HHA predicts that Medicare will not pay for the services ordered by the physician and the physician continues the prescription for those services, this means the HHA will reduce or terminate services to the beneficiary if Medicare were the sole payer for the services. On this basis, CMS characterizes such situations as "triggering events," as described in §60.2.3.1. When, in describing "triggering events," CMS says "an HHA proposes to reduce a beneficiary's home health services because it expects that Medicare will not pay" and "an HHA proposes to stop furnishing all home health services to a beneficiary, because it expects that Medicare will not continue to pay," CMS' premise is that Medicare is the sole payer for the services, and necessarily so since CMS is not promulgating instructions for other insurers. It is true that, on a practical basis, physician-prescribed services continue without interruption or reduction when a patient changes "payer eligibility" from Medicare to Medicaid. From the Medicare coverage vantage-point, however, there is a reduction or termination when Medicare, which has been paying, stops paying. In other words, there is a triggering event, which underlies the change in "payer eligibility."

60.2.4 - Routine HHABN Prohibition

(Rev. 1, 10-01-03)

An HHA will not be held to have violated the prohibition on routine HHABNs solely on the basis of the number of HHABNs which the user gives to beneficiaries, when those

HHABNs are justified by the HHA having a genuine reason to give an HHABN. (See §40.3.6, "Routine Notice Prohibition.")

60.2.5 - To Whom an HHABN Should Be Given

(Rev. 1, 10-01-03)

An HHABN may be given to a Medicare beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Ultimately, if a situation arises in which a beneficiary simply cannot receive an HHABN and notice cannot be given to an authorized representative, the beneficiary is protected by not having received an HHABN. An HHA's inability to give notice to a beneficiary directly or through an authorized representative does not allow the HHA to shift liability to the beneficiary.

60.3 - Delivery of HHABNs

(Rev. 1, 10-01-03)

60.3.1 - Delivery Must Meet Advance Beneficiary Notice Standards

(Rev. 1, 10-01-03)

An HHA (that is, a qualified notifier as defined in §40.3.2), shall notify a beneficiary by means of timely (as defined in §40.3.3) and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Delivery of an HHABN occurs when the beneficiary or authorized representative both has received the notice and can comprehend its contents. All HHABNs must include an explanation written in lay language of the HHA's reason for believing the items or services will be denied payment. HHABNs must meet the standards in §40.3, "Advance Beneficiary Notice Standards."

60.3.2 - HHABN Specific Delivery Issues

(Rev. 1, 10-01-03)

HHAs must provide HHABNs in every case where a reduction or termination of services is to occur, or where services are to be denied before being initiated, if there is a physician's order for such care and the HHA expects payment for the home health services to be denied by Medicare. (For situations in which a physician concurs in the reduction, termination, or denial of services, see §60.6.6. For situations in which services are statutorily excluded, see §60.2.2). If the HHA expects that Medicare will not pay for the care, the HHA must advise the beneficiary, orally and in writing, before home health care is initiated or continued that, in the HHA's opinion, the beneficiary will be fully and personally responsible for payment for the specified home health care that it furnishes. The HHA must issue notices each time, and as soon as, the HHA makes the assessment that it believes that Medicare payment will not be made. To be acceptable, an HHABN

must be on the approved form (Form CMS-R-296), must meet CMS' standards for cultural competency, must clearly identify the particular service, must state that the HHA believes Medicare is likely (or certain) to deny payment for the particular service, and must give the HHA's reason(s) for its belief that Medicare is likely (or certain) to deny payment for the service. The use of the Form CMS-R-296 is mandatory. Failure to provide a proper HHABN in situations where a physician has ordered the care may result in the HHA being held financially liable under the provisions on LOL, where such provisions apply. (See §40.2.) HHAs may also be sanctioned for violating the conditions of participation regarding beneficiary rights.

60.3.3 - Timely Delivery

(Rev. 1, 10-01-03)

The RHHI will reject notices that are not given timely. The HHA must notify the beneficiary well enough in advance before terminating or reducing home health services. "Well enough in advance" means the beneficiary has time to make other arrangements. If the HHA denies services to a beneficiary, the HHA must notify the beneficiary immediately after making the decision. Last moment delivery of an HHABN will be considered to be untimely, regardless of the HHA's intentions. Common sense must be applied to this criterion. If a beneficiary alleges they did not received notice timely, the RHHI will investigate the facts. If the HHA has clearly violated the timely delivery rule, the RHHI will hold that the notice was not properly delivered in advance of terminating or reducing service and that the beneficiary was not properly notified. HHAs must notify beneficiaries no later than the end of the business day following the day on which an assessment was made by the HHA. The RHHI will ask the HHA to justify any longer delays in notification.

60.3.4 - Actual Receipt of Notice Required

(Rev. 1, 10-01-03)

If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held financially liable where the LOL provisions apply and the HHA may be held financially liable. It is the HHA's responsibility to ensure that the beneficiary or the authorized representative actually receives a notice that they can comprehend. Failure to provide a comprehensible notice is also a violation of the conditions of participation and may result in enforcement action.

60.3.5 - Understandability and Comprehensibility of Notice

(Rev. 1, 10-01-03)

The beneficiary or authorized representative must be able to understand and comprehend the import of an HHABN for it to be an effective notice. In general, HHAs should not rely only on unfamiliar abbreviations, diagnosis codes, HCPCS codes, or similar technical or otherwise unfamiliar language, without an explanation in lay language, when

completing an ABN's "will not pay for" and "because" lines because the beneficiary is likely not to understand a cryptic, highly technical explanation. Of course, abbreviations, codes, etc., accompanying the spelled-out information, lay explanation, etc., are not per se confusing and will not, by themselves, invalidate an HHABN. The HHA is responsible for ensuring that the HHABN is completed in a manner such that the beneficiary can read and understand it sufficiently to make an informed consumer decision. An HHABN that the beneficiary cannot at all understand is defective and will not protect the HHA from financial liability.

60.4 - Form Instructions for the HHABN (Form CMS-R-296)

(Rev. 1, 10-01-03)

60.4.1 - General Rules

(Rev. 1, 10-01-03)

60.4.1.1 - The HHA is to prepare and deliver to the patient (Medicare beneficiary) or their authorized representative an HHABN when it expects Medicare probably will not pay for or will not continue to pay for services on the basis of one of the statutory exclusions listed in §60.1.

60.4.1.2 - Use of the OMB approved HHABN Form CMS-R-296 is mandatory. The HHA must ensure that the readability of the HHABN facilitates beneficiary understanding. No insertion into the blanks and boxes of the HHABN, if typed or printed, should use italics or any font that is difficult to read. An Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. If insertions are handwritten, they must be legible. In all cases, both the originals and copies of HHABNs must be legible and high-contrast. When Spanish language HHABNs are used, the HHA should make insertions on the form in Spanish to the best of their ability; where that is impossible, the HHA needs to take other steps as necessary to ensure that the beneficiary understands the notice. The form must be clear and obvious to the beneficiary that the HHABN is issued by the HHA rather than by the Medicare program. The contractor will reject any HHABN that does not meet these standards.

60.4.1.3 - An HHABN may not be modified except for the customizable header.

60.4.2 - Header of HHABN

(Rev. 1, 10-01-03)

60.4.2.1 - The header of the HHABN, above the title "HOME HEALTH ADVANCE BENEFICIARY NOTICE," is a customizable area of the Form CMS-R-296, which the HHA may customize for its own use, consistent with the requirements of §60.4.2.2**.**

60.4.2.2 - The HHABN's header must include the HHA's identifying information, including the HHA's name, address, and telephone number and TTY/TDD telephone number or directions for using your other telecommunication system for individuals with impaired speech or hearing. The HHA may elect to include their logo (if any). The following required elements must be included in the header. Within these general rules, the HHA may customize a notice header.

- Date - The HHA enters the delivery date of the HHABN, i.e., when it gave the notice personally to the patient or to the person acting on the patient's behalf. Where personal delivery is not possible, the HHA is to enter both the date it notified the patient by telephone and the date they mailed the notice.

- "Patient's name" Line - The HHA enters the name of the patient; do not substitute the name of an authorized representative.

- "Medicare # (HICN)" Line - The HHA enters the patient's health insurance claim number. An HHABN will not be invalidated solely for the lack of a Medicare HICN unless the beneficiary recipient of an HHABN alleges that someone else of the same name signed the HHABN and the matter cannot be resolved with certainty.

- "Attending physician" Line - The HHA enters the attending physician's name.

- "Physician's telephone number" Line - The HHA enters the attending physician's telephone number.

60.4.3 - Body of HHABN

(Rev. 1, 10-01-03)

60.4.3.1 - The paragraph entitled "We, _____ your home health agency, expect …," in the first line provided, enter the name of the HHA.

60.4.3.2 - In the same paragraph, in "… expect Medicare probably will not pay for: _____," in the second line provided, specify the home health care services for which Medicare is expected not to pay, in sufficient detail so that the patient can understand precisely what services may not be furnished and include any pertinent dates, e.g., "… furnished on or after [date]." It is essential that the effective date(s) be included in the specification of services.

60.4.3.3 - In the same paragraph, in the third line provided, "because: ____," give the specific reason why the HHA expects Medicare to deny payment. The reason cited must be in understandable lay language and must be sufficiently specific to allow the patient to understand the basis for the HHAs expectation that Medicare will deny payment, and, if necessary, to gather evidence to the contrary from a physician and/or others in support of the coverage of such services (e.g., "our clinical assessment of your condition indicates that you can benefit from physical therapy services twice weekly, but that additional physical therapy services each week would not be beneficial").

60.4.3.4 - On the line, "We estimate … cost about $_____," the HHA is required to enter the estimated cost of the services. The HHA is not required to express the cost estimate in any specific format. The HHA must respond timely, accurately, and completely to a patient, or authorized representative, who requests information about the extent of the patient's personal financial liability for home health care for which the HHA expects that Medicare may not, or may no longer, pay. The HHA must respond to the patient's request for a cost estimate in terms that the patient can understand.

60.4.3.5 - "You can telephone us at: ___" Lines - The HHA enters its office telephone number on the first blank line. The HHA enters its TTY/TDD telephone number (or directions for using the HHA's other telecommunication system for individuals with impaired speech or hearing) on the second blank line.

60.4.3.6 - "Your other insurance is: ___" Line - If the patient has any insurance other than Medicare, enter that insurance in this line. In the case of a Medicare-Medicaid dually-eligible beneficiary, refer to that patient's Medicaid coverage by the name for that coverage used in the patient's state, e.g., in California, enter "Medi-Cal."

60.4.4 - Option Boxes

(Rev. 1, 10-01-03)

60.4.4.1 - The HHA must enter the local RHHI's telephone numbers in Option A before presenting the HHABN to the patient. Enter the local RHHI's office telephone number on the first blank line and the RHHI's TTY/TDD telephone number (or directions for using the RHHI's other telecommunication system for individuals with impaired speech or hearing) on the second blank line. If the HHA does not have its RHHI's telephone number or TTY/TDD number, the HHA should call its servicing RHHI for the numbers.

60.4.4.2 - The HHA must not pre-select any option. Pre-selection is prohibited and will invalidate the HHABN.

60.4.4.3 - The patient must select one option.

If the patient selects Option A, the patient may receive the subject home care services, for which a demand bill must be submitted to Medicare for an official determination.

If the patient selects either box in Option B, the patient may receive the subject services but a claim for those services is not to be sent to Medicare unless the state Medicaid program acting as the beneficiary's subrogee demands the claim be submitted to Medicare. If the patient selects the box B.1 ("Please submit a claim to my other insurance, but not to Medicare"), send a claim to the state Medicaid program and/or to any other insurer, as may be appropriate. If the patient selects the box B.2 ("Do not submit a claim to either Medicare or my other insurance"), do not send a claim to Medicare, nor to the state Medicaid program, nor any other insurer, because the patient has elected to keep their health information confidential and does not want the information disclosed to any third party; in this case, the patient is on a private-pay basis.

If the patient selects Option C, the patient has elected not to receive the subject home health services.

60.5 - Signature Requirements for HHABN

(Rev. 1, 10-01-03)

- On the "Date" line, the patient or authorized representative, as defined in §40.3.5, enter the date on which they signed the HHABN.

- On the "Signature of patient …" line, the patient, or authorized representative, must sign their name.

- The patient may sign an HHABN. In the case of a beneficiary who is incapable or incompetent, their authorized representative, as defined in §40.3.5, may sign an HHABN.

- If the patient's (or authorized representative's) signature is absent from an HHABN, in case of a dispute as to the patient's (or authorized representative's) receipt of the HHABN, the RHHI will give credence to the patient's (or authorized representative's) allegations regarding the HHABN. However, if the patient (or the authorized representative) refuses to sign the HHABN but demands the services, the guidance in §40.3.4.6 should be followed.

- The HHA must obtain the signed (containing the signature of the patient or authorized representative) and dated HHABN with Option A, B.1, B.2, or C selected as to the action the beneficiary wants to take, from the beneficiary, either in person or, where this is not possible, via return mail from the beneficiary or authorized representative as soon as possible after the HHABN has been signed and dated. The beneficiary retains the patient's copy of the signed and dated HHABN and returns the original. The HHA annotates the original of the HHABN with the date of receipt from the beneficiary. The HHA is to return a copy of the HHABN, including the date of its receipt, within 30 calendar days to the beneficiary for the beneficiary's records. The HHA retains the original HHABN. These copies will be relevant in the case of any future appeal. Where the HHABN is signed and dated in the presence of the HHA's staff or employee, the annotation of the date of the HHA's receipt of the signed and dated HHABN may be made directly on both the original and patient's copy, and a second patient copy of the annotated original is not required.

- If a patient who chose "Option C. No." later requests that a claim be submitted to Medicare, consistent with option A, the HHA should annotate its copy of the HHABN with the date of its receipt of the new request, and return a copy of the annotated HHABN within 30 calendar days to the patient for their records.

- If the patient, or the authorized representative, refuses to sign the HHABN and/or refuses to choose any option, the HHA should annotate its copy of the HHABN,

indicating the circumstances and persons involved. If this occurs, the HHA must decide whether or not to furnish services to the patient in light of the fact that the patient has not agreed to be fully and personally responsible for payment for services that are not covered by Medicare. If, under these circumstances (i.e., the patient refuses to pay but demands the services), the HHA decides to provide the services, it should have a second person witness the provision of the HHABN and the patient's refusal to sign. They should both sign an annotation on the HHABN attesting to having witnessed said provision and refusal. Where there is only one person on site, the second witness may be contacted by telephone to witness the patient's refusal to sign the HHABN by telephone and may sign the HHABN annotation at a later time. The unused patient signature line on the HHABN form may be used for such an annotation; writing in the margins of the form is also permissible. (See §40.3.4.6.A.)

60.6 - Special Rules for HHABNs

(Rev. 1, 10-01-03)

60.6.1 - Reissuance of the HHABN

(Rev. 1, 10-01-03)

An HHABN remains effective for the predicted denial it communicates to the beneficiary, without periodic reissuance, for an indefinite period as long as no triggering event occurs. If a triggering event does occur, then another HHABN must be given immediately. A single HHABN covering an extended course of treatment is acceptable provided the HHABN identifies all items and services for which the HHA believes Medicare will not pay. If, as the extended course of treatment progresses, additional items or services are to be furnished for which the HHA believes Medicare will not pay, the HHA must separately notify the patient in writing (i.e., give the beneficiary another HHABN) that Medicare is not likely to pay for the additional items or services and obtain the beneficiary's signature on the HHABN. One year is the limit for use of a single HHABN for an extended course of treatment; if the course of treatment extends beyond one year, a new HHABN is required for the remainder of the course of treatment. An HHABN, once signed by the beneficiary, may not be modified or revised. When a beneficiary must be notified of new information, a new HHABN must be given. The beneficiary may request a demand bill at any point in their care.

60.6.2 - Acceptance or Rejection of HHABN

(Rev. 1, 10-01-03)

These instructions are to assist the RHHI in advising HHAs with respect to their responsibilities, in advising beneficiaries with respect to their rights and protections, and in dealing with complaints from beneficiaries about the lack of notice or defective notice. The HHA must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to

the notice. The HHA must answer inquiries from a beneficiary, or authorized representative, regarding the basis for the HHA's assessment that services may not be covered and, if requested by the beneficiary, or authorized representative, the HHA must give the beneficiary, or authorized representative, access to medical record information or other documents upon which the RHHI based their assessment, to the extent permissible or required under applicable state law. Where state law prohibits such direct disclosure, the HHA must advise a beneficiary, or authorized representative, who has requested access to such information how to obtain that information from the HHA once a demand bill has been submitted. The HHA must respond timely, accurately, and completely to a beneficiary, or authorized representative, who requests information about the extent of the beneficiary's personal financial liability for home health care for which the HHA expects that Medicare may not, or may no longer, pay. If a beneficiary, or authorized representative, or a physician, provides additional information with respect to Medicare coverage of the subject services, the HHA must timely submit that additional information to the RHHI. The RHHI will reject an HHABN in all cases in which the HHA does not meet these requirements.

60.6.3 - Effect of HHABN on Beneficiary

(Rev. 1, 10-01-03)

Under the statutory provision on LOL, a beneficiary who has received a proper HHABN and who has agreed to pay for the specified services will be fully and personally responsible for payment to the HHA if Medicare denies payment. The RHHI will not hold a beneficiary who does not receive an HHABN, or who receives a defective HHABN (i.e., one that does not meet the requirements of these instructions, or one on which an option was pre-selected by the HHA) financially liable under the LOL provisions, unless there is clear and obvious evidence that the beneficiary knew or could reasonably have been expected to know that Medicare would not make payment (in which case, the RHHI will hold the beneficiary financially liable).

60.6.4 - Financial Liability

(Rev. 1, 10-01-03)

An HHA that fails to comply with these instructions risks financial liability and/or sanctions. LOL shall apply as required by law, regulations, rulings and program instructions thereunder. Additionally, sanctions under the Conditions of Participation (COPs), when authorized by law and regulations, may be imposed.

60.6.5 - Limitation on Liability

(Rev. 1, 10-01-03)

The RHHI will hold financially liable, under LOL, any HHA that failed to provide notice, or provided a defective notice, to a beneficiary in a particular case, to which LOL (§1879 of the Act) applies, unless the HHA can demonstrate that it did not know, and could not

reasonably have been expected to know, that Medicare would not make payment, or there is clear and obvious evidence that the beneficiary knew that Medicare would not make payment. The HHA is to prepare and deliver to the patient (Medicare beneficiary) or their authorized representative an HHABN when they expect Medicare probably will not pay for or will not continue to pay for services. If an HHA advises a beneficiary that, in its view, Medicare probably will not pay, but does so in a defective manner such that the beneficiary cannot fully exercise their rights and protections (which the RHHI must assume to be the case when a notice was not executed and delivered properly by the HHA), the RHHI will consider that to be prima facie evidence that the HHA knew that Medicare would not make payment and not sufficient evidence to shift financial liability to the beneficiary. If a financially liable HHA collects from a beneficiary, the RHHI shall implement the beneficiary protections under §100.

60.6.6 - Home Care Not Ordered by Physicians

(Rev. 1, 10-01-03)

Medicare never pays for home health care not ordered by a physician. No HHABN is needed when care is reduced or terminated in accordance with a physician's order, where a physician does not order the services at issue, or where the physician agrees in writing with the HHA's assessment that the services are not necessary. The physician orders must be in writing and be entered into the beneficiary's record. The LOL provisions do not apply in these situations, but certain beneficiary protections under the COP do apply. An ABN (Form CMS-R-131) may be required if an HHA has been acting as a supplier of Part B services or supplies outside a home health plan of care.

60.6.7 - Regulatory Requirements

(Rev. 1, 10-01-03)

Under 42 CFR 484.10(c), "Condition of Participation: Patient rights; Standard: Right to be informed and to participate in planning care and treatment": the patient has the right to be informed, in advance, about the care to be furnished, and of any changes in the care to be furnished.

Under 42 CFR 484.10(e) "Condition of Participation: Patient rights; Standard: Patient liability for payment": (1) The patient has the right to be advised, orally and in writing, before care is initiated, of the extent to which payment may be expected from Medicare or other sources, and of the extent to which payment may required from the patient; and (2) The patient has the right to be advised, orally and in writing, of any changes in the information provided pursuant to subsection (1).

60.6.8 - Standards

(Rev. 1, 10-01-03)

In order to fulfill the requirements of 42 CFR 484.10(c), the beneficiary must be informed in a meaningful way, in advance, about the care to be furnished and of any changes in the care to be furnished, even where the physician concurs in the proposed change(s). In order to fulfill the requirements of 42 CFR 484.10(e), an HHA must give a notice to the beneficiary before care is initiated; and the notice must be in writing and also be orally explained to the beneficiary, and must specify the care to be furnished or any changes in the care to be furnished, as may be applicable, and the extent of the beneficiary's potential financial liability if they receive the proposed home health care. An HHA that does not notify beneficiaries, or is not timely with such notices, or gives defective notices, is in violation of the COPs. The RHHI shall refer violations of the COPs under 42 CFR 484.10(c) and/or under 42 CFR 484.10(e) to the responsible regional office.

60.6.9 - Effect of Furnishing HHABNs and Collection From Beneficiary

(Rev. 1, 10-01-03)

60.6.9.1 - Effective Notice

(Rev. 1, 10-01-03)

When HHABNs are properly used by an HHA the HHABNs will protect the HHA from financial liability under §1879(a)(1) of the Act, which limits beneficiaries' financial liability. A beneficiary who has been given a proper written HHABN, before a service was furnished, reduced, or terminated, giving notice of the likelihood (or certainty) that Medicare will not pay for the specific service and the reason therefore and who, after being so informed, has agreed to pay the HHA for the service, will be held financially liable. That is, that beneficiary will be found to have known in advance that Medicare will not pay, and the HHA will be free to bill and collect the related charges from the beneficiary.

60.6.9.2 - Defective Notice

(Rev. 1, 10-01-03)

Failure to meet the HHABN standards and procedures will expose an HHA to the risk of potential financial liability for denied services in cases where, in the absence of a proper HHABN, the beneficiary would be held not to have known, nor to reasonably have been expected to have known, that their claims for the denied services, they received, were likely to be denied by Medicare. Furthermore, any HHA held financially liable for failing to provide an HHABN, failure to provide an HHABN in a timely manner, or providing a defective HHABN to a beneficiary, will be precluded from collecting from the beneficiary and third party payers which includes Medicaid and may be required to make

refunds to the beneficiary, or the beneficiary's subrogees, or face possible sanctions for failure to do so. If an HHA is suspected of furnishing HHABNs with the intent to induce or coerce referrals for other services paid for by Medicare whereby anti-kickback statutes could be implicated, or if an HHA is suspected of issuing HHABNs for any fraudulent, abusive, or otherwise illegal purposes, the RHHI will refer the matter to the CMS regional office. An HHA that supplies a defective HHABN (e.g., one which does not meet the standards in §40.3) will not be protected from financial liability. A beneficiary who received a defective HHABN should be held not financially liable and the HHA that gave the defective HHABN should be held financially liable.

60.6.9.3 - Collection From Beneficiary

(Rev. 1, 10-01-03)

When an HHABN is properly executed and given timely to a beneficiary and, in fact, Medicare does deny payment on the related claim, the HHA may bill and collect from the beneficiary for that service. The HHA may collect at the time of service and refund the beneficiary that amount if Medicare does pay, or it may wait to collect from the beneficiary until Medicare denies payment, unless prohibited from collecting in advance of the Medicare payment determination by state or local law. Medicare does not limit the amount which the HHA may collect from the beneficiary in such a situation. A beneficiary's agreement to "be personally and fully responsible for payment" means that the beneficiary agrees to pay out-of-pocket or through any other insurance that the beneficiary may have, e.g., through employer group health plan coverage, through Medicaid, or through other Federal or non-Federal payment source.

60.6.9.4 - Unbundling Prohibition

(Rev. 1, 10-01-03)

HHABNs may not be used to shift financial liability to a beneficiary in the case of services for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made a bundled payment. Using an HHABN to collect from a beneficiary where full payment is made on a bundled basis would constitute double billing. An HHABN may be used to shift financial liability to a beneficiary in the case of services for which partial payment is bundled into other payments; that is, where part of the cost is not included in the bundled payment made by Medicare.

70 - Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)

(Rev. 1, 10-01-03)

A3-3730.1

Following are the standards for use by Skilled Nursing Facilities (SNFs) in implementing the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, model Form CMS-10055) notice of noncoverage requirements. This section provides instructions, consistent with the skilled nursing facility prospective payment process (SNF PPS), regarding the notice that SNFs must provide to beneficiaries in advance of furnishing what SNFs, utilization review (UR) entities, quality improvement organizations (QIOs), or Medicare contractors believe to be noncovered extended care services or items or of reducing or terminating ongoing covered extended care services or items. The SNFABN replaces the SNF Notices of Non-Coverage previously used for notification purposes. SNFs must also meet the ABN Standards in §40.3 of the MCPM in completing and delivering SNFABNs.

70.1 - Basic Requirements for SNFABNs

(Rev. 1, 10-01-03)

A SNFABN is a CMS-approved model written notice that the SNF gives to a Medicare beneficiary, or to her or his authorized representative, before extended care services or items are furnished, reduced, or terminated when the SNF, the UR entity, the QIO, or the Medicare contractor believes that Medicare will not pay for, or will not continue to pay for, extended care services that the SNF furnishes and that a physician ordered on the basis of one of the following statutory exclusions:

- Not reasonable and necessary ("medical necessity") for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member - §1862(a)(1); or

- Custodial care ("not a covered level of care") - §1862(a)(9).

Except for the exclusions specified above, there is no other statutory authority on which the limitation on liability (LOL, §1879) provision applies to SNF claims denied.

NOTE: The terminology "Medicare will not pay" is used here and in the SNFABN because it is a concept understandable to beneficiaries. A Medicare official determination in favor of the beneficiary will not necessarily result in **additional** Medicare payments being made under the SNF PPS.

70.1.1 - Approved Model Form

(Rev. 1, 10-01-03)

The SNFABN (viz., CMS-approved model Form CMS-10055) is for use with SNF PPS services. This form satisfies the requirements under LOL for advance beneficiary notice and the beneficiary's agreement to pay. The use of any other notices or of modified SNFABNs may be ineffective in protecting users from liability. The SNFABN must be prepared with an original and at least one patient copy, a SNF copy containing the signature of the patient or authorized representative, an attending physician copy, and (when necessary) a Medicare contractor copy. SNFs may produce SNFABNs using self-carboning paper and other methods of producing copies, including photocopying, printing, and electronic generation, but they should conform to the Form CMS-10055 design.

70.1.2 - User-Customizable Section

(Rev. 1, 10-01-03)

Users (SNFs) are permitted to customize the header and the "Items or Services" and "Because" areas on the Form CMS-10055. The contractor will not invalidate a SNFABN solely on the basis that the SNF included in the header and in the two other customizable areas some item(s) of information (e.g., information about the SNFABN's implications for the beneficiary's other insurers) which is/are not explicitly required by these instructions. The SNFABN is designed as a letter-size form; nevertheless, it may be expanded to a legal size form by a user, to allow increasing the size of the customizable header and the "Items or Services" and "Because" areas, to suit the user's particular needs. In any case, the SNFABN must be only one page in length and should be modified only in the specified user-customizable sections. The standard sections of the SNFABN (those sections which are not specified as user-customizable) should not be modified in any respect from the replicable PDF (abode acrobat) form. The use of improperly modified SNFABNs may be ineffective in protecting users from liability.

70.1.3 - Where to Obtain the SNFABN Form

(Rev. 1, 10-01-03)

The replicable copy of the Form CMS-10055 in PDF (Adobe Acrobat) format is available online at the CMS Beneficiary Notices Initiative (BNI) Web page at: http://www.cms.hhs.gov/medicare/bni/ under:

- Form CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNFABN).

70.2 - When and to Whom a SNFABN Should Be Given

(Rev. 1, 10-01-03)

70.2.1 - When and to Whom a SNFABN Should Be Given

(Rev. 1, 10-01-03)

Whether a SNFABN should be given in a particular instance depends on the SNF's expectation of Medicare payment or denial for extended care services that it furnishes.

- If the SNF expects Medicare to pay, a SNFABN should **not** be given.
- If the SNF "never knows whether or not Medicare will pay," a SNFABN should **not** be given.
- If the SNF expects Medicare to deny payment, the next question is: "On what basis is denial expected?"

70.2.2 - Situations inWhich SNFABN Is Not Given

(Rev. 1, 10-01-03)

SNFs are not to give patients SNFABNs in situations where they are not appropriate.

70.2.2.1 - Categorical Exclusions

(Rev. 1, 10-01-03)

With the exception of the two qualifying categorical exclusions, viz., the "not reasonable or necessary" ("medical necessity") exclusion under §1862(a)(1) and the "custodial care" exclusion under §1862(a)(9), if the extended care service or item is not a Medicare benefit (e.g., personal comfort items excluded under §1862(a)(6)), a SNFABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

70.2.2.2 - Technical Exclusions

(Rev. 1, 10-01-03)

With the exception of such qualifying technical exclusions as are provided under §§1861(i), 1861(s)(2)(D), 1861(w)(1), and 1888(e)(2)(A)(i); viz., an individual being furnished post-hospital extended care services while a resident in a skilled nursing facility, if Medicare is expected to deny payment for an item or service which is a Medicare benefit because it does not meet a technical benefit requirement (e.g., SNF stay not preceded by the required prior three-day hospital stay), a SNFABN should not be given. (See §90, "Form CMS-20007 NEMBs.")

70.2.2.3 - Services Not Under SNF PPS

(Rev. 1, 10-01-03)

SNFABNs are for use with Part A covered extended care services provided in the SNF setting. If Medicare is expected to deny payment for Part B covered medical and other health services which the SNF furnishes, either directly or under arrangements with others, to an inpatient of the SNF, where payment for these services cannot be made under Part A (e.g., the beneficiary has exhausted his/her allowed days of inpatient SNF coverage under Part A in his/her current spell of illness or was determined to be receiving a noncovered level of care), a SNFABN should not be given. For Part B services, a CMS-R-131 ABN may be used, if appropriate. (See §50.8.3, "Form CMS-R-131 ABNs.")

70.2.2.4 - When Extended Care Items or Services Will Not Be Furnished

(Rev. 1, 10-01-03)

The SNFABN is not to be given in circumstances in which the SNF will not furnish extended care items or services. (This rule is not applicable in the situation where the beneficiary elects to receive extended care items or services but refuses to sign the SNFABN attesting to being personally and fully responsible for payment, in which case, the SNF may then consider not furnishing the specified items or services (see §40.3.4.6).) A SNFABN is evidence of beneficiary knowledge about the likelihood of Medicare denial, for the purpose of determining financial liability for expenses incurred for extended care items or services furnished to a beneficiary and for which Medicare does not pay. Section 70.2.3 specifies that SNFABNs are to be given with respect to extended care items or services furnished to a beneficiary for which denial is expected. For a SNF to give a beneficiary a SNFABN and then refuse to furnish extended care items or services even though the beneficiary elects to receive these items or services by selecting Option 1, is tantamount to the prohibited practice (see §70.4.4.2) of the SNF pre-selecting Option 2 (not to receive items or services) on a SNFABN.

70.2.2.5 - M+C Enrollees and Non-Medicare Patients

(Rev. 1, 10-01-03)

The SNFABN is not to be used for Medicare M+C (Part C) enrollees nor for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B).

70.2.3 - Situations in Which SNFABN Should Be Given

(Rev. 1, 10-01-03)

If Medicare is expected to deny payment (entirely or in part) on the basis of one of the exclusions listed in §70.1 for extended care items or services that the SNF furnishes to a beneficiary, a SNFABN should be given to the beneficiary.

70.2.3.1 - Triggering Events

(Rev. 1, 10-01-03)

SNFs are required to give a SNFABN to Medicare beneficiaries (including dual-eligibles) when the SNF, the UR entity, the QIO, or the Medicare contractor believes that Medicare will not continue to pay for some or all of the extended care items or services a physician has ordered for the beneficiary. Because of the belief that Medicare will not pay for the extended care items or services ordered by the physician, the SNF is either going to deny, reduce, or terminate the items or services to the beneficiary unless the beneficiary agrees to be personally and fully responsible for payment for such items or services. (Note: A SNFABN is not given when the SNF is unwilling to furnish extended care items or services even if the beneficiary is willing to agree to be personally and fully responsible for payment for such items or services (see §70.2.2.4).) The SNF must give the Medicare beneficiary a SNFABN before reducing or terminating extended care items or services that the beneficiary already is receiving, and that Medicare has been paying for, if the physician's order for such items or services would still continue care, but the SNF, the UR entity, the QIO, or the Medicare contractor expects payment for the extended care items or services will be denied by Medicare. A SNFABN is required when a SNF determines that Medicare is not likely to pay for otherwise covered extended care items or services that a physician has ordered. SNFs must give a SNFABN whenever a triggering event occurs. (A triggering event is defined as one of three changes to services: initiation, reduction, or termination.) The following circumstances constitute the three triggering events for a SNFABN:

A - Initiation of Services

In the situation in which a SNF advises a beneficiary that it will not accept the beneficiary as a Medicare patient because it expects that Medicare will not pay for the extended care items or services that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it furnishes extended care items or services to the beneficiary.

B - Reduction of Services

In the situation in which a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay for a subset of extended care items or services, or for any items or services at the current level and/or frequency of care that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it reduces items or services to the beneficiary.

C - Termination of Services

In the situation in which a SNF proposes to stop furnishing all extended care items or services to a beneficiary, because it expects that Medicare will not continue to pay for the items or services that a physician has ordered, the SNF must provide a SNFABN to the beneficiary before it terminates such extended care items or services.

70.2.3.2 - Dual-Eligibles

(Rev. 1, 10-01-03)

If the patient is a Medicare-Medicaid dual-eligible and a triggering event occurs, the SNF needs to give the patient (or authorized representative) a SNFABN.

70.2.3.3 - Medicare as Sole Payer

(Rev. 1, 10-01-03)

When the SNF predicts that Medicare will not pay for extended care items or services ordered by the physician and the physician continues the prescription for those items or services, this means the SNF will reduce or terminate extended care items or services to the beneficiary if Medicare were the sole payer for the items or services. On this basis, we characterize such situations as "triggering events," as described in §70.2.3.1. When, in describing "triggering events," we say "a SNF proposes to reduce a beneficiary's extended care items or services because it expects that Medicare will not pay" and "a SNF proposes to stop furnishing all extended care items or services to a beneficiary, because it expects that Medicare will not continue to pay," our premise is that Medicare is the sole payer for the items or services, and necessarily so since we are not promulgating instructions for other insurers. It is true that, on a practical basis, physician-prescribed items or services continue without interruption or reduction when a patient changes "payer eligibility" from Medicare to Medicaid. From the Medicare coverage vantage-point, however, there is a reduction or termination when Medicare, which has been paying, stops paying. In other words, there is a triggering event, which underlies the change in "payer eligibility."

70.2.4 - Routine SNFABN Prohibition

(Rev. 1, 10-01-03)

A SNF will not be held to have violated the prohibition on routine SNFABNs solely on the basis of the number of SNFABNs which the user gives to beneficiaries, when those SNFABNs are justified by the SNF having a genuine reason to give a SNFABN. (See §40.3.6, "Routine Notice Prohibition.")

70.2.5 - To Whom a SNFABN Should Be Given

(Rev. 1, 10-01-03)

A SNFABN may be given to a Medicare beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Ultimately, if a situation arises in which a beneficiary simply cannot receive a SNFABN and this notice cannot be given to an authorized representative, the beneficiary is protected by not having received a SNFABN. A SNF's inability to give notice to a beneficiary directly or through an authorized representative does not allow the SNF to shift liability to the beneficiary.

NOTE: These SNFABNs do not apply to swing-bed determinations.

70.3 - Delivery of SNFABNs

(Rev. 1, 10-01-03)

70.3.1 - Delivery Must Meet Advance Beneficiary Notice Standards

(Rev. 1, 10-01-03)

A SNF (that is, a qualified notifier as defined in §40.3.2) shall notify a beneficiary by means of timely (as defined in §40.3.3) and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Delivery of a SNFABN occurs when the beneficiary or authorized representative both has received the notice and can comprehend its contents. All SNFABNs must include an explanation written in lay language of the SNF's, the UR entity's, the QIO's or the Medicare contractor's reason for believing the items or services will be denied payment. SNFABNs must meet the standards for approved model notice language in §40.3, "Advance Beneficiary Notice Standards."

70.3.2 - SNFABN Specific Delivery Issues

(Rev. 1, 10-01-03)

SNFs must provide SNFABNs in every case where a reduction or termination of items or services is to occur, or where items or services are to be denied before being initiated, if there is a physician's order for such care and the SNF, the UR entity, the QIO, or the Medicare contractor expects payment for the extended care items or services to be denied by Medicare. (For situations in which a physician concurs in the reduction, termination, or denial of items or services, see §70.6.6. For situations in which services are statutorily excluded, see §70.2.2). If the SNF, the UR entity, the QIO, or the Medicare contractor expects that Medicare will not pay for the care, the SNF must advise the beneficiary, orally and in writing, before the extended care item or service is initiated or continued that, in the SNF's opinion, the beneficiary will be fully and personally responsible for payment for the specified extended care item or service that it furnishes. The SNF must issue notices each time, and as soon as, the SNF, the UR entity, the QIO, or the Medicare contractor makes the assessment that it believes that Medicare payment will not be made. To be acceptable, a SNFABN (Form CMS-10055) must meet CMS' standards for cultural competency, must clearly identify the particular extended care item or service, must state that the SNF believes Medicare is likely (or certain) to deny payment for the particular item or service, and must give the SNF's, the UR entity's, the QIO's or the Medicare contractor's reason(s) for its belief that Medicare is likely (or certain) to deny payment for the item or service. The SNF makes an original and two copies of the SNFABN (if the contractor requires a copy, one more copy will be made). The SNF gives the original to the beneficiary (or authorized representative); sends the first copy to the beneficiary's attending physician, and keeps the second copy. The Form CMS-10055

SNFABN is an approved model notice. The online Form CMS-10055 SNFABN should be as closely replicated as possible. Failure to provide a proper SNFABN in situations where a physician has ordered the extended care item or service may result in the SNF being held financially liable under the provisions of Limitation on Liability (LOL), where such provisions apply. (See §40.2.) SNFs may also be sanctioned for violating the conditions of participation (viz., 42 CFR 483.10) regarding resident (beneficiary) rights.

70.3.3 - Timely Delivery

(Rev. 1, 10-01-03)

The contractor will reject SNFABNs that are not given timely. The SNF must notify the beneficiary well enough in advance before terminating or reducing extended care items or services. “Well enough in advance” means the beneficiary has time to make other arrangements. If the SNF, the UR entity, the QIO, or the Medicare contractor denies services, the SNF must notify the beneficiary as required in §70.6.9.2. Last moment delivery of a SNFABN will be considered to be untimely, regardless of the SNF’s intentions. Common sense must be applied to this criterion. If a beneficiary alleges she or he did not receive notice timely, the Medicare contractor will investigate the facts. If the SNF has clearly violated the timely delivery rule, the Medicare contractor will hold that the notice was not properly delivered in advance of terminating or reducing extended care items or services and that the beneficiary was not properly notified. The Medicare contractor will ask the SNF to justify any delays in notification.

70.3.4 - Actual Receipt of Notice Required

(Rev. 1, 10-01-03)

If the beneficiary is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held financially liable where the LOL provisions apply and the SNF may be held financially liable. It is the SNF’s responsibility to ensure that the beneficiary or the authorized representative actually receives a notice that they can comprehend. Failure to provide a comprehensible notice is also a violation of the conditions of participation and may result in enforcement action.

70.3.5 - Understandability and Comprehensibility of Notice

(Rev. 1, 10-01-03)

The beneficiary or authorized representative must be able to understand and comprehend the SNFABN for it to be an effective notice. In general, SNFs should not use abbreviations, diagnosis codes, HCPCS, or similar technical or otherwise unfamiliar language when completing an SNFABN’s “Items or Services” and “Because” customizable areas because the beneficiary is likely not to understand them. Of course, abbreviations, codes, etc., accompanying the spelled-out information are not per se confusing and will not invalidate a SNFABN. The SNF is responsible for ensuring that the SNFABN is completed in a manner such that the beneficiary can read and understand

it. A SNFABN that the beneficiary cannot understand is defective and will not protect the SNF from financial liability.

70.4 - Form Instructions for the SNFABN (Form CMS-10055)

(Rev. 1, 10-01-03)

70.4.1 - General Rules

(Rev. 1, 10-01-03)

The SNFABN (i.e., model Form CMS-10055) is not a replacement for, but is in addition to, the required UR entity notices**.** The SNFABN protects the SNF from liability in the event the patient, for some reason, does not receive the UR entity notice.

70.4.1.1 - Delivery of SNFABN When Based on Statutory Exclusion

(Rev. 1, 10-01-03)

The SNF is to prepare and deliver to the patient (Medicare beneficiary) or the patient's authorized representative a SNFABN when it, the UR entity, the QIO, or the Medicare contractor expects Medicare probably will not pay for or will not continue to pay for extended care items or services on the basis of one of the statutory exclusions listed in §70.1.

70.4.1.2 - Guidelines for Replicating the SNFABN Form

(Rev. 1, 10-01-03)

Use of the SNFABN is for model language purposes only and should be replicated as closely as possible. The SNF must ensure that the readability of the SNFABN facilitates beneficiary or authorized representative understanding. No insertions into the blank lines and the two customizable sections of the SNFABN, if typed or printed, should be in italics or be in any font that is difficult to read. If insertions are handwritten, they must be legible. An Arial or Arial Narrow font, or a similarly readable font, in the font size range of 10 point to 12 point, is recommended. Black or dark blue ink on a white background is strongly recommended. A visually high-contrast combination of dark ink on a pale background is required. Low-contrast combinations and block shading are prohibited. In all cases, both the originals and copies of the SNFABN must be legible and of high-contrast. The form must be clear and obvious to the beneficiary that the SNFABN is issued by the SNF rather than by the Medicare program. The Medicare contractor will reject any SNFABN that does not meet these standards.

70.4.1.3 - Modification of the SNFABN Form

(Rev. 1, 10-01-03)

A SNFABN may not be modified except for the header and the two customizable areas; i.e., the "Items or Services" and "Because" sections of the model Form CMS-10055.

70.4.2 - Header of SNFABN

(Rev. 1, 10-01-03)

70.4.2.1 - Customization of CMS-10055 SNFABN Header

(Rev. 1, 10-01-03)

The header of the SNFABN, located above the title "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)," is a customizable section of the model Form CMS-10055, which the SNF may customize for its own use, consistent with the requirements of §70.4.2.2**.**

70.4.2.2 - Guidelines for Customizing the SNFABN Header

(Rev. 1, 10-01-03)

The SNFABN's header should have the identifying information it requires as a billing entity. The SNF also must include at the top of the SNFABN's header its name, address, and telephone and TTY/TDD telephone numbers or directions for using its other telecommunication system for individuals with impaired speech or hearing. The SNF may elect to include its logo (if any). It is only within these general rules that the SNF can customize the header of the SNFABN.

70.4.3 - Body of SNFABN

(Rev. 1, 10-01-03)

70.4.3.1 - Entering the Required Date(s) on the CMS-10055 SNFABN

(Rev. 1, 10-01-03)

On the "Date of Notice" line of the SNFABN, the SNF must enter the delivery date, i.e., the date on which the SNF gave the notice personally to the patient or to the patient's authorized representative. Where personal delivery is not possible, the SNF is to include both the date it notified the patient or her or his authorized representative by telephone and the date it mailed the SNFABN.

70.4.3.2 - Specifications Required for the "Items or Services" Section of the SNFABN

(Rev. 1, 10-01-03)

In the "Items or Services" section of the SNFABN, the SNF must specify the extended care items or services for which Medicare is expected not to pay (see §70.4.2). The specification must be in sufficient detail so that the patient understands precisely what extended care items or services may not be furnished and include any pertinent dates, e.g., "furnished on or after [date]". It is essential that the effective date(s) be included in the specification of services. The phrase "Items or Services" must also be included in this section. The SNF may customize (see §70.1.2) this section for its own use.

70.4.3.3 - Specifications Required for the "Because" Section of the SNFABN

(Rev. 1, 10-01-03)

In the "Because" section of the model SNFABN form, the SNF must give the specific reason(s) why it, the UR entity, the QIO, or the Medicare contractor expects Medicare to deny payment (see §70.4.2). The reason(s) cited must be in understandable lay language and must be sufficiently specific to allow the patient to understand the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's expectation that Medicare will deny payment. If necessary, the SNF is to gather evidence to the contrary from the physician and/or others in support of the coverage of such services (e.g., "our clinical assessment of your (the patient's) condition indicates that you can benefit from physical therapy services twice weekly, but that daily physical therapy services would not be beneficial"). The word "Because" must be included in this section. The SNF may customize (see §70.1.2) this section for its own use.

70.4.3.4 - Answering Inquiries About the SNFABN Notification

(Rev. 1, 10-01-03)

In the first bullet of the SNFABN that begins, "Ask us to explain …," the SNF is required to answer inquiries from a patient or the patient's authorized representative who requests further information and/or assistance in understanding and responding to the SNFABN, including the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that extended care items or services may not be covered. The SNF's refusal to respond to such inquiries may result in the SNFABN being invalidated and, thus, ineffective in protecting the SNF from liability.

70.4.3.5 - Providing Cost Estimation(s) for Items or Services on the SNFABN

(Rev. 1, 10-01-03)

On the first line of the second bullet of the SNFABN that reads, "Estimated Cost: $," the SNF may provide the patient with an estimated cost of the extended care items or services at issue. The patient may ask about the cost of the items or services and jot down an amount on this line. The SNF should respond to inquiries regarding the estimated cost to the best of its ability. The lack of an amount on this line, or an amount which is different from the final actual cost, does not invalidate the SNFABN; a SNFABN is not considered to be defective on that basis, unless otherwise specified in instructions to specific categories of users. In the case of a SNFABN that includes multiple extended care items or services, it is permissible for the SNF to give estimated amounts for the individual items or services rather than an aggregate estimate of costs. Amounts may be provided either with the description of extended care items and services (i.e., in the "Items or Services" section) or on the "Estimated Cost" line.

70.4.3.6 - Providing Non-Medicare Insurance Information on the SNFABN

(Rev. 1, 10-01-03)

The second line of the second bullet of the SNFABN that reads, "Your other insurance is:" is provided for a user, that is required by other instructions, to enter the name of the patient's other insurance (e.g., Medicaid, Medigap, employee plan, etc.). Any user, not otherwise required to do so, may enter this information at its own discretion.

70.4.3.7 - Providing Contractor Information on the SNFABN

(Rev. 1, 10-01-03)

In the third bullet of the SNFABN that begins, "If in 90 days you have not gotten ... " the SNF is required to enter (on each of the lines so designated) the name, address, and telephone and TTY/TDD telephone numbers of the contractor to which the associated Medicare claim will be submitted. The information specified on these individual lines permits the patient or the patient's authorized representative to write or telephone the contractor directly should a determination on the associated Medicare claim not be received within 90 days.

70.4.3.8 - Required Guidelines in Preparation for Submitting Medicare Claims

(Rev. 1, 10-01-03)

In the fourth bullet of the SNFABN that begins, "If you receive …," the SNF is required to submit to Medicare a claim for any and all extended care items or services furnished,

except those that may be explicitly specified in other instructions. If, in compliance with other instructions, the SNF does not submit a claim to Medicare, the SNF is to delete or mark out the fourth bullet before delivering the SNFABN to the patient or the patient's authorized representative. In the instance where the patient or authorized representative requests submission of a claim for furnished extended care items or services not explicitly specified in instructions, the SNF is required to notify the patient or authorized representative when that claim has been submitted to the Medicare contractor. The SNF is prohibited from billing the patient or authorized representative for any items or services at issue until the contractor has determined coverage on the associated Medicare claim.

70.4.3.9 - Providing Appropriate Recipient Name on the SNFABN

(Rev. 1, 10-01-03)

On the "Patient's Name:" line of the SNFABN, the SNF is to enter the name of the patient, not substituting the name of the authorized representative.

70.4.3.10 - Providing the Medicare Health Insurance Claim Number on the SNFABN

(Rev. 1, 10-01-03)

On the "Medicare # (HICN):" line of the SNFABN, the SNF is to enter the patient's Medicare Health Insurance Claim Number (HICN). A SNFABN is not invalidated solely for the lack of a Medicare HICN unless the recipient of the SNFABN alleges that someone else of the same name signed the SNFABN and the Medicare contractor cannot resolve the matter with certainty.

70.4.3.11 - Providing Date of Signature on the SNFABN

(Rev. 1, 10-01-03)

On the "Date" line of the SNFABN, the patient, or the patient's authorized representative should enter the date on which she or he signed the SNFABN. If the SNF writes in the date and the beneficiary or authorized representative does not dispute the date, that date is acceptable. A SNFABN is not invalidated simply because the date is typed or printed.

70.4.4 - Option Boxes

(Rev. 1, 10-01-03)

70.4.4.1 - Selecting an Option on the SNFABN

(Rev. 1, 10-01-03)

For Options 1 and 2 on the SNFABN, the patient or authorized representative is to personally select an option by making a mark in the chosen checkbox 1 or 2. SNFABNs with both checkboxes marked are unacceptable and will not protect the SNF from liability. If the patient or authorized representative marks the wrong checkbox accidentally or because either one has changed her or his mind, she or he should mark the correct checkbox and should cross out the erroneously marked checkbox and write her or his initials next to it. A new SNFABN is not required unless the patient or authorized representative changes her or his mind a second time.

70.4.4.2 - Prohibition of Pre-Selection of an Option on the SNFABN

(Rev. 1, 10-01-03)

Any SNFABN on which the SNF pre-selects an option will not be acceptable as evidence of beneficiary notice. Pre-selecting options is prohibited and will invalidate the SNFABN.

70.4.4.3 - Effect of Beneficiary's Option Selection

(Rev. 1, 10-01-03)

The patient or the authorized representative must select one option.

- If the patient selects Option 1, the patient may receive the subject extended care items or services, for which a demand bill must be submitted to Medicare for an official determination.

- If the patient selects Option 2 the patient has elected not to receive the subject extended care items or services.

70.4.5 - Proper Denial Paragraphs

(Rev. 1, 10-01-03)

The denial paragraphs (found below under Condition) cover common reason(s) why the extended care items or services are noncovered under Medicare. The SNF may use these denial paragraphs as inserts in the "Because" and "Items or Services" sections of the SNFABN (see §§70.4.3.2 and 70.4.3.3). Where no paragraph exists to explain the reason(s) why the extended care items or services are believed to be noncovered, the SNF

is to develop new, or modify current, language to fit the situation. The SNF is to forward the newly prepared language to the Medicare contractor associated with processing its Medicare claims. The associated Medicare contractor will submit the SNF's language to CMS for review and, as appropriate, for inclusion in the MCPM.

NOTE: If applicable, the SNF is to substitute therapy and type of therapist for skilled nursing and skilled nurse. If applicable, the SNF is to substitute URC for "we" (e.g., "we or URC believe that the services you (the patient) received are noncovered."). If applicable, the SNF is to adjust the verb reflections or tense for those paragraphs containing admission denial information.

Condition: Nonskilled care - full denial

Denial Paragraph: Medicare covers medically necessary skilled nursing care needed on a daily basis. You only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry out your plan of care. Therefore, we believe that your care cannot be covered under Medicare.

Condition: Specific nonskilled service provided - no skilled care (full denial)

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service). This does not require the skills of a licensed nurse to perform the service or to manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

Condition: Specify nonskilled service provided - (partial denial)

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You only needed (specify service) after (date). Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay beginning (date) is not covered under Medicare.

Condition: Observation and management of care plan - no significant change

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. You needed skilled nursing care beginning (date) to observe and evaluate your condition. There is no indication of further likelihood of significant changes in your care plan or of acute changes or complication in your condition. Since you no longer need skilled nursing or skilled rehabilitation services on a daily basis, we believe you stay after (date) is not covered under Medicare.

Condition: Observation and management of care plan - condition improved

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. Because of your condition, you needed a skilled nurse from (date) through (date)

to evaluate and manage your care plan. Your condition has improved so the services you need can safely and effectively be given by nonskilled persons. Since you no longer require skilled nursing and did not need skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare after (date).

Condition: Teaching and training activities - partial denial

Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You had learned to perform the tasks ordered by your physician by (date) but the therapist continued services. Since you did not need skilled services after that date, we believe your stay is not covered under Medicare beginning (date).

Condition: Teaching and training activities - no skilled service

Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You needed only to be reminded to follow the physician's instructions. This does not require the skills of a professional nurse or therapist. Therefore, we believe that this service is not covered under Medicare.

Condition: Teaching and training activities - little or no progress

Denial Paragraph: Medicare covers medically necessary skilled nursing or rehabilitation services you need including teaching and training activities for a reasonable time where progressive learning is demonstrated. You received teaching and training for a reasonable time but demonstrated you were not able, at this time, to learn or make progress to perform the activities ordered by your physician. Therefore, we believe that skilled services are not covered under Medicare after (date).

Condition: Nursing not needed for foley care

Denial Paragraph: Medicare covers daily skilled nursing care related to the insertion, sterile irrigation and replacement of urethral catheter if the use of the catheter is reasonable and necessary for the active treatment of a disease of the urinary tract or for patients with special medical needs. Skilled nursing is not considered medically necessary when urethral catheters are used only for mere convenience or the control of incontinence. Since your catheter was inserted for convenience or the control or your incontinence, we believe that your care is not covered under Medicare.

Condition: Repetitive exercises - partial denial

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services. The medical information shows that the only therapy services you needed beginning (date) were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical

complications which would have required that services be performed by a qualified therapist. We believe therapy services are not covered under Medicare after (date).

Condition: Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology.)

Denial Paragraph: Medicare covers medically necessary skilled rehabilitative services when needed on a daily basis. The therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified (specify) therapist to perform and/or to supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, we believe your stay is not covered under Medicare.

Condition: Therapy to maintain function after a maintenance program has been established

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services to establish a safe and effective program to maintain your functional abilities. This program was established and beginning (date), the (specify) therapy services you received were to carry out this program. These services do not require the supervision or skills of a (specify) therapist and, therefore, we believe that the services are not/would not be covered under Medicare.

Condition: Specific skilled service is not reasonable and necessary (service not specific or effective)

Denial Paragraph: Medicare covers medically necessary skilled care when needed on a daily basis. The (specify service(s)) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these service(s) is/are not considered a specific and/or effective treatment for your condition. Since the service(s) you received was/were not reasonable or necessary for the treatment of your condition, we believe your stay is not covered under Medicare.

Condition: No material improvement in relation to therapy services required - full denial

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. The (specify) therapy services provided was/were not reasonable in relation to the expected improvements in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe your stay is not covered under Medicare.

Condition: No material improvement in relation to therapy services required - partial denial

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. While you required skilled (specify) therapy from (date) to

(date), the medical information shows that the (specify) therapy services after that time is not reasonable in relation to the expected improvements in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, we believe your stay after (date) is not covered under Medicare.

Condition: Frequency not reasonable and necessary

Denial Paragraph: Medicare covers medically necessary skilled care when needed on a daily basis. Although (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is/are not normally needed on a daily basis. The medical information does not show medical complications which require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary. Since you did not need skilled nursing or skilled rehabilitation on a daily basis, we believe your stay is not covered under Medicare.

Condition: Skilled rehabilitation services not received daily - no skilled nursing

Denial Paragraph: Medicare covers medically necessary skilled rehabilitation services when needed on a daily basis. Although you required skilled (specify) therapy, you did not receive therapy on each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, we believe that your stay is not covered under Medicare.

Condition: Skilled nursing services not daily

Denial Paragraph: Medicare covers medically necessary skilled care needed on a daily basis. Although you required skilled nursing services, you do/did not need them on a daily basis. Because you do/did not need daily skilled nursing or skilled rehabilitation, we believe Medicare will not cover your stay.

70.5 - Signature Requirements for SNFABN

(Rev. 1, 10-01-03)

- On the "Signature of patient …" line of the SNFABN, the patient, or authorized representative, should sign her or his name.

- The patient may sign a SNFABN. In the case of a beneficiary who is incapable or incompetent, her or his authorized representative, as defined in §40.3.5, may sign a SNFABN.

- If the patient's (or authorized representative's) signature is absent from a SNFABN, in case of a dispute as to the patient's (or authorized representative's) receipt of the SNFABN, the Medicare contractor will give credence to the patient's (or authorized representative's) allegations regarding the SNFABN.

However, if the patient (or the authorized representative) refuses to sign the SNFABN but demands extended care items or services, the guidance in §40.3.4.6 should be followed.

- The SNF must obtain the signed (containing the signature of the patient or authorized representative) and dated SNFABN with Option 1 or 2 selected as to the action the beneficiary wants to take, from the beneficiary, either in person or, where this is not possible, via return mail from the beneficiary or authorized representative as soon as possible after the SNFABN has been signed and dated. The beneficiary retains the patient's copy of the signed and dated SNFABN and returns the original. The SNF annotates the original of the SNFABN with the date of receipt from the beneficiary. The SNF is to return within 30 calendar days a copy of the SNFABN, including the date of its receipt, to the beneficiary for her or his records. The SNF retains the original SNFABN. These copies will be relevant in the case of any future appeal. Where the SNFABN is signed and dated in the presence of the SNF's staff or employee, the annotation of the date of the SNF's receipt of the signed and dated SNFABN may be made directly on both the original and patient's copy, and a second patient copy of the annotated original is not required.

- If a patient who chose "Option 2 No." later requests that a claim be submitted to Medicare, consistent with Option 1, the SNF should annotate its copy of the SNFABN with the date of its receipt of the new request and return a copy of the annotated SNFABN within 30 calendar days to the patient for her or his records.

- If the patient, or the authorized representative, refuses to sign the SNFABN and/or refuses to choose any option, the SNF should annotate its copy of the SNFABN, indicating the circumstances and persons involved. If this occurs, the SNF must decide whether or not to furnish the items or services to the patient in light of the fact that the patient has not agreed to be fully and personally responsible for payment for extended care items or services that are not covered by Medicare. If, under these circumstances (i.e., the patient refuses to pay but demands the items or services) the SNF decides to provide the extended care items or services, it should have a second person witness the provision of the SNFABN and the patient's refusal to sign. They should both sign an annotation on the SNFABN attesting to having witnessed said provision and refusal. Where there is only one person on site, the second witness may be contacted by telephone to witness the patient's refusal to sign the SNFABN by telephone and may sign the SNFABN annotation at a later time. The unused patient signature line on the SNFABN form may be used for such an annotation; writing in the margins of the form is also permissible. (See §40.3.4.6.A.)

70.6 - Special Rules for SNFABNs

(Rev. 1, 10-01-03)

70.6.1 - Effect of Furnishing SNFABNs and Collection From Beneficiary

(Rev. 1, 10-01-03)

70.6.1.1 - Effective Notice

(Rev. 1, 10-01-03)

When SNFABNs are properly used by a SNF, the SNFABNs will protect the SNF from financial liability under §1879(a)(1) of the Act, which limits beneficiaries' financial liability. A beneficiary who has been given a proper written SNFABN, before an extended care item or service is furnished, reduced, or terminated, giving notice of the likelihood (or certainty) that Medicare will not pay for the specific item or service and the reason therefore and who, after being so informed, has agreed to pay the SNF for the extended care item or service, will be held financially liable. That is, that beneficiary will be found to have known in advance that Medicare will not pay, and the SNF will be free to bill and collect the related charges from the beneficiary.

70.6.1.2 - Defective Notice

(Rev. 1, 10-01-03)

Failure to meet the SNFABN standards and procedures will expose a SNF to the risk of potential financial liability for denied extended care items or services in cases where, in the absence of a proper SNFABN, the beneficiary would be held not to have known, nor to reasonably have been expected to have known, that her or his claims for the denied items or services he or she received, were likely to be denied by Medicare. Furthermore, any SNF held financially liable for failing to provide a SNFABN, failure to provide a SNFABN in a timely manner, or providing a defective SNFABN to a beneficiary will be precluded from collecting from the beneficiary and third-party payers which includes Medicaid. If a SNF is suspected of furnishing SNFABNs with the intent to induce or coerce referrals for other extended care items or services paid for by Medicare whereby anti-kickback statutes could be implicated, or if a SNF is suspected of issuing SNFABNs for any fraudulent, abusive, or otherwise illegal purposes, the Medicare contractor will refer the matter to the CMS regional office. A SNF that supplies a defective SNFABN (e.g., one which does not meet the standards in §40.3) will not be protected from financial liability. A beneficiary who received a defective SNFABN should be held not financially liable and the SNF that gave the defective SNFABN should be held financially liable.

70.6.1.3 - Collection From Beneficiary

(Rev. 1, 10-01-03)

When a SNFABN is properly executed and given timely to a beneficiary and Medicare denies payment on the related claim, the SNF must wait for the beneficiary to receive a denial Medicare payment determination before it can collect payment on the related claim. Medicare does not limit the amount that the SNF may collect from the beneficiary in such a situation. A beneficiary's agreement to "be personally and fully responsible for payment" means that the beneficiary agrees to pay out of pocket or through any other insurance that the beneficiary may have, e.g., through employer group health plan coverage, through Medicaid, or through other Federal or non-Federal payment source.

70.6.1.4 - Unbundling Prohibition

(Rev. 1, 10-01-03)

SNFABNs may not be used to shift financial liability to a beneficiary in the case of services for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be financially liable for payment for an extended care item or service because Medicare made a bundled payment. Using a SNFABN to collect from a beneficiary where full payment is made on a bundled basis would constitute double billing. A SNFABN may be used to shift financial liability to a beneficiary in the case of extended care items or services for which partial payment is bundled into other payments; that is, where part of the cost is not included in the bundled payment made by Medicare.

70.6.2 - Reissuance of the SNFABN

(Rev. 1, 10-01-03)

A SNFABN, model Form CMS-10055, remains effective for the predicted denial it communicates to the beneficiary, without periodic reissuance, for an indefinite period as long as no triggering event occurs. If a triggering event does occur, then another SNFABN must be given immediately. A single SNFABN covering an extended course of treatment is acceptable provided the SNFABN identifies all extended care items and services for which the SNF, the UR entity, the QIO, or the Medicare contractor believes Medicare will not pay. If, as the extended course of treatment progresses, additional extended care items or services are to be furnished for which the SNF, the UR entity, the QIO, or the Medicare contractor believes Medicare will not pay, the SNF must separately notify the patient in writing (i.e., give the beneficiary another SNFABN) that Medicare is not likely to pay for the additional extended care items or services and obtain the beneficiary's signature on the SNFABN. One year is the limit for use of a single SNFABN for an extended course of treatment; if the course of treatment extends beyond one year, a new SNFABN is required for the remainder of the course of treatment. A SNFABN, once signed by the beneficiary, may not be modified or revised. When a

beneficiary must be notified of new information, a new SNFABN must be given. The beneficiary may request a demand bill at any point in her or his care.

70.6.3 - Acceptance or Rejection of SNFABN

(Rev. 1, 10-01-03)

These instructions are to assist the Medicare contractor in advising SNFs with respect to their responsibilities in advising beneficiaries with respect to their rights and protections and in dealing with complaints from beneficiaries, or authorized representatives, about the lack of notice or defective notice. The SNF must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to the notice. The SNF must answer inquiries from a beneficiary, or authorized representative, regarding the basis for the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that extended care items or services may not be covered and, if requested by the beneficiary, or authorized representative, the SNF must give the beneficiary, or authorized representative, access to medical record information or other documents upon which the Medicare contractor based its assessment, to the extent permissible or required under applicable state law. Where state law prohibits such direct disclosure, the SNF must advise a beneficiary, or authorized representative, who has requested access to such information how to obtain that information from the SNF once a demand bill has been submitted. The SNF must respond timely, accurately, and completely to a beneficiary, or authorized representative, who requests information about the extent of the beneficiary's personal financial liability for extended care items or services for which the SNF, the UR entity, the QIO, or the Medicare contractor expects that Medicare may not, or may no longer, pay. If a beneficiary or authorized representative or a physician provides additional information with respect to Medicare coverage of the subject extended care items or services, the SNF must timely submit that additional information to the Medicare contractor. The Medicare contractor will reject a SNFABN in all cases in which the SNF does not meet these requirements.

70.6.4 - Effect of SNFABN on Beneficiary

(Rev. 1, 10-01-03)

Under the statutory provision of LOL, a beneficiary who has received a proper SNFABN and who has agreed to pay for the specified extended care items or services will be fully and personally responsible for payment to the SNF if Medicare denies payment. The Medicare contractor will not hold a beneficiary who does not receive a SNFABN, or who receives a defective SNFABN (i.e., one that does not meet the requirements of these instructions, or one on which an option was pre-selected by the SNF) financially liable under the LOL provisions, unless there is clear and obvious evidence that the beneficiary knew or could reasonably have been expected to know that Medicare would not make payment (in which case, the Medicare contractor will hold the beneficiary financially liable).

70.6.5 - Financial Liability

(Rev. 1, 10-01-03)

A SNF that fails to comply with the SNFABN instructions risks financial liability and/or sanctions. LOL shall apply as required by law, regulations, rulings and program instructions thereunder. Additionally, sanctions under the Conditions of Participation (COPs), when authorized by law and regulations, may be imposed.

70.6.6 - Limitation on Liability

(Rev. 1, 10-01-03)

The Medicare contractor will hold financially liable, under LOL, any SNF that failed to provide notice, or provided a defective notice, to a beneficiary in a particular case, to which LOL (§1879 of the Act) applies, unless the SNF can demonstrate that it did not know, and could not reasonably have been expected to know, that Medicare would not make payment, or there is clear and obvious evidence that the beneficiary knew that Medicare would not make payment. The SNF is to prepare and deliver to the patient (Medicare beneficiary) or her or his authorized representative a SNFABN when the SNF, the UR entity, the QIO, or the Medicare contractor expects that Medicare probably will not pay for, or will not continue to pay for, extended care items or services. If a SNF advises a beneficiary that, in its view, Medicare probably will not pay, but does so in a defective manner such that the beneficiary cannot fully exercise her or his rights and protections (which the Medicare contractor must assume to be the case when a SNFABN was not executed and delivered properly by the SNF), the Medicare contractor will consider that to be prima facie evidence that the SNF knew that Medicare would not make payment and not sufficient evidence to shift financial liability to the beneficiary. If a financially liable SNF collects from a beneficiary, the Medicare contractor shall implement the beneficiary protections under §100.

70.6.7 - Extended Care Items or Services Not Ordered by Physicians

(Rev. 1, 10-01-03)

Medicare never pays for extended care items or services not ordered by a physician. No SNFABN is needed when extended care items or services are reduced or terminated in accordance with a physician's order, where a physician does not order the items or services at issue, or where the physician agrees in writing with the SNF's, the UR entity's, the QIO's, or the Medicare contractor's assessment that the extended care items or services are not necessary. The physician orders must be in writing and be entered into the beneficiary's record. The LOL provisions do not apply in these situations, but certain beneficiary protections under the COP do apply. An ABN (Form CMS-R-131) may be required if a SNF has been acting as a supplier of Part B services or supplies outside a physician's plan of care.

70.6.8 - Regulatory Requirements

(Rev. 1, 10-01-03)

- Under 42 CFR 483.10, "Condition of Participation: Resident rights."

70.6.9 - Standards

(Rev. 1, 10-01-03)

70.6.9.1 - Establishing When Beneficiary Is On Notice of Noncoverage

(Rev. 1, 10-01-03)

If the beneficiary has previously been informed in writing that the extended care items or services were noncovered as a result of a prior stay for the same condition, the beneficiary is liable, but only if it is clear that she or he (or her or his authorized representative) knew that the circumstances were the same. With this exception, the beneficiary is presumed not to have known, nor to have been expected to know, that the extended care items or services are not covered unless, or until, she or he receives notification from an appropriate source (see §70.6.9.2).

70.6.9.2 - Source of Beneficiary Notification

(Rev. 1, 10-01-03)

- Where the SNF serves as the source of beneficiary notification.
    - The SNF on or before the day of admission furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary that the extended care item(s) or service(s) is noncovered.
    - The SNF, during the inpatient stay, timely furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying that the beneficiary no longer required covered extended care item(s) or service(s).
    - The SNF, when advised by the Medicare contractor that the beneficiary's covered extended care items or services have ceased, that very day furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary of the Medicare contractor's determination.
- Where the UR entity serves as the source of beneficiary notification.
    - The UR entity (the group or committee responsible for conducting the SNF's UR) timely furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary that the extended care item(s) or service(s) is no longer covered.

- Where the QIO serves as the source of beneficiary notification.

    - The QIQ, where a beneficiary is in a swing bed, timely furnishes to the beneficiary, or to her or his authorized representative, a SNFABN notifying the beneficiary that the extended care item(s) or service(s) is not covered or the item(s) or service(s) is no longer covered.

- Where a Medicare contactor serves as the source of beneficiary notification.

    - The beneficiary, or authorized representative, receives from the Medicare contractor her or his first notification of noncoverage (e.g., the Medicare contractor's denial notice).

70.6.9.3 - Determining the Notification Date for the Denial Paragraph

(Rev. 1, 10-01-03)

SNFs are to insert in the denial paragraph, if applicable, of the SNFABN's "Because" section (see §70.4.5) the appropriate notification date. In instances where the:

- SNF determines prior to, or upon admission, that the services will not be covered, the SNF is to insert the date the determination was made;

- SNF determines that further services will not be covered, the SNF is to insert the first day on which the services are not covered, usually the day following the date of the SNFABN;

- UR entity advises the SNF that the beneficiary's stay was not medically necessary upon admission, the SNF is to insert the date of the first day on which the stay is not medically necessary;

- UR entity advises the SNF that a further stay is not medically necessary, the SNF is to insert the date of the first day on which the beneficiary's stay is not medically necessary; or

- Medicare contractor advises the SNF of the noncoverage of extended care item(s) or service(s), the SNF is to insert the date the covered item(s) and service(s) ended.

70.6.9.4 - Requesting a Medicare Decision

(Rev. 1, 10-01-03)

A bill for noncovered extended care items or services will only be submitted to Medicare if the beneficiary or her or his authorized representative so requests. Therefore, in order for a beneficiary or authorized representative to appeal the decision of noncoverage on a claim, she or he must request the SNF to submit the bill to Medicare. (See Chapter 29 of the Medicare Claims Processing Manual, "Appeals of Claims Decisions.")

80 - Hospital ABNs (Hospital-Issued Notices of Noncoverage - HINN)

(Rev. 1, 10-01-03)

Citations and Authority

The statutory authorities applicable to issuances of Hospital ABNs (Hospital-Issued Notices of Noncoverage - HINNs) are found at §§1879 and 1154(e) of the Act. The regulatory authorities for issuing Hospital ABNs are found at 42 CFR 489.34, 411.404, and 412.42(c). A hospital (including one with swing-beds) has the authority to issue Hospital ABNs to beneficiaries or their authorized representatives if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary, is not delivered in the most appropriate setting, or is custodial in nature.

80.1 - When and to Whom a Hospital ABN Should Be Given

(Rev. 1, 10-01-03)

The Hospital ABN may be given prior to admission, at admission, or at any point during the inpatient hospital stay. The hospital is not required to issue a Hospital ABN when it does not plan to bill the beneficiary, e.g., when the beneficiary does not dispute a planned discharge from the hospital and no noncovered services will be furnished. There are 10 distinct Hospital ABNs:

- Hospital ABN 1 - Admission or Preadmission Hospital ABN
- Hospital ABN 2 - Continued-Stay Hospital ABN When the Attending Physician Concurs. (See Hospital ABN 10 for when the attending physician does not concur.)
- Hospital ABN 3 - Continued Stay/Swing Bed Only/Attending Physician Concurs/ Patient Changes from Acute to NF Level of Care
- Hospital ABN 4 - Continued Stay/Swing Bed Only/Attending Physician Concurs/Patient Changes From Acute to SNF Level of Care
- Hospital ABN 5 - Continued-Stay Hospital ABN When the QIO Concurs
- Hospital ABN 6 - Continued Stay/Swing Bed Only/QIO Concurs/Patient Changes From Acute to NF Level of Care
- Hospital ABN 7 - Continued Stay/Swing Bed Only/QIO Concurs/Patient Changes From Acute to SNF Level of Care

- Hospital ABN 8 - Continued Stay/Swing Bed Only/Patient Changes From SNF to NF or Custodial Care

- Hospital ABN 9 - Direct Preadmission/Admission to NF Swing Bed

- Hospital ABN 10 – Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization (used for a continued-stay Hospital ABN when the attending physician does not concur).

80.1.1 - Admission or Preadmission Hospital ABNs

(Rev. 1, 10-01-03)

The QIO issues a Hospital ABN when the hospital determines that the admission is not medically necessary, is inappropriate, or is custodial in nature. (See Hospital ABN 1.) The hospital need not obtain the attending physician's concurrence or the QIO's prior to issuing the preadmission or admission Hospital ABN. This also applies to Hospital ABNs related to direct admissions to swing beds (i.e., beneficiary is admitted to the swing bed after he/she was discharged from another hospital), or when you determine that the beneficiary does not need SNF services. (See Hospital ABN 9.)

80.1.2 - Continued Stay Hospital ABNs

(Rev. 1, 10-01-03)

The hospital may issue a continued stay Hospital ABN when it determines that a beneficiary no longer requires continued inpatient care and either the attending physician or the QIO concurs. If the beneficiary does not dispute the determination that continued inpatient care is no longer required, the hospital is not required to issue a Hospital ABN since no noncovered services would then be furnished. Before the hospital can issue a continued stay notice of noncoverage, the hospital must consider the admission to be covered.

80.1.2.1 - Attending Physician Concurs

(Rev. 1, 10-01-03)

If the attending physician concurs in writing (e.g., written discharge order) with the hospital's determination that the beneficiary no longer requires inpatient care, the hospital may issue a notice of noncoverage to the beneficiary. (See Hospital ABNs 2 through 4.)

80.1.2.2 - Attending Physician Does Not Concur

(Rev. 1, 10-01-03)

The hospital may issue a notice to the beneficiary (or his/her authorized representative) (Hospital ABN 10) when the beneficiary's physician disagrees with the hospital's proposed notice of noncoverage and the QIO is requested to review the case. The

hospital may use its own letterhead, but may not alter or change the language. The hospital must give the notice to the beneficiary (or his/her authorized representative) concurrently when it requests the QIO's review. The QIO will develop procedures to monitor issuance of that notice to beneficiaries (or their authorized representatives). For example, at the time the QIO solicits the beneficiary's views, the QIO must ask the beneficiary (or his/her authorized representative) if he/she received the notice.

The hospital may request, either by phone or in writing, that the QIO review the case immediately. Review must be completed within two working days of either the hospital's request or receipt of any additional information the QIO requested, (e.g., copies of medical records). The QIO will determine, on a case-by-case basis, whether a medical record is needed to make the determination as to the medical necessity and appropriateness of the admission and days of care. If the QIO concurs with the hospital's decision, the hospital will be notified that it may issue one of the notices shown in Hospital ABNs 5, 6, or 7 or the QIO will issue its own denial notice.

NOTE: In cases where the beneficiary requires an SNF level of care, do not issue a notice of noncoverage if an SNF bed is not available. Medicare pays hospitals, in outlier cases, for days awaiting placement until an SNF bed is available, and the medical record documentation indicates that SNF placement is actively being sought.

80.1.2.3 - Advance Continued Stay Hospital ABN

(Rev. 1, 10-01-03)

The hospital may project and determine when acute care furnished to a beneficiary would end, and issue a continued stay Hospital ABN (with the attending physician's concurrence or the QIO's). If the hospital is unable to determine in advance that the beneficiary will not require acute inpatient hospital care as of a certain date, it may give the notice of noncoverage in advance of that date, but ordinarily no earlier than three days before the first noncovered day.

EXAMPLES:

a. The beneficiary had hip surgery and requires rehabilitative services but not at an acute hospital level of care. The hospital determines that the most appropriate setting for those services would be a SNF, and make arrangements to transfer the beneficiary (within three days) since a SNF bed will be available.

b. The beneficiary is recovering from an uneventful post surgical period (after a cholecystectomy). The hospital predicts that within two days the beneficiary will no longer require injections for pain control and will tolerate a regular diet and ambulation.

The advance notice does not relieve you or the attending physician of the responsibility for monitoring the beneficiary's condition/level of care changes, or for making appropriate discharge planning. If after the notice is issued, the beneficiary's

condition/level of care changes and acute care is further required (or the SNF bed is no longer available), rescind your notice of noncoverage.

80.1.3 - Combined Notices in Swing-Bed Situations

(Rev. 1, 10-01-03)

"Combined notices" apply to situations where the beneficiary is in an acute care hospital which has beds certified as swing beds, and he/she no longer requires an acute level of care. Hospital ABNs 4 and 7 are applicable when the beneficiary requires an SNF level of care. Hospital ABNs 3 and 6 are applicable when the beneficiary requires a nursing facility (NF) level of care.

NOTE: Effective October 1, 1990, both SNFs and intermediate care facilities participating in the Medicaid program are referred to as NFs.

The discharge from the acute care bed and admission to the (SNF or NF) swing-bed are essentially paper transactions, with no physical movement of the beneficiary. The purpose of the combined notice is to notify the beneficiary (or his/her authorized representative) that neither the acute nor SNF care is medically necessary (Hospital ABNs 3 and 6), or that the beneficiary no longer requires acute care hospital services, but will begin to receive SNF swing-bed services (Hospital ABNs 4 and 7). The combined notice also notifies the beneficiary (or his/her authorized representative) that if he/she disagrees with the hospital's decision, an immediate QIO review may be requested.

Hospital ABNs 4 and 7 also explain that the beneficiary (or his/her authorized representative) is liable for any applicable deductible and coinsurance amounts, and for any convenience services or items normally not covered by Medicare, but related to acute hospital and SNF swing bed services.

Issue the combined notice of noncoverage with either the attending physician's or the QIO's concurrence. The two post-discharge planning days applicable to PPS hospital cases (see 42 CFR 412.42(c)) would not apply to this situation. The beneficiary's liability for payment begins the day following the date of receipt of the notice. The beneficiary may request the QIO's immediate review. However, the beneficiary's liability remains the same as specified in the Hospital ABN.

80.1.4 - Continued Stay Hospital ABN in Swing Beds Treated as SNF Beds

(Rev. 1, 10-01-03)

The hospital does not need the attending physician's concurrence or the QIO's to issue a continued stay Hospital ABN to a beneficiary when SNF swing bed services are no longer needed. (See Hospital ABN 8.) The immediate review provisions of OBRA 1986 and OBRA 1987 do not apply to stays in SNF swing beds. These notices are also subject to QIO review.

80.1.5 - Delivery of Hospital ABN

(Rev. 1, 10-01-03)

A hospital (that is, a qualified notifier as defined in §40.3.2) shall notify a beneficiary by means of timely (as defined in §40.3.3) and effective (as defined in §40.3.4) delivery of a proper notice document (as defined in §40.3.1) to a qualified recipient, viz., to the individual beneficiary or to the beneficiary's authorized representative (as defined in §40.3.5). Delivery of a Hospital ABN occurs when the beneficiary or authorized representative both has received the notice and can comprehend its contents. All Hospital ABNs must include an explanation written in lay language of the hospital's, the UR entity's, the QIO's or the Medicare contractor's reason for believing the items or services will be denied payment. Hospital ABNs must meet the standards for approved model notice language in §40.3, "Advance Beneficiary Notice Standards."

80.1.6 - Qualified Recipients of Hospital ABNs

(Rev. 1, 10-01-03)

If the patient is a Medicare FFS beneficiary and a triggering event occurs (that is, one of the ten situations described in §80.1), the hospital needs to give the patient (or the patient's authorized representative, as defined in §40.3.5) a Hospital ABN. If the patient is a Medicare-Medicaid dual-eligible and a triggering event occurs, the hospital needs to give the patient (or authorized representative) a Hospital ABN. The Hospital ABN is not to be used for Medicare M+C (Part C) enrollees nor for non-Medicare patients because it is to be used solely for individuals enrolled in the Medicare Fee-For-Service (FFS) program (Parts A and B).

80.2 - Issuing the Appropriate Hospital ABN

(Rev. 1, 10-01-03)

A. Admission or Preadmission Hospital ABN

The hospital may issue a Hospital ABN under 42 CFR 411.404 before the beneficiary is admitted (preadmission notice), or upon admission (an admission notice). Preadmission/admission Hospital ABNs may be issued by the utilization review committee or hospital directly, based on Medicare coverage guidelines, prior CMS notices, bulletins, or other written guides or directives from intermediaries, carriers, or QIOs.

B. Continued Stay Hospital ABN

The process for issuing a continued stay Hospital ABN is the same for all types of hospitals, i.e., hospitals paid under the prospective payment system (PPS) or hospitals not paid under the prospective payment system (non-PPS). The regulatory authority under which these notices may be issued is determined by how Medicare pays the hospital.

- PPS Hospitals: For hospitals that are paid under the prospective payment system (PPS), and are participating in State payment control systems (e.g., Maryland), or demonstration projects (e.g., The Finger Lakes area of New York), referred to hereafter as short-term acute care hospitals in waivered States (see 42 CFR 489.34), such hospitals may issue continued stay Hospital ABNs under the authority of 42 CFR 412.42(c).

- Non-PPS Hospitals: For hospitals that are paid on a reasonable cost basis, such hospitals may issue continued stay Hospital ABNs under the authority of 42 CFR 411.404.

- For hospitals that are swing-bed hospitals providing skilled nursing facility (SNF) services to a beneficiary in a bed treated as a SNF bed, such hospitals may issue a continued stay Hospital ABN to the beneficiary when these services are no longer required under the authority of 42 CFR 411.404.

80.3 - Hospital ABNs (HINNs)

(Rev. 1, 10-01-03)

HO-414.11

80.3.1 – Hospital ABN Content Standards

(Rev. 1, 10-01-03)

Hospital ABNs (the advance beneficiary notices commonly referred to as hospital-issued notices of noncoverage or HINNs) must contain specific information for the protection of beneficiaries, as well as the hospital. The Hospital ABN to the beneficiary (or his/her authorized representative, as defined in §40.3.5) must closely conform to the content of the model language provided for Hospital ABNs 1 through 9 in §80.3.3-§80.3.5.9. Hospital ABN 10 [§80.3.6] is mandatory and cannot be altered by hospitals. Hospital ABNs must meet the standards for approved model notice language in §40.3, "Advance Beneficiary Notice Standards."

A Hospital ABN must explain:

- Dates the care is determined to be noncovered and why, (e.g., the admission is noncovered because the services could be performed safely and effectively on an outpatient basis);

- Who made the determination (e.g., the hospital with the concurrence of the attending physician, or hospital with QIO's concurrence);

- That the notice is not an official Medicare determination;

- The beneficiary's appeal rights;

- The procedures for requesting QIO review;
- What effects the notice and a QIO appeal request will have on the beneficiary's liability, including exactly when liability begins; and
- The notice must contain signature and date lines for the beneficiary (or his/her authorized representative) to sign.

Hospital ABNs must not mislead the beneficiary (or authorized representative) nor misstate the hospital's authority to issue, or responsibility for issuing, the notice. The notice cannot contain, for example:

- Statements and implications that the decision of noncoverage was not made by the hospital, but by someone else (e.g., by CMS); or
- Inaccurate information as to the beneficiary's responsibility for payment.

80.3.2 - Hospital ABNs Model Language

(Rev. 1, 10-01-03)

In the absence of an approved standard Hospital ABN form, the approved model notice language for the ten Hospital ABNs following in §80.3.3-§80.3.6 constitutes the proper notice documents. A notifier's unapproved modification of either a standard form or model notice language may render that notice defective. (See §40.3.1, "Proper Notice Documents.")

80.3.3 - Hospital ABN Header Text

(Rev. 1, 10-01-03)

Hospital Letterhead

_____

Date of Notice

_____	_____
Name of Patient	Admission Date
_____	_____
Address	Health Insurance Claim (HIC) Number
_____	_____
City, State, Zip Code	Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____: (*Insert the name of the addressee.*)

80.3.4 - Hospital ABN End Text

(Rev. 1, 10-01-03)

QIO Address:

(*QIO Name*)

(*Address*)

(*Telephone Number*)

Sincerely,

_____

(*Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.*)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (*name of hospital*) at (*time*) on (*date*). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

Signature of patient or authorized representative Time Date

cc: QIO

Attending Physician

80.3.5 – Messages for Body of Hospital ABNs 1-9

(Rev. 1, 10-01-03)

Hospitals should insert the appropriate message text, from §80.3.5.1-§80.3.5.9 below, between the Header Text in §80.3.3 and the End Text in §80.3.4 to compose a proper Hospital ABN (#s 1-9) for a particular purpose. Italics within parentheses indicate insertions. Footnotes indicate certain insertions to be made as appropriate. The footnote numbers should not be included in the actual ABNs. Notifiers insert the message text from §80.3.6 after the Header Text in §80.3.3 to compose a proper Hospital ABN 10 "Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization."

80.3.5.1 - Hospital ABN 1 Message - Admission or Preadmission

(Rev. 1, 10-01-03)

The purpose of this notice is to inform you that we find that your admission for (*specify services or condition*) is not covered under Medicare because (*specify services to be furnished or condition to be treated*) (*specify is/are medically unnecessary*) or (*could be safely furnished in another setting*) This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to (*be admitted to/remain in*) the hospital, you will be financially responsible for _____.1/

This notice, however, is not an official Medicare determination. The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*), and to make that determination.

- **If you disagree with our conclusion:** (*Select as appropriate*)

  Preadmission:

  Request **immediately**, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

  Admission:

  Request **immediately**, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- **If you do not wish an immediate review:**

You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.

- **Results of the QIO Review:**

  The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.

  IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on (*specify date*). 1/

1/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

80.3.5.2 - Hospital ABN 2 Message - Continued Stay (Attending Physician Concurs)

(Rev. 1, 10-01-03)

This notice is to inform you that we have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*). Your attending physician has been advised and has concurred that beginning (*specify date of first noncovered day*) further (*specify services to be furnished or condition to be treated*) (*specify is/are medically unnecessary*) or (*could be furnished safely in another setting*). This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs for the care you receive, except for those services for which you are eligible under Part B beginning on (*specify date*).1/ If you leave on (*specify date*)1/, you will not be liable for costs for care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

However, this notice is not an official Medicare determination. The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*), and to make that determination.

- **If you disagree with our conclusion:**

  Request immediately, **by noon of the first working day** after receipt of this notice, an **immediate review by telephone, or in writing**. You may make this request through us or directly to the QIO at the address listed below.

  The QIO will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the hospital).

- **If you do not request review by noon of the first working day after receipt of this notice:**

  You may still request QIO review at any point during your stay or within 30 days after you receive this notice, whichever is longer. Request this QIO review at the address listed below.

- **QIO Review Results:**

  The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL:

You are responsible for payment for all services beginning on (*specify date*)1/ unless you have requested an immediate review.

If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you receive the QIO's notification.

1/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.

For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

80.3.5.3 - Hospital ABN 3 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes From Acute to NF Level of Care)

(Rev. 1, 10-01-03)

This notice is to inform you that we have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*). Your attending physician has been advised and has concurred that beginning (*specify date of first noncovered acute care day*) further (*specify services to be furnished or condition to be treated*) (*specify is/are medically unnecessary*) or (*could be furnished safely in another setting*). This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on (*specify date*).1/ If you leave the hospital on (*specify date*), you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

However, this notice is not an official Medicare determination. The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*) and to make that determination.

- If you disagree with our conclusion:

Request **immediately**, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- If you do not request an immediate review:

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- QIO Review Results:

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on (*specify date*).1/

1/ Insert: the date following the day of receipt of the hospital notice.

80.3.5.4 - Hospital ABN 4 Message - Continued Stay - Swing Bed Only (Attending Physician Concurs) (Patient Changes From Acute to SNF Level of Care)

(Rev. 1, 10-01-03)

This notice is to inform you that we have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*). Your attending physician has been advised and has concurred that beginning (*specify date of first noncovered acute care day*), you no longer need an acute level of care. You will begin to receive the type of hospital services that are furnished in a skilled nursing facility (SNF) beginning (*specify date of first SNF swing-bed day*). This is known as SNF swing-bed services. Medicare will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days in the benefit period).

However, this notice is not an official Medicare determination. The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*) and to make that determination.

- If you disagree with our conclusion and want an immediate review:

Request *immediately*, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us, or directly to the QIO at the address listed below.

- If you do not request an immediate review:

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- QIO Review Results:

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will continue to receive acute care services covered under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you will continue to receive SNF swing bed services paid under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, or convenience services or items normally not covered by Medicare.

80.3.5.5 - Hospital ABN 5 Message - Continued Stay (QIO Concurs)

(Rev. 1, 10-01-03)

We have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*) and has determined that further hospitalization is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*). The (*name of the QIO*) has concurred with our decision that beginning (*specify date of first noncovered day*) further (*specify services to be furnished or condition to be treated*) (*specify is/are medically unnecessary*) or (*could be safely furnished in another setting*). You will also receive a notice from (*name of QIO*) confirming the review decision.

We have advised your attending physician of the denial of further inpatient hospital care. You should discuss other arrangements with your attending physician for any further health care you may require.

If you decide to stay in the hospital, you will be responsible for payment for all services provided to you by this hospital, except for those services for which you are eligible to receive payment under Part B, beginning (*specify date*).1/

- If you disagree with this decision:

You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

- If you do not request an expedited reconsideration:

You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by (*name of QIO*).

- QIO Reconsideration Results:

The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning (*specify date*).

1/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.

For specialty hospital and PPS-exempt units, insert: the date specified by the QIO. The beneficiary's liability begins on the day following the date of receipt of the notice.

80.3.5.6 - Hospital ABN 6 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes From Acute to NF Level of Care)

(Rev. 1, 10-01-03)

We have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*) and has determined that further hospitalization paid under Medicare is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*). The (*name of QIO*) has concurred with our decision that beginning (*specify date of noncovered acute care day*) further (*specify services to be furnished or condition to be treated*) (*specify is/are*) medically unnecessary or could be safely furnished in another setting. You will also receive a notice from (*name of QIO*) confirming the review decision.

We have advised your attending physician of the denial of further acute hospital care. Upon receipt of this notice, the items and services which you receive will no longer be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on (*specify date*).1/ You should discuss other arrangements with your attending physician for any further health care you may require.

- If you disagree with this decision and want an expedited reconsideration:

You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

- If you do not request an expedited reconsideration:

You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by (*name of QIO*).

- QIO Reconsideration Results:

The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning (*specify date*).1/ If you leave the hospital on (*specify date*)1/, you will not be liable for costs of care except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

_____

1/ Insert: The date of the day following receipt of the QIO and hospital notification.

80.3.5.7 - Hospital ABN 7 Message - Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes From Acute to SNF Level of Care)

(Rev. 1, 10-01-03)

This notice is to inform you that we have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*) and has determined that acute care services are not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*). The (*name of QIO*) has concurred with our decision that beginning (*specify date of first noncovered acute care day*) you no longer require an acute level of care. You will begin to receive the type of hospital services which are rendered in a skilled nursing facility (SNF) beginning (*specify date of first SNF swing-bed day*). This is known as SNF swing-bed services. The Medicare program will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days (100) in the benefit period).

- If you disagree with this decision and want an expedited reconsideration:

You may request **by telephone or in writing** an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us, or to the QIO at the address listed below.

- If you do not request an expedited reconsideration:

You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by (*name of QIO*).

- QIO Reconsideration Results:

The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.

IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that you require acute care), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that you do not require acute care), you will continue to receive SNF swing-bed services paid under Medicare. You will be responsible for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

80.3.5.8 - Hospital ABN 8 Message - Continued Stay - Swing Bed Only (Patient Changes From SNF to NF or Custodial Care)

(Rev. 1, 10-01-03)

We have reviewed the medical services you have received for (*specify services or condition*) from (*date of admission*) through (*date of last day reviewed*) and have determined that further hospitalization paid under the Medicare program is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

We have advised your attending physician of the denial of further skilled nursing care. Upon receipt of this notice, the items and services which you receive will no longer be covered under the Medicare program. The care that you need now is not skilled nursing care, and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on (*specify date*).1/ You should discuss other arrangements with your attending physician for any further health care you may require.

This notice is not an official Medicare determination. The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*) and to make that determination.

- If you disagree with our conclusion and want an immediate review:

Request **immediately**, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.

- If you do not request an immediate review:

You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- QIO Review Results:

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on (*specify date*).1/

1/ Insert: the date of the day following receipt of the hospital notice.

80.3.5.9 - Hospital ABN 9 Message - Direct Preadmission/Admission to NF Swing Bed

(Rev. 1, 10-01-03)

The purpose of this notice is to inform you that we find that your admission for (*specify service or condition*) is not covered under Medicare because the services to be performed (*specify are not considered skilled care or constitute custodial care*). This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss other arrangements with your attending physician for any further health care you may require. If you decide to (*be admitted to/remain in*) the hospital, you will be financially responsible for 1/.

This notice, however, is not an official Medicare determination. The (*name of QIO*) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (*name of State*) and to make that determination.

- If you disagree with our conclusion and want an immediate review: (*Select as appropriate*)

Preadmission:

Request **immediately**, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, a review of the facts in your case. You may make this request through us, or directly to the QIO by telephone or in writing to the address listed below.

Admission:

Request **immediately**, or at any point during your hospital stay, an immediate review of the facts in your case. You may make this request through us, or directly to the QIO by telephone or in writing at the address listed below.

- If you do not wish an immediate review:

You may still request a review within 30 calendar days from the date of receipt of this notice to the address specified below.

- Results of the QIO Review:

The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization and will inform you of your reconsideration and appeal rights.

IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any

applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment of all services beginning on (*specify date*).1/ If you leave the hospital on (*specify date*)1/, you will not be liable for costs for care, except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

1/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible to receive payment under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission (i.e., before 3:00 P.M.), insert: "customary charges for all services furnished after receipt of the hospital notice, except for those services for which you are eligible to receive payment under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the days following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

80.3.6 - Hospital ABN 10 Message - Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization

(Rev. 1, 10-01-03)

We have has determined that you no longer require an acute (*hospital inpatient*) level of care. Because your doctor disagreed with this decision we are asking the Quality Improvement Organization (*Name of QIO*) to review your case.

(*Name of QIO*) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the Quality Improvement Organization.

Sincerely,

_____

(Title, e.g., Chairperson of Utilization Review Committee, Medical Staff, etc.)

The hospital must insert the above message text after the Header Text in §80.3.3 to compose a proper Hospital ABN 10 "Hospital Notice to Beneficiary of Review of Need for Continued Hospitalization."

80.4 - Signature Requirements

(Rev. 1, 10-01-03)

80.4.1 - Acknowledgment of Receipt

(Rev. 1, 10-01-03)

The hospital must document the date and time the beneficiary or his/her authorized representative (as defined in §40.3.5**.**) received the Hospital ABN. The hospital must obtain an acknowledgment of receipt (including date and time) signed by the beneficiary (or his/her authorized representative). A copy of this acknowledgment is to be kept in the medical records.

80.4.2 - Beneficiary Signature Refusal

(Rev. 1, 10-01-03)

If the beneficiary (or his/her authorized representative) refuses to sign the acknowledgment, the hospital must immediately document on the Hospital ABN that the patient refused to sign and prepare a report for the hospital's files (i.e., medical records). (See §40.3.4.6.) The date of refusal is then considered the date of receipt.

80.4.3 - Signature Requirements Under Special Circumstances

(Rev. 1, 10-01-03)

Hospitals are responsible for determining whether the beneficiary, upon admission, is mentally competent and capable of transacting business (as opposed to being incapable of handling his/her own affairs, unable to sign and negotiate checks). The hospital must develop procedures to use when the beneficiary is incapable or incompetent and the hospital cannot obtain the signature of his/her authorized representative as defined in §40.3.5.) through direct personal contact. When the hospital mails the notice to the beneficiary's authorized representative, it must phone the beneficiary's authorized representative simultaneously. (See §40.3.4.2.) The date of the phone conversation is the date of receipt of the notice.

When direct phone contact cannot be made, the hospital must send the notice to the authorized representative by certified mail, return receipt requested. The date that someone at the authorized representative's address receives (whether or not he or she signs) the notice is considered the date of receipt.

Hospitals must employ other procedures that have been reviewed and approved by the QIO and when needed for review, provide the QIO with proof of proper notification.

NOTE: Delivery of a Hospital ABN occurs when the beneficiary (or authorized representative) both has received the Hospital ABN and can comprehend its contents.

Hospital ABNs must comply with the Effective Delivery standards in §40.3.4.

80.5 - QIO Review Authority for Hospital ABNs

(Rev. 1, 10-01-03)

Section 1154(e) of the Act requires Quality Improvement Organizations (QIOs) to review all hospital issued continued stay notices of noncoverage (Hospital ABNs), upon request by a Medicare beneficiary (or his/her authorized representative) or the hospital. This statutory provision does not apply to QIO review involving SNF swing-bed services.

A. If a beneficiary (or his/her authorized representative) receives a Hospital ABN with only the concurrence of the attending physician, is still an inpatient, and requests an immediate review by the QIO before noon of the first working day after the date of receipt of the notice:

- The QIO requests that the hospital provides it with the medical records by close of business of the first working day after the date the beneficiary (or his/her authorized representative) receives the notice;

- The QIO reviews the case and notifies the beneficiary (or his/her authorized representative), the hospital, and the attending physician of its decision by the first full working day after the date of receipt of the beneficiary's request and the required medical records from the hospital.

- If the beneficiary (or his/her authorized representative) made such a request and did not know, nor could reasonably have been expected to know, that continued inpatient hospital stay was not necessary (§1879(a)(2) of the Act), the hospital may not charge the beneficiary before noon of the day after the day the beneficiary (or his/her authorized representative) received the QIO's decision.

B. Section 1154(e)(2) of the Act requires hospitals to notify a beneficiary (or his/her authorized representative) when the hospital requests the QIO's review of its decision because the attending physician disagrees with such hospital's issuance of the Hospital ABN. This notice is given to the beneficiary (or his/her authorized representative) concurrently when the request is made for the QIO review. (See Hospital ABN 10.)

C. QIO Solicitation of Views. The QIO solicits the beneficiary's views (or those of the beneficiary's authorized representative) whenever:

- The beneficiary (or his/her authorized representative) requests that the QIO review the Hospital ABN; or

- The hospital requests the QIO because the attending physician disagrees with the hospital's decision to issue a Hospital ABN.

NOTE: PPS and non-PPS hospitals can issue a Hospital ABN when a SNF bed is available regardless of the beneficiary's (or his/her authorized representative's) refusal of placement. The policy also applies to situations involving a change in the patient's level of care from acute to SNF swing bed services. Although this change is a paper transaction, the swing bed hospital must give a Hospital ABN because it has a (SNF) bed available for the patient.

The QIOs' review responsibilities are explained in greater detail in Chapter 7 of the Quality Improvement Organization Manual.

80.6 - QIO Monitoring of Hospital ABNs

(Rev. 1, 10-01-03)

Purpose

The QIO monitors the content of the Hospital ABN and the accuracy of the hospital's determination. Upon a beneficiary's or hospital's request for review, the QIO determines whether the Hospital ABN is appropriate and accurate.

When Hospital ABNs are issued and no request for review is made, the QIO ensures on an ongoing basis that:

- Hospitals followed the appropriate process;
- The content of the notice is accurate/appropriate; and
- The hospital's decision to issue the notice is correct.

The QIO monitors the hospital to ensure that the hospital is issuing the Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization (Hospital ABN 10) timely to the beneficiary when the hospital requests QIO review.

80.6.1 - Ongoing Monitoring

(Rev. 1, 10-01-03)

- Identification of Cases - The QIO identifies cases, where the hospital has issued a Hospital ABN using:
    - The copy of the (preadmission, admission, or continued stay) Hospital ABN the hospital submitted to the QIO within three working days of the Hospital ABN issuance; and
    - The processed claims data.

NOTE: The hospital must submit a bill for all inpatient stays, including those for which no payment can be made. Although no monies are involved with "No-pay bills," a claim is required because hospitalization could extend a Medicare beneficiary's benefit period.

80.6.2 - Inappropriate Hospital ABN

(Rev. 1, 10-01-03)

An inappropriately issued Hospital ABN would be any case where:

- The hospital's finding is invalid (e.g., where the admission was covered) and where continued acute care was medically necessary;
- The content of the notice is not in compliance with §80.3;
- The patient was charged for services without a notice;
- The patient requires SNF care and there was no available SNF bed;
- A continued stay Hospital ABN is issued without the concurrence of the QIO or the attending physician (except in cases where the level of care changes from SNF swing bed services to NF); and
- The beneficiary did not receive written notice when discharged from acute care and admitted to SNF or NF swing bed services.

NOTE: In cases involving an admission Hospital ABN where the QIO determines that the beneficiary's condition changed from nonacute to acute, the QIO will assign a deemed date of admission. Since the QIO agreed that the Hospital ABN was not issued in error, the case will not count against the hospital as long as the hospital did not charge the beneficiary for the covered acute inpatient services.

80.7 - Notices in Investigational/Experimental Procedures Situations

(Rev. 1, 10-01-03)

The hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (e.g., experimental procedures) that are excluded from coverage as medically unnecessary, if the hospital has informed him/her in writing. (See 42 CFR 412.42(d).) Since the hospital is required to submit investigational services/items to the respective intermediary for approval, the hospital must follow the instructions as to the language to use in the Hospital ABN.

80.8 - Beneficiary Liability

(Rev. 1, 10-01-03)

After the hospital issues a Hospital ABN, the beneficiary (or his/her authorized representative) is considered to have knowledge that services are not covered and the beneficiary is liable for customary charges as specified below.

80.8.1 - Preadmission Hospital ABNs

(Rev. 1, 10-01-03)

The beneficiary is liable for customary charges for all services furnished if he/she is admitted after receipt of a preadmission Hospital ABN.

80.8.2 - Admission Hospital ABNs

(Rev. 1, 10-01-03)

80.8.2.1 - Hospital ABN Issued On the Day of Admission

(Rev. 1, 10-01-03)

The beneficiary is liable for customary charges for all services furnished after the Hospital ABN is received. However, to hold a beneficiary liable for charges on the day of admission, the hospital must issue the Hospital ABN no later than 3:00 PM on the day of admission. If the hospital does not meet these requirements, the beneficiary is protected from liability until the day following receipt of the Hospital ABN (e.g., a notice issued for an admission after 3:00 PM or a late evening admission).

80.8.2.2 - Hospital ABN Issued After the Day of Admission

(Rev. 1, 10-01-03)

The beneficiary is liable for customary charges for all services furnished beginning the day following the date of receipt of the Hospital ABN.

80.8.3 - Continued Stay Hospital ABNs

(Rev. 1, 10-01-03)

80.8.3.1 - For Hospital ABNs Issued With the Concurrence of the Attending Physician

(Rev. 1, 10-01-03)

Where the Beneficiary's (or His/Her Authorized Representative) Requested QIO Review by Noon of the First Working Day After the Day He/She Received the Hospital ABN and He/She Meets the Conditions of §1879(a)(2).

- The beneficiary's liability will begin at noon of the day following notification of the QIO's determination, and

- The hospital will be held financially liable for costs incurred from the date of the Hospital ABN, as the hospital knew that services were noncovered (as demonstrated by issuance of the Hospital ABN).

NOTE: If the hospital does not provide the medical records by close of business of the first working day after the date that the beneficiary (or his/her authorized representative) receives the Hospital ABN, the beneficiary's liability will not begin until noon of the day following notification of the QIO's determination.

80.8.3.2 - For Hospital ABNs Issued With the Concurrence of the QIO, or With the Concurrence of the Attending Physician

(Rev. 1, 10-01-03)

Where the Beneficiary (or His/Her Authorized Representative) Does Not Request QIO Review by Noon of the First Working Day After the Day He/She Received the Hospital ABN and the Beneficiary or (His/Her Authorized Representative) Meets the Conditions of §1879(a)(2):

- For hospitals that are short term/acute care hospital paid under PPS or located in a waivered State, the beneficiary is liable for customary charges for services furnished beginning the third day following the date of receipt of the hospital notice;

- For hospitals that are paid on a reasonable cost basis, the beneficiary is liable for customary charges for services furnished beginning the day following the date of receipt of the hospital notice; or

- For Hospital ABNs involving swing-bed situations (i.e., notices issued to a beneficiary when his/her level of care changes from acute to SNF or NF, or from

SNF to NF), the beneficiary is liable for customary charges for services furnished beginning the day following the date he/she receives the Hospital ABN.

NOTE: If the beneficiary leaves the facility on the day following the date of receipt of the Hospital ABN, the beneficiary is liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services normally not covered by Medicare.

80.8.4 - Grace Days

(Rev. 1, 10-01-03)

When the hospital issues a Hospital ABN, the beneficiary's liability begins in accordance with the policies described in §80.8 A-C. The QIO will not approve payment for additional days for purposes of post-discharge planning (i.e., grace days).

The specific statutory, regulatory, and policy provisions that take into consideration the need for post-discharge planning, e.g., 42 CFR 412.42(c), specifies that the beneficiary is liable beginning the third day following the date of receipt of the Hospital ABN. This provides time between notification and liability for post-discharge planning. (These days are not grace days.)

Section 1154(a)(2)(b) of the Act specifies that such grace days may only be provided in cases where the provider did not know and could not reasonably have been expected to know that payment would not otherwise be made for such services under Medicare. A provider who issues a Hospital ABN has demonstrated knowledge that Medicare will not cover the services and, therefore, §1154(a)(2)(B) (grace days) is not applicable to Hospital ABN situations.

80.9 - Provider Liability

(Rev. 1, 10-01-03)

The hospital is considered to have knowledge, as of the date of its Hospital ABN, that furnished (or proposed) services were noncovered if the hospital issued a Hospital ABN to the beneficiary. (See 42 CFR 411.406(d).)

80.10 - Right to a Reconsideration

(Rev. 1, 10-01-03)

80.10.1 - QIO Disagrees With the Hospital's Determination

(Rev. 1, 10-01-03)

If the QIO disagrees with the hospital's determination of noncoverage (i.e., the QIO determines that the case was covered), the QIO's decision is not subject to

reconsideration, as this is neither a denial determination nor a QIO determination under §1154 of the Act.

80.10.2 - QIO Agrees With the Hospital's Determination

(Rev. 1, 10-01-03)

If the QIO agrees with the hospital's determination either prior to or after issuance of the hospital's notice, the QIO will issue a denial notice. The QIO's determination is subject to reconsideration in accordance with 42 CFR Part 478.

90 - Form CMS-20007 - Notices of Exclusions From Medicare Benefits (NEMBs)

(Rev. 1, 10-01-03)

For all expected denials of Medicare payments for items and services for which an ABN is not used because neither LOL nor RR applies, the Notice Of Exclusions From Medicare Benefits (NEMB) Form CMS-20007 may be used to advise beneficiaries, before items or services that are not Medicare benefits are furnished, that Medicare will not pay for them. NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions. The NEMB may be used, on an entirely voluntary basis, by physicians, practitioners, suppliers and providers to advise their Medicare patients of the services that Medicare never covers, for which it is not appropriate to use ABNs.

The NEMB Form CMS-20007 is available online in English and Spanish at the CMS Beneficiary Notices Initiative (BNI) Web page at http://www.cms.hhs.gov/medicare/bni/ and also at the CMS Medlearn Web site http://www.cms.hhs.gov/medlearn/refabn.asp at the Advance Beneficiary Notice (ABN) Quick Reference Guide Web page, under "Notice of Exclusions from Medicare Benefits (NEMB, Form CMS-20007). For the online replicable copies of Form CMS-20007 forms in PDF format, go directly to:

English CMS-20007 http://cms.hhs.gov/medicare/bni/20007_English.pdf

Spanish CMS-20007 http://cms.hhs.gov/medicare/bni/20007_Spanish.pdf

Physicians, practitioners, suppliers and providers may use notices of their own design rather than the NEMB form. Some professional associations, with the assistance and approval of CMS, have developed service-specific NEMB type notices to advise Medicare beneficiaries of the limits of Medicare coverage for certain items and services. Those service-specific notices, which are not government notices but proprietary notices of the authoring associations, are also available in PDF format at the BNI and ABN links given above.

90.1 - General Rules

(Rev. 1, 10-01-03)

The use of the NEMB is at the user's discretion. The imperative voice in §90.1-§90.5 is premised on "your" (the user's/notifier's) voluntary decision to use the standard Form CMS-20007 NEMB.

90.1.1 - Using NEMBs With Categorical Denials

(Rev. 1, 10-01-03)

Prepare and deliver to the patient (Medicare beneficiary), or person acting on his or her behalf, an NEMB when it is known that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any categorical statutory exclusion listed in the third box on the form. In this case, insert a mark in check-off box number 2. An NEMB **IS NOT** used for either of the following two categorical exclusions that trigger statutory protections:

- The service may be denied as "not reasonable and necessary" ("medical necessity") - §1862(a)(1) of the Act; or
- The service may be denied as "custodial care" - §1862(a)(9) of the Act.

90.1.2 - Using NEMBsWith Technical Denials

(Rev. 1, 10-01-03)

Prepare and deliver to the patient (Medicare beneficiary), or person acting on his or her behalf, an NEMB when it is known that Medicare will not pay for, or will not continue to pay for, items or services on the basis of any technical statutory exclusion, that is, for any failure to meet completely the statutory definition of a Medicare benefit. In this case, insert a mark in check-off box number 1 in the second box on the form. An NEMB **IS NOT** used for any of the following six technical exclusions that trigger statutory protections:

- The home health care patient does not need intermittent skilled nursing care - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B] of the Act;
- The home health care patient is not confined to the home - §1814(a)(2)(C) [Part A] or §1835(a)(2)(A) [Part B] of the Act;
- The patient in hospice is found not to be terminally ill – §1861(dd)(3)(A) of the Act;
- The patient received a prohibited telephone solicitation ("cold call") in the case of medical equipment & supplies - §1834(a)(17)FIRST(B) of the Act;

- The supplier does not have a supplier number, in the case of medical equipment & supplies denials - §1834(j)(1) of the Act; or

- The supplier has not obtained a required advance coverage determination in the case of medical equipment & supplies denials – §1834(a)(15) of the Act.

90.1.3 - Readability and Understandability

(Rev. 1, 10-01-03)

The readability of the NEMB facilitates patient understanding. It is best to avoid the use of italics or any font that is difficult to read. A readable font in the font size range of 10 point to 12 point, is highly recommended. Black or dark blue ink on a white background is highly recommended. A visually high-contrast combination of dark ink on a pale background is best. Use of low-contrast combinations and block shading is discouraged as they are hard to read. If insertions are handwritten, they need to be legible. Both the originals and any copies of NEMBs need to be legible and high-contrast. When Spanish language NEMBs are used, it is best to make insertions on the form in Spanish to the best of your ability. Where that is impossible, you should take other steps as necessary to ensure that the patient understands the notice.

90.1.4 - Modification of the Form CMS-20007

(Rev. 1, 10-01-03)

If the approved NEMB Form CMS-20007 is used, the header and/or the footer may be customized, but the published notice may not be modified. The NEMB notice may be used in whole or in part to design a the notice, but “Form No. CMS-20007” must be deleted from the bottom of the form.

90.1.5 - Using the Standard Form CMS-20007

(Rev. 1, 10-01-03)

Sections 90.2 - 90.5, inclusive, of these instructions are applicable to the use of the standard NEMB Form CMS-20007.

90.2 - Header

(Rev. 1, 10-01-03)

90.2.1 - Options for Header

(Rev. 1, 10-01-03)

The header of the NEMB, above the title “NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB),” has been left blank for the discretionary use of form users. Inserting material in the header is not required. The header may be customized own

use. The guidance in paragraphs 90.1.3 and 90.2.2 is meant to be informative, not directive.

90.2.2 - Customizing the Header

(Rev. 1, 10-01-03)

The NEMB's header may include your identifying information, including your name, address and telephone number, and/or other information at your discretion. You may elect to include your logo (if any). The following elements may be included in the header, but you may customize the header, or not, according to your particular needs.

- Date - The date on which the notice is personally given to the patient or person acting on his or her behalf. Where personal delivery is not possible, both the date the patient was notified by telephone and the date the notice was mailed may be included.

- Patient's Name - The name of the patient (rather than the name of a person acting on his or her behalf);

- Medicare # (HICN) - The patient's health insurance claim number; and

- Physician - The attending physician's name and telephone number.

90.3 - Explanation Box

(Rev. 1, 10-01-03)

Insert in the space provided in the first box on the form following "Medicare will not pay for:", the description of the items or services about which notice is being given. A reason for Medicare noncoverage may also be included here.

In the case of the technical exclusion (check-off box number 1), inclusion of a reason is advisable since the check-off box number 1 explanation, "Because it does not meet the definition of any Medicare benefit," is very general. [EXAMPLE: "Medicare will not pay for: *your ambulance transport, because you could be transported by another means of transportation*."]

In the case of the categorical exclusion (check-off box number 2), inclusion of a reason is of lesser importance since the checked-off exclusion will provide the basis reason for noncoverage; but additional explanation is permissible.

90.4 - Check-Off Boxes

(Rev. 1, 10-01-03)

When you give an NEMB because you know Medicare will not pay for, or will not continue to pay for, items or services on the basis of any technical statutory exclusion,

that is, for any failure to meet completely the statutory definition of a Medicare benefit, insert a mark in check-off box number 1 in the second box on the form.

When you give an NEMB because you know Medicare will not pay for, or will not continue to pay for, items or services on the basis of any categorical statutory exclusion listed in the third box on the form, insert a mark in check-off box number 2 in the third box on the form. Also, insert a mark in the smaller check-off box to the left of the specific exclusion. If you wish to also circle the exclusion, or otherwise highlight it, that is permissible.

90.5 - Footer

(Rev. 1, 10-01-03)

The footer of the NEMB has been left blank for the discretionary use of form users. Inserting material in the footer is not required. You may customize the footer for your own use. The guidance in paragraphs A.3 and E.2 is meant to be informative, not directive. The NEMB's footer may include a patient signature block, liability statement, and/or other information at your discretion. The following elements may be included in the footer, but you may customize the footer, or not, according to your particular needs.

- **Date** - The date on which you gave the NEMB to the patient or person acting on his or her behalf and/or the date on which the patient, or person acting on his or her behalf, signed the NEMB. If personal delivery is not possible, you may include both the date you notified the patient by telephone and the date you mailed the notice.

- **Patient's Name** - The name of the patient (rather than the name of an authorized representative).

- **Signature Line** - The patient, or person acting on his or her behalf, may be asked or required to sign his or her name.

100 - Indemnification Procedures for Claims Falling Within the Limitation on Liability Provision

(Rev. 1, 10-01-03)

A3-3446, B3-7320

Section 1879(b) of the Act provides that when a provider, practitioner, or supplier is held liable for the payment of expenses incurred by a beneficiary for noncovered items or services and such provider, practitioner, or supplier requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program indemnifies the beneficiary or other person(s).

Further, any such indemnification payments are considered overpayments to the provider, practitioner, or supplier.

A provider, practitioner, or supplier who is determined liable may not seek payment from a third party payer. (See §30.2.B.)

100.1 - Contractor and Social Security Office (SSO) Responsibility in Indemnification Claims

(Rev. 1, 10-01-03)

A3-3446.1, B3-7320.1

The contractor, SSO, RO, or central office may receive requests or inquiries concerning indemnification. However, a beneficiary or person(s) who made payment on behalf of the beneficiary to a liable provider usually visits his/her nearest SSO or deals directly with the contractor to file a request for indemnification.

Those offices are responsible for assisting beneficiaries or any person(s) in filing claims for indemnification.

100.2 - Conditions for Indemnification

(Rev. 1, 10-01-03)

A3-3446.2, B3-7300.5, B3-7320.2

A beneficiary or any person(s) who assumed financial responsibility for payment is indemnified for claims filed if all of the following conditions are met:

- The contractor has determined that the beneficiary is without liability under authority of §1879 of the Act for items and services furnished by a provider, practitioner, or supplier;

- The contractor or the QIO has determined that the provider, practitioner, or supplier is liable under §1879 for the items and services furnished to the beneficiary. A provider, practitioner, or supplier is considered to have knowledge that payment will not be made under Medicare for items or services in a particular claim where the following evidence is established regarding the provider, practitioner, or supplier;

  (1) Evidence that a provider, practitioner, or supplier knew, or could reasonably be expected to have known, of exclusion of items or services

  - General notice to the medical community regarding exclusion of certain items or services: e.g., colonic irrigation, acupuncture.

  - General notice to the medical community that services exceeding certain frequencies would be denied or subject to additional review, e.g., vitamin B12 injections, or nursing home visits more frequent than once a month.

- Written notice to the particular provider, practitioner, or supplier that a type of service or item would be noncovered in all or certain circumstances.

A distinction must be maintained between coverage rules that specify that a type of service or item would be not reasonable or necessary in all or certain circumstances, and utilization guidelines the contractor established to identify excessive services. Any written policies or other internal edits that are disclosed to a provider, practitioner, or supplier would not be considered as a "notice" of exclusion, since they are used for referring claims for further development rather than as rules to make a contractor coverage decision.

In addition to instances when the Medicare program has given notice, the allegation of a provider, practitioner, or supplier is not accepted without further verification in situations of potential program abuse involving a pattern of unnecessary services by a provider, practitioner, or supplier to a number of beneficiaries. When a provider, practitioner, or supplier frequently renders unnecessary services, i.e., services that significantly exceed the frequency with which the general medical community renders them, it is reasonable to expect the provider, practitioner, or supplier to know that such a pattern deviates from the standard practice.

(2) Evidence that provider, practitioner, or supplier did not have knowledge of exclusion of services.

In contrast to subsection 1, there may be situations where an assumption can be made that neither the beneficiary nor the provider, practitioner, or supplier had knowledge of exclusion, and liability can be limited by the reviewer without a statement by either party. In the following situations, further development would not be necessary:

a. The service is for a type of treatment that can be rendered only by a physician, but the contractor has not previously denied payment for the treatment, and it is not unreasonable that a particular physician might consider the treatment appropriate. In order to determine whether the services are reasonable and necessary, the contractor requests its physician consultant or CMS to advise whether the services are covered. This is a case for which there are no general coverage guidelines for the services; the contractor has not advised either the physician or the medical community regarding the coverage of the services; and the contractor is uncertain without expert consultation. In such a case, it may be presumed that neither the beneficiary nor the physician could have known that the services would be noncovered.

b. The item or service is ordinarily covered, but a question is raised as to whether it is reasonable and necessary in treatment of a particular diagnosis. Neither the provider, practitioner, or supplier nor the medical

community has been advised that the item or service is not covered for that diagnosis. The case requires a determination by the contractor's medical consultant or is referred to CMS for guidance. As in example (a), the liability of both parties should be limited.

c. The provider, practitioner, or supplier is newly arrived in the contractor service area, and the contractor has not yet communicated to the provider, practitioner, or supplier information in an existing general notice that the item or service is not covered, always or under certain circumstances.

NOTE: If any provider, practitioner, or supplier could reasonably be expected, by virtue of normal medical knowledge, to know that the service was unneeded, the presumption suggested in the above examples would not apply.

- The requester for indemnification has paid the provider, /practitioner or supplier all or some of the charges for items and services for which the beneficiary's liability has been waived under §1879 of the Act; and

- The requester seeks indemnification by filing a written statement prior to the end of the sixth month following:

  - The month in which payment was made to the provider, practitioner or supplier; or

  - The month in which the contractor advised the beneficiary that the beneficiary was not liable for the noncovered items or services, whichever is later.

The contractor extends the 180-day time limit if good cause is shown. It uses the principles for reconsideration or review requests outlined in Chapter 29, "Appeals of Claim Decisions."

100.3 - Development and Documentation of Indemnification Requests

(Rev. 1, 10-01-03)

A3-3446.3, B3-7320.3

When the contractor receives a request or inquiry concerning indemnification directly from the beneficiary or the beneficiary's authorized representative, it must obtain the following information and documentation:

- Identifying information sufficient for the contractor to locate the claim(s) for noncovered items or services for which payment has been made to the provider, practitioner, or supplier by the beneficiary or other person and for which the liability of the beneficiary was limited. Ordinarily, the initial MSN or reconsideration/review determination suffices.

- A statement on Form SSA-795, “Statement of Claimant or Other Person,” (see §100.10, Exhibit 4) to the effect that the requester paid the provider, practitioner, or supplier all or some of the charges for the noncovered items or services for which the beneficiary’s liability was limited. The statement must specify the amount the requester has paid the provider, practitioner, or supplier. If the requester submits this information in a letter, the letter serves as the signed statement.

100.3.1 - Proof of Payment

(Rev. 1, 10-01-03)

The following types of documentation are sufficient to establish that payment was made in the amount alleged:

- An itemized bill from the provider, practitioner, or supplier reflecting the items and services for which the provider, practitioner, or supplier has been found liable and has received payment along with the payer’s cancelled check, money order receipt, or statement of receipt from the provider, physician, or supplier;

- A summary bill from the provider, practitioner, or supplier which pertains to the items and services for which the provider, practitioner, or supplier has been found liable and has collected from the beneficiary or other person along with the payer’s cancelled check, money order receipt, or a statement of receipt from the provider, practitioner, or supplier showing the same total amount;

- The payer’s cancelled check, money order receipt, or the statement of receipt from the provider, practitioner, or supplier if the contractor’s records reflect the provider, practitioner, or supplier’s charges for the items and services for which the provider, practitioner, or supplier has been found liable and these equal the total of the amount paid; or

- If the requester alleges that the provider, practitioner, or supplier did not furnish an itemized bill or a receipted statement and no other proof of payment is available, the contractor obtains a statement on Form SSA-795 to this effect from all parties involved, including the provider, physician, or supplier if possible. The statement should describe the circumstances, such as the manner of payment, and the reasons for not obtaining a receipt or any proof of payment. If there were any witnesses to the payment, the contractor obtains their statements on Form SSA-795. The contractor refers any questions as to the acceptability of proof of payment to the RO.

When the beneficiary or other person on behalf of the beneficiary initially contacts the SSO, that office sends the statements and evidence relevant to the indemnification claim to the appropriate contractor. If future contact with the beneficiary or other person is necessary, the contractor proceeds with a direct contact unless the assistance of the SSO is needed.

100.4 - Beneficiary Requests Indemnification, but Had No Financial Interest in the Claim

(Rev. 1, 10-01-03)

A3-3446.4, B3-7320.4

If a request for indemnification is received from the beneficiary but the beneficiary did not have full financial interest in the claim, then any other person(s) who made full or partial payment to the provider, practitioner, or supplier must be contacted to ascertain if that person wishes to file for indemnification.

If the individual declines to file for the indemnification payment, the SSO or contractor staff should assist in preparing a statement to that effect for the individual's signature. No payment is made in this instance; however, the contractor notifies all involved parties.

If more than one person helped pay the bill; e.g., sons and daughters of the beneficiary got together and each paid a portion of the bill; the contractor must determine the indemnification amount for each payer unless they all agree in writing that payment is to be made to one person. Explain this to the requester for indemnification in such instances.

100.5 - Questionable Indemnification Requests Procedure

(Rev. 1, 10-01-03)

A3-3446.5, B3-7320.5

If the contractor receives a request for indemnification that does not appear to meet the conditions outlined in §100.2, and there is some uncertainty concerning the indemnification claim, it undertakes development to resolve the issues. If the issues cannot be adequately resolved, it obtains the assistance of the RO.

100.6 - Determining the Amount of Indemnification

(Rev. 1, 10-01-03)

A3-3446.6, B3-7320.6

In accordance with §1879(b) of the Act, the contractor indemnifies the beneficiary or other person(s) for actual charges paid to a provider, practitioner, or supplier, rather than the usual allowable charges as determined by the Medicare program, PPS amounts, or established per diem rates that apply to certain provider, practitioner, or suppliers.

Additionally, §4096 of P.L. 100-203 (OBRA of 1987) revises certain limitation on liability requirements for indemnification under §1879(b) of the Act. A beneficiary qualifying for indemnification for denied items and services furnished on or after January 1, 1988 is no longer responsible for paying deductible and coinsurance charges

related to the denied claim. Where such indemnification is made, the contractor may not charge the beneficiary's Medicare utilization record for the denied items and services furnished.

100.7 - Notifying the Provider, Practitioner, or Supplier

(Rev. 1, 10-01-03)

A3-3446.7, B3-7320.7

After the contractor has reviewed the claim for indemnification and the indemnification amount has been determined, it notifies the provider or physician/supplier of the proposed indemnification action. (A sample letter for these situations is contained in §100.10, Exhibit l.) The essential elements of this written notice are:

An explanation of the items and services for which the provider or physician/supplier is liable with reference to the original notice to the provider or physician/supplier.

- A statement of the provision of §1879 which allows the program to indemnify the beneficiary and recover an overpayment from the provider, practitioner, or supplier;
- An explanation of the amount determined payable to the requester for indemnification;
- A statement that the amount the contractor has determined to be payable is paid to the requester and that it constitutes an overpayment to the provider, practitioner, or supplier which is to be recovered from future Medicare payments made to it;
- A statement encouraging the provider, practitioner, or supplier to refund any amount(s) already collected; and
- A reminder to the provider, practitioner, or supplier of his/her/its Medicare appeal rights.

If the provider, practitioner, or supplier does not respond to this notice within 15 days, the contractor makes payment to the requester in accordance with §100.8. If the provider, practitioner, or supplier disputes the indemnification or the amount to be paid, the contractor resolves any discrepancies before making payment. The payment process takes place even if the provider, practitioner, or supplier might appeal the contractor's initial determination which held the provider, practitioner, or physician liable and that appeal is still pending at the time payment of the indemnification amount is to take place. If the appeal decision reverses the initial determination, then adjustments are to be made at that time in the contractor and provider, practitioner, or supplier records. In all cases, the contractor encourages the provider, practitioner, or supplier to refund any and all amounts collected to this point. If the provider, practitioner, or supplier chooses to refund any money collected, the contractor verifies that such a refund has actually been made to the requester.

100.8 - Making Payment Under Indemnification

(Rev. 1, 10-01-03)

A3-3446.8, B3-7320.8

The contractor pays the indemnification amount if the provider, practitioner, or supplier does not make refund. It takes action to recover this amount as an overpayment from the provider, practitioner, or supplier. Also, it issues a letter of explanation to the requester for indemnification. (See §100.10, Exhibit 2 and Exhibit 3.) It sends a copy of this notice to the provider, /practitioner or supplier. The fundamental points of the notice include:

- Name of the provider, practitioner, or supplier and dates the services in question were rendered; and
- the amount of the indemnification check that the requester is to receive.

100.9 - Limitation on Liability Determination Does Not Affect Medicare Exclusion

(Rev. 1, 10-01-03)

B3-7300.9

A determination to limit the liability of the beneficiary, as well as a finding that the physician's or supplier's liability may be limited and program payment made, does not change noncovered items or services into covered items or services. This means that the coverage question can still be raised as an issue in a hearing subsequent to a review determination that authorized program payment under §1879. It also means that, for purposes of determining the amount in controversy for a Part B hearing, payment made under §1879 should be disregarded because coverage is still at issue and the amount charged is still in controversy.

100.10 - Exhibits

(Rev. 1, 10-01-03)

A3-3446.9, B3-7320.10

1. Letter to Provider (Institutional Services).
2. Letter to Beneficiary Who Requests Indemnification (Institutional Services).
3. Letter to Someone Other Than Beneficiary Who Requests Indemnification.
4. Letter to Practitioner or Supplier (Noninstitutional Services)
5. Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)

6. Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services)

7. Form SSA-795, Statement of Claimant or Other Person.

Exhibit 1 - Letter to Provider

(Rev. 1, 10-01-03)

To: Provider

Dear Administrator:

Under §1879 of the Social Security Act, a Medicare beneficiary is relieved of the liability for certain noncovered services if the beneficiary did not know and could not reasonably have been expected to know that the items or services were not covered. Further, the law provides that the provider is liable if it is found that the provider knew or could reasonably have been expected to know that the items or services were not covered by Medicare.

On (date of limitation on liability notice), your facility was notified that the services provided to (beneficiary's name) during the period (_____) to (_____) were not covered under Medicare and that you were liable for these items and services.

(Requester's name) has submitted evidence that establishes that he paid your facility (amount paid) for the services received by (beneficiary's name). Because your facility has collected payment from (requester's name) after being determined liable for these services, §1879(b) of the Act requires that the Medicare program make direct payment (indemnification) to him for this amount, for which (beneficiary's name) is responsible.

A check in the amount of (amount of check) is being sent to (requester's name). This indemnification payment represents an overpayment to your facility and it will be withheld from future Medicare payments due you unless you advise this office that refund of the incorrect amount(s) has been made to (requester's name).

If you do not agree with the amount determined to have been paid you, please contact this office in writing within 15 days of the date of this letter.

Sincerely yours,

Exhibit 2 - Letter to Beneficiary Who Requests Indemnification

(Rev. 1, 10-01-03)

Dear (Beneficiary's Name):

Your request for refund of improper payment under §1879 of the Social Security Act (the limitation on liability provision) for the noncovered services provided you at (name of provider) from (date) to (date) has been received.

The evidence submitted establishes that, even though you were not responsible for the services you received, you paid (provider's name) (amount paid) for the services. Your refund for these payments to (name of provider) has been calculated to be (indemnification amount). This figure represents full repayment for the charges you paid.

Your Medicare utilization record will not be charged where noncovered services were provided to you and you were determined not liable.

If you have any questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer to visit your local social security office, please take this letter with you.

Sincerely yours,

Exhibit 3 - Letter to Someone Other Than Beneficiary Who Requests Indemnification

(Rev. 1, 10-01-03)

Dear (Person's Name):

Your request for refund of improper payment under Section 1879 of the Social Security Act (limitation of liability provision) for the noncovered services provided (beneficiary's name) at (name of provider) from (date) to (date) has been received.

It was determined that (beneficiary's name) was not liable for the services. The evidence you submitted establishes that you paid (provider) (amount paid) for the services provided (beneficiary's name). Your refund has been calculated to be (indemnification amount). This figure represents full repayment based on the expenses incurred by (beneficiary's name) in the amount of $(amount).

If you have any questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer, you may visit the local social security office. If you do, take this letter with you.

Sincerely yours,

Exhibit 4 - Letter to Practitioner or Supplier (Noninstitutional Services)

(Rev. 1, 10-01-03)

Dear _____:

Under §1879 of the Social Security Act, a Medicare beneficiary is relieved of the liability for certain categories of noncovered items or services submitted as assigned claims if the beneficiary did not know and could not reasonably be expected to know that the items or services would not be covered. Further, the law provides that the practitioner or supplier will be liable for the charges if it is found that he/she knew or could reasonably be expected to know that Medicare would not cover the items or services.

On (date of limitation on liability notification), you were notified that the following items or services provided to (name of beneficiary) were not covered and that you were liable for the charges for these items or services:

Description of Services	Date Provided

(Beneficiary or other person on behalf of beneficiary) has submitted evidence which establishes that he/she paid you $_____ for the items or services described above. Since it has been determined that you are liable for the items or services, §1879(b) of the Act requires that the Medicare program make payment (indemnification) to him/her for this amount. The amount of this payment will be treated as an overpayment to you and appropriate collection action will be taken unless you advise this office that refund has been made to (name of requester).

If you do not agree with the amount that (name of requester(s)) has established he/she paid you, please notify this office.

If we do not hear from you regarding the amount of the payment or that you will make refund directly by_____ (15 days after date of this notice) payment will be made to (name of requester(s)) and action will be taken to collect the overpayment from you.

If you disagree with this determination, you may request a review. The bases for such a review are: (1) that the services you provided were reasonable and necessary; (2) that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services; or (3) that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. The request for review must be in writing, and it must be filed within 120 days of the date of notice of the initial determination. If you have already received an adverse review determination, and the amount in controversy is $100 or more, you may request a hearing within 6 months of the date of the review determination. Our office or your social security office will assist you if you need help in requesting a review or a hearing. You need not file another request for a review or a hearing if you already have taken such action.

Exhibit 5 - Letter to Beneficiary Who Requests Indemnification (Noninstitutional Services)

(Rev. 1, 10-01-03)

Dear (Beneficiary's name):

Your request for indemnification (i.e., refund of improper payment) under §1879 of the Social Security Act (the limitation on liability provision) for the noncovered services provided you by (physician's/supplier's name) on (date) has been received.

The evidence submitted establishes that you paid (physician/supplier) (amount paid) for the noncovered services. It was determined (upon review or hearing, if applicable) that you were not liable for these charges. Your refund for these payments to (physician/supplier) has been calculated to be (indemnification amount). This figure represents full repayment for the charges you paid.

If your (physician/supplier) requests review of this claim, it is possible that Medicare might find that your (physician/supplier) also did not know that Medicare would not pay for this service, or that this service should not have been denied. In that case, Medicare would pay your (physician/supplier) for this service. Also, you would be responsible for any deductible and coinsurance amounts. If this happens, you will receive a copy of the notice to your (physician/supplier).

Any future items or services of this type provided to you will be your responsibility because this is your notice that Medicare does not cover these services.

If you have further questions concerning this matter, please call this office. If you prefer to visit your social security office, please take this letter with you.

Exhibit 6 - Letter to Someone Other Than Beneficiary Who Requests Indemnification (Noninstitutional Services)

(Rev. 1, 10-01-03)

Dear (Person's name):

Your request for indemnification (i.e., refund of improper payment) under §1879 of the Social Security Act (limitation on liability provision) for the noncovered services provided (beneficiary's name) by (name of physician/supplier) on (date) has been received.

It was determined (upon review or hearing, if applicable) that (beneficiary's name) was not liable for the charges.

The evidence establishes that you paid (physician/supplier) (amount paid) for the services provided (beneficiary's name). Your refund has been calculated to be (indemnification amount). This figure represents full repayment for the expenses incurred by (beneficiary's name).

If his/her (physician/supplier) requests a review of this claim, it is possible that Medicare might find that the (physician/supplier) also did not know that Medicare would not pay for this service, or that this service should not have been denied. In that case, Medicare would pay the (physician/supplier) for this service. Also, (beneficiary's name) would be responsible for any deductible and coinsurance amounts. If this happens, (beneficiary's name) will receive a copy of the notice to his/her (physician/supplier).

Any future items or services of this type provided to (beneficiary's name) will be his/her responsibility because this is your notice that Medicare does not cover these services.

If you have further questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer to visit the social security office, please take this letter with you.

Exhibit 7 - Statement of Claimant or Other Person

(Rev. 1, 10-01-03)

Link to an exhibit of the Form SSA-795, "Statement of Claimant or Other Person," at:

http://www.ssa.gov/online/ssa-795.pdf.

110 - Contractor Instructions for Application of Limitation On Liability

(Rev. 1, 10-01-03)

110.1 - Payment Under Limitation on Liability

(Rev. 1, 10-01-03)

A3-3441

When it is determined during the course of a beneficiary's inpatient stay or during the patient's course of home health visits, or during a patient's course of treatment from a practitioner, physician or other supplier that the care is not covered but both the beneficiary and the provider of services are entitled to limitation on liability, the Medicare program may make payment for the noncovered services up to the date of notice and, if, for inpatient or home health services, the FI determines that additional time is needed to arrange for post-discharge care, also for a "grace period" of l day after the date of notice to the provider or to the beneficiary, whichever is earlier. If it is determined that even more time is required in order to arrange post-discharge care, 1 additional "grace period" day may be paid for. (See §§30 and 40 for definition of notice.)

When the provider is given notice as described in §40.1, it is required to advise the beneficiary in writing of the determination on the same date it received the FI's notice. Where the provider fails to give the beneficiary such timely notice, the beneficiary is protected from liability until the beneficiary receives the notice.

For example, if a SNF received the FI's notice of noncoverage on February 15 but failed to advise the beneficiary until February 19, the beneficiary is protected from liability through February 19 - the date on which the beneficiary first received notice. However, the SNF is entitled to program payment only through the date - February 15 - on which it received notice, and for whatever "grace period" is allowed thereafter. In a case in which a SNF received the FI notice on February 15 but failed to give the beneficiary notice until the next day - February 16 - the beneficiary and provider, if the FI determines that additional time is needed to arrange post-discharge care, would be protected from liability under the "grace period" only for the additional day - February 16 - unless it is determined that even more time is required to arrange post-discharge care, in which case 1 additional "grace period" day may be paid for.

NOTE: The "grace period" is applicable only where circumstances have permitted program payment under §1879 of the Act, i.e., limitation on liability was applicable both to the beneficiary and the provider of services. Where the FI concurs with a URC's decision that covered care has ended, any payments made during the "grace period" after the URC's notice are made under the authority of that statutory provision (§1814 of the Act) rather than under §1879.

110.2 - When to Make Limitation on Liability Decisions

(Rev. 1, 10-01-03)

A3-3442

A - Initial Claims

In implementing the limitation on liability provision, the contractor makes a coverage decision before making a limitation on liability decision. Section 1879 of the Act provides that limitation on liability can be allowed only in cases:

> Where - (1) a determination is made that, by reason of §1862(a)(l) or (9) or by reason of a coverage denial described in subsection (g) of the Act, payment may not be made under Part A or Part B of this title for any expenses incurred for items or services furnished an individual by a provider of services... (Section 1879(a)(1) of the Social Security Act.)

NOTE: Subsection (g) refers to home health service denials under §§1814(a)(2)(C) and 1835(a)(2)(A), i.e., the patient is or was not confined to home; or the patient does or did not need skilled nursing care on an intermittent basis; and to hospice denials under §1861(dd)(3)(A) for services determined to be noncovered because the beneficiary was not "terminally ill".

Only after the contractor makes a decision that care is not reasonable or necessary, is custodial, is not reasonable and necessary for the palliation or management of terminal illness in hospice denials, or does not meet the homebound or intermittent nursing care requirements in home health service denials, or does not meet the "terminally ill" condition for hospice care, should a determination be made regarding limitation on liability. In every such case there will be two parts to the limitation on liability determination:

1. Whether and when the beneficiary knew or should have known that the services were noncovered, and

2. Whether and when the provider knew or should have known that the services were noncovered.

In any case where the provider gave the beneficiary notice that the services would be noncovered, the contractor will find that the provider knew that the services were noncovered.

B - Reconsideration/Review

At the reconsideration/review level, again the contractor first makes a determination on the coverage issue. It considers the question of limitation on liability, if applicable, only if the initial adverse coverage decision is wholly or partially affirmed. (See Chapter 29, "Appeals of Claim Decisions," for discussion of the appeals process.)

110.3 - Preparation of Denial Notices

(Rev. 1, 10-01-03)

A3-3443

The provider and beneficiary notification procedures discussed in §§30 and 40 for determining liability do not change the instructions for the preparation and issuance of denial notices in Medicare Claims Processing Manual, Chapter 21, "Medicare Summary Notices."

Accordingly, in cases where the services are found to be custodial care or not reasonable and necessary, or in the case of HHA services, are denied for technical reasons under §1814(a)(2)(C) or §1835(a)(2)(A), or in the case of hospice services, are denied for technical reasons under §1861(dd)(3)(A):

An MSN denying the service(s) is sent to the beneficiary in cases where only the beneficiary is entitled to limitation on liability for any part of the noncovered stay. The notice advises the beneficiary of the beneficiary's entitlement to indemnification (see §§100.) in the event the provider seeks payment from the beneficiary for the noncovered services. It uses MSN messages 50.36.2:

> It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

All denial notices explain any decision regarding limitation on liability for either the provider, practitioner, or supplier or the beneficiary. (See Chapter 21, "Medicare Summary Notices.")

All denial notices, where either the beneficiary or provider, practitioner, or supplier has been found liable, must state that the provider has a right to reconsideration/review (as applicable) when it has been determined that the beneficiary will not exercise appeal rights, or when the beneficiary's liability has been entirely waived but the provider, practitioner, or supplier is fully or partially liable.

Providers, practitioners, and suppliers do not receive a separate written notification or copy of the MSN. Providers, practitioners, and suppliers must utilize the coding information (e.g., ANSI X12N Reason Codes) conveyed via the financial remittance advice (RA) to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

110.4 - Bill Processing

(Rev. 1, 10-01-03)

A3-3445

Where payment is made under the limitation on liability provision, because it was determined that both the provider, practitioner, or supplier and the beneficiary did not know and could not have been expected to know that services were not reasonable and necessary, the usual deductible and coinsurance amounts apply.

When payment under limitation on liability is made for noncovered services, the contractor processes the bill in the same manner as any payment bill for covered services. For institutional services, if both the beneficiary and the provider have liability waived, the FI charges the number of days or visits paid for under the limitation on liability provision to the beneficiary's utilization record. For noninstitutional services, it applies deductible and coinsurance, and, where applicable, statutory limits on services.

For situations where the contractor determines that the provider, practitioner, or supplier knew or should have known that the services were not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the services were not reasonable and necessary, the beneficiary qualifies for indemnification and is not responsible for paying deductible and coinsurance charges related to the denied claim. Additionally, where such indemnification is made, the contractor does not charge the beneficiary's Medicare utilization record days, visits, deductibles, or coinsurance (nor does it apply statutory limits, e.g., the psychiatric services Limit) for the denied items and services furnished.

The contractor follows the no-payment procedures in the relevant bill processing instructions in the following cases:

- Either the beneficiary or the provider/practitioner/supplier, or both knew or should have known that services were not covered.

- The provider, practitioner, or supplier knew or should have known that the services were not covered even though the beneficiary did not know. In these cases, the notice to the beneficiary will have informed the beneficiary that, even though no Medicare payment is being made, the beneficiary is not liable for the cost of the services and that the beneficiary may be indemnified for any improper payments the beneficiary made to the provider, practitioner, or supplier.

Where no Medicare payment is made because limitation on liability does not apply, or where payment ceases because of notice in a noncovered case, the normal provisions for no-payment situations apply.

For ancillary and outpatient services billed on the Form CMS-1450, the provider follows the instructions in Chapter 4 for hospitals, Chapter 7 for SNFs, and Chapter 10 for HHAs to process bills for these types of claims. Further, where ancillary services may not be

paid under Part A because they were rendered in connection with a noncovered inpatient stay, the provider may still bill under Part B for ancillary services that may be covered under §1861(s)(3)-(9) of the Act.

110.5 - Contractor Review of ABNs

(Rev. 1, 10-01-03)

110.5.1 - General Rules

(Rev. 1, 10-01-03)

A - Generally, notifiers (physicians, practitioners, suppliers, providers) are not required to routinely submit copies of ABNs (CMS-R-131) to their Medicare contractor along with their claims (see §50.6.3). This is based on a rebuttable administrative presumption that a certain modifier (GA) or occurrence code (32) on the claims signify that notifiers are using the proper standard form CMS-R-131 and are preparing and delivering ABNs in compliance with the instructions in this Chapter.

B - Contractors may and should request CMS-R-131 ABNs (or any other ABN if the circumstances demand) be submitted to them for review in any circumstance in which the contractor is not confident that the administrative presumption is correct or in which the contractor has good reason to examine the ABNs of either particular notifiers or any class of notifiers. In the case where a contractor requests submission of copies of ABNs, the notifiers must submit such copies (see §50.6.3).

C - All Hospital ABNs (HINNs) will be reviewed by QIOs (see §80.5) and all HHABNs and SNFABNs will be reviewed when the contractor performs complex medical review of the demand bills.

110.5.2 - Situations in Which Contractor Review of ABNs is Indicated.

(Rev. 1, 10-01-03)

Circumstances involving ABNs (viz., with respect to claims on which there is any payment denial, that include either or both the GA modifier and occurrence code 32, and that do not include a copy of the ABN) in which the contractor should not be confident that the administrative presumption, viz., that notifiers are using the proper form and are properly preparing and delivering ABNs, is correct and should request submission of ABNs include, but are not limited to, the following:

A - Any claim where the contractor has any indication that the notifier may not have given proper notice, either no notice at all or defective notice, whether based on the contractor's experience (with the notifier or class of notifiers, or with the class of items or services), on beneficiary complaint, on any other plausible allegation, or on any other reasonable basis. (Contractors, of course, may not make baseless or capricious requests for routine submission of ABNs.)

B - Any claim for payment for more than one item or service. (In such cases, the contractor must ascertain which item(s) and/or service(s) the ABN specified and, therefore, to which claimed item(s) and/or service(s) the ABN applies with respect to assigning liability to the beneficiary. Liability is shifted to the beneficiary only if the ABN accurately specifies the items or services and if the specified expected reason for denial turns out to be the actual reason for denial.)

C - Any claim for an item or service for which there is a coverage frequency limit, and which includes one or more other items or services which are not frequency-limited. (Since ABNs may be given routinely for frequency-limited items and services, it is predictable that virtually all claims which include any frequency-limited item or service will include the GA modifier and/or occurrence code 32. When other, non-frequency-limited items or services are included on such a claim, any ABN specifying a frequency-limit as the expected reason for denial would not be applicable to the liability determination with respect to any item or service on such a claim that is not frequency-limited, nor with respect to any different frequency-limited item or service.)

D - Any claim for an item or service for which there is a coverage frequency limit and on which there is a payment denial on any basis other than exceeding the frequency limit. (Since the notifier can be reasonably expected to have given routine notice on the basis of the frequency limit, and since an ABN specifying a frequency-limit as the expected reason for denial would not be applicable to the liability determination with respect to any item or service on such a claim that is denied on any basis other than that particular frequency limit, such ABNs need to be reviewed for their correct application to any denial.)

E - Any claim about which there is any suspicion of fraud or abuse, whether with respect to the notifier, the category of notifiers, or the class of items or services involved.

110.5.3 - Other Reasons for Contractor Request for Copies of ABNs

(Rev. 1, 10-01-03)

Other good reasons for contractors to request submission of copies of ABNs include, but are not limited to, the following:

A - Any need that arises from the hearings and appeals processes for documentation.

B - Any practical need to identify the particular items and/or services, dates of service, reasons for predicting Medicare denial of payment, or other pertinent facts about the beneficiary notification.

C - Any plausible allegation or dispute as to the form, content, or delivery of a particular ABN or a particular group of ABNs, e.g., all ABNs furnished by a particular notifier, all ABNs for a particular item, etc.

D - For the purposes of a data analysis, utilization study, or other investigation or study.

120 - Carrier Specific Instructions for Application of Limitation on Liability

(Rev. 1, 10-01-03)

B3-7300, B3-7320.10

120.1 - Documentation of Notices Regarding Coverage

(Rev. 1, 10-01-03)

B3-7300.6

A critical step in the implementation of the limitation on liability provision is the distribution by carriers of notices regarding coverage issues to the medical community, or to specific segments of it, such as laboratories or certain physician specialty groups. An ongoing program of communication by carriers is essential. Timely communication of existing general notices to physicians and suppliers new to a carrier's service area is essential. The existence of written general notices will often determine the extent of program liability. As a minimum, the carrier should have a program for dissemination of the coverage guidelines published in the National Coverage Determinations Manual and the Medicare Benefit Policy Manual, as well as other guidelines contained in this manual for determining medical necessity and others issued from time to time in other CMS issuances.

120.2 - Availability of Coverage Notices to Operating Personnel

(Rev. 1, 10-01-03)

B3-7300.7

All review personnel should have ready access to a file of general notices regarding coverage for processing review cases involving the issue of limitation on liability. The complete file should also be readily available to hearing officers.

In addition to general notices, the carrier must have a mechanism for identifying and locating correspondence with individual physician/suppliers regarding coverage of particular services or items. This mechanism should meet at least the following minimum requirements:

- The carrier must be able to determine if a practitioner or supplier has been sent an explanation, in lieu of, or in addition, to, a routine MSN denial notice, that a type of service or item is not reasonable and necessary. Such explanation may consist of a general notice or may be individual correspondence with the

physician/supplier such as is usually found in carrier correspondence units or comparable units. Claims history files can also be checked, but these are generally useful only when the identical item or service in question has been previously denied as not meeting the requirements of §1862(a)(1);

- A copy of such an explanation must be readily available to review personnel and hearing officers; and

- Procedures must be established requiring that a check of all files be made to determine if such an explanation was ever sent before the physician/supplier's liability is limited.

Once a physician/supplier receives an explanation of denial for an item or service after a review determination, that determination would be considered a notice that should be readily accessible for future use for a similar claim(s).

120.3 - Applicability of Limitation on Liability Provision to Claims for Outpatient Physical Therapy Services Furnished by Clinics

(Rev. 1, 10-01-03)

B3-7300.10

A - General

The limitation on liability provision is applicable to claims for items or services furnished by a physician-directed outpatient physical therapy (OPT) clinic that are denied on the basis of §1862(a)(1).

The limitation on liability determination for OPT clinic claims will be made by carriers at the initial determination level, in accordance with §120.4. The procedures discussed in §120.2, second bullet, for determining a physician's/supplier's liability will be followed when processing this category of claims.

120.4 - Limitation on Liability Notices to Beneficiaries From Carriers

(Rev. 1, 10-01-03)

B3-7300.4

The carrier adds MSN Limitation of Liability Message 50.36.2 to the MSN sent to the beneficiary (who is presumed not to have knowledge of nonpayment by Medicare) at the time of the initial determination.

To message 50.36.2, it also adds the following language:

> Do not apply if your (doctor/supplier) told you in writing, before furnishing the service, that Medicare would not pay.

The carrier adds MSN Limitation of Liability Message 50.36.1 to the MSN sent to the beneficiary (who is held to have had knowledge of nonpayment by Medicare) at the time of the initial determination.

The carrier adds, from the Remittance Advice Remarks Codes, the Justification for Services Remark M25 to the RA sent to the physician/supplier (who is presumed to have knowledge of nonpayment by Medicare) at the time of the initial determination.

The carrier adds, from the Remittance Advice Remarks Codes, the Justification for Services Remark M38 to the RA sent to the physician/supplier who is held to be not liable because the beneficiary is held liable at the time of the initial determination.

In addition to the above, as appropriate, the carrier notifies both the beneficiary and the physician/supplier at the time of the initial determination of their appeal rights (this is contained on the back of the MSN and the RA).

120.5 - Carrier Reviews in Assignment Cases Conducted at the Request of Either the Beneficiary or the Assignee

(Rev. 1, 10-01-03)

B3-7300.4.B.2

In every review where the limitation on liability provision is applicable, the determination consists of two stages. The first stage is a new, independent and critical reexamination of the facts regarding the coverage issue. If the original decision regarding coverage was appropriate, the second stage is the decision whether to limit the liability of the beneficiary and, if so, whether to also limit the liability of the provider, practitioner, or supplier.

Reviews in assignment cases are conducted at the request of either the beneficiary or the assignee. Frequently, the review request is received from only one of the parties, either the provider/physician/supplier or the beneficiary, and the only notice to the other party that a review has been requested is a copy of the determination, i.e., after the fact. In a limitation on liability case, the parties may have adverse interests in the limitation on liability decision, since a provider, practitioner, or supplier may seek to show reason why the beneficiary’s liability should not be limited in order to be able to collect his/her fee from the beneficiary. Therefore, when the carrier receives a request for a review, it sends a notice that a request has been filed to the other party to the review indicating that that party may submit additional evidence. This is necessary to satisfy the statutory requirement that both parties be informed of their rights and privileges in the review process. These procedures extend to the hearing process as well.

120.5.1 - Guide Paragraphs for Carriers to Use Where §1879 Is Applicable at Review Level

(Rev. 1, 10-01-03)

B3-7300.4.C

The carrier uses the following paragraphs (in addition to other required review decision paragraphs, such as language on aggregating claims to meet the amount in controversy for a fair hearing) where the limitation on liability provision applies at the review level in the various situations shown below:

Situation I - To the provider, practitioner, or supplier when neither the provider, practitioner, or supplier nor the beneficiary is determined liable (program payment made under §1879 of the Act)

Paragraph(s):

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a physician/supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare, if neither the beneficiary nor the physician/supplier knew, or could reasonably have been expected to know, that the services were excluded. The services affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have reaffirmed that these services are excluded under Medicare. However, since we find that neither (beneficiary's name) nor you knew, or could reasonably have been expected to know, that the services were excluded from coverage, the Medicare program will reimburse you under this provision of the law for the reasonable charge for the services, less any deductible and coinsurance. (Beneficiary's name) is responsible for any deductible and coinsurance amounts. Upon receipt of this notice, it will be considered that you now have knowledge of the exclusion of (description of service) for similar conditions, and this limitation of liability will not apply to future claims for the same or substantially similar services.

cc: Beneficiary

Situation II - To provider, practitioner, or supplier when the provider or practitioner orsupplier is held liable

Paragraph(s);

Section 1879 of the Social Security Act permits Medicare payment to be made on behalf of a beneficiary to a provider or practitioner or supplier who has accepted assignment for certain services for which payment would otherwise not be made under Medicare, if neither the beneficiary nor the provider, practitioner, or supplier knew, or could reasonably have been expected to know, that the services were excluded. The services

affected by this provision are those that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. After reviewing (beneficiary's name's) claim for (description of services), we have determined that (beneficiary's name) did not know and could not have been expected to know, that these services were excluded from coverage. However, we find that (select applicable phraseology from the following): (l) based upon the claim of (date) which was a similar claim in which payment was denied; (2) (our notification to you of (date) that such services are excluded); (3) (or any other basis used to determine the provider, practitioner, or supplier to be liable)), you knew, or could have been expected to know, that these services were excluded. We also find that you did not notify the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services. Because of this, you are held liable for the full charges for the services.

We have also reviewed the claim with regard to the issue of whether the services were not reasonable and necessary. We found that the prior decision was correct; the services were not reasonable and necessary.

If you disagree with this determination regarding your liability, on the basis that the services were necessary, or on the basis that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services, or on the basis that you notified the beneficiary in writing, before the services were furnished, that Medicare likely would not pay for the services; and if the amount in controversy is $100 or more, you may request a hearing within 6 months of the date of this notice, at which time you may present any new evidence that would have a material effect on this determination. Our office or your social security office will assist you if you need help in requesting a hearing.

cc: Beneficiary

Situation III - To the beneficiary when the beneficiary is held liable

Paragraph(s):

We have reviewed your claim for (description of the services). When we reviewed your claim, we considered two things. First, we considered whether the service you received was necessary. Medicare will only pay for necessary services. We found that the prior decision was correct. The service was not necessary.

Second, we considered whether you knew, or were told, that Medicare would not pay. Medicare would not hold you liable if you did not know and your (doctor/supplier) did not tell you in advance, in writing, that Medicare would not pay. In that case, we would pay you any amount you pay or paid your (doctor/supplier) for the service. Our review shows that (choose one of the following to complete the sentence: (**the (doctor/ supplier) told you in writing, before giving the service, that Medicare would not pay); (this service had been denied on other claims for you); OR (we told you in a letter dated (DATE) that Medicare would not pay for this service))**. Since we believe

you knew Medicare would not pay for this service, Medicare cannot pay. You are liable for the charges.

If you do not agree with our decision and $100 or more is involved, **ask for a hearing.** The person holding the hearing will decide whether the service was necessary. That person will also decide whether you knew, or were told, Medicare would not pay. You must ask for a hearing within 6 months of the date of this notice. At the hearing, you may present any new evidence which would affect our decision. If you need help, your social security office will help you request a hearing.

cc: Physician/Supplier

Situation IV - Rider paragraph to be included in the copy of the notice to the beneficiary when the physician/supplier is held liable

If you paid any amounts to (physician's/supplier's name) for this service, Medicare will pay you back the amount you paid. To get this payment, bring or send to this office three things. (1) A copy of this notice. (2) Your (doctor's/supplier's) bill. (3) A receipt or other proof you have paid the bill.

(See §§120.4 for handling requests for indemnification where payment has been made to a liable practitioner or supplier.)

130 - Intermediary Specific Instructions for Application of Limitation on Liability

(Rev. 1, 10-01-03)

130.1 - Applicability of the Limitation on Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B

(Rev. 1, 10-01-03)

A3-3444

The following sections discuss how the limitation on liability provision is applied to claims involving ancillary, outpatient and rural health clinic services billed on Form CMS-1450 (Provider Billing for Medical and Other Health Services), where reimbursement is sought under Part B. The FI determines whether limitation on liability applies to these categories of claims when the basis for the denial is that the services were not reasonable and necessary (under §1862(a)(l) of the Act).

130.1.1 - Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services

(Rev. 1, 10-01-03)

A3-3444.1

A presumption will be made that the beneficiary did not know that items or services are not covered unless there is evidence to the contrary. Indication on the claim that the beneficiary received proper advance beneficiary notice before receiving the noncovered ancillary, outpatient, or rural health clinic services is evidence to the contrary which rebuts the presumption in the beneficiary's favor. The definitions of proper "advance beneficiary notice" to the beneficiary are set forth in §40.3.

130.1.2 - Determining Provider Liability in Claims for Ancillary and Outpatient Services

(Rev. 1, 10-01-03)

A3-3444.2

The procedures in §30.2 apply for determining liability for providers. A provider may have its liability waived in an individual claim if it can establish that it did not know and could not have been expected to know that Medicare would not make payment for the items or services.

130.2 - Prior Hospitalization and Transfer Requirements for SNF Coverage as Related to Limitation on Liability

(Rev. 1, 10-01-03)

A3-3431.1

In order to qualify for post-hospital extended care services, the individual must meet the prior hospitalization and transfer requirements discussed in "Coverage of Extended Care Services Under Hospital Insurance," Chapter 8 of the Medicare Benefit Policy Manual. The following sections discuss the relationship of these requirements to the limitation on liability provision.

A - Three-Day Prior Hospitalization

Before Medicare can pay for post-hospital extended care services, it must determine whether the beneficiary had a prior qualifying hospital stay of at least three consecutive calendar days. When a beneficiary's liability for a hospital stay is waived, the hospital days to which the limitation on liability applies **cannot** be used to satisfy the 3-day prior hospitalization requirement, since the services rendered during the days in question were found noncovered because they were not considered reasonable and necessary or because

they constituted custodial care. (See “Coverage of Extended Care (SNF) Services Under Hospital Insurance,” Chapter 8, of the Medicare Benefit Policy Manual for determining whether the 3-day prior hospitalization requirement is met.) If a beneficiary’s hospital stay was partially covered, the FI considers the covered portion of the stay in determining whether the SNF prior hospitalization requirement is met.

B - Transfer Requirements

1 - Transfer Period

The FI applies the limitation on liability provision where it determines that all the SNF care received during the period serving to satisfy the transfer requirements described in “Coverage of Extended Care Services Under Hospital Insurance,” Chapter 8 of the Medicare Benefit Policy Manual, either constituted custodial care or was not reasonable and necessary.

Where the FI determines that only the beneficiary’s liability can be waived, the limitation on liability applies through the date of the notice to the beneficiary including any inpatient days beyond the transfer period. If the provider is also entitled to limitation on liability and program payment is possible under the limitation on liability provision, such payment is appropriate through the date of the notice and, if the FI determines that additional time is needed to arrange for post-discharge care, for up to 24 hours after the date of notice to the provider or the beneficiary, whichever is earlier. If the FI determines that even more time is needed to arrange post-discharge care, up to 24 additional hours may be paid for. (See §50.)

Where a beneficiary who is entitled to limitation on liability starts to require and receives reasonable and necessary or noncustodial services only **after** the expiration of the SNF transfer period, the beneficiary nevertheless may have his/her liability waived for days where such services were rendered, in addition to those days waived during the noncovered transfer period **but only through the date of notice to the beneficiary**. If the provider is also entitled to limitation on liability, program payment may be made under the limitation on liability provision through the date of notice of noncoverage and, if the FI determines that additional time is needed to arrange for post-discharge care, for a “grace period” of l day thereafter. If the FI determines that even more time is needed to arrange post-discharge care, 1 additional “grace period” day may be paid for. (See §50.) This payment is made because it is inequitable to waive liability for noncovered services rendered during the transfer period but not for a period thereafter (prior to notice) during which the beneficiary needed and received an otherwise covered level of care.

2 - Delayed Transfer Due to Medical Appropriateness

The law also provides for an extension of the usual 30-day time limit for transfer where the patient’s condition makes it medically appropriate. (“Coverage of Extended Care Services Under Hospital Insurance,” in the Medicare Benefit Policy Manual, Chapter 8.) However, if the FI determines that such an extension is not allowable

because an interval of more than 30 days for transfer to a SNF was not medically appropriate, it denies the SNF services because the transfer requirement was not met. The limitation on liability provision is not applicable in such a case.

130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds

(Rev. 1, 10-01-03)

A3-3431.2

A - General

Payment for SNF and hospital claims may not be denied solely on the basis of a beneficiary's placement in a non-certified bed of a participating SNF or hospital. When requested by the beneficiary or his/her authorized representative, a provider must submit a claim to the FI for services rendered in a non-certified bed. When the FI reviews a claim for services rendered in a non-certified bed, it first determines whether the beneficiary consented to the placement. (See subsection C.) If the FI finds that the beneficiary consented, it denies the claim. If it finds that the beneficiary did not consent, it determines whether there are any other reasons for denying the claim. (See subsection D.) If there is another reason for denying the claim, the FI denies it. However, if none of the reasons for denial exist, beneficiary liability must be waived as provided under §1879(e) of the Act and a further determination must be made as to whether the provider, rather than the Medicare program, must accept liability for the services in question. (See "Coverage of Extended Care Services Under Hospital Insurance" in the Medicare Benefit Policy Manual, Chapter 8.)

B - Provider Notice Requirements

When a SNF or hospital places a patient in a noncertified or inappropriately certified portion of its facility because it believes the patient does not require a covered level of care, or for any other reason, it must notify the patient (or authorized representative) in writing that services in a noncertified or inappropriately certified bed are not covered.

The provider uses the Advance Beneficiary Notice (ABN), Form CMS-R-131-G to advise the beneficiary of its decision to place him/her in a noncertified bed, using language such as:

> We are placing you in a part of this facility that is not appropriately certified by Medicare because (you do not require a level of care that will qualify as skilled nursing care/or covered hospital services under Medicare)/(or state any other reasons for the noncertified bed placement). Nonqualifying services furnished a patient in a noncertified or inappropriately certified bed are not payable by Medicare. However, you may request us to file a claim for Medicare benefits. Based on this claim,

Medicare will make a formal determination and advise whether any benefits are payable to you.

The provider uses Condition Code 20 to indicate the bill is a demand bill. It uses Occurrence Code 31 to indicate the date it notified the beneficiary that he/she no longer required a covered level of care. The presence of this code on the bill indicates the provider has provided the beneficiary with an ABN on the indicated date, and has a copy available for the FI's inspection.

The provider uses Occurrence Span Code 76 to indicate the period of beneficiary liability (i.e., the period for which CMS allows the provider to charge the beneficiary).

C - Determining Beneficiary Consent

The CMS presumes that the beneficiary did not consent to being placed in a noncertified bed. In order to rebut the presumption of nonconsent, the provider must indicate on the bill (using Occurrence Code 31) the date it provided the beneficiary with an ABN notifying the beneficiary that the accommodations would no longer be covered; and requested the beneficiary's signed acknowledgement (on the ABN) of having received such a statement. Moreover, in any case in which a Medicare beneficiary gives his/her consent to placement in a noncertified bed, the provider must, if requested by the FI (contemplated only at an appeal level of claim processing), submit a copy of the ABN signed by the beneficiary to the FI, for a determination of the ABN's validity. The ABN must be signed by the beneficiary (provided he/she is competent to give such consent) or by the beneficiary's authorized representative. If the beneficiary or his/her authorized representative refuses to sign the form, the provider may annotate the file to indicate it presented the ABN to the beneficiary (or his/her authorized representative), but the beneficiary refused to sign. As long as the provider's ABN notifies the beneficiary of the likely Medicare noncoverage, the beneficiary's refusal to sign the ABN does not render it invalid. (See §40.3.4.6.)

If any of the above requirements is not met, the FI automatically determines the ABN is defective.

When the FI receives requests for payment (demand bill as indicated by Condition Code 20 on the UB-92) with an indication that the provider has provided the beneficiary or his/her authorized representative, an ABN (Occurrence Code 31 on the UB-92), the FI denies the claim and notifies the beneficiary that §1879 limitation on liability cannot be applied because of the beneficiary's valid consent to be cared for in a noncertified or inappropriately certified bed.

If the FI determines that the ABN is not valid, the FI processes the claim in accordance with §130.4.

If the beneficiary appeals the initial denial, the FI obtains the ABN from the provider and determines whether it is valid. If the FI determines that the ABN is invalid, it notifies the provider and the beneficiary that payment **may** be made to the extent that all other requirements are met.

D - Determining Whether Other Requirements for Payment are Met

Denials still are appropriate for any of the following reasons. The FI must undertake the development needed to permit a determination as to whether:

- The patient did not receive or require otherwise covered hospital services or a covered level of SNF care;
- The benefits are exhausted;
- The physician's certification requirement is not met;
- There was no qualifying 3-day hospital stay (applicable to SNFs only); or
- Transfer from the hospital to the SNF was not made on a timely basis. (However, if transfer to an institution which contains a participating SNF is made on a timely basis, a claim cannot be denied solely on the grounds that the transfer requirement is not met because the bed in which the beneficiary is placed is not a certified SNF bed.)

The FI denies cases falling within these categories under existing procedures. Also, if the beneficiary receives care in a totally nonparticipating institution, denial on the grounds that the beneficiary was not in a participating SNF or hospital is still appropriate.

130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

(Rev. 1, 10-01-03)

A3-3431.3

The FI presumes that the provider properly notified the beneficiary of the noncoverage and the beneficiary assented if the claim includes Occurrence Code 31, and Occurrence Span Code 76.

The following development occurs only if the beneficiary appeals the FI's decision that the beneficiary may not have liability waived because the provider gave him/her timely notice that Medicare would not cover the accommodation; and that he/she consented to being placed in a noncertified bed.

A - Beneficiary Liability

If the FI determines that the beneficiary did not consent to placement in the noncertified bed within the participating facility (see §130.3.C), and that no other basis for denial of the claim exists (see §130.3.D), it finds the beneficiary not liable under §1879 of the Act.

B - Provider Liability

If the beneficiary is found not liable under §1879, liability may rest with the provider, or with the program. Liability rests with the Medicare program, unless any of the following conditions exist, in which case the provider is liable for the services.

- The provider did not give timely written notice to the beneficiary of the implications of receiving care in a noncertified or inappropriately certified bed as discussed in §130.3.B;

- The provider failed to provide the beneficiary with an appropriate ABN and/or did not attempt to obtain a valid consent statement from the beneficiary. (See §130.3.C.); or

- The FI determined from medical records in its claims files that it is clear that the beneficiary required and received services equivalent to a covered level of SNF care, or that constituted covered hospital services, and the provider had no reasonable basis for placing the beneficiary in a noncertified bed. Following are examples of situations in which it would be found that the provider did in fact have a reasonable basis to place a beneficiary in a noncertified bed:

EXAMPLES

- The FI, a QIO, or Utilization Review Committee had advised the provider that the beneficiary did not require a covered level of SNF care or covered hospital services;

- The beneficiary's attending physician specifically advised the provider (verified by documentation in the medical record) that the beneficiary no longer required a covered level of care or services;

- A beneficiary not requiring covered services had a change in his/her condition that later required a covered level of care or services and the provider had no certified bed available (of course, the SNF transfer requirement must be met, see the Medicare Benefit Policy Manual, Chapter 8.); or

- The FI has other sufficient evidence to determine that the provider acted in good faith but inadvertently placed the beneficiary in a noncertified bed.

140 - Physician Refund Requirements (RR) Provision for Nonassigned Claims for Physicians Services Under §1842(l) - Instructions for Carriers and Physicians

(Rev. 1, 10-01-03)

B3-7330

Following are the procedures for implementing §1842(l) of the Act. Under §9332(c) of OBRA 1986 (P.L. 99-509), which added §1842(l) to the Act, new liability protections for Medicare beneficiaries affect nonparticipating physicians.

140.1 - Services Furnished Before October 1, 1987

(Rev. 1, 10-01-03)

Before October 1, 1987, a physician who did not accept Medicare assignment was permitted to collect from a Medicare beneficiary his/her full charge for services which were subsequently denied because they were not reasonable and necessary under §1862(a)(1) of the Act, even though the beneficiary may not have known that Medicare would not pay for the services. This was in contrast to the rules applicable to assigned claims. Where a physician agrees to accept assignment (either on an individual claims basis or by entering into a Medicare participation agreement), the physician is effectively precluded by the indemnification procedures under the limitation of liability provision from receiving payment for services that are not reasonable and necessary if it is established that the physician knew or should have known that Medicare would not pay for the services and the beneficiary did not. However, under the limitation of liability provision, program payment may be made to the physician if neither the physician nor the patient knew, nor could reasonably have been expected to know, that Medicare would not pay for the items and services.

140.2 - Services Furnished Beginning October 1, 1987

(Rev. 1, 10-01-03)

Under §1842(l) of the Act, effective for services furnished on or after October 1, 1987, nonparticipating physicians who

1. Do not accept assignment,

2. Do not claim payment after the death of the beneficiary, and

3. Do not bill under the indirect payment procedure must refund to beneficiaries any amounts collected for physicians' services which are denied because they are not reasonable and necessary under §1862(a)(1).

This provision is applicable in any case in which the carrier denies payment or reduces the level of payment on the basis of §1862(a)(1). In the latter situation, there is, in effect, a denial of the more extensive service or procedure on the basis that it is not reasonable and necessary under §1862(a)(1), even though Medicare payment is made for the less extensive service or procedure (e.g., an intermediate office visit is allowed as a brief office visit). Where a reduction in the level of payment occurs, the physician must refund to the beneficiary any amounts he/she collects which exceed his/her maximum allowable actual charge (MAAC) for the less extensive procedure. Of course, in the unusual case where the physician's MAAC for the less extensive service equals or exceeds his/her actual charge for the more extensive service, no refund is required.

Section 1842(l) of the Act applies only to physicians' services subject to the Medicare Economic Index (MEI). Certain services, such as those involving injections that can be given by a paramedical person other than a physician (e.g., pneumococcal and hepatitis vaccine injections) which may be denied under §1862(a)(1) are not physicians' services for purposes of the MEI. Therefore, denials of payment on the basis of §1862(a)(1)(B) of the Act for those services are not subject to §1842(l) refund requirements. Additionally, services of physician extenders (e.g., physician's assistants, nurse practitioners, MEDEXes, etc.) are not physicians' services and are not subject to §1842(l) refund requirements. The application of §1842(1) refund requirements on the correct statutory basis, i.e., only on the basis of §1862(a)(1), and only to physicians' services subject to the MEI, is essential. Incorrect application improperly takes away physicians' rights to bill beneficiaries for denied services and incurs unnecessary expenses for review, development, fair hearings, and appeals.

140.3 - Time Limits for Making Refunds

(Rev. 1, 10-01-03)

A required refund must be made within specified time limits. Physicians who knowingly and willfully fail to make refund within these time limits may be subject to civil money penalties and/or exclusion from the Medicare program. Under §1842(1), a refund of any amounts collected must be made to the beneficiary within the following time limits:

- If the physician does not request review of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the physician receives notice of the initial determination. (See §140.6 for notice requirements.); or

- If the physician requests review within 30 days of receipt of the notice of the initial determination, the refund must be made to the beneficiary within 15 days after the date the physician receives the notice of the review determination.

140.4 - Situations Where a Refund Is Not Required

(Rev. 1, 10-01-03)

Under §1842(1), a refund is not required of the physician if either of the following conditions is met:

- The physician did not know and could not reasonably have been expected to know that Medicare would not pay for the services because they were not reasonable and necessary. To determine whether the physician knew, or could reasonably have been expected to know, use the rules for determining physician liability under §1879. (See §30.2.); or

- Before the service was furnished, the physician notified the beneficiary in writing of the likelihood that Medicare would not pay for the specific service and, after being so informed, the beneficiary signed a statement agreeing to pay the physician for the service.

To qualify for waiver of the refund requirements of §1842(1), the advance notice to the beneficiary must be in writing, must clearly identify the particular service, must state that the physician believes Medicare is likely to deny payment for the particular service, and must give the physician's reason(s) for his/her belief that Medicare is likely to deny payment for the service. The Advance Beneficiary Notice (ABN, Form CMS-R-131), given in compliance with §40.3 and §50, satisfies the statutory requirements for the physician's advance notice and the beneficiary's agreement to pay.

140.5 - Appeal Rights

(Rev. 1, 10-01-03)

Nonparticipating physicians have the same rights to appeal the carrier's determination in an unassigned claim for physicians' services if the carrier denies or reduces payment on the basis of §1862 (a)(1) as they or participating physicians have in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the physician knew or should have known that Medicare would not pay for the service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the service or, if so informed, did not sign a statement agreeing to pay. In addition to the beneficiary's right to appeal the carrier's decision to deny or reduce payment on the basis of §1862 (a)(1), the beneficiary becomes a party to any request for review filed by the physician. Since the beneficiary and the physician may have adverse interests in a decision regarding refund, it is essential to notify the beneficiary in any case in which the physician requests review of the denial or reduction in payment or asserts that a refund is not required because one of the conditions in §140.4 is met. (See Chapter 29, "Appeals for detailed appeals instructions.")

140.6 - Processing Initial Denials

(Rev. 1, 10-01-03)

In any unassigned claim for physician's services furnished on or after October 1, 1987, in which the carrier denies or reduces payment on the basis of §1862(a)(1), the carrier will send separate notices to both the beneficiary and the physician. In some cases, the beneficiary (or physician) may submit a copy of an ABN which satisfies the requirements in §140.4. The carrier should not make an automatic finding that the service is not reasonable and necessary merely because the beneficiary has submitted an ABN. The fact that there is an acceptable ABN must in no way prejudice the carrier's determination as to whether there is or is not sufficient evidence to justify a denial under §1862(a)(1). In the case where there is an acceptable ABN, the carrier will mail a standard denial MSN notice to the beneficiary. In the absence of an acceptable ABN, and depending on whether there is a full denial or a partial reduction in payment, the carrier will include, in addition to one of the "medical necessity" denial notices, one of the following notices in the MSN sent to the beneficiary.

140.6.1 - Initial Beneficiary Notices

(Rev. 1, 10-01-03)

Notice 1 - Full Denial

> If the doctor should have known that Medicare would not pay for the denied services and did not tell you in writing before providing the services, you may be entitled to a refund of any amounts you paid. However, if the doctor requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your doctor's office.

Notice 2 - Reduction in Payment

> If the doctor should have known that Medicare would not pay for the more extensive service and did not tell you this in writing before providing the service, you may be entitled to a refund of any amount you paid which is more than the doctor is allowed by law to charge under Medicare for the less extensive service. However, if the doctor requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for the more extensive service and do not hear anything about a refund within the next 30 days, contact your doctor's office.

In addition, add the following paragraph:

> You could have avoided paying $_____, the difference between the maximum amount the doctor or supplier is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

140.6.2 - Initial Physician Notices

(Rev. 1, 10-01-03)

Include in the notice to the physician the following:

- The patient's name and health insurance claim number;
- A description of the service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN; and
- Depending on whether the beneficiary submitted a copy of an acceptable ABN with his/her claim, include in the notice to the physician one of the following.

Notice 1 - Advance Beneficiary Notice Received Prior to Initial Determination

> (The service identified above has been denied because/although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service. Since you informed the beneficiary in writing prior to furnishing the service that Medicare was likely to deny payment for the (more extensive) service and the beneficiary signed a statement agreeing to pay, the beneficiary is liable for (this/the more extensive) service.

or

Notice 2 - Advance Beneficiary Notice Not Submitted

> (The service identified above has been denied because/Although payment has been made to the patient for a less extensive service,) the information furnished did not substantiate the need for the (more extensive) service).
>
> If you have collected (any amount from the patient/any amount that exceeds your maximum allowable actual charge (MAAC) for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service; or

- If you notified the beneficiary in writing before providing the service that you believed that Medicare was likely to deny the service, and the beneficiary signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that Medicare does not pay for this service, you should request review of this determination review by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within this 30 day period, you may delay refunding the amount to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review of the determination at any time within six months of receiving this notice. A review requested after the 30 day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(1) of the Social Security Act. Section 1842(1) specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program.

If you have any questions about this notice, please contact (Carrier contact, telephone number).

The carrier will ensure that the telephone number puts the physician in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply to claims the carrier automatically denies under the A/B link procedures. In those cases, the QIO is responsible for notifying the

beneficiary and physician of the refund requirements of §1842(1) and making the refund determination where appropriate.

140.7 - Processing Beneficiary Requests for Review

(Rev. 1, 10-01-03)

Where a beneficiary requests a review of the initial denial or reduction in payment, the carrier will process the review in the normal fashion except that, where the review results in a reversal to full or partial payment, the carrier will include the following special paragraph in the review notice sent to the beneficiary:

> The doctor who furnished this service has been informed of this decision and advised that he/she may collect (his/her full charge for the service/up to the maximum amount he/she is allowed by law to charge under Medicare for the less extensive service for which payment has been made).

If the reversal is for the less extensive service, the carrier will incorporate in the notice the following:

> You could have avoided paying $_____, the difference between the maximum amount the doctor is allowed to charge and the amount Medicare approved for the lesser service, if the claim had been assigned.

The carrier will send the physician who furnished the service a separate notice which clearly identifies the service for which full or partial payment is being made (i.e., includes the patient's name, health insurance claim number, a description of the service billed by procedure code, date and place of service, and amount of the charge. Where only partial payment is being made, the carrier will clearly indicate the less extensive service for which payment has been made). The carrier will include the following language:

> You were previously advised that Medicare payment could not be made for this service. However, after reviewing this claim, we have determined that payment may be made (for a less extensive service). Therefore, if you have already refunded the amounts you collected from the beneficiary for this service, you may recollect (these amounts/any amounts which do not exceed your maximum allowable actual charge (MAAC) for the less extensive service for which payment has been made).

140.8 - Processing Physician Requests for Review

(Rev. 1, 10-01-03)

Where a physician requests a review, the carrier will notify the beneficiary as discussed in §140.5. The review process consists of three stages, even though the physician may be contesting only one issue (e.g., the physician may assert that he/she did not know, and

could not have reasonably have been expected to know, that Medicare would not pay for the services).

140.8.1 - Review of the Denial or Reduction in Payment

(Rev. 1, 10-01-03)

The first part of the review is a new, independent, and critical reexamination of the facts regarding the denial or reduction in payment. If the carrier finds that the initial denial or reduction in payment was appropriate, the carrier will go on to §140.8.2.

140.8.2 - Beneficiary Given ABN and Agreed to Pay

(Rev. 1, 10-01-03)

A physician who has given the beneficiary an ABN and has obtained the beneficiary's signed statement agreeing to pay, is not required to make a refund. If the physician claims to have given an ABN to the beneficiary, the carrier will ask the physician to furnish a copy of the signed ABN. The carrier will examine the ABN to determine whether it meets the guidelines in §140.4. In the absence of acceptable evidence of advance notice, the carrier will go on to §140.8.3.

140.8.3 - Physician Knowledge

(Rev. 1, 10-01-03)

In determining whether the physician knew, or could reasonably have been expected to know, that Medicare would not pay for the services, the carrier will apply the same rules that are applicable in determining physician liability under §1879 of the Act. (See §30.2.)

140.9 - Guide Paragraphs for Inclusion in Review Determination

(Rev. 1, 10-01-03)

The carrier, upon completion of its review, will send the physician a review notice and send a copy to the beneficiary. If the initial payment determination is reversed to full or partial payment, the carrier will include in the review notice the physician notice language required in §140.7. Otherwise, the carrier will include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

Under §1842(l) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the services, the physician notified the beneficiary in writing that Medicare would not pay for

the services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Physician Did Not Know That Medicare Would Not Pay For the Services

Under §1842(1) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the physician did not know, and could not reasonably have been expected to know, that Medicare does not pay for the services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of services) for similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

Under §1842(1) of the Social Security Act, a physician who does not accept assignment and collects any amounts from a Medicare beneficiary for services for which Medicare does not pay on the basis of §1862(a)(1) of the Social Security Act, must refund these amounts to the beneficiary. A refund is not required if (1) the physician did not know, and could not reasonably have been expected to know, that Medicare would not pay for the services; or (2) the physician notified the beneficiary in writing before furnishing the services that Medicare would not pay for the services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case. You must therefore refund any amount you collected for these services within 15 days from the date you receive this notice. Although you have 6 months from the date of this notice in which to request a hearing on this decision if the amount in controversy is $100 or more, a refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. If we paid for a less extensive procedure, you need refund only the amount which exceeds your maximum allowable actual charge (MAAC) for the less extensive procedure. The beneficiary has been sent a copy of this notice. Physicians who knowingly and willfully fail to make appropriate refunds may be subject to assessments of double the violative charges, civil money penalties (up to $2000 per violation), and/or exclusion from the Medicare program for a period of up to 5 years.

140.10 - Physician Fails to Make Refund

(Rev. 1, 10-01-03)

Under §1842(1) of the Act, a physician who knowingly and willfully fails to make refund within the time limits in §140.3 may be subject to sanctions (i.e., civil money penalties and/or exclusion from the Medicare program). Generally, the failure of a physician to make a refund comes to the carrier's attention as a result of a beneficiary complaint to the carrier, Social Security Administration (SSA), or CMS. If necessary, the carrier will contact the beneficiary to clarify the information in the complaint and to determine the amount the beneficiary paid the physician for the denied services. If the carrier determines that a physician failed to make a refund, it will contact the physician in person or by telephone to discuss the facts of the case. The carrier will attempt to determine why the amounts collected have not been refunded and will explain that the law requires that the physician make refund to the beneficiary and that if he/she fails to do so, the OIG may impose civil money penalties and assessments, and sanctions. The carrier will make a dated report of contact and include the information relayed to the physician and the physician's response. The carrier will recontact the beneficiary in 15 days to determine whether the refund has been made. When the amount in question is $300 or more or where there are at least three outstanding violations by the physician, the carrier will contact the Sanctions Coordinator in the appropriate field office of the OIG by telephone to discuss whether referral to OIG is appropriate. If the case should be referred, the carrier will make the referral to the regional OIG Sanctions Coordinator in accordance with the procedures following. The carrier should not make a referral until the physician's appeal rights have been exhausted, or until the time limit for an appeal has passed.

140.11 - OIG Referral Procedures

(Rev. 1, 10-01-03)

The carrier will include in the sanction recommendation to the OIG/FO (to the extent appropriate) the following:

- Identification of the Subject - The subject's name, address and a brief description of the subject's special field of medicine.
- Origin of the Case - A brief description of how the violations were discovered.
- Statement of Facts - A statement of facts in chronological order describing each failure to comply with the refund requirements in §1842(1).
- Documentation - Copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiary and the physician regarding the physician's failure to make refund.

- Other Significant Issues - Any information that may be of value in the event of a hearing to bar a physician from receiving Medicare payment.

140.12 - Imposition of Sanctions

(Rev. 1, 10-01-03)

Section 1842(1)(3) of the Act provides that if a physician knowingly and willfully fails to make a required refund, the Secretary may impose the sanctions provided in §§1842(j)(2) of the Act. These include assessments of double the violative charges, civil money penalties (up to $2000 per violation), and/or exclusion from the Medicare program for a period of up to five years. However, sole community physicians and physicians who are the sole source of an essential specialty are not excluded from the program. The OIG makes determinations to levy a monetary penalty or program exclusion based upon a failure to make a refund.

150 - DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies under §§1834(a)(18), 1834(j)(4), and 1879(h) - Instructions for Carriers and Suppliers

(Rev. 1, 10-01-03)

AB-02-168 Part II

Following are the procedures for implementing §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act. Under §132 of SSAA-1994 (Social Security Act Amendments of 1994, P.L. 103-432) which adds §1834(a)(18) to the Act, and under §133 of SSAA-1994 which adds §1834(j)(4) and §1879(h) to the Act, new liability protections for Medicare beneficiaries affect suppliers of medical equipment and supplies. All suppliers who sell or rent medical equipment and supplies to Medicare beneficiaries are subject to the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act. Beneficiaries' liability for payment for certain items and services, that is, for otherwise covered medical equipment and supplies as defined in §150.10, which are furnished on or after January 1, 1995, and for which Medicare payment is denied for one of several reasons specified below, may be limited as follows. For both assigned and unassigned claims, for which the supplier knew or should have known of the likelihood that payment would be denied (that is, the supplier is held to be liable) and for which the beneficiary did not know, the beneficiary has no financial responsibility and the refund provisions of the Act apply in virtually all cases. The single exception to this rule of applicability is that, with respect to medical equipment and supplies for which the supplier accepted assignment and for which payment is denied because the item or service is not medically reasonable and necessary under §1862(a)(1) of the Act, the §1879 Limitation on Liability provisions which applied to such denials prior to January 1, 1995, still apply. The refund provisions do not apply to these denials.

In claims for medical equipment and supplies, payment reductions may be based on partial denials of coverage for additional expenses not attributable to medical necessity.

A medical necessity "partial denial" is the denial of coverage for the unnecessary component of a covered item or service, when that component is in excess of the beneficiary's medical needs. Any such excess component is not medically reasonable and necessary and therefore, under §1862(a)(1) of the Act, it is not covered. A partial denial may be used to base payment on the least costly, medically appropriate, alternative. The beneficiary liability protections of §1879 and of §1834(j)(4) of the Act apply to any payment reductions due to partial denials of coverage for medical equipment or supplies on the basis of medical necessity under §1862(a)(1) of the Act. (See §140 for its similar provision for the applicability of the refund requirements under §1842(l) of the Act to partial denials of coverage for physicians' services.)

When the refund provisions of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act apply and the supplier is held to be liable, a required refund must be made on a timely basis. Suppliers which knowingly and willfully fail to make refund within specified time limits may be subject to civil money penalties and/or exclusion from the Medicare program.

Refund is not required if the supplier is held not to be liable, that is, if it is held that the supplier did not know and could not reasonably have been expected to know that Medicare would not pay on the basis of §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or §1862(a)(1) of the Act, or if it is held that, before the item or service was furnished, the beneficiary was informed by the supplier that Medicare would not pay and the beneficiary agreed to pay for the item or service. In any case where the supplier is held not to be liable, the beneficiary is liable for payment.

150.1 - Definition of Medical Equipment and Supplies

(Rev. 1, 10-01-03)

The following definitions of medical equipment and supplies control the application of the provisions of this section.

150.1.1 - Unassigned Claims Denied on the Basis of the Prohibition on Unsolicited Telephone Contacts

(Rev. 1, 10-01-03)

For unassigned claims denied on the basis of the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act; and
- Medical supplies, as described in §1861(m)(5) of the Act, including catheters, catheter supplies, ostomy bags, and supplies related to ostomy care.

150.1.2 - Unassigned Claims Denied on the Basis of Not Being Reasonable and Necessary

(Rev. 1, 10-01-03)

For unassigned claims denied on the basis of not being reasonable and necessary under §1862(a)(1) of the Act; or Medicare payment being denied in advance under §1834(a)(15) of the Act; the term “medical equipment and supplies” means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act; and
- Such other items as the Secretary may determine.

150.1.3 - Unassigned Claims Denied on theBasis of Failure of the Supplier to Meet Supplier Number Requirements

(Rev. 1, 10-01-03)

For unassigned claims denied on the basis of failure of the supplier to meet supplier number requirements under §1834(j)(1) of the Act, the term “medical equipment and supplies” means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act;
- Home dialysis supplies and equipment, as described in 1861(s)(2)(F) of the Act;
- Immunosuppressive drugs, as described in 1861(s)(2)(J) of the Act;
- Therapeutic shoes for diabetics, as described in 1861(s)(12) of the Act;
- Oral drugs prescribed for use as an anticancer therapeutic agent, as described in 1861(s)(2)(Q) of the Act;
- Self-administered erythropoietin, as described in 1861(s)(2)(P) of the Act; and
- Such other items as the Secretary may determine.

150.1.4 - Assigned Claims Denied on the Basis of the Prohibition on Unsolicited Telephone Contacts

(Rev. 1, 10-01-03)

For assigned claims denied on the basis of the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act; or Medicare payment being denied in advance under §1834(a)(15) of the Act; the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act; and
- Such other items as the Secretary may determine.

150.1.5 - Assigned Claims Denied on the Basis of Failure of the Supplier to Meet Supplier Number Requirements

(Rev. 1, 10-01-03)

For assigned claims denied on the basis of failure of the supplier to meet supplier number requirements under §1834(j)(1) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act;
- Home dialysis supplies and equipment, as described in 1861(s)(2)(F) of the Act;
- Immunosuppressive drugs, as described in 1861(s)(2)(J) of the Act;
- Therapeutic shoes for diabetics, as described in 1861(s)(12) of the Act;
- Oral drugs prescribed for use as an anticancer therapeutic agent, as described in 1861(s)(2)(Q) of the Act;
- Self-administered erythropoietin, as described in 1861(s)(2)(P) of the Act; and
- Such other items as the Secretary may determine.

150.1.6 - Assigned Claims Denied on the Basis of Not Being Reasonable and Necessary

(Rev. 1, 10-01-03)

For assigned claims denied on the basis of not being reasonable and necessary under §1862(a)(1) of the Act, the term "medical equipment and supplies" means:

- Durable medical equipment, as defined in §1861(n) of the Act;
- Medical supplies, as described in §1861(m)(5) of the Act;
- Prosthetic devices, as described in §1861(s)(8) of the Act;
- Orthotics and prosthetics, as described in §1861(s)(9) of the Act;
- Surgical dressings, as described in §1861(s)(5) of the Act; or
- Such other items as the Secretary may determine.

150.2 - Items and Services Furnished on an Unassigned Basis on or After January 1, 1995

(Rev. 1, 10-01-03)

Nonparticipating suppliers which (1) Do not accept assignment, (2) Do not claim payment after the death of the beneficiary, and (3) Do not bill under the indirect payment procedure, if held to be liable, must refund to beneficiaries any amounts collected for medical equipment and supplies for which Medicare payment is denied for one of the following reasons:

- Under §1834(a)(18)(A) of the Act, the supplier violated the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act; or
- Under §1834(j)(4) of the Act, the supplier did not meet supplier number requirements under §1834(j)(1); or the item is denied in advance under §1834(a)(15) of the Act; or payment is denied as not reasonable and necessary under §1862(a)(1) of the Act.

In any such payment denial under §1834(a)(17)(B), §1834(j)(1), §1834(a)(15), or §1862(a)(1) of the Act, the beneficiary has no financial responsibility and the refund provisions of §§1834(a)(18), 1834(j)(4) or 1879(h) of the Act, as appropriate, apply, if it is held that the supplier knew or should have known of the likelihood that payment would be denied and that the beneficiary did not know.

For medical equipment and supplies furnished prior to January 1, 1995, Federal law does not limit beneficiaries' liability with respect to unassigned claims for which payment was denied.

150.3 - Items and Services Furnished On an Assigned Basis On or After January 1, 1995

(Rev. 1, 10-01-03)

Under §1879(h) of the Act, suppliers, whether nonparticipating or participating, which accept assignment, if held to be liable, must refund to beneficiaries any amounts collected for medical equipment and supplies for which Medicare payment is denied for one of the following reasons:

- Under §1879(h)(1) of the Act, payment is denied because the supplier did not meet the supplier number requirements under §1834(j)(1) of the Act;
- Under §1879(h)(2) of the Act, payment is denied in advance under §1834(a)(15) of the Act; and
- Under §1879(h)(3) of the Act, payment is denied based on §1834(a)(17)(B) of the Act, the prohibition on unsolicited telephone contacts.

In any such payment denial under §1834(j)(1), §1834(a)(15), or §1834(a)(17)(B) of the Act, the beneficiary has no financial responsibility and the refund provisions apply, if it is held that the supplier knew or should have known of the likelihood that payment would be denied and that the beneficiary did not know. However, in a denial of an assigned claim under §1862(a)(1) of the Act (i.e., payment is denied because the item or service is not reasonable and necessary), the §1879 Limitation on Liability provisions which applied to such denials prior to January 1, 1995, still apply.

150.4 - Time Limits for Making Refunds

(Rev. 1, 10-01-03)

A refund of any amounts collected must be made to the beneficiary on a timely basis. Refund is considered to be on a timely basis only if made within the following time limits:

- If the supplier does not request review of the initial denial or reduction in payment within that time, the refund must be made to the beneficiary within 30 days after the date the supplier receives the remittance advice (RA).
- If the supplier requests review within 30 days of receipt of the notice of the initial determination, the refund must be made to the beneficiary within 15 days after the date the supplier receives the notice of the contractor’s determination of the supplier’s appeal.

150.5 - Supplier Knowledge Standards for Waiver of Refund Requirement

(Rev. 1, 10-01-03)

A refund is not required of the supplier if the supplier did not know and could not reasonably have been expected to know that Medicare would not pay for the medical equipment or supplies. Following are the knowledge standards applicable to the different types of denials.

150.5.1 - Knowledge Standards for §1862(a)(1) Denials

(Rev. 1, 10-01-03)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay on the basis of medical necessity, apply the same rules that are applicable in determining supplier liability under §1879 of the Act.

150.5.2 - Knowledge Standards for §1834(a)(15) Denials

(Rev. 1, 10-01-03)

150.5.2.1 - Denial of Payment in Advance

(Rev. 1, 10-01-03)

Denial of payment in advance under §1834(a)(15) of the Act refers both to cases in which the supplier requested an advance determination and the DMERC determined that the item would not be covered, and to cases in which the supplier failed to request an advance determination when such a request is mandatory.

150.5.2.2 - When a Request for an Advance Determination of Coverage Is Mandatory

(Rev. 1, 10-01-03)

A request for an advance determination of coverage of medical equipment and supplies is mandatory under §1834(a)(15)(C)(i) & (ii) of the Act, respectively, when:

- The item is on the list developed by the Secretary under §1834(a)(15)(A) of items which are frequently subject to unnecessary utilization in your carrier service area; or

- The supplier is on the list developed by the Secretary under §1834(a)(15)(B) of the Act of suppliers for which a substantial number of claims have been denied as not medically reasonable and necessary under §1862(a)(1) of the Act or the

Secretary has identified a pattern of overutilization resulting from the business practice of the supplier.

150.5.2.3 – When a Request for an Advance Determination of Coverage Is Optional

(Rev. 1, 10-01-03)

A request for an advance determination of coverage of medical equipment and supplies is optional under §1834(a)(15)(C)(iii) of the Act when the item is a customized item (other than inexpensive items specified by the Secretary) and the patient to whom the item is to be furnished or the supplier requests an advance determination.

150.5.2.4 - Presumption for Constructive Notice

(Rev. 1, 10-01-03)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would deny payment in advance under §1834(a)(15) of the Act, presume that the supplier knew that Medicare would not pay in all cases in which the supplier failed to request a mandatory advance determination, on the basis of constructive notice of the lists of items and of suppliers to the supplier through the DMERC's regular newsletter/bulletin publication. The supplier would have to submit convincing evidence to the contrary to rebut this presumption.

150.5.2.5 - Presumption When Advance Determination was Requested

(Rev. 1, 10-01-03)

In determining whether the supplier knew, or could reasonably have been expected to know, before furnishing the item, that Medicare would deny payment in advance under §1834(a)(15) of the Act, presume that the supplier knew that Medicare would not pay in all those cases in which a request for advance determination was made, and the DMERC denied payment in advance on the basis that the item is not reasonable and necessary under §1862(a)(1) of the Act or that the item is not covered. This is a nonrebuttable presumption.

150.5.2.6 - Presumption for Listed Overutilized Items

(Rev. 1, 10-01-03)

Any denial of a claim for a particular item furnished by a particular supplier because the item is on the §1834(a)(15)(A) list of potentially overutilized items is actual notice to that supplier that an advance determination must be requested for all future claims for that item, and for any other items which are identified in the same notification of denial as being on the list of potentially overutilized items. Presume, on that basis, that that supplier has knowledge that an advance determination must be requested for all future

claims for any and all items which are identified in the notification of denial as being on the list of potentially overutilized items. This is a nonrebuttable presumption.

150.5.2.7 - Presumption for Listed Suppliers

(Rev. 1, 10-01-03)

Any denial of a claim for an item furnished by a particular supplier because the supplier is on the §1834(a)(15)(B) list of suppliers, is actual notice to that supplier that an advance determination must be requested for all future claims for any item of medical equipment and supplies which that supplier furnishes. Presume, on that basis, that that supplier has knowledge that an advance determination must be requested for all future claims for any and all items of medical equipment and supplies which it furnishes. This is a nonrebuttable presumption.

150.5.2.8 - Presumption for Medical Necessity

(Rev. 1, 10-01-03)

In the case of an optional request for an advance determination of coverage of a customized item of medical equipment and supplies under §1834(a)(15)(C)(iii) of the Act by the patient to whom the item is to be furnished or the supplier, in determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would deny payment in advance under §1834(a)(15) of the Act, presume that the supplier knew that Medicare would not pay in all cases in which you denied payment in advance on the basis that the item is not reasonable and necessary under §1862(a)(1) of the Act or that the item is not covered. This is a nonrebuttable presumption.

150.5.2.9 - Presumption About Beneficiary Knowledge

(Rev. 1, 10-01-03)

Presume that a Medicare beneficiary does not know, and cannot reasonably be expected to know, that Medicare will deny, or has denied, payment in advance under §1834(a)(15) of the Act unless and until the beneficiary has received a proper advance beneficiary notice (ABN) to that effect from the supplier before the item is furnished to them. (See Section I.2.D.3 regarding ABNs for such cases.)

150.5.3 - Knowledge Standards for §1834(a)(17)(B) Denials

(Rev. 1, 10-01-03)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay because of the prohibition on unsolicited telephone contacts under §1834(a)(17)(B) of the Act, presume that the supplier knew that Medicare would not pay on the basis of constructive notice to the supplier through publication of the prohibition on such contacts through the DMERC's professional relations function, as

well as publicity through trade organizations' own publications, professional training, conventions, etc. The supplier would have to submit convincing evidence to the contrary, showing ignorance of the prohibition on the supplier's part, to rebut this presumption. A single denial of a claim for any item furnished by a particular supplier on the basis of the prohibition on unsolicited telephone contacts shall be held to be actual notice of the prohibition to that supplier; and that supplier shall be considered, on that basis, to have had knowledge that payment would be denied for all such future claims, even those for different items of medical equipment and supplies. That is, after a single denial under §1834(a)(17)(B) of a claim by a particular supplier, the presumption of that supplier's knowledge becomes nonrebuttable.

150.5.4 - Knowledge Standards for §1834(j)(1) Denials

(Rev. 1, 10-01-03)

In determining whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay due to failure to meet supplier number requirements under §1834(j)(1) of the Act, presume that the supplier knew that Medicare would not pay. Every supplier is expected to know whether or not it has a supplier number, and to know that Medicare will not make payment for medical equipment and supplies furnished a Medicare beneficiary by a supplier which does not have a supplier number. All suppliers should have this knowledge on the basis of the DMERC's professional relations function, as well as publicity through trade organizations' own publications, professional training, conventions, etc. The supplier would have to submit extraordinary evidence to the contrary to rebut this presumption. If a supplier submits evidence the DMERC finds credible, consult your regional office before rebutting the presumption of supplier knowledge. After a single denial under §1834(j)(1) of a claim by a particular supplier, the presumption of that supplier's knowledge becomes nonrebuttable.

150.5.5 - Additional Knowledge Standards for All Medical Equipment and Supplies Denials

(Rev. 1, 10-01-03)

The DMERC may make a determination, as provided for in Section I.2.D.2.b. imputing a lack of knowledge to a supplier, on the basis that the supplier did not know and could not reasonably have been expected to know that Medicare would not pay, if the supplier did not know and could not reasonably have been expected to know that a purchase (or rental) of medical equipment or supplies involved a Medicare beneficiary.

150.6 - Advance Beneficiary Notice Standards for Waiver of Refund Requirement

(Rev. 1, 10-01-03)

A refund is not required of the supplier if, before the medical equipment or supplies were furnished, the beneficiary was informed by the supplier that Medicare would not pay for

the specific item or service and, after receiving such an advance beneficiary notice, the beneficiary agreed to pay for the item or service. This requirement for advance notice may be satisfied by a properly executed Advance Beneficiary Notice (ABN) Form CMS-R-131 used in accordance with the instructions at §50.

150.7 - Appeal Rights

(Rev. 1, 10-01-03)

Nonparticipating suppliers have the same rights to appeal the DMERC's determination in an unassigned claim for medical equipment and supplies if the DMERC denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act as they or participating suppliers have in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the item or service. In addition to the beneficiary's right to appeal the DMERC's decision to deny payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, the beneficiary becomes a party to any request for review filed by the supplier. Since the beneficiary and the supplier may have adverse interests in a decision regarding refund, it is essential to notify the beneficiary in any case in which the supplier requests review of the denial or asserts that a refund is not required because one of the conditions in §150.5 is met. (See Chapter 29, "Appeals of this Claims Decision," for detailed appeals instructions.)

150.8 - Processing Initial Denials

(Rev. 1, 10-01-03)

In any unassigned claim for medical equipment and supplies furnished on or after January 1, 1995, in which the DMERC denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, send separate notices to both the beneficiary (a Medicare Summary Notice (MSN)) and the supplier (a remittance advice (RA)).

NOTE: This instruction to send a remittance advice to the supplier in the case of denial of an unassigned claim is a specific requirement of §1834(a)(18)(C) of the Act, incorporated by reference into §1834(j)(4) and §1879(h) of the Act, applicable to denials of claims for medical equipment and supplies furnished on or after January 1, 1995.

If the beneficiary signed an ABN which satisfies the requirements in subsection II.6 and the supplier included a GA modifier on the Form CMS-1500 to that effect, do not make an automatic finding that the claim should be denied on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, merely because the supplier submitted a GA modifier. The fact that an ABN was given to the beneficiary will in no way prejudice the DMERC's determination as to whether there is or is not sufficient evidence to justify a denial. In the case where there is an ABN, mail a standard denial

MSN notice to the beneficiary. If the beneficiary did not sign an ABN and the supplier included a GZ modifier on the Form CMS-1500 to that effect, include, in addition to one of the denial notices in Chapter 21, "Medicare Summary Notices," the following initial beneficiary notice in the MSN sent to the beneficiary.

A. Initial Beneficiary Notice

(**MSN 8.54**)

If the supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your supplier.

(**MSN 8.54**) - In Spanish

Si el suplidor hubiera sabido que Medicare no pagaría por los artículos o servicios negados y no le informó por escrito, antes de proveerle los artículos o servicios, que Medicare probablemente negaría el pago, usted podría tener derecho a recibir un reembolso por cualquier cantidad que pagó. Sin embargo, si el suplidor pide una revisión de esta reclamación en 30 días, un reembolso no es requerido hasta que completemos nuestra revisión. Si usted pagó por este servicio y no escucha nada sobre un reembolso en 30 días, comuníquese con su suplidor.

B. Initial Supplier Notice

Include in the notice to the supplier the following;

- The patient's name and health insurance claim number;
- A description of the item or service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN, (see Chapter 21, "Medicare Summary Notices"); and
- If the supplier submitted a GA modifier (signed ABN obtained), include in the notice to the supplier the following Notice 1. However, if the supplier submitted a "-GZ" modifier (a signed ABN was not obtained), include in the notice to the supplier the following Notice 2.

Notice 1. – Signed Advance Beneficiary Notice Obtained

(**Remark Code N124**)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

or

Notice 2. – Signed Advance Beneficiary Notice Not Obtained

(**Remark Code N125**)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: if you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or if you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30-days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision.

You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not

> tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.
>
> The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (carrier contact, telephone number).

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply where the carrier automatically denies Part B services related to hospital inpatient services denied by the Quality Improvement Organization (QIO). In those cases, the QIO is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act and making the refund determination where appropriate.

150.9 - Processing Beneficiary Requests for Review

(Rev. 1, 10-01-03)

Where a beneficiary requests a review of the initial denial, process the review in the normal fashion except that, where the review results in a reversal, include the following special paragraph in the review notice sent to the beneficiary:

> The supplier which furnished this item or service has been informed of this decision and advised that it may collect its full charge for the item or service.

Send the supplier which furnished the item or service a separate notice which clearly identifies the item or service for which payment is being made (i.e., include the patient's name, health insurance claim number, a description of the item or service billed by procedure code, date and place of service, and amount of the charge. Include the following language:

> You were previously advised that Medicare payment could not be made for this item or service. However, after reviewing this claim, we have determined that payment may be made. Therefore, if you have already refunded the amounts you collected from the beneficiary for this item or service, you may recollect these amounts.

150.10 - Processing Supplier Requests for Review

(Rev. 1, 10-01-03)

Where a supplier requests a review, notify the beneficiary as discussed in §150.7. The review process consists of three stages, even though the supplier may be contesting only one issue (e.g., the supplier may assert that it did not know, and could not have reasonably have been expected to know, that Medicare would not pay for the items or services).

150.10.1 - Review of the Denial of Payment

(Rev. 1, 10-01-03)

The first stage of the review is a new, independent, and critical reexamination of the facts regarding the denial of payment. If the DMERC finds that the initial denial of payment was appropriate, go on to §150.10.2**.**

150.10.2 - Beneficiary Given Advance Beneficiary Notice and Agreed to Pay

(Rev. 1, 10-01-03)

A supplier which has given the beneficiary an ABN and has obtained the beneficiary's signed statement agreeing to pay, is not required to make a refund. If the supplier claims to have given an ABN to the beneficiary, the DMERC will ask the supplier to furnish a copy of the ABN. Examine the ABN to determine whether it meets the standards in §40.3 and §50. In the absence of acceptable evidence of advance beneficiary notice, go on to §150.10.3.

150.10.3 - Supplier Knowledge

(Rev. 1, 10-01-03)

A supplier which did not know and could not reasonably have been expected to know that Medicare would not pay for the medical equipment or supplies is not required to make a refund. If the supplier claims not to have had any such knowledge, the DMERC will determine whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay by applying the knowledge standards provided in §150.5.

150.11 - Guide Paragraphs for Inclusion in Review Determination

(Rev. 1, 10-01-03)

Upon completion of the review, the DMERC will send the supplier a review notice. Send a copy to the beneficiary. If the initial payment determination is reversed to payment,

include in the review notice the supplier notice language required in §150.9. Otherwise, include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

> Under §1834(a)(18) and under §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the items or services, the supplier notified the beneficiary in writing that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above items or services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Supplier Did Not Know That Medicare Would Not Pay For the Services

> Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the supplier did not know, and could not reasonably have been expected to know, that Medicare does not pay for the items or services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above items or services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of item or service) similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

> Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these

> amounts to the beneficiary. A refund is not required if (1) The supplier did not know, and could not reasonably have been expected to know, that Medicare would not pay for the items or services; or (2) The supplier notified the beneficiary in writing before furnishing the items or services that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case. You must therefore refund any amount you collected for these items or services within 15 days from the date you receive this notice. Although you have 6 months from the date of this notice in which to request a hearing on this decision if the amount in controversy is $100 or more, a refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. The beneficiary has been sent a copy of this notice.

Suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties (up to $10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program.

NOTE: For claims presented to the carrier prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

150.12 - Supplier Fails to Make Refund

(Rev. 1, 10-01-03)

Under §1834(a)(18)(B) of the Act, a supplier which knowingly and willfully fails to make refund within the time limits in §150.4 may be subject to sanctions under §1128A the Act (i.e., civil money penalties (up to $10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program).

NOTE: For claims presented to the carrier prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

Generally, the failure of a supplier to make a refund to a beneficiary comes to the DMERC's attention as a result of a beneficiary complaint or a referral from the Social Security Administration (SSA) or the CMS. Document beneficiary complaints and, if necessary, contact the beneficiary to clarify the information in the complaint and determine the amount the beneficiary paid the supplier for the denied items or services. If the DMERC determines that a supplier failed to make a refund, the DMERC will contact the supplier in person or by telephone (if that is not feasible, contact the supplier by letter) to discuss the facts of the case. The DMERC will attempt to determine why the amounts collected have not been refunded. Explain that the law requires that the supplier make a refund to the beneficiary and that if it fails to do so, the Secretary may impose civil money penalties, assessments, and exclusion from the Medicare program. Make a

dated report of contact. Include the information relayed to the supplier and the supplier's response. Recontact the beneficiary in 15 days to determine whether the refund has been made. Do not make any referral to the CMS regional office until the supplier has been formally notified to refund the money and the supplier's appeal rights have been exhausted, or until the time limit for an appeal has passed.

150.13 - CMS Regional Office (RO) Referral Procedures

(Rev. 1, 10-01-03)

Prior to submitting any materials to the RO, the DMERC will contact the RO to determine how to proceed in referring a potential sanction case. When referring a sanction case to the region, include in the sanction recommendation (to the extent appropriate) the following:

Background of the Subject

The subject's business name, address, Medicare Identification Number, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment and supplies business.

Origin of the Case

A brief description of how the violations were discovered.

Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiaries and the supplier regarding the supplier's failure to make refunds. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and Health Insurance Claim Number;
- Claim Control Number;
- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;

- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Other Significant Issues

Include any information that may be of value to the RO while they review and possibly develop a case to impose sanctions.

150.14 - Imposition of Sanctions

(Rev. 1, 10-01-03)

Section 1834(a)(18)(B) of the Act provides that if a supplier knowingly and willfully fails to make required refunds, the Secretary may impose the sanctions provided in §1842(j)(2) of the Act in the same manner as such sanctions are authorized under §1128A of the Act. These include civil money penalties, assessments, and exclusion from the Medicare program for a period of up to five years. The CMS RO will make the determination on whether to proceed in developing a monetary penalty or program exclusion case based upon a failure to make refunds.

150.15 - Supplier's Right to Recover Resaleable Items for Which Refund Has Been Made

(Rev. 1, 10-01-03)

If the DMERC denies Part B payment for an item of medical equipment or supplies on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, and the beneficiary is relieved of liability for payment for that item under §1834(a)(18) of the Act, the effect of the denial, subject to State law, cancels the contract for the sale or rental of the item and, if the item is resaleable or re-rentable, permits the supplier to repossess that item for resale or re-rental. In the case of consumable items or any other items which are not fit for resale or re-rental and which cannot be made fit for resale or re-rental, suppliers are strongly discouraged from recovering these items since such actions reasonably could be viewed as purely punitive in nature. If a supplier makes proper refund under §1834(a)(18) of the Act, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resalable or re-rentable.

Alternatively, when the contract of sale or rental is cancelled on the basis described above, whether or not the supplier physically repossesses the resaleable or re-rentable item, the supplier may enter into a new sale or rental transaction with the beneficiary with respect to that item as long as the beneficiary has been informed of their liability. If the circumstances which preclude payment for the item have been removed, e.g., the supplier has now obtained a supplier number, the supplier may submit to the DMERC a new Part B claim based on the resale or re-rental of the item to the beneficiary. If Part B

payment is still precluded, the supplier can establish the beneficiary's liability for payment for the denied resold or re-rented item by giving the beneficiary an ABN notifying the beneficiary of the likelihood that Medicare will not pay for the item and obtaining the beneficiary's signed agreement to pay for the item. The resale or re-rental of the item to the beneficiary does not change the fact that the beneficiary is relieved of liability in connection with the original transaction.

Under the capped-rental method, if the DMERC determines that the supplier is obligated to make a refund, the supplier must repay Medicare those rental payments that the supplier has received for the item. However, the Medicare beneficiary must return the item to the supplier.