Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-01-77 **Date: JUNE 27, 2001**

This Program Memorandum re-issues Program Memorandum A-00-43, Change Request 1192 dated July 27, 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1192

SUBJECT: Advance Beneficiary Notices (ABNs) for Services for Which Institutional Part B Claims Will be Processed by Fiscal Intermediaries

Attached to this Program Memorandum (PM) are instructions in two parts and a single exhibit. Part I of this PM instructs providers and suppliers: (1) regarding the advance beneficiary notices (ABNs) that institutional providers must provide to beneficiaries in advance of furnishing what they believe to be noncovered Part B services and that any supplier or provider must provide to beneficiaries in advance of furnishing what they believe to be noncovered Part B services for which the claims will be submitted to fiscal intermediaries, and (2) the process required for submitting demand bills. Additionally, Part I discusses approved notice language, set forth at Exhibit 1, that may be used to provide notice to beneficiaries. This PM requires you to publish verbatim, in a provider bulletin to providers and any affected suppliers, no later than **August 31, 2000**, the instructions set forth in Part I and Exhibit 1. Part II of this PM provides specific instructions to you regarding your functions as a fiscal intermediary with respect to ABNs and demand bills claims processing, and requires you to process demand bills taking into account the requirements enunciated in Part I.

The instructions in this PM provide guidance with respect to the requirements for notices and demand bill processing. The instructions in this PM supersede any conflicting current instructions in Medicare Intermediary Manual, Part 3 (MIM) §§3722.4, 3730 and in Hospital Manual §§414ff. The approved notice language discussed in Part I, and set forth at Exhibit 1, is the OMB-approved model Part B ABN. A proposed revised uniform notice is to be submitted in the near future to the Office of Management and Budget and published in the ***Federal Register*** in accordance with the requirements of the Paperwork Reduction Act (PRA) and the regulations promulgated thereunder. Interested parties will have an opportunity to comment upon the proposed uniform notice and to have any such comments taken into consideration, before a final uniform notice is approved, published and becomes mandatory.

The effective date of this PM is July 1, 2000.

The implementation date of this PM is July 1, 2000.

This PM may be discarded *July 1, 2002.*

These instructions should be implemented within your current operating budget.

Questions related to this request should be addressed to Robin Getzendanner at RGetzendanner@hcfa.gov, telephone number (410) 786-9621.

Attachment

Part I - Instructions for Providers and Suppliers for the Provision of Advance Beneficiary Notices and for Mandatory Claims Submission (Demand Bills)

These instructions on the use of Advance Beneficiary Notices (ABNs) for the purposes of the Limitation on Liability (LOL) provision under §1879 of the Social Security Act (the Act), apply equally to all* claims for Part B services furnished by institutional providers and/or processed by fiscal intermediaries (i.e., inclusive of claims submitted by a physician or other supplier for processing by a fiscal intermediary). Utilize ABN procedures for these Part B services; do not give inpatient notices of noncoverage (e.g., NONCs/HINNs) to beneficiaries for Part B services.

* With respect to services furnished in an emergency room, an OIG/HCFA Special Advisory Bulletin published on 11/10/99 advises that "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/her medical condition, may not permit an individual to make a rational, informed consumer decision. The following instructions do not apply to services furnished in an emergency room before a patient is stabilized. Do not give an ABN to a beneficiary in an emergency room who has not been stabilized. ABNs given to any individual who is in a medical emergency or otherwise under great duress cannot be considered to be proper notice.

A. Advance Beneficiary Notices (ABNs) and Liability for Claims for Part B Services.--

1. Basic Requirements for ABNs.--An ABN is a written notice you give to a Medicare beneficiary before Part B services are furnished when you believe that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under §1862(a)(1) of the Act). If you expect payment for the services to be denied by Medicare, advise the beneficiary before services are furnished that, in your 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. You must issue notices each time, and as soon as, you make the assessment that you believe Medicare payment will not be made for medical necessity reasons. You are not required to give ABNs to beneficiaries for routine screening tests, which are statutorily excluded from Medicare payment under the routine physical exclusion (i.e., under §1862(a)(7) of the Act). If you fail to provide a proper ABN in situations where one is required, you may be held liable under the provisions on LOL, where such provisions apply.

2. Evidence that the Beneficiary is Liable.--In deciding whether the beneficiary or his/her authorized representative knew, or could reasonably have been expected to know, that items and services s/he received were not reasonable and necessary, the beneficiary's allegation that s/he did not know, in the absence of evidence to the contrary, will be acceptable evidence for LOL. However, there may be evidence that will rebut such an allegation. 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, you notified the beneficiary in writing, using approved ABN language, of the likelihood that Medicare would not pay for the specific service and, after being so informed, the beneficiary agreed to pay you for the service, personally or through other insurance, as evidenced by a signed agreement to pay.

3. Approved Notice Language.--The latest version of the OMB-approved ABN for Part B services (OMB Approval No. 0938-0566, Form No. HCFA-R-131) satisfies these requirements for your ABN and the beneficiary's agreement to pay. The approved notice language attached to Part 1 of these instructions as Exhibit 1, is the current OMB-approved ABN for Part B services. The ABN in Exhibit 1 may be appropriately modified by replacing the words "physician/supplier" with the word "provider", and by replacing the words "physician/supplier that he or she" with the words "provider that it", and still be acceptable for ABN purposes.

B. Requirements for the Use of ABNs.--

1. Reason for Predicting Denial.-- Statements of reasons for predicting Medicare denial of payment similar to those in Medicare Carriers Manual, Part 3 (MCM) §§7012, Item 15.0ff., "Medical Necessity" 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 you believe the services will be denied as not reasonable and necessary. To be acceptable, your ABN must give the beneficiary an idea of why you are 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 you for it personally.

2. Prohibition of Generic and Blanket Notices.--

a. Generic Notice Prohibition: The requirement for advance beneficiary notice is not satisfied by a signed statement by the beneficiary to the effect that, should Medicare deny payment under §1862(a)(1), the beneficiary agrees to pay for the service. Routine notices to beneficiaries, which do no more than state that Medicare denial of payment is possible, or that you never know whether Medicare will deny payment, are considered not to be acceptable evidence of advance beneficiary notice.

b. Blanket Notice Prohibition: You should not give an ABN to a beneficiary unless you have some genuine doubt regarding the likelihood of Medicare payment as evidenced by your stated reasons; your giving ABN for all claims or services is not an acceptable practice.

3. Format.--You must ensure that the design and readability of your ABN facilitate beneficiary understanding. No body text or heading should use a font size less than 12-point font. Italics or any typeface that is difficult to read should not be used. Put your logo (if any), name, address and telephone number at the top of the ABN form. It must be clear and obvious to the beneficiary that you, rather than the Medicare program, issued the ABN.

4. Delivery of ABN.--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 a detailed explanation written in lay language as to why you believe the services will be denied payment. An incomprehensible notice, or a notice, which the individual beneficiary or his/her authorized representative is incapable of understanding due to the particular circumstances (even if others may understand), is not sufficient notice.

a. You should hand-deliver the ABN to the beneficiary or authorized representative. Delivery is your responsibility and non-receipt of notice probably will protect the beneficiary from liability and may result in your being held liable under the LOL provisions. For this reason, it is in your own best interest (as well as being in the beneficiary's best interest) for you to hand-deliver ABNs to beneficiaries.

b. A telephone notice to a beneficiary, or authorized representative, will not constitute sufficient evidence of proper notice for purposes of limiting any potential liability because the content of the telephone contact usually cannot be verified. A telephone notice must be followed up immediately with a mailed notice or a personal visit at which written notice is delivered in person.

c. 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). 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, other steps must be taken 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 is not capable of receiving the notice, then the beneficiary has not received proper notice and cannot be held liable where the LOL provisions apply and you may be held liable.

d. You must timely answer inquiries from a beneficiary, or authorized representative, who requests further information and/or assistance in understanding and responding to the notice. You must answer inquiries from a beneficiary, or authorized representative, regarding the basis for your assessment that services may not be covered. You 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 services for which you expect that Medicare may not pay.

e. A patient must be notified well enough in advance of receiving a medical service so that the patient can make a rational, informed consumer decision. For example, do not give an ABN to a patient as s/he is connected to a test device or after s/he is already on the table for a MRI. Such last moment delivery of notice can be considered to be coercive, regardless of the provider's intentions. In such a case, the delivery of the ABN may not be considered timely and the beneficiary may not be held liable.

C. Signature of Beneficiary.--

1. The generally applicable rules of the Medicare program with respect to who may sign for a beneficiary apply to signing notices, including ABNs. Whenever you furnish services to a beneficiary who is incapable of signing a notice, his or her representative who signs for other matters in accordance with Medicare rules also may sign a notice.

2. You must obtain the signed ABN from the beneficiary, either in person, or where this is not possible, via return mail from the beneficiary or person acting on the beneficiary's behalf, as soon as possible after it is signed. The ABN should be annotated with the date of your receipt from the beneficiary. Return a copy of the ABN, including the date of your receipt, within 30 calendar days to the beneficiary for his or her records. You must also retain a copy of the ABN. These copies will be relevant in the case of any future appeal.

3. If the beneficiary or the person acting on the beneficiary's behalf refuses to sign the ABN, annotate your copy of the ABN, indicating the circumstances and persons involved. If this occurs, you may decide not to furnish services to the beneficiary because the beneficiary has not agreed to be personally responsible for payment for services that are not covered by Medicare.

D. Collection from Beneficiary.--When you properly execute an ABN and give it timely to a beneficiary who agrees to pay in the event of denial by Medicare and, in fact, Medicare denies payment on the related claim, you may bill and collect from the beneficiary for that service. Medicare does not limit the amount, which you may collect from the beneficiary in such a situation.

E. Demand Bills.--You always must submit a claim for an initial determination when you gave an ABN on the basis of the likelihood of denial of payment for a service as "not reasonable and necessary" under Medicare program standards. On such a claim, enter "occurrence" code 32 on the UB-92 in one of the fields numbered 32 through 35. This code indicates the date you gave the ABN to the beneficiary. It is the "occurrence" code, and not the "condition" code that indicates to the fiscal intermediary that an ABN has been issued. In addition to placing the "occurrence" code on the claim, you must also enter "condition" code 20 in one of the fields numbered 24 through 30 to indicate that you realize the services on the claim probably or certainly are at a noncovered level of

care or otherwise excluded from coverage, but the beneficiary wants an initial determination. You may submit claims, for initial determination, for statutorily excluded services (e.g., routine physicals and screening tests, cosmetic surgery, personal comfort items), if the beneficiary requests it. On claims for statutorily excluded services, enter a "condition" code 21 on the UB-92 in one of the fields numbered 24 through 30 to indicate that you realize that the furnished services are excluded, but that you are requesting a denial notice from Medicare in order to bill Medicaid or other insurers. This is also known as a "no-pay" claim.

Exhibit 1.-- Advance Beneficiary Notice (OMB Approval No. 0938-0566. Expiration Date: 8/31/02. Form No. HCFA-R-131).

Exhibit 1

Advance Beneficiary Notice (ABN)

Physician/Supplier notice:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for (specify particular services(s)) for the following reasons: (give the reason(s) for predicting that Medicare will deny payment) .

Beneficiary agreement:

I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed,

(Beneficiary Signature)

OMB Approval No. 0938-0566. Expiration Date: 8/31/02. Form No. HCFA-R-131

Part II - Fiscal Intermediary Instructions with Respect to the Provision of Advance Beneficiary Notices and Mandatory Claims Submission (Demand Bills)

These instructions on the use of Advance Beneficiary Notices (ABNs) for the purposes of the Limitation on Liability (LOL) provision under §1879 of the Social Security Act, with respect to claims for Part B services furnished by institutional providers and/or processed by fiscal intermediaries, are meant to correct the current situation in which ABN procedures which should be utilized for these services are not being applied properly and, in many cases, inpatient notices of noncoverage (e.g., NONCs/HINNs) are being given, inappropriately, to beneficiaries. These instructions on the use of ABNs apply equally to all* claims for Part B services furnished by institutional providers and/or processed by fiscal intermediaries (i.e., inclusive of claims submitted by a physician or other supplier for processing by a fiscal intermediary). ABN procedures must be utilized for these Part B services; inpatient notices of noncoverage must not be given to beneficiaries for Part B services.

* With respect to services furnished in an emergency room, an OIG/HCFA Special Advisory Bulletin published on 11/10/99 advises that "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/her medical condition, may not permit an individual to make a rational, informed consumer decision. The following instructions do not apply to services furnished in an emergency room before a patient is stabilized. A provider may not shift liability to a beneficiary in an emergency room by giving an ABN to the beneficiary when the beneficiary has not been stabilized. ABNs given to any individual who is in a medical emergency or otherwise under great duress cannot be considered to be proper notice.

A. Use of Advance Beneficiary Notices (ABNs) in Determining Liability for Claims for Part B Services.--

1. Basic Requirements for ABNs.--A Part B ABN is a written notice a provider or supplier gives to a Medicare beneficiary before Part B services are furnished when the provider or supplier believes that Medicare will not pay for some or all of the services. If the provider or supplier expects payment for the services to be denied by Medicare, the provider or supplier must advise the beneficiary before 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 or supplier must issue notices each time, and as soon as, it makes the assessment that Medicare payment will not be made. If a provider or supplier fails to provide a proper ABN in situations where one is required, you may find the provider or supplier to be liable under the provisions on LOL, where such provisions apply.

2. Determining Whether or Not the Beneficiary is Liable.--In deciding whether the beneficiary or his/her authorized representative knew, or could reasonably have been expected to know, that items and services s/he received were not reasonable and necessary, the beneficiary's allegation that s/he did not know, in the absence of evidence to the contrary, will be acceptable evidence for LOL. However, there may be evidence that will rebut such an allegation. For example, when a beneficiary is receiving a course of treatment and had received a previous denial notice stating that the services were excluded from coverage, the previous denial notice, if it pertains to similar or reasonably comparable items or services, would constitute evidence that the beneficiary did have knowledge of exclusion. 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 notified the beneficiary in writing, using approved advance beneficiary notice language, of the likelihood that Medicare would not pay for the specific service

and, after being so informed, the beneficiary agreed to pay the provider for the service, personally or through other insurance, as evidenced by a signed agreement to pay.

3. Approved Notice Language.--The latest version of the OMB-approved ABN for Part B services (OMB Approval No. 0938-0566, Form No. HCFA-R-131) satisfies these requirements for the provider's advance beneficiary notice (ABN) and the beneficiary's agreement to pay. The approved notice language attached to Part I of these instructions as Exhibit 1 is the current OMB-approved ABN for Part B services. The ABN in Exhibit 1 may be appropriately modified by replacing the words "physician/supplier" with the word "provider", and by replacing the words "physician/supplier that he or she" with the words "provider that it", and still be acceptable for ABN purposes.

B. Requirements for the Use of ABNs.--

1. Reason for Predicting Denial.--Statements of reasons for predicting Medicare denial of payment similar to those in Medicare Carriers Manual, Part 3 (MCM) §§7012, Item 15.0ff., "Medical Necessity" 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 provider believes the services will be denied as not reasonable and necessary. To be acceptable, the ABN must give the beneficiary an idea of why the provider 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, i.e., out-of-pocket or through other insurance. Do not accept generic ABNs, blanket ABNs, or ABNs with defective formats, as effective notice to beneficiaries.

2. Prohibition of Generic and Blanket Notices.--

a. Generic Notice Prohibition: The requirement for advance beneficiary notice is not satisfied by a signed statement by the beneficiary to the effect that, should Medicare deny payment under §1862(a)(1), the beneficiary agrees to pay for the service. Routine notices to beneficiaries, which do no more than state that Medicare denial of payment is possible, or that the provider never knows whether Medicare will deny payment, are considered not to be acceptable evidence of advance beneficiary notice. The notice must specify the service and the reason that denial by Medicare is expected.

b. Blanket Notice Prohibition: A provider should not give an ABN to a beneficiary unless the provider has some genuine doubt regarding the likelihood of Medicare payment as evidenced by its stated reasons; giving advance beneficiary notices for all claims or services 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.

3. Format.--The provider or supplier must ensure that the design and readability of its ABN facilitate beneficiary understanding. No body text or heading should use a font size less than 12-point font. Italics or any typeface that is difficult to read should not be used. The provider or supplier must put its logo (if any), its name, address and telephone number at the top of its ABN form. It must be clear and obvious to the beneficiary that the provider or supplier, rather than the Medicare program, issued the ABN.

4. Delivery of ABN.--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 a detailed explanation written in lay language of the provider's reason for believing the services will be denied payment. Do not accept an incomprehensible notice, or a notice, which the individual beneficiary or his/her authorized representative is incapable of understanding due to the particular circumstances (even if others may understand).

a. The provider should hand-deliver the ABN to the beneficiary or authorized representative. Delivery is the provider's responsibility. If the beneficiary alleges non-receipt of notice and the provider cannot show that notice was received by the beneficiary, do not find that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay; i.e., hold the provider liable and the beneficiary not liable.

b. Do not consider a telephone notice to a beneficiary, or authorized representative, to be sufficient evidence of proper notice for purposes of 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, accept the time of the telephone notice as the time of ABN delivery.

c. Do 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 provider 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, hold that the beneficiary did not receive proper notice, hold that the beneficiary is not liable, where the LOL provisions apply, and hold the provider liable.

d. Hold that a beneficiary did not receive proper notice in any case where you find that the provider did not timely answer inquiries from a beneficiary, or authorized representative, who requested further information and/or assistance in understanding and responding to the notice; or that the provider did not answer inquiries from a beneficiary, or authorized representative, regarding the basis for its assessment that services may not be covered; or that the provider did not respond timely, accurately, and completely to a beneficiary, or authorized representative, who requested information about the extent of the beneficiary's personal financial liability for services for which the provider expected that Medicare may not pay. A provider's failure to provide information to a beneficiary subverts the purpose of the ABN, to permit the beneficiary to make an informed consumer decision.

e. A patient must be notified well enough in advance of receiving a medical service so that the patient can make a rational, informed consumer decision. Last moment delivery of an ABN may be considered to be coercive, regardless of the provider's intentions. If a beneficiary alleges s/he was coerced into accepting medical services by receiving the ABN at the last moment, investigate the facts. If the provider violated this timely delivery rule, hold that the notice was not properly delivered and that the beneficiary therefore is not liable.

C. Signature of Beneficiary.--

1. The generally applicable rules of the Medicare program with respect to who may sign for a beneficiary apply to signing notices, including ABNs. Whenever a beneficiary is incapable of signing a notice, you may accept an ABN signed by his or her representative who signs for other matters in accordance with Medicare rules.

2. The provider must obtain the signed ABN from the beneficiary, either in person, or where this is not possible, via return mail from the beneficiary or person acting on the beneficiary's behalf, as soon as possible after it is signed. The ABN should be annotated with the date of the provider's receipt from the beneficiary. The provider must return a copy of the ABN, including the date of its receipt from the beneficiary, within 30 calendar days to the beneficiary for his or her records, and must also retain a copy of the ABN. These copies will be relevant in the case of any future appeal.

3. If the beneficiary or the person acting on the beneficiary's behalf refuses to sign the ABN, the provider may annotate its copy of the ABN, indicating the circumstances and persons involved, and might decide not to furnish services to the beneficiary because the beneficiary has not agreed to be personally responsible for payment for services that are not covered by Medicare.

D. Collection from Beneficiary.--When an ABN was properly executed and given timely to a beneficiary who agreed to pay in the event of denial by Medicare and, in fact, Medicare denies payment on the related claim, the provider may bill and collect from the beneficiary for that service. Medicare does not limit the amount, which the provider may collect from the beneficiary in such a situation. Medicare charge limits do not apply. 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. Demand Bills.--The provider always must submit a claim for an initial determination when an ABN was given on the basis of the likelihood of denial of payment for a service as "not reasonable and necessary" under Medicare program standards. On such a claim, an "occurrence" code 32 should appear on the UB-92 in one of the fields numbered 32 through 35. This code indicates the date the ABN was furnished by the provider. It is the "occurrence" code and not the "condition" code that indicates to you that an ABN has been issued.

In addition to placing the "occurrence" code on the claim, the provider must also enter "condition" code 20 in one of the fields numbered 24 through 30 to indicate that the provider realizes the services on the claim probably or certainly are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary wants an initial determination. Do not routinely deny payment for services billed with "condition" code 20; the provision of an ABN by the provider only represents the provider's assessment that Medicare will deny payment. You must make your initial determination on the usual bases, without being influenced by "condition" code 20 being on the claim.

Providers may submit claims, for initial determination, for statutorily excluded services (e.g., routine physicals and screening tests, cosmetic surgery, personal comfort items), if the beneficiary requests it. On claims for statutorily excluded services, a "condition" code 21 should appear on the UB-92 in one of the fields numbered 24 through 30 to indicate that the provider realizes that the furnished services are excluded, but they are requesting a denial notice from you in order to bill Medicaid or other insurers. This is also known as a "no-pay" claim. Handle such a claim in the same manner as you handle all other claims with "condition" code 21 entered on them.