

MEDICARE FOR ALL

OCTOBER 17, 2019

State Representative
Susan Johnson
Serving Windham/Willimantic



Medicare Coverage & Appeals

- **What services are covered by Medicare Part A?**
- **What services are covered by Medicare Part B?**
- **What ISN'T covered by Medicare?**
- **How can I appeal a Medicare denial?**
- **What are my rights and responsibilities regarding Medicare Part D?**

Part A Coverage

- **Inpatient hospital services (note: the appeals process for Inpatient Hospital Services currently differs from the standard process outlined below).**
- **Inpatient skilled nursing facility services**
- **Some home health Services**
- **Hospice services**

Part B Coverage

- **Physicians' services**
- **Some home health Care**
- **Services and supplies, including drugs and biologicals which cannot be self-administered, furnished incidental to physicians' services**
- **Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests**
 - **These are just a few: Please refer to your handouts for a complete list**

Non-Covered Items and Services Standard Appeals Process for Part A and Part B *Redetermination*

- **No minimum claim amount**
- **Must be filed within 120 days of receipt of "Initial Determination"**
- **Filed with Medicare Contractor**
- **Reviewed and decided by Medicare Contractor**

Non-Covered Items and Services Standard Appeals Process for Part A and Part B *Redetermination Determination*

- **No minimum claim amount**
- **Must be filed within 120 days of receipt of "Initial Determination"**
- **Filed with Medicare Contractor**
- **Reviewed and decided by Medicare Contractor**

Non-Covered Items and Services Standard Appeals Process for Part A and Part B *Administrative Law Judge (ALJ) Hearing*

- Amount in controversy must be at least \$150.00 for 2016 increasing to \$160.00 for 2017**
- Must be filed within 60 days of receipt of "Reconsideration Determination"
- Filed with Office of Medicare Hearings and Appeals (OMHA)
- Reviewed and decided by an Administrative Law Judge from the U.S. Dept of Health and Human Services

Non-Covered Items and Services

Standard Appeals Process for Part A and Part B

Medicare Appeals Council (MAC)

- Amount in controversy must be at least \$150.00 for 2015 and 2016 increasing to \$160.00 for 2017**
- Must be filed within 60 days of receipt of ALJ "Hearing Decision"
- Filed with U.S. Dept of Health and Human Services
- Reviewed and decided by U.S. Dept of Health and Human Services Medicare Appeals Council

Non-Covered Items and Services

Standard Appeals Process for Part A and Part B

Judicial Review

- Amount in controversy must be at least \$1500.00 for 2016, increasing to \$1560.00 for 2017**
- Must be filed within 60 days of receipt of "MAC Decision"
- Filed with U.S. District Court
- Reviewed and decided by U.S. District Court

Advance Beneficiary Notice (ABN)

- Also called a waiver of liability
- Health provider should issue if they believe Medicare will not pay for a service
- May receive ABN if beneficiary has Original Medicare, NOT Medicare Advantage
- Beneficiary decides whether they will get the care and accept financial responsibility
- An ABN does NOT mean Medicare will not cover service – it is possible Medicare will cover the service
- For a Medicare decision, ABN must be signed, and beneficiary must receive the care
- Beneficiary must ask provider to bill Medicare for service provided as the provider is NOT required to submit the claim to Medicare.

Waiver of Liability Statement

Enrollee's Name

Enrollee ID Number

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature

Date

Special Rules for Hospital Claims

- Hospital inpatients denied Medicare can request an “expedited review” by the QIO (. QIO must issue decision within three working days.
- New expedited appeals regulations protect only those inpatients who did not know or could not reasonably have been expected to know that payment would not be made from liability
- Beneficiary may request reconsideration review by the QIC for an unfavorable decision
- If the reconsideration decision is unsatisfactory and at least \$200 remains in controversy, the beneficiary may request an ALJ hearing.
- Hearing requests must be made in writing within 60 days of receipt of the reconsideration decision
- If the hearing request is unsatisfactory, a beneficiary has 60 days to request a review from the Medicare Appeals Council (MAC). If \$2,000 remains in controversy after the hearing, the case may proceed into United States District Court

Medicare Advantage

Medicare Part C, Medicare Managed Care

- Offered by private companies approved by Medicare
- Provide all Part A and Part B coverage, may offer additional coverage
 - Vision
 - Hearing
 - Dental
 - Health/wellness
- Most include Medicare Part D (Prescription Drug Coverage)
- Each plan can charge different out-of-pocket expenses, and have different rules for enrollees to access services

Medicare Advantage

Medicare Part C, Medicare Managed Care) Appeals and Grievances

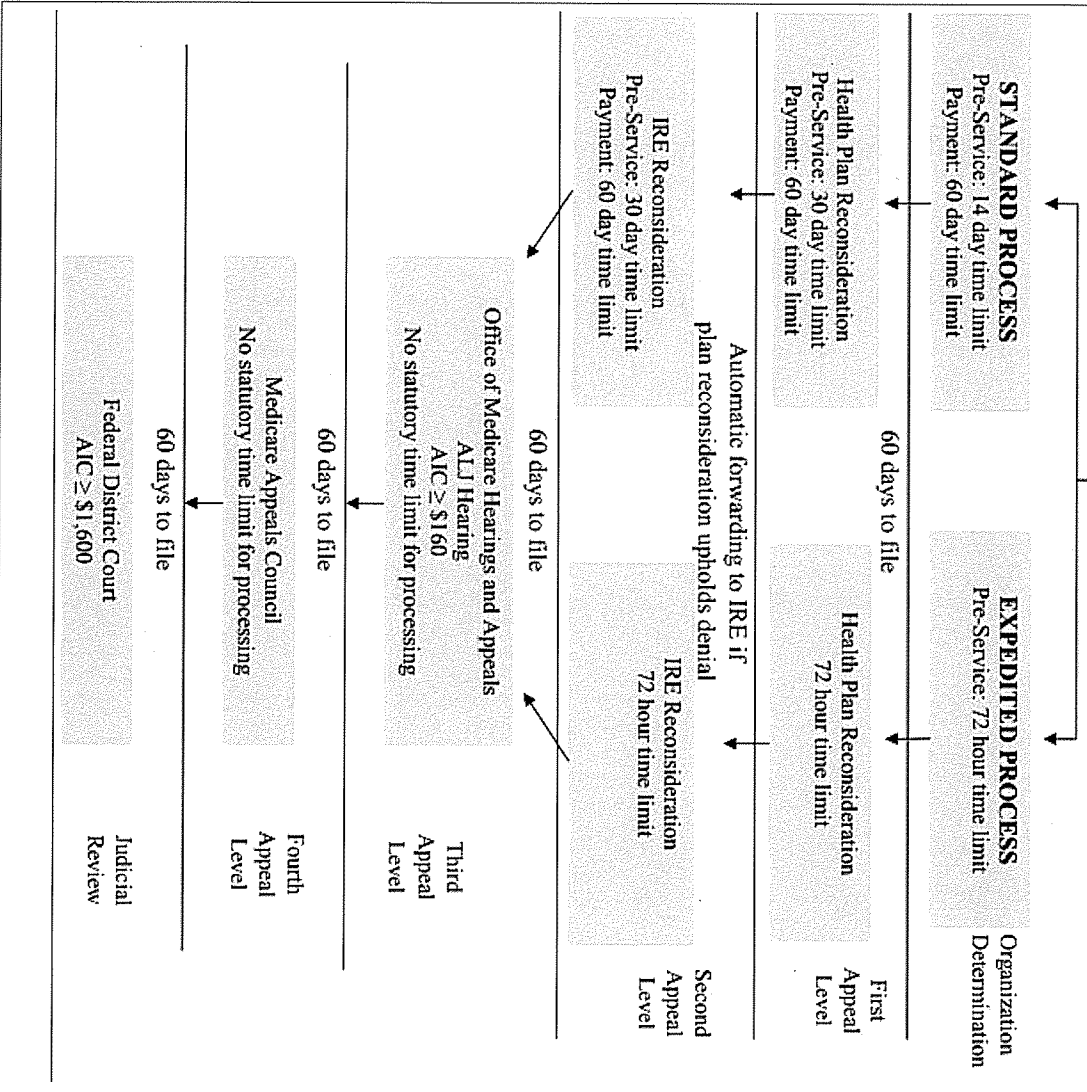
- A Medicare Advantage (MA) enrollee may appeal if the MA plan denies coverage for a service.
- An MA plan is required to provide enrollees with information regarding the appeals process.
- MA plans are required to have internal grievance procedures, provide information to members regarding this grievance process in the plan's written membership rules, along with timetables and information to utilize the grievance process.

Medicare Part C Appeals

- Medicare Part C appeals process is different than traditional Medicare
 - Initial determinations are known as “organization determinations,” and reconsideration determinations are made by the MA plan
- If a reconsidered decision is denied in whole or in part, it is sent automatically to the Part C Independent Review Entity (IRE), an external review organization hired by CMS to review Medicare Advantage reconsidered decisions. This decision may be appealed to an ALJ, as in Part A or Part B appeals above.

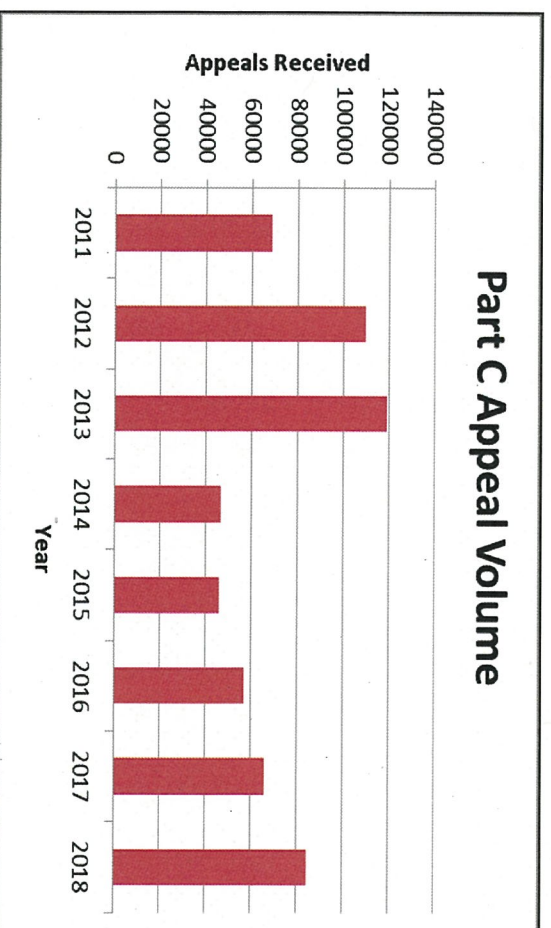
Medicare Managed Care (Part C - Medicare Advantage)

Organization Determination/Appeals Process



Medicare Part C Reconsideration Volume

- From Jan. 1, 2018 – Dec. 31, 2018
 - QIC received 84,383 reconsideration requests
 - 3.95 reconsiderations per 1,000 enrollees
 - Expedited cases represented 15.78% of all appeals




Medicare Part C Grievance Procedures

- The grievance procedures are to be used in all cases that do not involve an “organization determination”
- Controversies about hours of service, location of facilities, or courtesy of personnel
- A grievance must be filed either orally or in writing no later than 60 days after the circumstance giving rise to the grievance.

Questions & Answers



Medicare Coverage & Appeals

 [medicareadvocacy.org/medicare-info/medicare-coverage-appeals](https://www.medicareadvocacy.org/medicare-info/medicare-coverage-appeals)

- [What services are covered by Medicare Part A?](#)
- [What services are covered by Medicare Part B?](#)
- [What ISN'T covered by Medicare?](#)
- [How can I appeal a Medicare denial?](#)
- [What are my rights and responsibilities regarding Medicare Part D?](#)

For other information, follow one of the links below or scroll down the page.

[PART A COVERAGE](#)

[PART C APPEALS \(Medicare Advantage\)](#)

[PART B COVERAGE](#)

[SELF-HELP PACKETS \(Request your own appeals\)](#)

[STANDARD APPEALS \(Part A and Part B\)](#)

[DISCHARGE PLANNING ADVOCACY TIPS](#)

[EXPEDITED REVIEW](#)

[ARTICLES AND UPDATES](#)

[SPECIAL RULES FOR HOSPITAL CLAIMS](#)

Generally, coverage is available when services are medically reasonable and necessary for treatment or diagnosis of illness or injury.

Part A Coverage

- Inpatient hospital services (note: the appeals process for Inpatient Hospital Services currently differs from the standard process outlined below).
- Inpatient skilled nursing facility services
- Some home health Services
- Hospice services

Part B Coverage

- Physicians' services;
- Some home health Care;

- Services and supplies, including drugs and biologicals which cannot be self-administered, furnished incidental to physicians' services;
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray therapy, radium therapy and radioactive isotope therapy;
- Surgical dressings, and splints, casts and other devices used for fractures and dislocations;
- Durable medical equipment;
- Prosthetic devices;
- Braces, trusses, artificial limbs and eyes;
- Ambulance services;
- Some outpatient and ambulatory surgical services;
- Some outpatient hospital services;
- Some physical therapy services;
- Some occupational therapy;
- Some outpatient speech therapy;
- Comprehensive outpatient rehabilitation facility services;
- Rural health clinic services;
- Institutional and home dialysis services, supplies and equipment;
- Ambulatory surgical center services;
- Antigens and blood clotting factors;
- Qualified psychologist services;
- Therapeutic shoes for patients with severe diabetic foot disease;
- Influenza, Pneumococcal, and Hepatitis B vaccine;
- Some mammography screening;
- Some pap smear screening, breast exams, and pelvic exams;
- Some other preventive services including colorectal cancer screening, Diabetes training tests, bone mass measurements, and prostate cancer screening.

For more details, see our [Medicare Part B](#) page.

Non-Covered Items and Services

See this [release from the Centers for Medicare & Medicaid Services](#) for non-covered items and services as of September, 2013.

Standard Appeals Process for Part A and Part B:

1. Redetermination

- No minimum claim amount
- Must be filed within 120 days of receipt of "Initial Determination"
- Filed with Medicare Contractor
- Reviewed and decided by Medicare Contractor

2. Reconsideration Determination

- No minimum claim amount
- Must be filed within 180 days of receipt of "Redetermination"
- Filed with Qualified Independent Contractor (QIC)
- Reviewed by Qualified Independent Contractor (QIC)
- Decisions must be issued within 60 days, or case can be escalated to ALJ, below

3. Administrative Law Judge (ALJ) Hearing

- Amount in controversy must be at least \$150.00 for 2016 increasing to \$160.00 for 2017**
- Must be filed within 60 days of receipt of "Reconsideration Determination"
- Filed with Office of Medicare Hearings and Appeals (OMHA)
- Reviewed and decided by an Administrative Law Judge from the U.S. Dept of Health and Human Services

4. Medicare Appeals Council (MAC)

- Amount in controversy must be at least \$150.00 for 2015 and 2016 increasing to \$160.00 for 2017**
- Must be filed within 60 days of receipt of ALJ "Hearing Decision"
- Filed with U.S. Dept of Health and Human Services
- Reviewed and decided by U.S. Dept of Health and Human Services Medicare Appeals Council

5. Judicial Review

- Amount in controversy must be at least \$1500.00 for 2016, increasing to \$1560.00 for 2017**
- Must be filed within 60 days of receipt of "MAC Decision"
- Filed with U.S. District Court
- Reviewed and decided by U.S. District Court

Expedited Review

Beneficiaries may seek "expedited review " of a skilled nursing facility, home health, hospice or comprehensive outpatient rehabilitation facility (CORF) services discharge or termination.

Expedited review is available in cases involving a discharge from the provider of services, or a termination of services. ***A reduction in service is not considered a termination or discharge for purposes of triggering expedited review*** except in the case of skilled nursing facility care when the reduction of care from daily to intermittent will mean that the beneficiary is no longer eligible for Part A coverage. For home health care and CORF services, a successful appeal requires that a physician certify that "failure to continue the provision of such services is likely to place the individual's health at risk."

The provider must give the beneficiary a general, standardized notice at least two days in advance of the proposed end of the service. If the service is fewer than two days, or if the time between services is more than two days, then notice must be given by the next to last service. The notice describes the service, the date coverage ends, the beneficiary's financial liability for continued services, and how to file an appeal.

A beneficiary who wishes to exercise the right to an expedited determination must submit a request for a determination with the QIO in the state in which the beneficiary is receiving the services at issue. The request may be made in writing or by telephone, but ***the request must be made no later than noon of the calendar day following receipt of the provider's notice of termination***. If the QIO is unavailable to accept the beneficiary's request, the beneficiary must submit the request by noon of the next day the QIO is available. At that time, the beneficiary is given a more specific notice that includes a detailed explanation of why services are being terminated, a description of any applicable Medicare coverage rules and information on how to obtain them, and other facts specific to the beneficiary's case. The beneficiary is not financially liable for continued services until two days after receiving the notice, or the termination date specified on the notice, whichever is later.

Coverage of the services at issue continues until the date and time designated on the termination notice, unless the QIO reverses the provider's service termination decision. If the QIO's decision is delayed because the provider did not timely supply necessary information or records, the provider may be liable for the costs of any additional coverage, as determined by the QIO. If the QIO finds that the beneficiary did not receive valid notice, coverage of the provider services continues until at least 2 days after valid notice has been received. Continuation of coverage is not required if the QIO determines that coverage could pose a threat to the beneficiary's health or safety.

If the QIO upholds the decision to terminate services or discharge the beneficiary, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following the QIO's initial notification. The reconsideration will be conducted by the QIC, which must issue a decision within 72 hours of the request. If the QIC does not comply with the time frame, the beneficiary may "escalate" the case to the administrative law judge level.

Beneficiaries retain the right to utilize the standard appeals process rather than the new expedited process in all situations. A QIO may review an appeal from a beneficiary whose request is not timely filed, but the QIO does not have to adhere to the time frame for issuing a decision, and the limitation on liability does not apply.

Special Rules for Hospital Claims

Hospital inpatients denied Medicare during their stay may request an "expedited

review" of a Medicare denial by the QIO. These expedited requests must be decided by the QIO within three working days.

Under previous regulations, a hospital inpatient who received a denial notice from the hospital and requested review immediately avoided being charged until the QIO issued an initial determination. However, the new expedited appeals regulations protect only those inpatients who did not know or could not reasonably have been expected to know that payment would not be made from liability .

A beneficiary may request reconsideration review by the QIC for an unfavorable decision . If the reconsideration decision is unsatisfactory and at least \$200 remains in controversy, the beneficiary may request an ALJ hearing. Hearing requests must be made within 60 days of receipt of the notice of the reconsideration decision. The hearing request should be made in writing and should be filed with the entity identified in the reconsideration notice.

If the hearing request is unsatisfactory, a beneficiary may request a review from the Medicare Appeals Council (MAC). The request must be made within 60 days of receipt of the hearing decision. If \$2,000 remains in controversy after the hearing, the case may proceed into United States District Court.

Medicare Advantage ("Medicare Part C", "Medicare Managed Care") Appeals & Grievances

A Medicare Advantage (MA) enrollee also has the right to appeal if the MA plan denies coverage for a service. An MA plan is required to provide enrollees with information regarding the appeals process as part of the plan materials. The appeals procedures for Medicare Part C, including the timeframes for requesting appeals, are different than the appeal procedures for traditional Medicare. In MA cases, initial determinations are known as "organization determinations. " Organization determinations as well as the next level of review, reconsideration determinations , are made by the MA plan. If a reconsidered decision is denied in whole or in part, it is sent automatically to the Part C Independent Review Entity (IRE), an external review organization hired by CMS to review Medicare Advantage reconsidered decisions. The IRE decision may be appealed to an ALJ, as in Part A or Part B appeals above.

In addition, MA plans are required to have internal grievance procedures. The MA plan must provide information to members regarding this grievance process in the plan's written membership rules, along with timetables and information about the steps necessary to utilize the grievance process. Grievance procedures are separate and distinct from the appeals procedures. The grievance procedures are to be used in all cases that do not involve an "organization determination. " For example, controversies about hours of service, location of facilities, or courtesy of personnel would go through the grievance process. A grievance must be filed either orally or in writing no later than 60 days after the circumstance giving rise to the grievance.

****Amount in controversy is increased by the percentage increase in the medical care component price index.**

Articles and Updates

For older articles, please see [our article archive](#).



MEDICARE ADVANCE WRITTEN NOTICES OF NONCOVERAGE

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Table of Contents

Types of Advance Written Notices of Noncoverage.....	2
Issuing an Advance Written Notice of Noncoverage	3
Prohibitions and Frequency Limits	5
Completing an Advance Written Notice of Noncoverage	6
Collecting Beneficiary Payment.....	8
Financial Liability	8
ABN Claim Reporting Modifiers	8
When Not to Use an Advance Written Notice of Noncoverage	9
Resources	9

Learn about these Medicare advance written notices of noncoverage topics:

- Types of advance written notices of noncoverage
- Issuing an advance written notice of noncoverage
- Prohibitions and frequency limits
- Completing an advance written notice of noncoverage
- Collecting beneficiary payment
- Financial liability
- ABN claim reporting modifiers
- When not to use an advance written notice of noncoverage
- Resources

Types of Advance Written Notices of Noncoverage

An advance written notice of noncoverage helps a Medicare Fee-For-Service (FFS) beneficiary make an informed decision about items and services Medicare usually covers but may not pay because they are medically unnecessary. These Centers for Medicare & Medicaid Services (CMS) notices are approved for this purpose:

- All health care providers and suppliers must deliver an Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, when a Medicare payment denial is expected in order to transfer financial liability to the beneficiary. This includes:
 - Independent laboratories, Skilled Nursing Facilities (SNFs), and home health agencies (HHAs) providing Medicare Part B (outpatient) items and services
 - Hospice providers, HHAs, and Religious Nonmedical Health Care Institutions providing Part A items and services

The ABN helps the beneficiary decide whether to get the item or service Medicare may not cover and accept financial responsibility to pay for it. **If the beneficiary does not get written notice when it is required, they may not be financially liable if Medicare denies payment, and the provider or supplier may be financially liable instead.**

- SNFs, to transfer financial liability to the beneficiary, must issue a Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055, before providing a Part A item or service to a beneficiary Medicare usually pays, but may not pay because it's medically unnecessary, or it is custodial care.
- Hospitals issue a Hospital-Issued Notice of Noncoverage (HINN) prior to admission, at admission, or at any point during an inpatient stay if hospitals determine the beneficiary's care is not covered because it is:
 - Medically unnecessary
 - Not delivered in the most appropriate setting
 - Custodial in nature

The four HINNs hospitals issue are:

- Preadmission/Admission HINN, also known as HINN 1: Use prior to an entirely noncovered stay
- Notice of Hospital Requested Review (HRR), also known as HINN 10: Use for FFS and Medicare Advantage Program (Part C) beneficiaries when requesting Quality Improvement Organization review of a discharge decision without physician concurrence
- HINN 11: Use for noncovered items and services during an otherwise covered stay
- HINN 12: Use with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a noncovered continued stay
- Home Health Agencies issue Home Health Change of Care Notice (HHCCN), Form CMS-10280 to notify a beneficiary receiving home health care benefits about plan of care (POC) changes. The beneficiary must receive written notification before HHAs may reduce or terminate an item or service. It is important to note that the HHCCN is not a liability notice rather a change in care notice.

Issuing an Advance Written Notice of Noncoverage

When You Must Issue an Advance Written Notice of Noncoverage

To transfer financial liability to the beneficiary, the provider must issue an advance written notice of noncoverage (the notice):

- When an item or service is not reasonable and necessary under Medicare Program standards. Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:
 - Experimental and investigational or considered “research only”
 - Not indicated for diagnosis or treatment in this case
 - Not considered safe and effective
 - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is furnished
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)
- Before furnishing an item or service Medicare will not pay because (durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers):
 - The provider violated the prohibition against unsolicited telephone contacts
 - The supplier has not met supplier number requirements
 - The supplier is a non-contract supplier furnishing an item listed in a competitive bidding area
 - The beneficiary wants the item or service before Medicare receives the advance coverage determination

Non-Contract DMEPOS Suppliers

An ABN is valid if beneficiaries understand the meaning of the notice. Where an exception applies, beneficiaries have no financial liability to a non-contract supplier furnishing an item included in the Competitive Bidding Program unless they sign an ABN indicating Medicare will not pay for the item because they received it from a non-contract supplier and they agree to accept financial liability. For more information about non-contract DMEPOS supplier requirements, refer to the DMEPOS Competitive Bidding Program Non-Contract Supplier fact sheet.

Services must meet specific medical necessity requirements in the statute, regulations, guidance, and criteria defined by National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) (if any exist for the service reported). Every service billed must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

Limited coverage may result from NCDs or LCDs. NCDs limit Medicare coverage for specific services, procedures, or technologies on a national basis. The Secretary of the U.S. Department of Health & Human Services determines reasonable and necessary NCDs. Medicare Administrative Contractors (MACs) may develop an LCD to further define an NCD or in the absence of a specific NCD. This is a coverage decision made at their discretion to provide guidance to the public and the medical community within a specified geographic area. In most cases, the availability of this information indicates you knew, or should have known, Medicare would deny the item or service as medically unnecessary.

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

You are not required to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. For more information about noncovered services, refer to the Items and Services Not Covered Under Medicare booklet.

Three Events That Prompt Issuance of an Advance Written Notice of Noncoverage

These three “triggering events” may prompt an advance written notice of noncoverage:

- Initiations
- Reductions
- Terminations

Initiations

Initiations occur at the beginning of a new patient encounter, start of a POC, or when treatment begins. If you believe at initiation Medicare will not cover certain items or services because they are not reasonable and necessary, you must issue the notice prior to the beneficiary receiving the noncovered care.

Reductions

Reductions occur when a component of care decreases (for example, frequency or duration of a service). Do not issue the notice every time there is a reduction in care. If a reduction occurs and the beneficiary wants to continue receiving the care no longer considered medically reasonable and necessary, you must issue the notice prior to furnishing noncovered care.

For the HHCCN, reductions to the POC occur when an HHA reduces or stops items or services during a spell of illness while continuing others, including when one home health discipline ends but others continue.

Terminations

Terminations discontinue all or certain items or services. If services are terminated and the beneficiary wants to continue receiving care no longer considered medically reasonable and necessary, you must issue the notice prior to furnishing noncovered care.

For the HHCCN, terminations to the POC occur when an HHA ends delivery of all services.

Issuing an Advance Written Notice of Noncoverage When Multiple Entities Provide Care

When multiple entities provide care, Medicare does not require separate advance written notices of noncoverage. Any party involved in delivering care can issue the notice when:

- There are separate ordering and furnishing providers (for example, a physician orders a laboratory test and an independent laboratory delivers the ordered test)
- One health care provider delivers the technical component and another provider delivers the professional component of the same service (for example, a radiological test an independent diagnostic testing facility provides, and a physician interprets)
- The entity that obtains the signature on the notice is not the same entity billing the service (for example, one laboratory refers a specimen to another laboratory and the second laboratory bills Medicare for the test)

In these situations, you may enter the names of more than one entity in the header of the notice if the beneficiary can clearly identify whom to contact with billing questions.

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

Prohibitions and Frequency Limits

Routine Notice Prohibition

There is no reason to issue an advance written notice of noncoverage on a routine basis, except for:

- Experimental items and services
- Items and services with frequency coverage limitations
- Medical equipment and supplies denied because the supplier had no supplier number, or the supplier made an unsolicited telephone contact
- Services always denied for medical necessity

Other Prohibitions

You cannot issue an advance written notice of noncoverage to:

- Shift liability and bill the beneficiary for the services denied due to a Medically Unlikely Edit (MUE).
- A beneficiary in a medical emergency or under great duress (compelling or coercive circumstances). Advance written notice of noncoverage use in the emergency room or during ambulance transports may be appropriate in some cases (for example, a beneficiary who is medically stable and not under duress).
- Charge a beneficiary for a component of a service when Medicare makes full payment through a bundled payment.
- Transfer liability to the beneficiary when Medicare would otherwise pay for items and services.

Frequency Limits

Some Medicare-covered services have frequency limits. Medicare only pays for a certain quantity of a specific item or service in a given period for a diagnosis. If you believe an item or service may exceed frequency limits, issue the notice before furnishing the item or service to the beneficiary.

If you do not know the number of times the beneficiary got a service within a specific period, get this information from the beneficiary or other providers involved in their care. Contact your MAC or use the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) (270/271) to determine if a Medicare beneficiary met the frequency limits from another provider during the calendar year.

Extended Treatment

You may issue a single notice to cover extended treatment if it lists all items and services and the duration of treatment when you believe Medicare will not pay. If the beneficiary receives an item or service during the treatment that you did not list on the notice and Medicare may not cover it, you must issue a separate notice. A single notice for an extended course of treatment is only valid for 1 year. If the extended course of treatment continues after 1 year, issue a new notice.

Completing an Advance Written Notice of Noncoverage

An advance written notice of noncoverage should be:

- Issued (preferably in person) to, and understood by, the Medicare beneficiary or their representative.
- Completed on the approved, standardized notice format (when applicable), with all required blanks completed. It cannot exceed one page in length. You may include attachments listing additional items and services. If you use attachment sheets, they must clearly match the items or services in question with the reason a denial is expected and cost estimate information. Use a visually high-contrast combination of dark ink on a pale background. The print should be readable to the beneficiary. Medicare permits limited customization of the advance written notice of noncoverage, such as preprinting information in certain blanks.

- Issued far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options.
- Explained in its entirety, answering all questions related to the notice.
- Signed and dated by the beneficiary or their representative after they select one of the options. If you issue the notice on an electronic screen, offer a paper copy to the beneficiary and keep a copy for your records (whether the notice is signed on paper or electronically). If you maintain Electronic Medical Records, you may scan the signed hard copy for retention.
- Kept for 5 years from the date-of-care delivery when no other requirements under State law apply. Medicare requires you to keep a record of the notice in all cases, including when the beneficiary declined the care, refused an option, or refused to sign the notice.

If you can't issue the notice in person, you may issue it via direct telephone, email, mail, or secure fax machine (according to HIPAA policy). The beneficiary should not dispute the contact. You should document the contact in the beneficiary's records and keep a copy of the unsigned notice on file while you wait for the signed notice.

Telephone contacts must be immediately followed by either a hand-delivered, mailed, emailed, or faxed advance written notice of noncoverage. The beneficiary or the beneficiary's representative must sign and retain the notice and send you a signed copy to keep in the beneficiary's record. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in the beneficiary's records or on the notice.

For detailed instructions on completing an ABN, refer to the [Advance Beneficiary Notice of Noncoverage Interactive Tutorial](#).

When the Beneficiary Changes Their Mind

If the beneficiary changes their mind after completing and signing the notice, you should request they annotate the completed notice. They must sign and date the annotation and include a clear indication of their new option selection. If you cannot provide the notice in person, you may annotate the form to reflect the beneficiary's new option selection and immediately forward a copy to the beneficiary to sign, date, and return. You must provide a copy of the annotated notice to the beneficiary as soon as possible.

Beneficiary Refusal to Choose an Option or Sign the Advance Written Notice of Noncoverage

If the beneficiary or the beneficiary's representative refuses to choose an option or sign the notice, you should annotate the original copy indicating the refusal to choose an option or sign the notice. You may list any witnesses to the refusal, although a witness is not required. If a beneficiary refuses to sign a properly issued notice, consider not furnishing the item or service unless the consequences (health and safety of the beneficiary or civil liability in case of harm) prevent this option.

Collecting Beneficiary Payment

When an advance written notice of noncoverage is required, if you properly notify the beneficiary the item or service may not be covered, and they sign the notice, you may seek payment from them. If Medicare pays all or part of the claim for items or services previously paid by the beneficiary, you must refund the beneficiary the proper amount in a timely manner. Refunds are considered timely within 30 days after you receive the Remittance Advice from Medicare or within 15 days after a determination on an appeal if you or the beneficiary file an appeal.

Note: SNFs are not permitted to collect money for Part A services until Medicare makes an official payment decision on the claim. For dual eligible beneficiaries, including Qualified Medicare Beneficiaries (QMBs), distinct billing limitations apply.

Financial Liability

If you do not issue a required notice or Medicare finds the notice is invalid and you knew, or should have known, Medicare will not pay for a usually covered item or service, you may be financially liable. You cannot collect funds from the beneficiary. If you previously collected payment from the beneficiary, you must refund the beneficiary the proper amount in a timely manner.

ABN Claim Reporting Modifiers

Table 1. Using Modifiers for ABN Claim Reporting

Modifier	When to Use the Modifier
GA Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case	Report when you issue a mandatory ABN for a service as required and it is on file. You do not need to submit a copy of the ABN, but you must have it available on request.
GX Notice of Liability Issued, Voluntary Under Payer Policy	Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.
GY Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit	Report that Medicare statutorily excludes the item or service, or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.
GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary	Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

When Not to Use an Advance Written Notice of Noncoverage

Do not use an advance written notice of noncoverage for items and services you furnish under Medicare Advantage (Part C) or the Medicare Prescription Drug Benefit (Part D). You are not required to notify the beneficiary before you furnish items or services that are not a Medicare benefit or that Medicare never covers, such as:

- Services when there is no legal obligation to pay
- Services authorized or paid by a government entity other than Medicare (this exclusion does not include services paid by Medicaid on behalf of dual eligibles)
- Services required because of war
- Personal comfort items such as radios and televisions
- Eye examinations for prescribing, fitting, or changing eyeglasses
- Hearing aids

Resources

Table 2. Medicare Advance Written Notices of Noncoverage Resources

For More Information About...	Resource
Beneficiary Notices Initiative (BNI)	CMS.gov/Medicare/Medicare-General-Information/BNI
Contact Your MAC	CMS.gov/MAC-website-list
DME Supplier Requirements	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf (Sections 50.7.3.1–50.12)
Email Your Questions	RevisedABN_ODF@cms.hhs.gov
Forms and Instructions, Rules, and Financial Liability Protections	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf (Section 60.4.1) CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
HETS	CMS.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp
HHCCN Form Instructions	CMS.gov/Medicare/Medicare-General-Information/BNI/Downloads/HHCCN-Form-Instructions.pdf
Medicare Coverage	CMS.gov/Medicare-Coverage-Database CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html CMS.gov/Medicare/Coverage/CoverageGenInfo

Table 2. Medicare Advance Written Notices of Noncoverage Resources (cont.)

For More Information About...	Resource
Medicare Learning Network® Catalog of Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MUEs	CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Advance Beneficiary Notice of Noncoverage (ABN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish-Incl-Large-Print.zip
Advance Beneficiary Notice of Noncoverage Interactive Tutorial	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909183.html
DMEPOS Competitive Bidding Program Non-Contract Supplier	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243505.html
Home Health Change of Care Notice (HHCCN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/HHCCN-Forms-English-and-Spanish.zip
Hospital-Issued Notice of Noncoverage (HINN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/HINNs.zip
Items and Services Not Covered Under Medicare	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1253078.html
Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN)	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS019508.html

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Agency executive: Seema Verma, Administrator

Headquarters: Baltimore, MD

Founded: July 30, 1965, Independence, MO

Number of employees: 4,100

Jurisdiction: United States of America

Subsidiary: Center for Medicare and Medicaid Innovation

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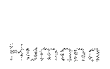
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