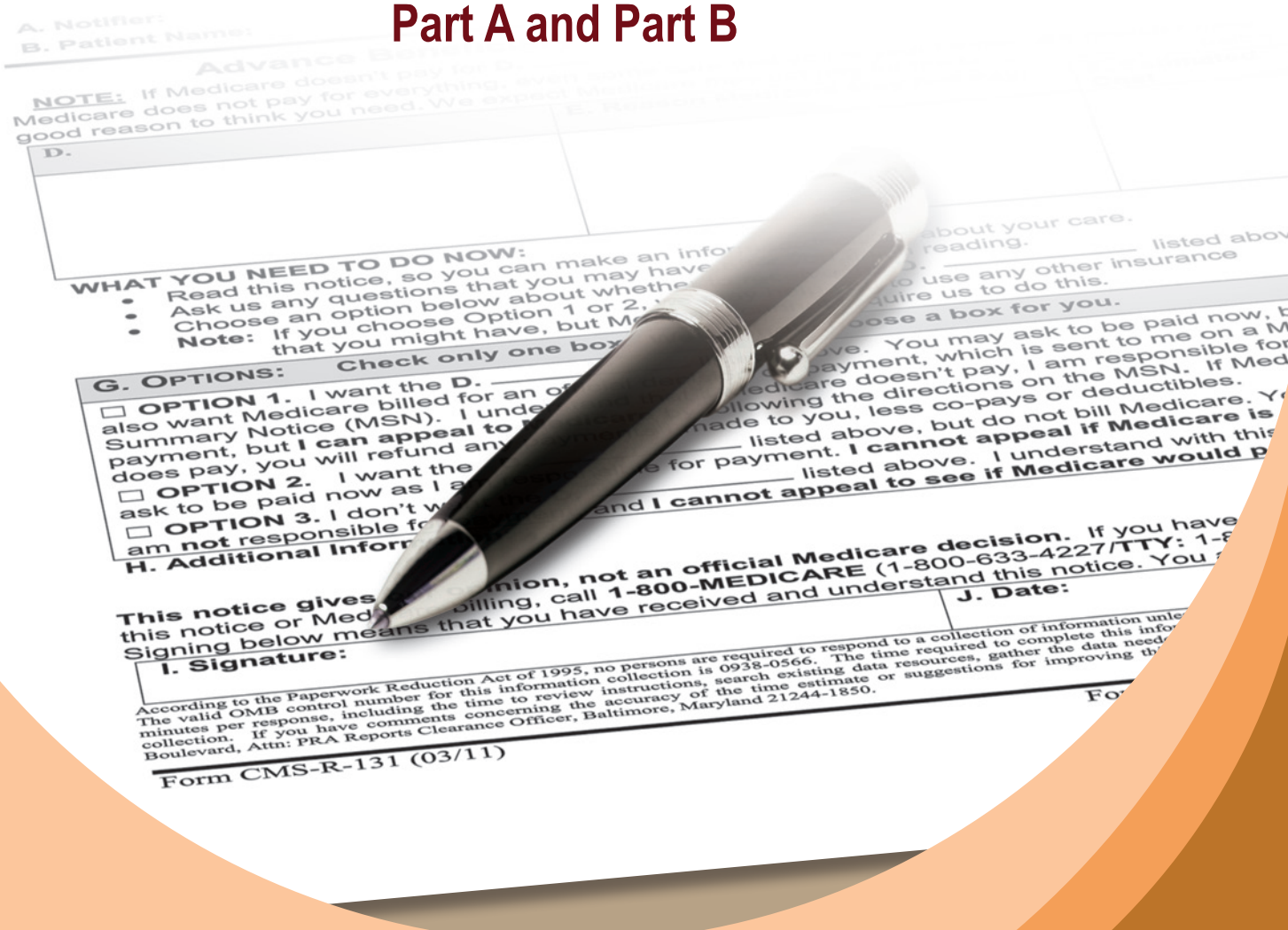
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

Advance Beneficiary Notice of Noncoverage (ABN)

Part A and Part B



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The Centers for Medicare & Medicaid Services (CMS) implemented the Advance Beneficiary Notice of Noncoverage (ABN) Form CMS-R-131. This booklet provides information to help providers and suppliers understand the Medicare requirements for when and how to issue an ABN.

WHAT IS AN ABN?

An ABN, Form CMS-R-131, is a standardized notice that you or your designee must issue to a Medicare beneficiary, before providing certain Medicare Part B (outpatient) or Part A (limited to hospice and Religious Nonmedical Healthcare Institutions only) items or services. You must issue the ABN when:

- You believe Medicare may not pay for an item or service,
- Medicare usually covers the item or service, and
- Medicare may not consider it medically reasonable and necessary for this patient in this particular instance.

Durable Medical Equipment (DME) suppliers must also uphold additional requirements for ABN issuance (listed on page 6).

Medical Necessity

Medicare defines medical necessity as services that are:

- Reasonable and necessary,
- For the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member, and
- Not excluded under another provision of the Medicare Program.

For information related to Medicare coverage, regulations, and processes, visit http://www.cms.gov/Medicare/Coverage/CoverageGenInfo on the CMS website.

You should only provide ABNs to beneficiaries enrolled in Original (Fee-For-Service) Medicare. The ABN allows the beneficiary to make an informed decision about whether to get services and accept financial responsibility for those services if Medicare does not pay. The ABN serves as proof that the beneficiary knew prior to getting the service that Medicare might not pay. **If you do not issue a valid ABN to the beneficiary when Medicare requires, you cannot bill the beneficiary for the service and you may be financially liable.**

The ABN also serves as an optional (voluntary) notice that you may use to forewarn beneficiaries of their financial liability prior to providing care that Medicare never covers. Medicare does not require you to issue an ABN in order to bill a beneficiary for an item or service that is not a Medicare benefit and never covered.

How Do I Know When Medicare Might Not Pay?

Medicare limits coverage of certain items and services by the diagnosis. If the diagnosis on the claim is not one that Medicare covers for the item or service, Medicare will deny the claim.

What Are Medicare Coverage Policies?

Limited coverage may result from National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). **Medicare expects you to know both current NCDs and LCDs**. NCDs describe whether Medicare pays for specific medical items, services, treatment procedures,

ICD-9-CM Coding

All services reported to the Medicare Program by a physician or non-physician practitioner must demonstrate medical necessity through the use of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding carried to the highest level of specificity for the date of service.

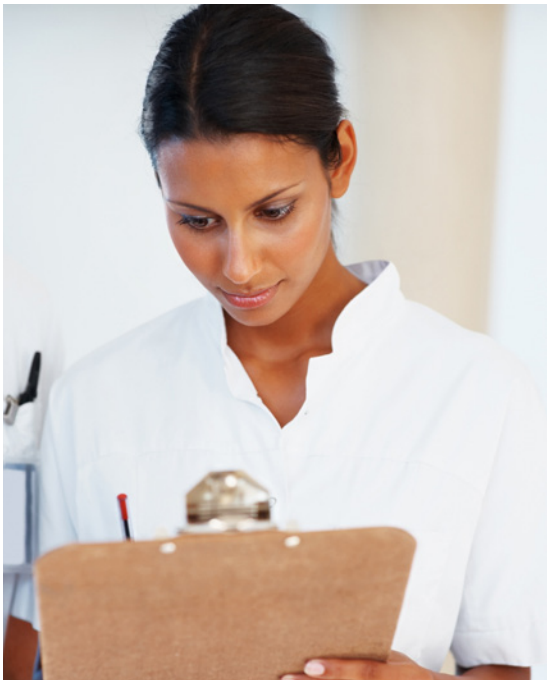
or technologies. In the absence of an NCD, LCDs indicate which items and services Medicare considers reasonable, medically necessary, and appropriate. In most cases, the availability of this information indicates that you knew, or should have known, that Medicare would deny the item or service as not medically necessary.

The Medicare Coverage Database (MCD) at http://www.cms.gov/medicare-coverage-database contains all NCDs and LCDs, local policy articles, and proposed NCD decisions. You may find published NCDs at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website. You may view official versions of LCDs by contractor, state, or alphabetically, at http://www.cms.gov/medicare-coverage-database on the CMS website.

What Are Frequency Limits?

Some services that Medicare covers are subject to frequency limitations. A frequency limit means that Medicare will pay for only a certain quantity of a specific item or service in a given time period. If you do not know the number of times the beneficiary got a service within a specific time frame, you can try to get this information from the beneficiary or other providers involved in his or her care. If you have reason to believe that the item or service you provide may exceed frequency limitations, you must issue an ABN to inform the beneficiary that he or she may be responsible for the charges if Medicare does not pay.

Key Points for Health Care Providers



- You must issue an ABN to the beneficiary **prior to** providing care that Medicare may not cover because it is not medically reasonable and necessary in this particular case.
- After the beneficiary signs a properly issued ABN indicating his or her choice to get the item or service and accept financial liability, Medicare permits you to bill the beneficiary.
- If you do not issue an ABN or Medicare finds the ABN invalid, in a situation requiring notice, you may not bill the beneficiary for the services, and you may be financially liable if Medicare does not pay.
- You may not use ABNs to charge a beneficiary for a component of a service when Medicare makes full payment through a bundled payment.
- Medicare prohibits you from using an ABN to transfer liability to the beneficiary when Medicare would otherwise pay for items and services.
- You must be enrolled as a Medicare supplier or provider to use the ABN.
- When you issue the ABN as a voluntary notice, the beneficiary does not check an option box or sign and date the notice.
- The ABN is issued for items and services covered under Part B. It is only issued for Part A care when it is issued by hospices and Religious Nonmedical Healthcare Institutions.

WHEN MUST I ISSUE AN ABN?

Mandatory ABN Uses

You must issue an ABN when you expect Medicare to deny payment for an item or service because it is not reasonable and necessary under Medicare Program standards or because Medicare considers it custodial care.

Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:

- Experimental and investigational,
- Not indicated for diagnosis and/or treatment in this case,
- Not considered safe and effective, or
- More than the number of services that Medicare allows in a specific period for the corresponding diagnosis.

Noncontract Suppliers

For more information, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DME_Noncontract_Factsheet_ICN900925.pdf on the CMS website.

Additional mandatory requirements apply to DME suppliers. DME suppliers must issue an ABN before providing the beneficiary with items or services if:

- The provider violated the prohibition against unsolicited telephone contacts,
- The supplier has not met supplier number requirements,
- The supplier is a noncontract supplier providing an item listed in a competitive bidding area, or
- Medicare requires an advance coverage determination.

WHEN MAY I ISSUE AN ABN?

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in these situations, you may issue an ABN voluntarily. Refer to the "What Claim Reporting Modifiers Do I Use?" section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.

Examples of Medicare Program exclusions include:

- Personal comfort items;
- Self-administered drugs and biologicals (i.e., pills and other medications not administered by injections);
- Cosmetic surgery (unless required for prompt repair of accidental injury or for improvement of a malformed body member);
- Eye exams for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses in the absence of disease or injury to the eye;
- Routine immunizations (except influenza, pneumococcal, and hepatitis B vaccinations; specific regulations regarding beneficiary responsibility apply for these services);

- X-rays and physical therapy provided by chiropractors;
- Hearing aids and routine hearing examinations;
- Routine dental services (i.e., care, treatment, filling, removal, or replacement of teeth);
- Supportive devices for the feet;
- Routine foot care (i.e., cutting or trimming corns or calluses, unless inflamed or infected; routine hygiene or palliative care or trimming of nails);
- Services furnished or paid by government institutions;
- Services resulting from acts of war; and
- Charges made to the Medicare Program for services furnished by a physician or supplier to his or her immediate relatives or members of his or her household.

WHEN AM I PROHIBITED FROM ISSUING AN ABN?

What Is the Routine Notice Prohibition?

Medicare prohibits you from issuing ABNs on a routine basis (i.e., where there is no reasonable basis for Medicare to not cover the item or service). You must ensure that a reasonable basis exists for noncoverage associated with the issuance of each ABN. Some situations may require a higher volume of ABN issuance, and as long as proper evidence supports each ABN use, you will not be violating the routine notice prohibition.

May I use an ABN to bill a beneficiary for services denied due to a Medically Unlikely Edit (MUE)?

No, you cannot use an ABN to shift liability and bill the beneficiary for the services denied due to an MUE. For more information on MUEs, visit http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html on the CMS website.

What About a Beneficiary in a Medical Emergency or Under Great Duress?

You should not obtain an ABN from a beneficiary in a medical emergency or under great duress (i.e., compelling or coercive circumstances). ABN use in the emergency room may be appropriate in some cases for a medically stable beneficiary with no emergent health issues.

HOW DO I ISSUE A VALID ABN?

Who Should Issue the ABN When Multiple Entities Render Care?

When multiple entities render care, Medicare does not require you to issue separate ABNs. Either party involved in the delivery of care can issue the ABN when:

- There are separate "ordering" and "rendering" providers (e.g., a physician orders a laboratory test and an independent laboratory delivers the ordered tests);
- One health care provider delivers the "technical" component and the other the "professional" component of the same service (e.g., radiological test that an independent diagnostic testing facility renders and a physician interprets); or
- The entity that obtains the signature on the ABN differs from the entity that bills for the service (e.g., when one laboratory refers a specimen to another laboratory, which then bills Medicare for the test).

Regardless of who issues the ABN, Medicare holds the billing entity responsible for effective issuance. In these situations, you may enter the names of more than one entity in the header of the ABN as long as the beneficiary can clearly identify whom to contact for billing questions.

To Whom Should I Issue an ABN?

You should issue the ABN to:

- The Medicare beneficiary; or
- The Medicare beneficiary's representative for the purposes of getting notice under applicable state or other law.

You and the beneficiary must each retain one copy of the signed ABN. If you maintain Electronic Medical Records (EMRs), you may scan the signed hard copy for retention.

How May I Format an ABN?

You must issue the ABN in the standardized notice format and it cannot exceed one page in length; however, Medicare permits attachments for listing additional items and services. If you use an attachment sheet, you must insert a notation such as "See Attached Page" in the Items and Services (D) area of the ABN. Attached pages must include the following:

- Beneficiary's name;
- Identification number (optional);
- Date of issuance;
- Table listing the additional items or services, the reasons Medicare may not pay, and the estimated costs; and
- A space below the table in which the beneficiary inserts his or her initials to acknowledge receipt of the attachment page.

You must use a visually high-contrast combination of dark ink on a pale background, and the print must be readable to the beneficiary.

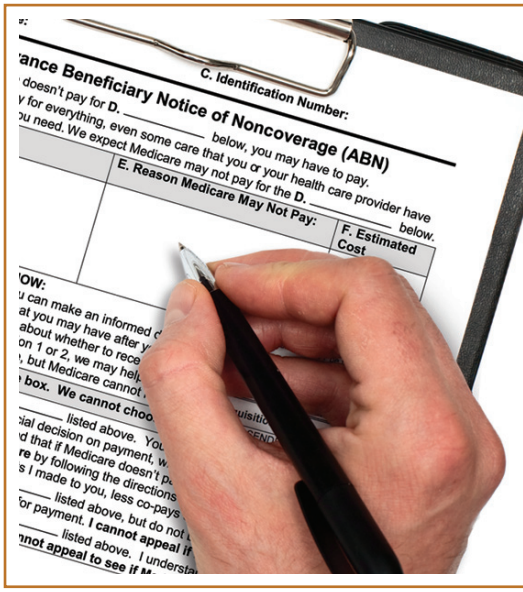
Medicare permits limited customization, such as preprinting information in certain blanks of the ABN. For more information, refer to the "Medicare Claims Processing Manual," Chapter 30, Section 50 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf on the CMS website.

How Do I Effectively Issue an ABN?

Medicare considers issuance of an ABN effective when the notice is:

- Issued (preferably in person) to and comprehended by a suitable recipient;
- The approved, standardized ABN with all required blanks completed;
- Provided far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options;
- Explained in its entirety with all questions related to the ABN answered; and
- Signed and dated by the beneficiary or his or her representative after he or she selected one option box on the ABN.

How Do I Issue an ABN Other Than In Person?



In circumstances when issuing an ABN in person is not possible, you may issue an ABN through the following means and according to Health Insurance Portability and Accountability Act (HIPAA) policies:

- Telephone,
- Mail,
- Secure fax machine, or
- E-mail.

When you do not issue the ABN in person, document the contact in the beneficiary's records. For Medicare to consider the issuance of an ABN effective, the beneficiary cannot dispute such contact. You must follow telephone contacts immediately by either a hand-delivered, mailed, e-mailed, or faxed ABN. The beneficiary or the beneficiary's representative must sign and retain the ABN and send a copy of the signed ABN to you for retention in the beneficiary's record.

Keep a copy of the unsigned ABN on file while awaiting receipt of the signed ABN. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the ABN.

HOW DO I COMPLETE AN ABN?

For the ABN and instructions on its use, visit http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website. You can find an example of an ABN on page 12 of this booklet.

The ABN consists of 5 sections and 10 blanks, which must appear in the following order from top to bottom:

Notifier(s) (A)

- You must place your name, address, and telephone number at the top of the ABN.
- If the billing and notifying entities differ, you may give the name of more than one entity in the notifier area; however, the beneficiary must be able to identify which entity to contact for billing questions.

Patient Name (B)

- You must enter the first and last name of the beneficiary getting the ABN. You should also use the middle initial if it appears on the beneficiary's Medicare card.

Identification Number (C)

- Medicare numbers, Health Insurance Claim Numbers (HICNs), or Social Security Numbers (SSNs) **must not** appear on the ABN.
- Insertion of an identification number, such as a medical record number or date-of-birth, is optional.

Body (D)

- You must list the general description of items or services believed to be noncovered on the blank line of the "NOTE."

Table (D, E, F)

- **First Block (D)**
  - You must list the specific items or services you believe to be noncovered.
  - In the case of upgrades, you must list the excess component(s) of the item or service for which you expect denial.
- **Reason Medicare May Not Pay (E)**
  - You must explain in beneficiary-friendly language why you believe Medicare may not cover each item or service. Commonly used reasons for noncoverage are:
    - Medicare does not pay for this test for your condition.
    - Medicare does not pay for this test as often as this (denied as too frequent).
    - Medicare does not pay for experimental or research use tests.

    NOTE: To be a valid ABN, at least one reason must apply to each item or service listed. You may apply the same reason for noncoverage to multiple items.

- **Estimated Cost (F)**
  - You must complete the Estimated Cost block to ensure the beneficiary receives all available information to make an informed decision about whether to obtain potentially noncovered services.
  - You must make a good faith effort to insert a reasonable estimate for all the items or services listed. In general, Medicare expects the estimate will fall within $100 or 25 percent of the actual costs, whichever is greater. Examples of acceptable estimates include, but are not limited to, the following:
    - For a service that costs $250:
      - "Between $150 – $300," or
      - "No more than $500."
    - You can bundle routinely grouped multiple items or services into a single-cost estimate.

Option 1, 2, or 3 (G)

The beneficiary, or his or her representative, must choose only one of the three options listed. Medicare does not permit you to make this selection.

- **If Option 1 is chosen:**
  - The beneficiary wants to get the item or services at issue and accepts financial responsibility. He or she agrees to make payment now, if required. **You must submit a claim to Medicare that will result in a payment decision that the beneficiary can appeal.**

    NOTE: If the beneficiary needs a Medicare claim denial for a secondary insurance plan to cover the service, the beneficiary should select Option 1.

- **If Option 2 is chosen:**
  - The beneficiary wants to get the item or services at issue and accepts financial responsibility. He or she agrees to make payment now, if required. You do not submit a claim to Medicare at the beneficiary's request. When the beneficiary chooses this option, you do not file a claim and there are no appeal rights.
  - You will not violate mandatory claims submission rules under Section 1848 of the Social Security Act when you do not submit a claim to Medicare at the beneficiary's written request when he or she selects this option.
- **If Option 3 is chosen:**
  - The beneficiary does not want the care in question and cannot be charged for any items or services listed. You do not file a claim and there are no appeal rights.

Additional Information (H)

You may use this space to provide additional clarification or information that may be useful to the beneficiary. For example:

- A statement advising the beneficiary to notify his or her health care provider about certain tests ordered but not gotten;
- An additional dated witness signature; or
- Other necessary annotations.

Medicare assumes you made annotations on the same date as that appearing with the beneficiary's signature, unless you include a separate date with the annotation.

Signature and Date Box (I, J)

Once the beneficiary reviews and understands the information contained in the ABN, the beneficiary, or his or her representative, should complete the Signature and Date box.

- **Signature:**
  - The beneficiary, or the beneficiary's representative, must sign the ABN to indicate that he or she got the ABN and understands its contents. If a representative signs, he or she should indicate "representative" after his or her signature.
- **Date:**
  - The beneficiary, or the beneficiary's representative, must write the date he or she signed the ABN. If the beneficiary experiences physical difficulty writing and requests assistance in completing this box, the notifier may insert the date.

Beneficiary Refuses to Complete or Sign the ABN

If the beneficiary refuses to choose an option and/or refuses to sign the ABN, you should annotate the original copy of the ABN indicating the refusal to sign. You may list any witnesses to the refusal on the ABN, although Medicare does not require this. If a beneficiary refuses to sign a properly issued ABN, you should consider not furnishing the item or service, unless the consequences (health and safety of the beneficiary, or civil liability in case of harm) prevent this option.

EXAMPLE OF AN ABN

For an example of an ABN, see below.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

WHAT DO I DO WITH THE VALID ABN?

In general, you should keep the ABN for 5 years from the date-of-care delivery when no other requirements under state law apply. Medicare requires you to keep a record of the ABN in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the ABN.

What If the Beneficiary Changes His or Her Mind?

If after completing and signing the ABN the beneficiary changes his or her mind, you should present the previously completed ABN to the beneficiary and request that he or she annotate the original ABN. The annotation must include a clear indication of his or her new option selection along with his or her signature and date of annotation. In situations where you cannot present the ABN to the beneficiary in person, you may annotate the form to reflect the beneficiary's new choice and immediately forward a copy of the annotated ABN to the beneficiary to sign, date, and return.

NOTE: In either situation, you must provide a copy of the annotated ABN to the beneficiary as soon as possible.

When Do I Need to Issue Another ABN for an Extended Course of Treatment?

You may issue a single ABN to cover an extended course of treatment if the ABN identifies all items and services and the duration of the period of treatment for which you believe Medicare will not pay. If the beneficiary receives an item or service during the course of treatment that you did not list on the ABN and Medicare may not cover it, you must issue a separate ABN.

A single ABN for an extended course of treatment remains valid for no more than 1 year. If the extended course of treatment continues after a year's duration, you must issue a new ABN.

May I Collect Payment from the Beneficiary?

A beneficiary's agreement to bear responsibility for payment on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare. You may bill and collect funds for noncovered items or services immediately after the beneficiary signs an ABN. If Medicare ultimately denies payment, you retain the funds collected.

However, if Medicare pays all or part of the claim for items or services previously paid by the beneficiary, or if Medicare finds you liable, you must refund the beneficiary the proper amount in a timely manner. Medicare considers refunds timely when made within 30 days after you get the Remittance Advice from Medicare or within 15 days after a determination on an appeal, if you or the beneficiary files an appeal.

If you do not issue a valid ABN to the beneficiary when Medicare requires, you cannot bill the beneficiary for the service and you may be financially liable.

WHAT IF I FAIL TO ISSUE A MANDATORY ABN OR ISSUE A DEFECTIVE ABN?

You will likely bear **financial liability** for items or services if you knew or should have known that Medicare would not pay for a usually covered item or service and you fail to issue an ABN or issue a defective ABN. In these cases, you **cannot collect funds from the beneficiary** and Medicare requires you to make prompt refunds if you previously collected payment.

WHAT CLAIM REPORTING MODIFIERS DO I USE?

The following are claim modifiers associated with ABN use. For specific instructions on filing claims associated with ABNs, see the "Medicare Claims Processing Manual," Chapter 1, Section 60 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf on the CMS website.

GA **Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case**
Use this modifier to 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 upon request.

GX **Notice of Liability Issued, Voluntary Under Payer Policy**
Use this modifier to report when you issue a voluntary ABN for a service that Medicare never covers because it is statutorily excluded or is not a Medicare benefit.

GY **Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit**
Use this modifier to report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit.

GZ **Item or Service Expected to Be Denied as Not Reasonable and Necessary**
Use this modifier to report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

RESOURCES

- For ABN manual instructions and ABN Form CMS-R-131, visit http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device. For a Medicare Learning Network® (MLN) Matters® Article on ABN, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7821.pdf on the CMS website.
- The MCD assists you with the latest information related to NCDs and LCDs, local policy articles, and proposed NCD decisions. For the MCD, visit http://www.cms.gov/medicare-coverage-database on the CMS website.
- For information related to coverage and important links, visit the Medicare Coverage Center at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo on the CMS website.
- The online CMS Internet-Only Manuals (IOMs) include CMS' program issuances, day-to-day operating instructions, policies, and procedures based on statutes, regulations, guidelines, models, and directives. For the NCD Manual, visit the IOM web page at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.
- The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about the Beneficiary Notices Initiative (BNI), refer to the "Medicare Billing – Beneficiary Notices Initiative (BNI)" section in the "MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.

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