DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Advance Beneficiary Notice of Noncoverage – Home Health and Hospice Services
PAGE: 1 of 11	**REPLACES POLICY DATED:** July 1, 2021
EFFECTIVE DATE: June 1, 2023	**REFERENCE NUMBER:** REGS.HHA.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated Home Health and Hospices Agencies performing and/or billing Medicare services. Specifically, the following departments:

Agency Administration/Management
Nursing Staff
Clinical Staff
Office Staff
Parallon Specialty Services
Scheduling
Ethics and Compliance Officer
Medical Directors
Non-physician Practitioners

PURPOSE: To outline the use of the mandatory Advance Beneficiary Notice of Noncoverage (ABN) for home health and hospice services not covered by Medicare fee-for-service.

POLICY:

Home Health Agencies

Prior to rendering a service, home health agencies (HHAs) should issue ABNs to Medicare fee-for-service beneficiaries if they plan to hold the patient financially liable and:

1. The care is not reasonable and necessary. For example, the service does not meet the requirements of a National Coverage Determination (NCD) /Local Coverage Determination (LCD).
2. Custodial care is the only care to be delivered.
3. The beneficiary is not homebound.
4. The beneficiary does not need skilled care on an intermittent basis.

ABN issuance is NOT required in the following home health situations:

1. Initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge.
2. Care that is never covered by Medicare under any circumstances (i.e., an HHA offers complimentary hearing aid cleaning and maintenance).
3. Telehealth monitoring used as an adjunct to regular covered home health care.
4. Noncovered items/services that are part of care covered in total under a Medicare bundled payment (e.g., HH prospective payment system (PPS) episode payment).

Hospices

Prior to rendering a service, hospice agencies should issue ABNs to Medicare fee-for-service beneficiaries if they plan to hold the patient financially liable and:

1. The beneficiary is not determined to be terminally ill.

2. Specific items or services that are billed separately from the hospice payment are not reasonable and necessary. For example, physician services.
3. The level of hospice care is determined to be not reasonable or medically necessary specifically for the management of the terminal illness and/or related conditions.

Home Health and Hospice Agencies

Prior to issuing an ABN, the home health and hospice agency (hereinafter referred to as "agency") may contact the ordering provider for additional information regarding the patient's case.

ABN must be delivered to the patient or representative prior to providing the items or services that are the subject of the notice.

If there is ambiguity as to whether the services are reasonable and necessary, the agency should proceed with obtaining an ABN in order to allow the Medicare Contractor to adjudicate the claim.

ABNs may be obtained for an extended course of treatment provided it identifies all items and services that may not be covered and does not extend more than one year.

Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage: ABNs may be issued to beneficiaries with QMB coverage (i.e., Medicaid coverage of Medicare premiums and cost sharing) and/or Medicaid coverage. If the provider has any indication that the beneficiary is a QMB and/or has Medicaid coverage, special guidelines outlined in the Procedure section of this policy must be followed.

Services for which ABNs are issued must be billed in accordance with the requirements within this policy.

If a proper ABN is not obtained for a service determined not to be reasonable and necessary, the patient cannot be held financially liable.

The use of the ABN for statutorily excluded services (e.g., self-administered drugs) is not required by Centers for Medicare and Medicaid Services (CMS). The guidance in this policy does not apply to situations where a voluntary ABN may be issued.

This policy does not address the use of the Home Health Change of Care Notice (HHCCN).

PROCEDURE:

USE OF THE ABN FORM

1. If the service to be provided is governed by an NCD or LCD, the pertinent information, including CPT/HCPCS codes and diagnosis codes if applicable, must be reviewed to determine if the service meets the requirements specified in the NCD and/or LCD and to determine if an ABN is necessary.
2. If the decision to issue an ABN is made, the ABN must **not** be provided:
   a. after services have been rendered.
   b. when an item or service is expected to be covered by Medicare.

c. without genuine reason to believe that Medicare may deny the item/service.

d. when the beneficiary is unable to comprehend the ABN (e.g., if the patient is comatose, confused or legally incompetent, he/she is unable to understand the implications of signing the ABN) and their authorized representative is not available.

COMPLETION OF THE ABN FORM

1. The agency must use the CMS-approved form (CMS-R-131) and may not be altered (see Attachment A). All fields on the ABN form must be completed in sufficient detail to specify the potentially non-covered service. All entries must be in Arial or Arial Narrow font in the size range of 10 – 12 point font or legibly handwritten. When Spanish-language ABNs are used, the insertions on the form must also be in Spanish.
2. Once the ABN is signed it may not be altered in any way. If additional services will be provided for which an ABN will be needed, a new ABN must be obtained. The signed ABN form should be distributed as follows: retain the original copy at the notifier's office (if other than the agency), give one copy to the patient, and retain one copy in the patient's electronic medical record.
3. The agency must include its name, address and telephone number in "Notifier(s)" section. The agency may also include their logo.
4. The first and last name of the patient must be entered in the "Patient Name" section.
5. The "Identification Number" section is optional; however, if completed, this section should include an identification number that ties the notice to the specific claim for which the ABN applies. The agency may enter the patient account number in this section. Medicare numbers or Social Security numbers must not appear on the notice.
6. The "Items and Services" section must include a general description of the items and services for which the ABN is being obtained in a language that is easy for the beneficiary to understand. It is not appropriate to only include a CPT/HCPCS code as a description. If a CPT/HCPCS is used then additional language must be provided describing the service. Whenever possible the general description of the service to be provided should be used. For example, use "Physical Therapy" as the description instead of "Services performed by a qualified Physical Therapist in the home health or hospice setting." This can apply to a reduction in services and should include the reduced frequency and/or duration and list all items or services believed to be non-covered.

7a. The HHA ABN form section titled Reason Medicare May Not Pay can be prepopulated with the following options:

a. "Medicare does not pay for care that is not medically reasonable and necessary."

b. "Medicare does not usually pay for custodial care, except for some hospice services."

c. "Medicare requires that a beneficiary cannot leave home (with certain exceptions) in order to cover services under the home health benefit."

d. "Medicare requires part-time or intermittent need for skilled nursing care in order to

cover services under the home health benefit."

e. "Other reason: _____."

NOTE: If the "Other" option is used a reason must also be entered as to why the HHA believes Medicare may not pay for the item or service.

7b. The Hospice ABN form sections titled Items and Services and Reason Medicare May Not Pay must be prepopulated with the following options:

a. Box 1: Item or Services: "The Medicare hospice benefit." Box 2: Because: "We have determined that you are not eligible under Medicare rules for certification as having a terminal prognosis as defined in the law."

b. Box 1: Item or Services: "The hospice General Inpatient Care level of care." Box 2: Because: "We have determined that you do not require this level of service."

c. Box 1: Item or Services: "The hospice Continuous Home Care level of care." Box 2: Because: "We have determined that you do not require this level of service."

When completing the ABN form one of the options must be utilized to indicate the reason why Medicare may not pay.

8. The Estimated Cost section of the ABN **must** be completed for any items or services listed as not being covered by Medicare. The ABN will **not** be considered valid if a good faith estimated cost is not included.

NOTE: When more than one item and/or service is at issue, the agency must enter separate cost estimates for each item or service as clearly as possible, including information on the period of time involved when appropriate. Multiple items or services that are routinely grouped can be bundled into a single cost estimate.

In general, the estimate should be within $100.00 or 25% of the actual cost, whichever is greater.

For example, a service that costs $250.00, the estimate could be listed as:

a. Any dollar estimate equal to or greater than $150.00.

b. "Between $150.00 - $300.00."

9. The beneficiary must select one of the three options listed in the Options section on the ABN form. Only one of the three options may be selected. If an option is not marked or more than one option is marked then the ABN will **not** be valid. The beneficiary may choose:

a. **Option 1** where they receive the item or service and Medicare is billed;

b. **Option 2** where they receive the item or service and are responsible for payment; or

c. **Option 3** where they refuse the item or service.

Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage:

When the beneficiary signs the ABN, he/she must be instructed to check **Option 1** on the ABN in order for a claim to be submitted for Medicare adjudication. **This is the only instance where the**

provider may indicate what option the beneficiary should choose. Strike through **Option Box 1** as shown below:

□ **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.~~

These edits are required because the provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries.

The agency may add a statement in the "Additional Information" section to help a dual eligible beneficiary better understand the payment situation such as, "We will submit a claim for this care with your other insurance," or "Your Medical Assistance plan will pay for this care."

Note: If there has been a State directive to submit a Medicare claim for a denial, the agency must mark the first check box when issuing the ABN.

If the beneficiary chooses Option 1, Occurrence Code 32 and the date the ABN was obtained must be entered on the UB. The exact items or services for which the ABN was obtained must be described within the system notes.

If the beneficiary chooses Option 2 or 3, Occurrence Code 32 should not be entered on the UB, since Medicare will not be billed in either scenario.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option".

10. The Additional Information section may be used to insert additional clarification that will be of use to beneficiaries.
11. The beneficiary or their representative must sign and date the ABN form. If the ABN form is not signed and dated it will not be considered valid.
12. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment, the ordering provider should be contacted to determine if non-performance of the services will compromise patient care.
13. If the beneficiary refuses to sign the ABN and be financially responsible in the event Medicare denies payment and demands that the services be performed, a second person should witness the provision of the ABN and the beneficiary's refusal to sign. The witness should sign an annotation on the ABN stating that he/she witnessed the provision of the ABN and the beneficiary's refusal to sign. The claim will be filed as if an ABN was obtained. In the case of a denial by Medicare, the beneficiary will be held liable per Section 1879(c) of the Social Security Act.

HCA Healthcare

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BILLING FOR SERVICES FOR WHICH AN ABN WAS OBTAINED

1. If the services are not reasonable and necessary and the beneficiary chose **Option 1** on the ABN:
   a. Occurrence code 32 must be reported to indicate the date that the ABN was provided to the beneficiary.
   b. The services must be reported in Total Charges on the UB.
   c. The GA modifier must be appended to the CPT/HCPCS code representing the service(s) for which the ABN was obtained.

   The Medicare Contractor will make a determination whether or not the services will be paid by Medicare.

   a. If the Medicare Contractor determines that the services are non-covered, the HHA/hospice must bill the beneficiary for the services for which an ABN was obtained.
   b. If the Medicare Contractor pays for the services then the beneficiary must not be billed for the services for which an ABN was obtained.

   Qualified Medicare Beneficiary (QMB) and/or Medicaid coverage:

   a. If Medicare denies a claim as not medically reasonable and necessary and a Remittance Advice (RA) is received, the claim may be crossed over to Medicaid for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue an RA based on this determination.
   b. If both Medicare and Medicaid deny coverage the beneficiary may be billed, subject to any state laws that limit beneficiary liability.
   c. Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the beneficiary in the following circumstances:
      - If Medicare denies the claim as not reasonable and medically necessary and the beneficiary has QMB coverage without full Medicaid coverage, the ABN would allow the provider to shift liability to the beneficiary per Medicare policy.
      - If Medicare denies the claim as not reasonable and medically necessary for a beneficiary with full Medicaid coverage, and subsequently, Medicaid denies coverage (or will not pay because the provider does not participate in Medicaid,) the ABN would allow the provider to shift liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.
2. If the services are not reasonable and necessary and the patient chose **Option 2** on the ABN, the services must not be billed to Medicare and Occurrence Code 32 must not be reported on the UB. The Parallon Specialty Services Billing Department must be informed of this decision by following established procedures for providing special instructions to the Medicare billers.

3. If the services are not medically necessary and the patient chose **Option 3** on the ABN, the beneficiary is choosing not to receive the items/services and no services will be billed to Medicare.
4. If the services have frequency limits:
   a. The services should be reported in Total Charges on the UB.
   b. The GA modifier must be appended to the CPT/HCPCS code representing the frequency limited service(s) if an ABN was obtained.
   c. Occurrence code 32 and the corresponding date must be reported when an ABN was obtained.
   d. The beneficiary must not be billed for the services if the Medicare Contractor pays for the services.
   e. The agency must bill the beneficiary for the services for which an ABN was obtained if the Medicare Contractor determines that the services have exceeded the frequency limits.
   f. The agency must not bill the beneficiary if the Medicare Contractor determines that the services have exceeded the frequency limits and an ABN was not obtained.
5. If the services are outside the scope of the LCD and/or NCD the services should be reported as covered in Total Charges on the UB.
6. If multiple ABNs are obtained for services included on one claim, occurrence code 32 and the date the ABN was provided must be reported for each ABN, even if the date is the same for each ABN.
7. If the services are not reasonable and necessary and an ABN was not obtained prior to rendering the non-covered services, the services must be reported as non-covered with the GZ modifier on the UB. The charges should be written off as non-covered/non-allowable and must **not** be claimed as Medicare Bad Debt Expense.

EDUCATION

Home health and hospice personnel must educate associates and staff members responsible for ordering, performing, overseeing and billing services regarding the contents of this policy.

The Agency Director is responsible for the implementation and monitoring of this policy within the home health and hospice agency.

REFERENCES:

1. Medicare National Coverage Determinations
2. HHH Medicare Contractor Local Coverage Determinations
3. CMS Pub. 60AB, Transmittal No. AB-02-114, July 31, 2002 – ABNs and DMEPOS Refund Requirements - Implementation of Form CMS-R-131, Advance Beneficiary Notice (ABN), and of Limits on Beneficiary Liability for Medical Equipment and Supplies
4. Medicare Claims Processing Manual (Pub 100-4), Chapter 30 – Financial Liability Protections, Sections 40 – 50

5. Medicare Claims Processing Manual (Pub 100-4), Chapter 1, Section 60
6. Medicare Program Integrity Manual (Pub 100-8), Chapter 13, Sections 1.1 and 1.3
7. CMS Form Instructions for Advance Beneficiary Notice of Non-coverage (ABN) OMB Approval Number: 0938-0566
8. Social Security Act Section 1862
9. CMS Frequently Asked Questions - Qualified Medicare Beneficiary Program – FAQ on Billing Requirements, July 2018

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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

If Medicare will not pay for a service, does that mean I do not need the service?

No. Your doctor bases decisions on a wide range of factors including your personal medical history, any medications you might be taking, and generally accepted medical practices. Even if your doctor believes a particular item/service is “good medicine,” and useful information to have in order to provide the best care for you, it is possible Medicare may not consider the service to be medically necessary for patients with your diagnosis.

What if I have questions?

If you have questions, you should discuss them with your physician and/or healthcare provider at the time of service.

For additional information contact your Medicare Representative

Important Information for Medicare Patients Concerning Non-covered Services

What is “Medical Necessity”?

Medicare covers only those services which are reasonable and necessary for your treatment. Medicare requires providers to report information regarding the patient’s diagnosis when seeking payment so that they can determine whether the services ordered were medically necessary.

What is an ABN?

An ABN is an Advance Beneficiary Notice of Noncoverage. The purpose of the ABN is to give you advance notice that Medicare may not pay for your services. The ABN tells you which item(s)/service(s) may not be reasonable and necessary and informs you that you will be financially responsible for the services should Medicare deny payment. When it is required, you will be asked to sign the ABN before services are performed.

What options do I have?

You have three options when an ABN form is presented to you. You may 1) receive the services and request that Medicare be billed for a determination. You agree to be responsible for payment of the services if Medicare does not consider them reasonable and necessary; 2) receive the services and Medicare not be billed. You will be responsible for the payment; or 3) refuse

to be responsible for payment of services that Medicare will not cover and, therefore, not receive the items or services.

What are my rights as a patient?

As a Medicare beneficiary, you have certain guaranteed rights. These rights protect you when you receive health care; assure you access to needed health care services; and protect you against unethical practices. Your rights include, but are not limited to:

- The right to information about what services are covered and how much you will have to pay
- The right to information about all treatment options available to you The right to appeal decisions to deny or limit payment for medical care

How does the billing process work?

Generally, your doctor will bill Medicare when you receive a service at their office. However, when your doctor orders items or services from a HHA/Hospice or outside of his or her office, the HHA/Hospice performs the items/services which were requested and the HHA/Hospice, not your doctor, bills Medicare directly for the services being performed for you. The HHA/Hospice provides Medicare with your Medicare number, the services performed, and your diagnosis provided by your doctor