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Acute Care Hospitals: Advance Beneficiary Notice of Noncoverage (CMS-R-131 Form) for Outpatient Services

5/8/2025

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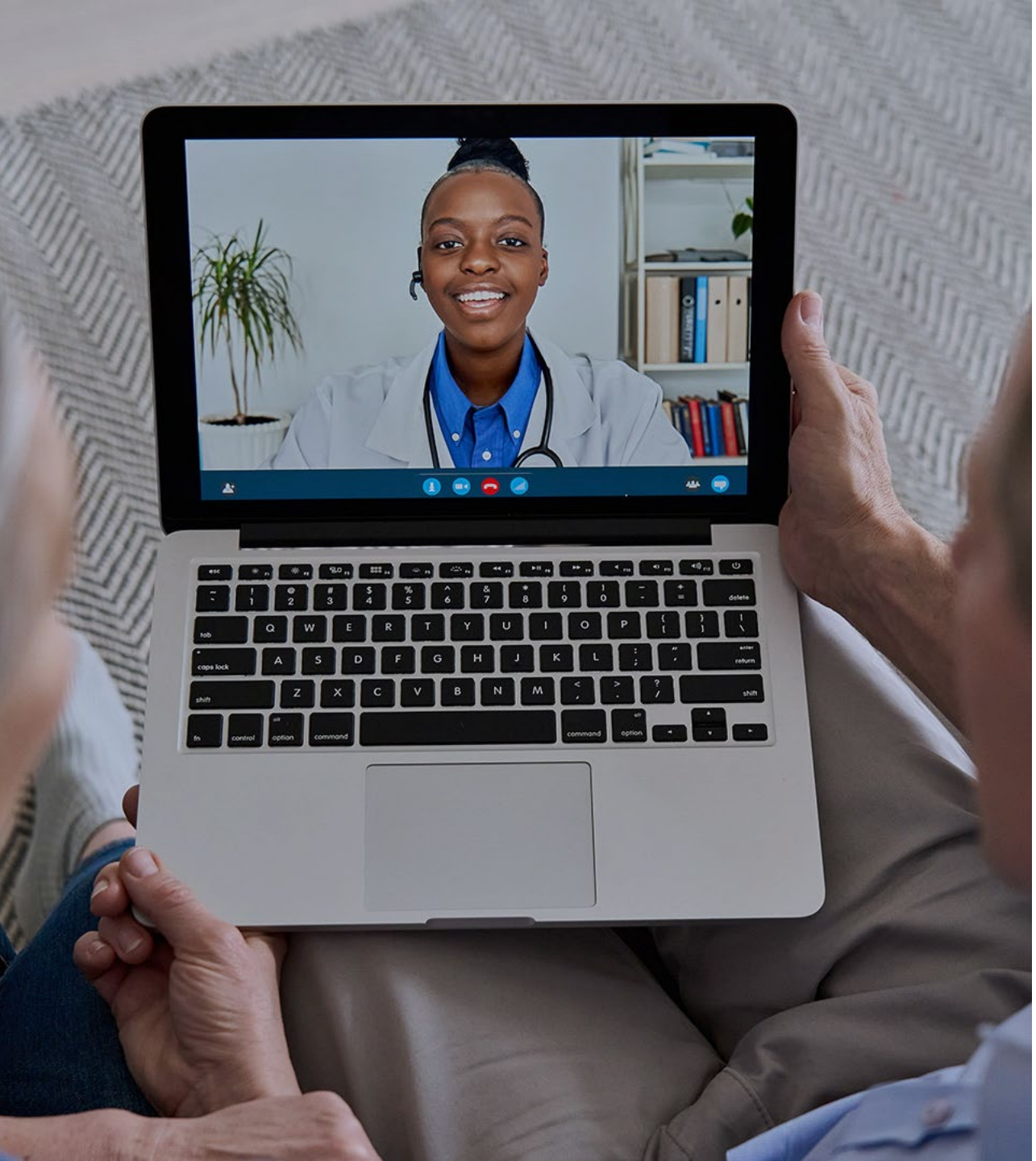

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Objectives

- Assist ACH providers with when and how to issue a proper ABN (Form CMS-R-131) for OP services
- Provide ABN billing guidelines and resources

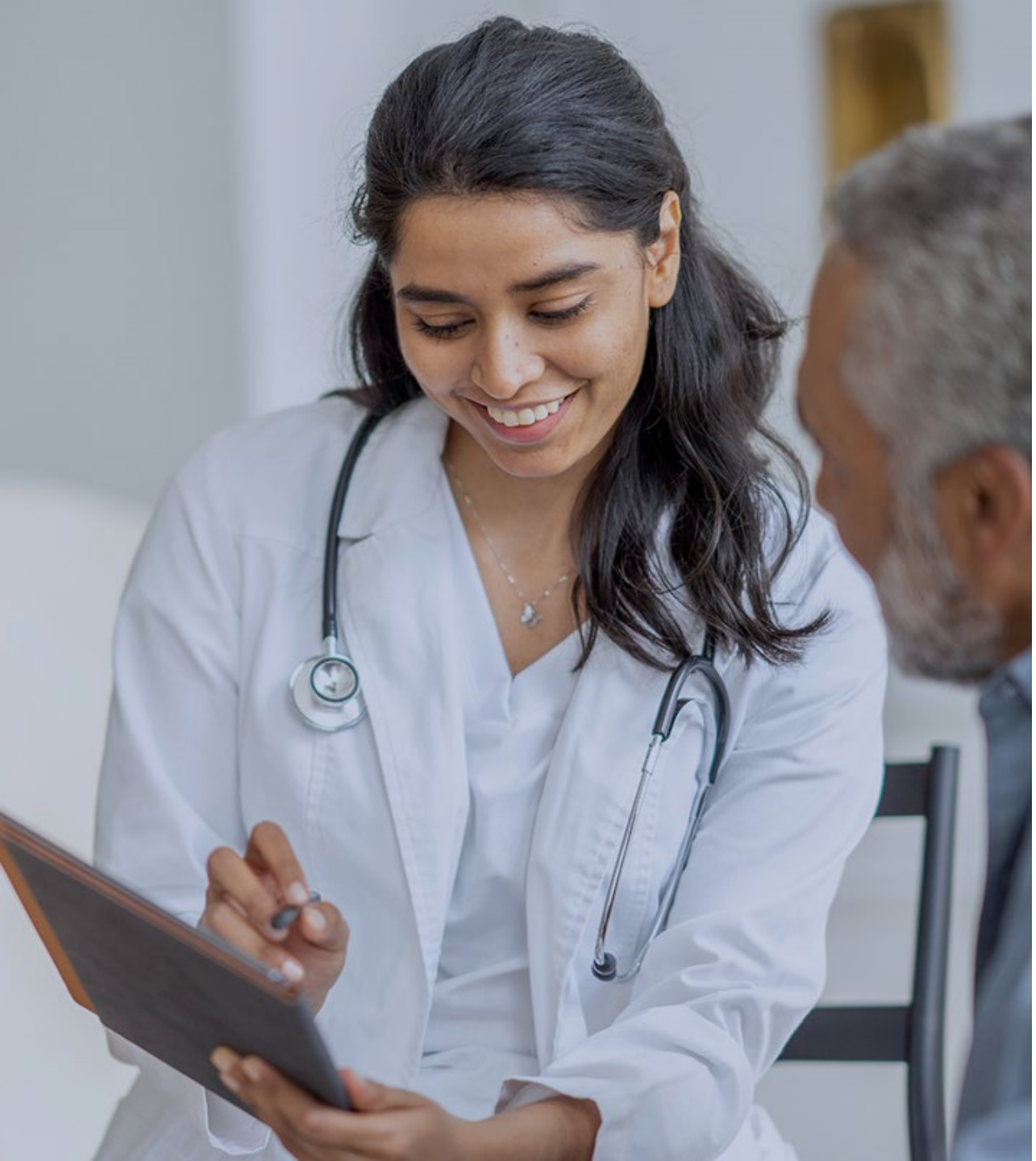
Today's Presenters

- Provider Outreach and Education Consultants
  - Jean Roberts RN, BSN, CPC
  - Christine Janiszcak

Agenda

- Medicare Coverage
- Three Payment Liability Conditions
- ABNs
- Mandatory ABN
- Voluntary ABN
- Dental Services: Exclusion and Exceptions
- Liability Modifiers and CCs 20/21
- Resources
- Resources: Additional Notices
- Questions

Medicare Coverage



Did You Know

- Not all services provided to Medicare beneficiaries are covered/payable under Medicare Program
- Examples of services that may not be covered
  - Services not medically reasonable and necessary
  - Foot care
  - Custodial care
  - Personal comfort items
  - Cosmetic surgery
  - Dental surgery

Understanding Medicare Coverage

- Statutory ability to shift liability only applies to items/services usually covered as part of established Medicare benefit per Title XVIII of SSA
  - Benefits not addressed in Title XVIII are statutorily excluded from Medicare coverage
    - Medicare not authorized to cover/reimburse

Understanding Medicare Coverage

- Financial liability occurs when items/services not covered by Medicare due to SSA Sections
  - 1862(a)(1): Services that otherwise may be covered but which are not medically R&N in individual case
  - 1862(a)(9): Custodial care which Medicare never covers
  - 1879(g)(1): Home care given to beneficiary who is neither homebound nor needs intermittent skilled services at home
  - 1879(g)(2): Hospice care given to someone not terminally ill

Understanding Medicare Coverage

- Provider must inform beneficiary when services not covered
- Must notify via written notice (e.g. ABN) prior to receiving services
  - Notice must specify reason

Provider Best Practices

- Review planned services and potential coverage/noncoverage for all applicable insurers
- Determine any potential beneficiary liability and reason for anticipated Medicare noncoverage
- Discuss planned services with beneficiary including any potential financial liability and cost estimate
- Issue any involuntary/voluntary notice per liability determination
- Allow beneficiary to determine if accepting any financial liability for identified services
  - Beneficiary has right to refuse service/not accept financial liability
- Render services per beneficiary's decision and bill accordingly

Three Payment Liability Conditions

Three Payment Liability Conditions

Statutorily Excluded

Items and services being billed are statutorily excluded from Medicare coverage. Items and services are not defined as a specific Medicare benefit per SSA; therefore, they are never paid.

Not Medically R&N

Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or provider

Presumed a Medicare Benefit

Item or service presumed to be a Medicare benefit and can be paid

Three Payment Liability Conditions

- Only **one of three** payment liability conditions apply to given item or service, or to given line of claim
  - When possible, split claims so one of these conditions apply per claim
  - Not always possible to split claims and multiple conditions/notices may apply to single claim
    - E.g.: For claims paid under OPPS, you must report all services provided on same day on same claim, with few exceptions

Payment Liability Condition One

Scenario	Payment Condition One
Description	Items and services not defined as a specific Medicare benefit are statutorily excluded from Medicare coverage per SSA
Notification (Prior to Billing)	Liability notices are voluntary (i.e., voluntary ABN); for statutory exclusions, there are no required Medicare notices
Billing	Items and services may be billed as noncovered on Medicare claims
Liability	Always denied in Medicare claims processing; beneficiaries are liable for these denials unless providers code claims to transfer liability to themselves

Payment Liability Condition One: Exclusions from Medicare Coverage (Voluntary ABN)

- When beneficiary elects to receive services excluded from Medicare per statute
  - Provider Informs beneficiary
    - Convey clear specific reason for Medicare noncoverage
    - Services will be billed to Medicare as noncovered and beneficiary will be financially liable
  - Include documentation in medical record that beneficiary informed of Medicare noncoverage
  - You **may use ABN for voluntary notification purposes** but not required to be issued

Payment Liability Condition Two

Scenario	Payment Condition Two
Description	Items and services being billed are either a reduction or termination of Medicare coverage, or are expected to be denied, leaving financial liability for a beneficiary or provider
Notification (Prior to Billing)	Liability notices are required • i.e.: expedited determination notice, ABN
Billing	Billing can vary, depending on ability to segregate into covered and noncovered portions (if both exist)
Liability	For any services that are not paid by Medicare, properly notified beneficiaries are usually liable for resulting denials

Payment Liability Condition Two: Not Medically R&N

- Provider determines service typically covered by Medicare not medically R&N for specific beneficiary/situation
  - Examples:
    - OP therapy exceeding threshold and you determine it does not qualify for exception
    - Beneficiary received R&N PT; subsequently, physician/therapist determined no longer R&N because no further improvement is anticipated; services now considered maintenance but beneficiary requests to continue PT

Payment Liability Condition Two: Mandatory ABN

- Provider **must** issue ABN when services reduced or terminated and thought to be not covered
  - Delivery of ABN can permit shift of liability
  - Issue ABN to beneficiary **before** you deliver services
    - Failure to issue ABN when required means you will not be able to shift liability to beneficiary
  - Document in medical records when you issue mandatory ABN
    - Example: Provider determines PT no longer R&N (met all goals) but beneficiary wants to continue PT

Payment Liability Condition Three

Scenario	Payment Condition Three
Description	Item or service is presumed to be a Medicare benefit and can be paid
Notification (Prior to Billing)	Liability notices, mandatory or voluntary, are never used in advance of billing
Billing	Billed with covered charges
Liability	If Medicare doesn't pay as expected, the specific reason for rejection or denial will determine liability according to established Medicare policy

Payment Liability Condition Three: Covered Services

- Condition occurs when provider billing for what is believed to be covered services
  - No ABN requirement
  - Noncovered charges not involved
  - Denials may result from processing

ABNs

ABN Is a Written Notice

- Must use ABN Form CMS-R-131
  - Approved by OMB
  - Must use current version containing expiration date 1/31/2026
  - FFS ABN
- Issuance of ABN
  - Mandatory
  - Voluntary

What Is an ABN?

- Written notice provider of services issues to FFS Medicare beneficiary in certain circumstances before rendering identified services
  - Explains Medicare payment expected to be denied
  - Allows beneficiary to make informed decision before services rendered
  - Shifts liability for payment to beneficiary if he/she chooses to obtain those services
- Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Section 50

When Should You Issue an ABN?

- Prior to rendering service(s) when Medicare denial anticipated
  - State reason you believe services will not be covered
    - Services not medically R&N
      - Examples: Preventive service exceeding frequency limitation
    - Care considered custodial
    - Therapy services above cap that do not qualify for therapy cap exception
- Beneficiary must comprehend contents
  - Cannot be under duress
  - Cannot be coerced
  - Informed consumer choice

Routine ABN Prohibition

- Routine use not effective
  - Routinely issued = defective notice
- Issue ABN when no specific identifiable reason to believe Medicare will not pay
  - Provider must have reason for anticipating Medicare will not make payment

Routine ABN Prohibition – Exceptions

Services always denied for medical necessity

Services where Medicare established statutory or regulatory frequency limitation on coverage or frequency limitation on coverage based on NCD/LCD

Experimental items and services

DME/medical equipment related

ABN Prohibitions

Cannot Issue ABN to...

Shift liability to bill beneficiary for services denied due to MUE

Cannot Issue ABN to...

Compel or coerce beneficiary in medical emergency or under great duress

Note: Issuing ABN in ER or during ambulance transports may be appropriate in some cases

Cannot Issue ABN to...

Charge beneficiary for part of service when Medicare covers through bundled payment

Cannot Issue ABN to...

Transfer liability to beneficiary when Medicare covers services

Delivery Requirements

- ABN considered to be effective when
  - Delivered to capable recipient by suitable notifier
  - Issued appropriate, fully completed ABN form
  - Delivered in person (if possible)
  - Provided far enough in advance – beneficiary considers all options
  - Explained in full – beneficiary's questions answered
  - Signed by recipient

Liability

- Beneficiary
  - Issued properly written and delivered ABN and agrees to pay knowing he/she may be held liable
    - Note: Beneficiary relieved of liability if did not receive proper notice when required
- Provider
  - Will be liable when should have known Medicare would not pay and fails to issue ABN when required or issues defective ABN
- CMS Beneficiary Notices Initiative (BNI)

Liability Conditions for Bundled Services

- ABN must apply to **all** of a bundled service or to **none** of it
- Bill entire bundled service as covered when you determine all or part of bundle of services certain to be covered and/or medically R&N
- Bill entire bundle of services as noncovered when you determine none of bundled will be covered

Obligation to Bill Medicare

- When you issue ABN
  - Beneficiary has right to request claim submission to Medicare for official payment decision
    - Beneficiary must receive service described in ABN and choose option 1

Emergency/Urgent Situation

- Do not issue ABN
  - In medical emergency or
  - When beneficiary under duress
- Issuing ABN in ER may be appropriate in some cases
  - Is beneficiary medically stable with no emergent health issues?
- When EMTALA applies, do not issue ABN
  - May reconsider if beneficiary capable after completion of medical screening exam and stabilization of any emergency medical condition

Period of Effectiveness: Repetitive or Continuous Noncovered Care

- ABN may remain effective up to one year if no other triggering event occurs
  - If new triggering event occurs, issue new ABN
- We investigate allegations of improper or incomplete notices
  - An improper or incomplete ABN may result in provider liability

Mandatory ABN

Mandatory ABN Billing

- Report OC 32 and date you issued mandatory ABN
  - Report services related to ABN with covered charges
  - If issued multiple ABNs, report multiple OC 32s and dates
  - Normal billing regulations apply
- Report modifier GA when applicable
  - Indicates ‘Waiver of liability statement on file, as required by payer policy’
  - Use when some services on claim relate to mandatory ABN
  - Do not report with any other liability-related modifier
  - Normal billing regulations apply

Mandatory ABN

- When billing for mandatory ABN related services, you may include on claim other covered and noncovered services
  - Report OC 32 and modifier GA (with covered charges) to identify services related to ABN
    - Do not report any other liability-related modifier(s)
- Medicare systems
  - Automatically deny lines submitted with OC 32 and/or modifier GA (with covered charges)
  - Assign beneficiary liability to claims
    - CARC 50 = “These are noncovered services because this is not deemed a medical necessity”

Dually Eligible/Qualified Medicare Beneficiary (QMB and/or Medicaid Coverage)

- You must have dually eligible beneficiary check Option Box 1 **after** striking through:

> ☐ **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.~~

- Dually eligible beneficiary must not be billed when ABN issued
- When both Medicare and Medicaid claim adjudication decisions completed
  - ABN may be used to shift liability to beneficiary – subject to any state laws limiting liability

Voluntary ABN

Voluntary ABN

- Not required to notify beneficiary before furnishing item or service Medicare never covers or not a Medicare benefit
  - Voluntary use of ABN allowed (not required) for certain services
- May issue voluntary ABN for care
  - Statutorily excluded from coverage (SSA Section 1862)
    - Not required to bill Medicare excluded services
  - Technical benefit requirement not met (SSA Section 1861)

Voluntary ABN Considerations

- When you issue ABN voluntarily
  - Serves as courtesy to beneficiary to notify of impending financial obligation
  - Do not ask beneficiary to choose an option box or sign notice
- Medicare billing
  - Not required to bill but may do so voluntarily
  - When billing related to voluntary ABN, do not report modifier GA
  - Consider billing liability modifier or CC

Dental Services: Exclusion and Exceptions

Excluded Dental Services

- Dental Exclusion: Applies to IP and OP
- Medicare does not cover items and services for care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth
  - Periodontium – complex structure that surrounds and supports teeth
    - Includes
      - Gingivae
      - Dentogingival junction
      - Periodontal membrane
      - Cementum
      - Alveolar bone (alveolar process and tooth sockets)

Excluded Dental Services Examples

- Routine dental care
- Tooth extraction – impacted tooth
- Dental services performed in connection with excluded services
  - Prepare mouth for dentures
  - Alveoplasty
  - Dental ridge reconstruction
  - Frenectomy
  - Removal of torus palatinus
- Dental services related to other noncovered services

Inextricably Linked

- Services connected to dental services when patient requires hospitalization due to:
  - Patient's underlying medical condition and clinical status; or
  - Severity of dental procedure
- Dental services so integral to other medically necessary services that clinical success of that service dependent upon, or inextricably linked to, dental services
  - Applies to Part A and Part B, including whether IP or OP

Inextricably Linked

- Care coordination is vital to ensure health care providers have information necessary to decide whether dental service is inextricably linked to a Medicare-covered service
  - Different providers (such as a doctor and a dentist) must coordinate care to provide
    - Medicare-covered services to treat the illness
    - Dental services that are integral to clinical success of medical service

Documentation of Care Coordination

- Care coordination must be documented and must provide evidence to support exchange of information, or integration, between health care providers furnishing medical services and dental services
  - Example of care coordination may include a referral or exchange of information between medical doctor and dentist
- FYI: Must be Medicare-enrolled provider to bill for providing Medicare-covered dental services

Examples of Dental Services Integral to Medicare-Covered Services

- Dental or oral exams as part of a comprehensive workup before Medicare-covered
  - Organ transplant, including hematopoietic stem cell and bone marrow transplant
  - Cardiac valve replacement
  - Valvuloplasty procedures
  - Chemotherapy, chimeric antigen receptor (CAR) T-cell therapy, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used to treat cancer
  - Services to stabilize or immobilize teeth related to reducing a jaw fracture

Dental Services Resources

- CMS website: Medicare Dental Coverage
- Our website
  - Part A Dental
  - Part B Dental
- CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*
  - Chapter 4
    - Section 10.3: Certification for Hospital Admissions for Dental Services
  - Chapter 5
    - Section 70: Physician Defined
    - Section 70.2: Dentists

Dental Services Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
  - Chapter 1

    Section 30: Drugs and Biologicals

    Section 70: Inpatient Services in Connection With Dental Services
  - Chapter 15

    Section 60: Services and Supplies Furnished Incident-to a Physician's/NPP's Professional Service,

    Section-120C: Dentures

    Section 150: Dental Services
  - Chapter 16

    Section 140: Dental Services Exclusion

Dental Services Resources

- CR13181: Medicare Policy Updates for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (MPFS) Final Rule
- CR13190: Educational Instructions for the Implementation of the Medicare Payment Provisions for Dental Services as Finalized in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule
- CR13649: Utilization of KX Modifier Medicare Physician Fee Schedule Payment for Dental Services Inextricably Linked to Covered Medical Services
  - Effective 7/1/2025 for services billed to Part B MAC

Liability Modifiers and CCs 20/21

Modifier GA

- Report when covered **and** noncovered services on ABN-related claim
  - Must report OC 32
  - Only line items with modifier GA considered related to ABN
  - Report all ABN-related charges as covered
    - Beneficiary liable for services billed with modifier GA/OC 32
- May bill other line items on same claim with covered or noncovered charges

Modifier GY

- Report when item or service statutorily excluded or does not meet definition of any Medicare benefit
  - Report applicable charges as noncovered
  - ABN not required but may be voluntarily issued
    - Beneficiary liable for services billed with modifier GY
- May also report modifier GX on claim

Modifier GX

- Report when you issued a voluntary notice of liability
  - Report applicable charges as noncovered
  - ABN not required but may be voluntarily issued
  - Claim denied as beneficiary liable
- Medicare systems allow modifier GX to be reported on same claim as modifier GY (service statutorily excluded)

Modifier GZ

- Report when you expect denial due to lack of medical necessity
  - Denotes that item or service expected to be denied as not medically R&N; however, you did not issue required ABN
  - Report applicable charges as noncovered
- Provider will be liable for services billed with modifier GZ
  - We will not perform complex Medical Review and will automatically deny claim line(s) submitted with CAGC CO/CARC 50

Did You Know

- Billing guidelines in this presentation apply to all liability modifiers discussed today as well as those included in CMS IOM Publication100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 60.4.2 table "Definition of Modifiers Related to Non-covered Charges/ABNs for Institutional Billing"
  - Liability modifiers required when noncovered services cannot be split into entirely noncovered claims
  - Provider liability modifiers cannot be used on entirely noncovered claims when some services are beneficiary liable

Demand Bill: Condition Code 20

- Report in situations where issuing ABN not appropriate and beneficiary demands Medicare determination
  - Report charges related to CC 20 as noncovered
    - TOB frequency = 0 when you report all charges as noncovered
  - Unrelated covered charges allowed
    - TOB as applicable
  - Do not report OC 32 and/or CC 21 with CC 20
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 60

Insurance Denial: Condition Code 21

- Report to obtain Medicare denial to use when billing secondary or other insurances
  - No services in dispute by beneficiary
  - Report all charges as noncovered
  - Do not report any modifiers
  - Report total charges = noncovered charges
  - TOB frequency = 0
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 60
- Billing Medicare for a Denial - Condition Code 21

Resources

CMS Resources

- Beneficiary Notices Initiative (BNI)
  - ABN (Form CMS-R-131)
    - To deliver a valid ABN provider must use most recent version of CMS-R-131
    - FFS ABN Form and Instructions
- MLN Booklet®
  - *Medicare Advance Written Notices of Noncoverage (MLN006266)*
  - *Items and Services Not Covered Under Medicare (MLN906765)*
- MLN Educational Tool (MLN909183): *Advance Beneficiary Notice of Non-coverage Tutorial*
- Medicare Dental Coverage
  - Includes: What Are Inextricably Linked Dental Services?

CMS Resources

- CMS IOM Publications
  - 100-02, *Medicare Benefit Policy Manual*, Chapter 16 – General Exclusions From Coverage
  - 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 60 – Provider Billing of Non-covered Charges on Institutional Claims
  - 100-04, *Medicare Claims Processing Manual*, Chapter 30 – Financial Liability Protections
- Documentation
  - MLN Fact Sheet®: *Complying with Medical Record Documentation Requirements*
  - CMS Documentation Matters Toolkit
  - Medicare Coverage Guidance Documents

CMS Resources

- MLN Matters®
  - MM13548: *Medicare Claims Processing Manual Updates – HCPCS Billing Codes & Advance Beneficiary Notice of Non-coverage Requirements*, effective 5/15/2024
    - Updates CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Physicians/Nonphysician Practitioners
  - MM12242: *Section 50 in Chapter 30 of Publication 100-04 Manual Updates,* effective 10/14/2021
    - Updates CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Financial Liability Protections

NGSMedicare.com Resources

- Acronym Search Tool
- Capable Recipients for the Advance Beneficiary Notice of Noncoverage
- Billing Medicare for a Denial – Condition Code 21

Resources: Additional Notices

Outpatient Beneficiary Notices

- FFS MOON: Medicare Outpatient Observation Notice
  - Hospitals and CAHs required to provide MOON to Medicare beneficiaries informing them they are outpatients receiving observation services and not inpatients of hospital or CAH
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30 Financial Liability Protections, Section 400 – Part A Medicare Outpatient Observation Notice

Inpatient Beneficiary Notices

- CMS FFS & MA IM – Provides additional information on IM and DND
  - Important Message from Medicare (IM)
    - Beneficiary notice issued within two days of inpatient admission to explain rights as a patient
    - A follow-up copy is provided up to two days, and no later than four hours, before inpatient discharge
  - Detailed Notice of Discharge (DND)
    - Issued to inpatient who requests expedited review of discharge to explain specific reason for discharge
- CMS MLN® Booklet: *Medicare Advance Written Notices of Non-coverage*

Inpatient Beneficiary Notices

- Hospital-Issued Notice of Noncoverage (HINN)
  - HINN 1: Preadmission/Admission HINN – entirely noncovered stay
  - HINN 10: Notice of Hospital Requested Review (HRR) – used when hospital requests BFCC-QIO review of a discharge decision without physician concurrence
  - HINN 11: Used for noncovered services during an otherwise covered stay
  - HINN 12: Used in association with Hospital Discharge Appeal Notice to inform beneficiary of potential financial liability for noncovered continued inpatient stay
- Inpatient Hospital Issued Notices

Inpatient Beneficiary Notices: Medicare Change of Status Notice (MCSN)

- FFS MCSN
- Effective 10/11/2024 and implemented 2/15/2025
- Hospitals/CAHs providing inpatient level of care must issue MCSN to beneficiary who was formally admitted as inpatient but being reclassified from inpatient to outpatient receiving observation services
  - Must deliver MCSN notice to all beneficiaries eligible for expedited determination process while still an inpatient to notify them of their right to appeal their reclassification (status change from an inpatient to an outpatient receiving observation services) with their BFCC-QIO
    - Must deliver as soon as possible, but no later than 4 hours prior to discharge

Medicare Change of Status Notice (CMS-10868)

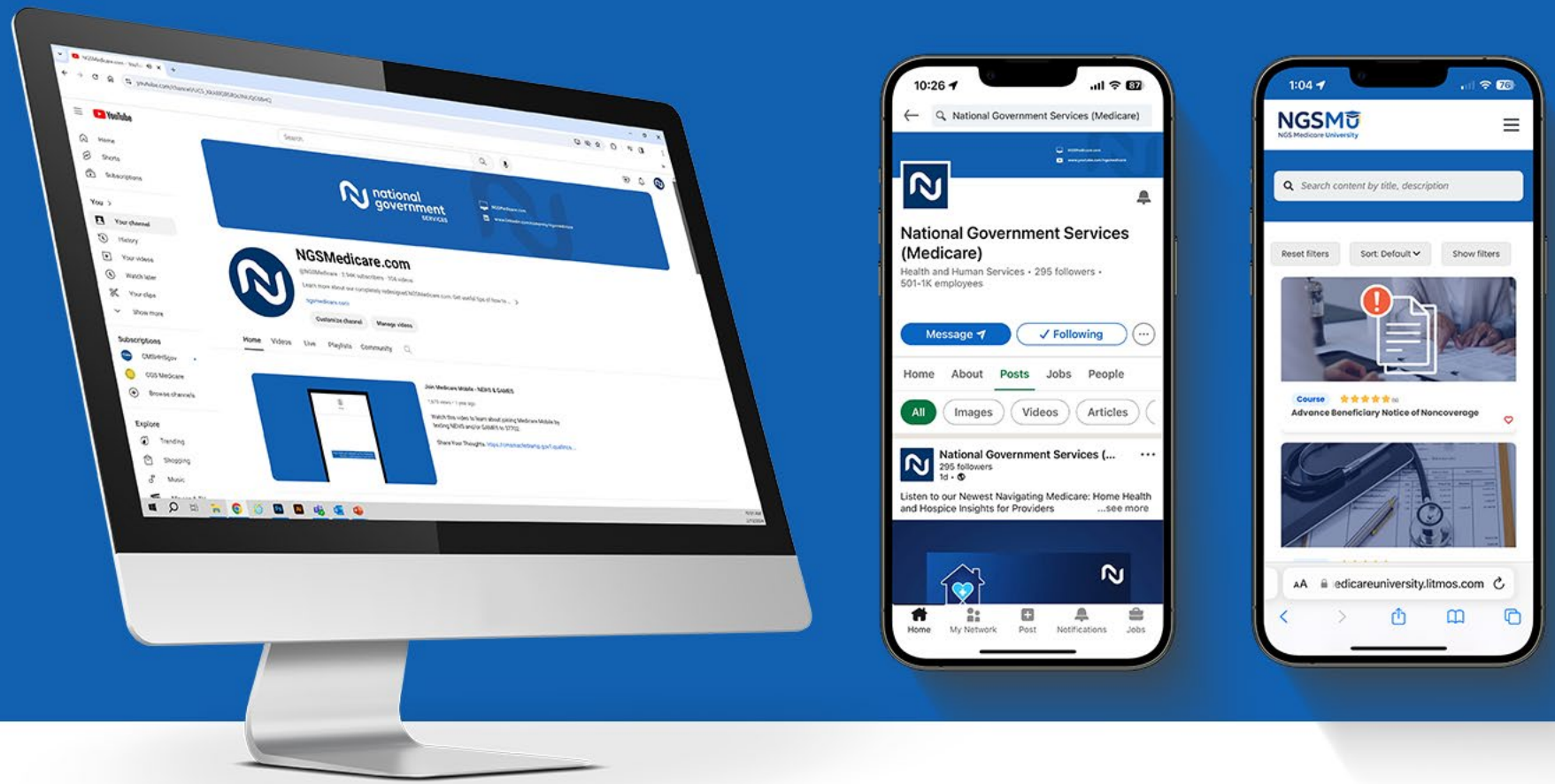
- MCSN Form: Medicare Change of Status Notice (CMS-10868)
- Additional information
  - CR 13918 "Billing Instructions Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)"
  - MLN Matters® *MM13846: Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services)*
  - Medicare Change of Status Notice

SNF ABN

- CMS FFS SNF ABN and SNF ABN (Form CMS-10055)
  - SNF IP stay: Used for Part A items/services to transfer financial liability to beneficiary before providing a Part A item/service usually covered, but may not be covered due to being medically unnecessary or custodial care

Questions?

Thank you!



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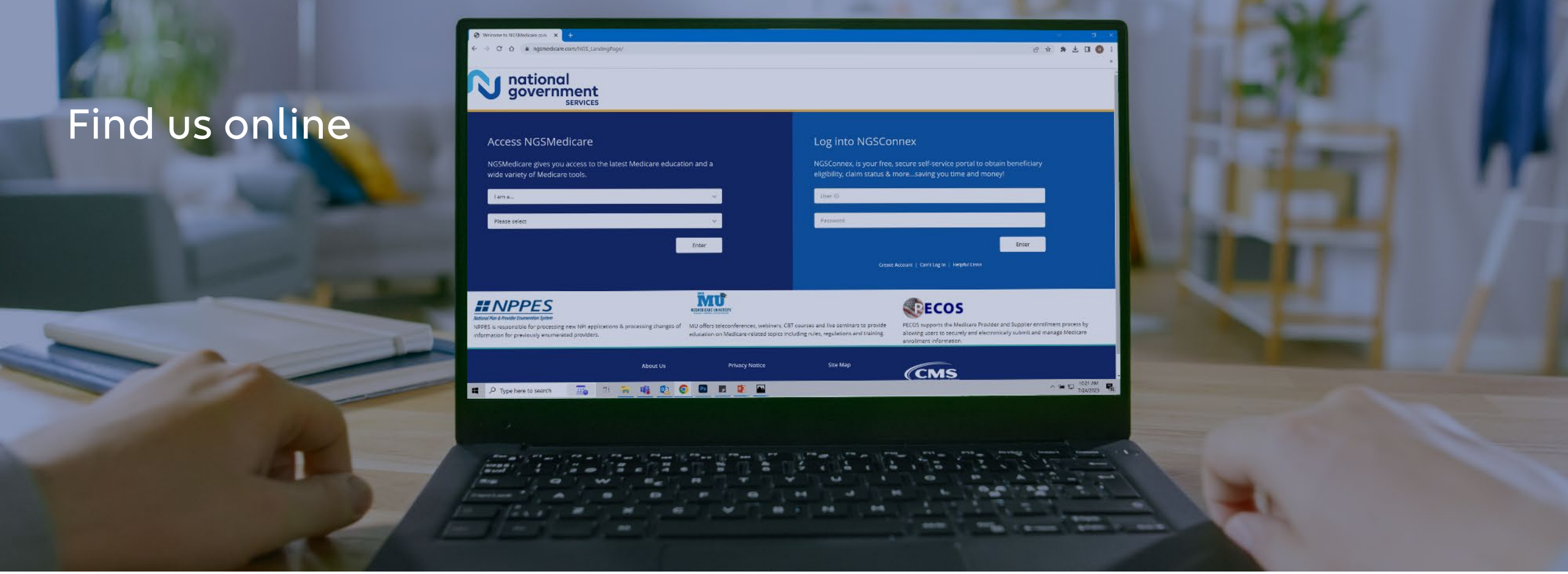

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