Advance Beneficiary Notice of Non-coverage (ABN) and Notice of Medicare Non Coverage in Hospice (NOMNC)

Tips for Hospice Providers
(Reviewed Revised May 2014)

Revisions to this compliance guide include updates regarding when to issue an ABN for medications.

Advance Beneficiary Notice of Non-coverage (ABN)

ABN details:
- Providers furnishing services that Medicare is not expected to cover, must issue an ABN.
- The ABN and the expedited determination notice must be issued together only when all covered care is being terminated for coverage reasons and the beneficiary is expected to continue receiving non covered care.
- **No ABN is required** if no further services will be provided.

Reasons for hospice providers to issue the ABN:
The three situations that would require issuance of the ABN to a hospice patient are:
1. Ineligibility because the beneficiary is not “terminally ill” (defined in §1879(g)(2) of the Act)
2. Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary (defined in either §1862(a)(1)(A) or §1862(a)(1)(C))
3. The level of hospice care is determined to be not reasonable or medically necessary (defined in §1862(a) (1) (A) or §1862(a) (1) (C)) specifically for the management of the terminal illness and/or related conditions.
   - When a patient who is at the general inpatient (GIP) level of care no longer qualifies for that level of care, the provider must transition the patient to another care environment and cease billing Medicare for the GIP daily rate. If the patient/representative refuse to leave the inpatient unit at this time, the provider should issue an ABN to the patient/representative for the difference between the general inpatient daily rate and the routine home care daily rate.
   - Room and board charges are not part of the Medicare Hospice Benefit, and an ABN cannot be issued to the patient/representative for this charge.
Process flow for issuance of the ABN in hospice:
Non-covered services expected to continue: Patient is no longer terminally ill and agrees with discharge, but wishes hospice service to continue and assumes responsibility for payment. The provider issue the NOMNC form **two (2) calendar days** before the coverage is scheduled to end and also issues the ABN form.

Hospice Care Delivered by Non-Hospice Providers
- It is the notifier’s responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive care in a hospital that is not under contract with the hospice or if the beneficiary continues an inpatient hospital stay, which is no longer deemed medically necessary by the hospice.
- The hospice may delegate delivery of the ABN to the hospital in these cases.

When ABNs Are Not Required for Hospice Services
- **Revocations** - Hospice beneficiaries or their representatives can revoke the hospice benefit. Revocations are not considered terminations under liability notice policy since the beneficiary is exercising his or her own freedom of choice. Therefore no ABN is required.

  - **Respite Care Beyond Five Consecutive Days** - Mandatory notification is not required when respite care exceeds five consecutive days, because payment for respite care is limited to this time period under the Act. Respite care on the sixth consecutive day is therefore considered outside the definition of the hospice benefit, and the hospice provider is not required to issue an ABN. However, CMS encourages hospice providers to give the ABN as a voluntary notice to inform patients of possible financial liability in such cases.

  - **Transfers** - Beneficiaries are allowed one transfer to another hospice during a benefit period. However, subsequent transfers within the same benefit period are not permitted. In either case, an ABN is not required.

  - **Emergent care not approved/ coordinated by the hospice provider** - When a beneficiary enrolls in hospice, s/he is instructed to co-ordinate all of their care through the hospice agency or else it might not be covered by Medicare. The hospice is not required to issue an ABN for care that the beneficiary seeks that may not be covered by the hospice benefit such as going to an ER without the hospice’s directive to do so. The Centers for Medicare and Medicaid Services (CMS) clarified the issue of patient liability for unapproved care related to the terminal illness in an FAQ published in 2012.
This FAQ reads as follows:

When a hospice patient goes to a hospital for care for the terminal illness or related conditions without the hospice arranging for it, who is responsible for the bill?

For the duration of an election of hospice care, an individual waives all rights to Medicare payments for any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. If a beneficiary seeks hospital care for the terminal illness or related conditions without the hospice arranging it, then the beneficiary is liable for the cost of those hospital services. (FAQ7645)

Hospice providers should inform the patient about uncovered care verbally and in writing at admission and periodically throughout the service period. If a patient/family appear to be anxious or there is a high level of dysfunction in the home, a hospice provider may consider reviewing the information about unapproved care coverage with the patient and family.

- Medications –
  - Not reasonable and necessary, not provided by hospice - Sometimes a beneficiary requests a certain medication that a hospice can’t or won’t provide because it’s not reasonable and necessary for the palliation and management of the terminal illness and related conditions. The cost of such a medication, which is not reasonable and necessary for the management of the terminal illness or related conditions, would be a beneficiary liability. If the hospice does not provide the medication, the hospice is not obligated to and an issue an ABN is not be required
  - Not reasonable and necessary, but provided by hospice - If the hospice provides the medication even though it is not reasonable and necessary, the hospice must issue an ABN in order to charge the beneficiary for the medication.
    - NOTE: If the hospice covers medications that are not related to the terminal illness or related conditions, it would not be considered inducement unless the hospice advertised this was their practice.
  - Regardless of whether or not the hospice furnishes the drug, if the beneficiary feels that the Medicare hospice should cover the cost of the drug, the beneficiary may submit a claim for the medication directly to Medicare on Form CMS-1490S. If the claim is denied, the beneficiary may file an appeal of that determination under the appeals process set forth in part 405, subpart I.
  - If the beneficiary desires to continue taking drugs that are not covered by Medicare Part A or Part D, then the hospice must fully inform the beneficiary of his or her financial liability. Beneficiaries who disagree with such determinations may appeal the decision through the Medicare fee-for-service appeals process if the determination relates to Part A or B coverage and the Part D appeals process if the determination relates to Part D coverage. Beneficiaries may also submit quality of care complaints to a Quality Improvement Organization when the beneficiary prefers a non-formulary drug because,
for example, it’s believed to be more efficacious than the formulary drug prescribed by the hospice.

- **DME, or Supplies** - An ABN should **not** be issued when Durable medical equipment (DME) or supplies that may be related to the terminal illness are deemed not part of the hospice palliative plan of care by the physician. These are items that are not billed separately from the hospice per diem payment.

**ABN forms:**
Hospice providers are required to use ABN form CMS-R-131. Mandatory use date of the following form was January 1, 2012.

- [Revised ABN CMS-R-131 Form and Instructions [ZIP, 201KB]]
- [Revised ABN Manual Instructions [PDF, 578KB]] – CMS Chapter 30 includes all guidance regarding the issuance of the ABN during hospice care and also includes examples of care scenarios related to ABN issuance.
- [CMS Fee for Service ABN information page: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html]

### Notice of Medicare Non Coverage in Hospice (NOMNC)

**NOMNC details:**
Based on the provisions of the November 2004 final rule, SNFs, HHAs, CORFs, and hospices must provide the Notice of Medicare Provider Non-Coverage (Generic Notice) to Medicare beneficiaries no later than two (2) days before the effective date of the end of the coverage that their Medicare coverage will be ending. Providers may deliver the NOMNC earlier than two days preceding the end of covered services; however, its delivery should be closely tied to the impending end of coverage.

- **If state regulations for discharge notice require more than 2 days, the provider is required to follow the more stringent regulation.**
- Providers must deliver a NOMNC to all beneficiaries eligible for the expedited determination process, even if they agree with the termination of services.
- Providers must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that they received the notice and understand that the termination decision can be disputed. If the beneficiary refuses to sign the NOMNC, you should annotate the notice to that effect, and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Please note that beneficiaries who refuse to sign the NOMNC still remain entitled to an expedited determination.
- Providers may deliver NOMNC and DENC forms to representatives whom the beneficiary has authorized and appointed to act on their behalf during the appeal process. A beneficiary may designate an appointed representative via the “Appointment of Representative” form, the CMS-1696 which can be found at [http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) on the CMS website. Providers should inform the representative of
the beneficiary about the right to appeal a coverage termination decision, and include the following information:

- The last day of covered services, and the date when the beneficiary’s liability is expected to begin;
- The beneficiary’s right to appeal a coverage termination decision;
- A description of how to request an appeal by a QIO;
- The deadline to request a review as well as what to do if the deadline is missed; and
- The telephone number of the QIO to request the appeal.

The patient/representative may be contacted by the provider by telephone. The date the provider communicates the information is considered the NOMNC’s receipt date and providers should annotate the NOMNC to document the telephone contact with the beneficiary on the day of telephone contact, reflecting that all of the information indicated above was included in the communication. The annotated NOMNC should also include the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. Providers must place a dated copy of the annotated NOMNC in the beneficiary’s medical file, and mail a NOMNC to the representative the day the telephone contact is made.

If providers communicate the NOMNC information in writing, a hard copy of the NOMNC must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g. FedEx, UPS). Providers should keep in mind that the burden is on the provider to demonstrate that timely contact was attempted with the representative and that the notice was delivered. The date that someone at the representative’s address signs (or refuses to sign) the receipt is considered the date received. Place a copy of the annotated NOMNC in the beneficiary’s medical file.

As an alternative to both telephone or hardcopy contact, if both you and the representative agree, you may send the notice by fax or e-mail; however your fax and e-mail systems must meet the HIPAA privacy and security requirements.

Process flow for issuance of the NOMNC in hospice:

Patient is no longer eligible for hospice services and beneficiary agrees with discharge; Provider issues the generic NOMNC two (2) calendar days before the coverage is schedule to end.

NOMNC forms:
• Providers should use the CMS 10123 (Original Medicare notice) as the NOMNC issued to beneficiaries. (CMS Form 10123 was revised and effective on May 1, 2012)

• The NOMNC form is two pages and may include the provider’s business logo and contact information at the top of the notice. **NOTE:** the NOMNC must remain two pages.

• Providers can also include information in the optional “Additional Information” section relevant to the beneficiary’s situation.

• Links to CMS Form 10123:
  
  o **UPDATED - Notice of Medicare Non-Coverage (NOMNC) - English and Spanish [ZIP, 68KB]**
  
  o **UPDATED - Instructions for Notice of Medicare Non-Coverage [PDF, 52KB]**
  

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**Detailed Explanation of Non-Coverage (DENC)**

**DENC details:**

• If the beneficiary does not agree that coverage should end after receiving the NOMNC, the beneficiary may request an expedited review of the termination decision by the Quality Improvement Organization (QIO) in that State.

• The provider then must furnish the Detailed Explanation of Non-Coverage (DENC) to the beneficiary explaining why services are no longer covered.

• The beneficiary must contact the QIO (either by telephone or in writing) by noon of the day before the NOMNC’s effective date. (If the QIO is unable to accept the request, the beneficiary must submit the request by noon of the next day the QIO is available).

• The beneficiary:
  
  1) Must be available to answer questions or supply information requested by the QIO;
  2) May (but is not required to) supply additional information to the QIO that he or she believes is pertinent to the case.

• When a QIO notifies a provider of a beneficiary request for an expedited determination, the provider must deliver the beneficiary a DENC by close of business the day they are notified, supply the QIO with copies of the NOMNC and DENGs by close of business of the day of the QIO notification, and also supply (by telephone, in writing, or electronically) all information, including medical records, that the QIO requests. If the provider contacts by telephone, they must place a written record of the information provided into the patient record.

• Beneficiaries have the right to access or request copies of, any documentation provided to the QIO. A provider may charge the beneficiary a reasonable amount to cover the costs of duplicating and delivering the documentation, which must be provided to the beneficiary by close of business of the first day after the information, is requested.

• Generally, the QIO’s review will be completed **within 72 hours** of the QIO’s receipt of the beneficiary’s request for a review. Once the QIO decision has been made, the hospice and beneficiary are notified.

• The delivery of the DENC must occur **in person by close of business of the day the QIO notifies you** that the beneficiary has requested an expedited determination. You may also choose to deliver the
DENC with the NOMNC. It does not require a signature, but should be explained in the event of a beneficiary’s refusal to sign upon delivery.

QIO Decision and continuation of care

If the QIO decision is favorable to the beneficiary but there are no physician orders to continue care, the hospice **cannot** provide care. The ordering physician should be made aware of the QIOs decision, and given the opportunity to reinstate the orders. The beneficiary can also see other personal physicians to write orders, or find another service provider. **The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.**

Process flow for issuance of the DENC in hospice:

**Scenario #1 – Timely QIO decision:** Patient is no longer eligible for hospice and provider has issued NOMNC form 10123; beneficiary/ representative does not agree with the hospice’s decision to discharge; Hospice issues DENC form 10124 to patient/representative. The hospice is only responsible for continuing covered care until the effective date on the NOMNC.

**Scenario #2 – Untimely QIO decision:** Patient is no longer eligible for hospice and provider has issued NOMNC form 10123; beneficiary/ representative does not agree with the hospice’s decision to discharge; Hospice issues DENC form 10124 to patient/representative. The hospice is only responsible for continuing covered care until the effective date on the NOMNC.
DENC forms:

- The DENC must contain the following information:
  - A specific and detailed explanation of why services are either no longer reasonable and necessary or no longer covered;
  - A description of, and citations to, the Medicare coverage rule, instruction, or other policies applicable to the review; and
  - The facts specific to the beneficiary’s discharge and provider’s determination that coverage should end.

- Providers should use the Detailed Explanation of Non-Coverage, or DENC, with the form number CMS 10124. (CMS Form 10124 was revised and effective on May 1, 2012)
  - UPDATED - Detailed Explanation of Non-Coverage (DENC) - English and Spanish [ZIP, 87KB]
  - UPDATED - Instructions for Detailed Explanation of Non-Coverage [PDF, 26KB]
  - CMS Fee for Service DENC information page: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

Resources:

- CMS Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections
- CMS CR 7903 - Expedited Determinations for Provider Service Terminations (May 24, 2013)
- CMS MM7903 - Expedited Determinations for Provider Service Terminations (May 24, 2013)
- MLN article SE0538-New Expedited Review Process for Disputed Terminations of Medicare-Covered Services in SNFs, HHAs, CORFs, and Hospices (June 24, 2005)
- Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Final 2014 Guidance [ZIP, 2MB]