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

Tips for Hospice Providers

February 2022

Advance Beneficiary Notice Quick Reference Guide

Purpose	To provide written notice to beneficiary in advance of furnishing item or service when that Medicare probably won't pay for items or services in order to shift financial liability to the beneficiary for the denial. Communicates information to beneficiaries on: • Financial liability • Appeal rights and protections Provides financial protection for providers.
When use is required	The three situations that would require issuance of the ABN by a hospice are when items and services are usually paid under Part A **1.** Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in §1879(g)(2) of the Act; or **2.** Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either §1862(a)(1)(A) or §1862(a)(1)(C); or **3.** The level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.
When not required	**1.** Revocation **2.** Respite Care Beyond Five Consecutive Days **3.** Transfers **4.** Failure to Meet the Face-to-Face Requirement **5.** Room and Board Costs for Nursing Facility Residents **6.** End of all Medicare covered hospice care unless patient wants to continue to receive hospice care that will not be covered by Medicare (no longer eligible) (issued along with Detailed explanation of Noncoverage after the Notice of Medicare Noncoverage.
Timing	Issued in advance to allow beneficiary to make an informed choice about whether or not to get items or services.
Who issues	Hospice.
Form required	Required to use CMS-R-131. Notifier retains original and provides copy to beneficiary Retain original for five years.
Signature	Beneficiary or authorized representative must sign.
What ifs?	If the beneficiary or authorized representative refuses to choose an option and/or refuses to sign the ABN when required, the notifier should annotate the original copy of the ABN indicating the refusal to sign or choose an option. Provide a copy of annotated ABN to beneficiary.

Source: Medicare Claims Processing Manual (cms.gov) Chapter 30 – Financial Liability Protections

Using the right form:
Providers need to ensure they are using the current version of the ABN form, which can be found on the CMS website, ABN page. The current version expires 6/2023. From a practice standpoint, the OLD forms may be included in admission packets and the hospice has not checked to make sure they are current.

CMS requirements:
The Centers for Medicare and Medicaid Services (CMS) requires a provider to notify Medicare beneficiaries when a service may not be covered under the Medicare program. The Advance Beneficiary Notice of Non-coverage must be completed by the provider, or his/her representative, and signed by the patient before a service is rendered.

The ABN advises the patient that the service they are about to receive may not be covered by Medicare. The form must include a description of the service, along with the estimated out-of-pocket cost and the reason why Medicare may potentially deny the service. The services itemized on the form must be clearly explained to the patient (or his/her representative). Thus, the ABN allows the patient to make an informed decision regarding whether or not to receive the service.

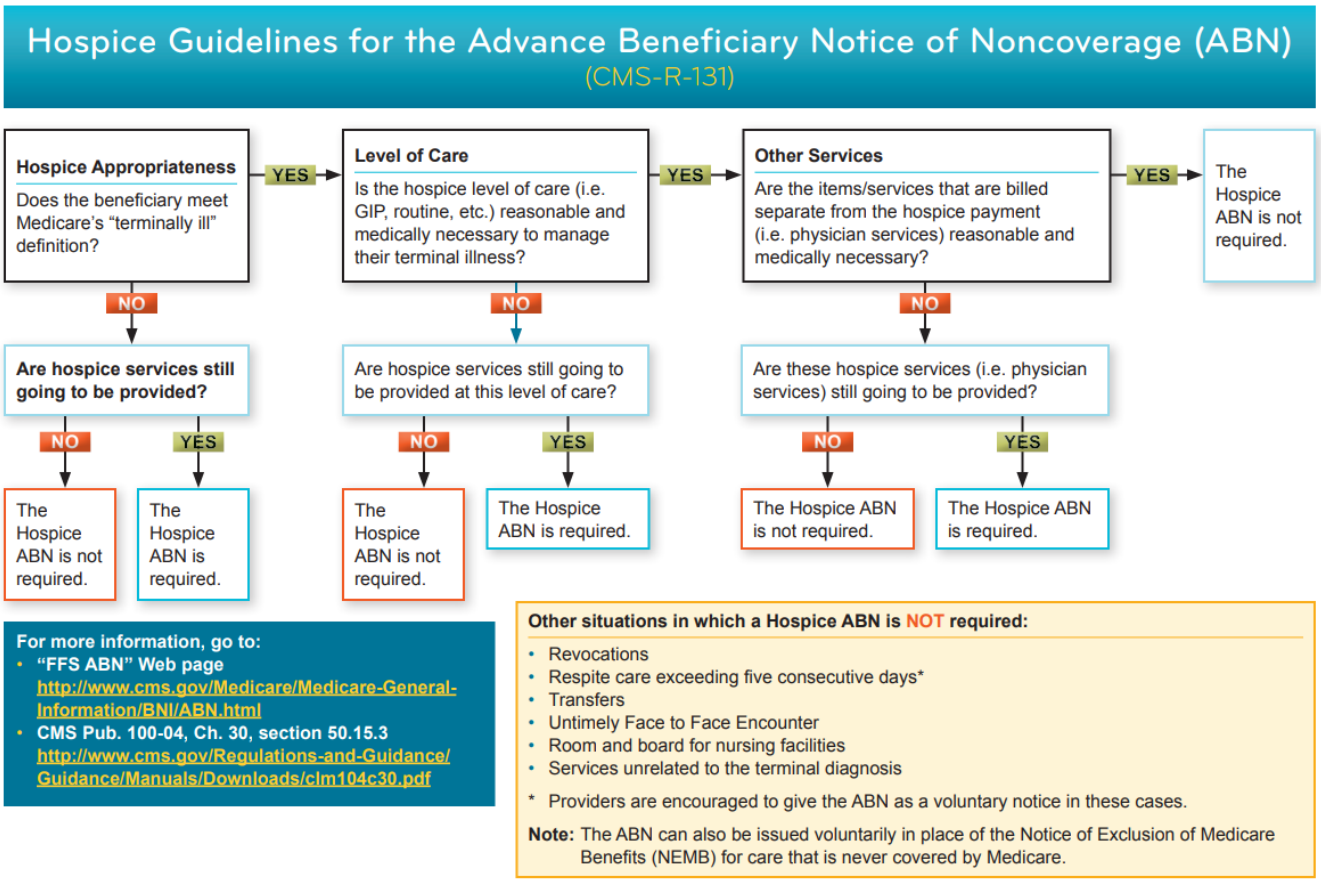
Reasons for hospice providers to issue the ABN:

Mandatory use of the ABN is very limited for hospices. Hospice providers are responsible for providing the ABN when required as listed below for items and services billable to hospice are usually paid under Medicare Part A. Hospices are not responsible for issuing an ABN when a hospice patient seeks care outside of the hospice's jurisdiction.

The three situations that would require issuance of the ABN by a hospice are:

1. Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in §1879(g)(2) of the Act; or
2. Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either §1862(a)(1)(A) or §1862(a)(1)(C); or
3. The level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

Guidelines for Issuance of the ABN in Hospice:
CGS has posted a very helpful flow chart for the use of the ABN in hospice.



ABNs Are Not Required for Hospice Services in These Situations:

- **Revocation: -** 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/her own freedom of choice. Therefore, no ABN is required**.**

- **Respite Care Beyond Five Consecutive Days**: Respite care is limited to five consecutive days under the Act. When respite care exceeds five consecutive days, an ABN is not required since additional days of respite care are not part of the hospice benefit. CMS encourages hospice providers to give the ABN as an optional notice to inform patients of financial liability when more than five days of respite care will be provided.

- **Transfer:** 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.

- **Failure to Meet the Face-to-Face Requirement -** The ABN must not be issued when the face-to-face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face-to-face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill.

- **Room and Board Costs for Nursing Facility Residents:** Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

- **End of all Medicare covered hospice care:** End of all Medicare covered hospice care unless patient wants to continue to receive hospice care that will not be covered by Medicare (no longer eligible) (issued along with Detailed explanation of Noncoverage after the Notice of Medicare Noncoverage.

- **Medications**
  - **Related to terminal illness and related conditions but not reasonable and necessary and not provided by hospice -** If the hospice does not provide the medication, the hospice **is not** required to issue an ABN. Sometimes a beneficiary requests a certain medication that a hospice cannot or will not provide because it is 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 necessaryfor the management of the terminal illness or related conditions, would be a beneficiaryliability.
  - **Related to terminal illness and related conditions but not reasonable and necessary and 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 thehospice advertised this was their practice.

  - If the beneficiary desires to continue taking drugs that are not covered by Medicare PartA 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 is believed to be more efficacious than the formulary drug prescribed by thehospice.

  - **Patient requests election statement addendum** – This is not a part of the ABN process. In some cases, a patient or their representative will request an addendum specifying what items, services or drugs would be considered unrelated and not covered by the hospice. Refer to § 418.24 - Election of hospice care for more detailed information.

- **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 perdiem payment.
    - **Patient requests election statement addendum** – This is not a part of the ABN process. In some cases, a patient or their representative will request an addendum specifying what items, services or drugs would be considered unrelated and not covered by the hospice. Refer to § 418.24 - Election of hospice care for more detailed information.

ABN Resources:

- Beneficiary Notice Initiative – forms included here
- CMS Fee for Service ABN information page
- CMS Chapter 30 Medicare Claims Processing Manual (cms.gov) includes all guidance regarding the issuance of the ABN during hospice care and also includes examples of care scenarios related to ABN issuance.
- Guidelines for issuing the ABN can be found beginning in Section 50 in the Medicare Claims Processing Manual, 100-4, Chapter 30 (PDF).

Notice of Medicare Non-Coverage in Hospice (NOMNC)

Quick Reference Guide

Purpose	To allow beneficiary to • Appeal provider decision to terminate services • Receive a rapid decision via Expedited Determination (ED) process • Be protected from financial liability during the process
When use is required	When all hospice Medicare services are ending due to lack of terminality. Must be delivered even if beneficiary agrees with discharge
When not required	Care ending at beneficiary's request or initiative • Revocation • Transfer • Discharge out of service area Discharge for cause
Timing	Delivered to beneficiary or representative no less than 2 days before planned discharge.
Who issues	Hospice
Form required	CMS 10123-NOMNC
Signature	Beneficiary or authorized representative must sign.
What ifs?	If the beneficiary refuses to sign the NOMNC the provider 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. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

Hospices are required to provide a Notice of Medicare Non-Coverage (NOMNC) expedited determination notices are given to beneficiaries when all Medicare covered services are being terminated when no longer terminally ill. Hospice must provide the Notice of Medicare Provider Non-Coverage (Generic Notice) to Medicare beneficiaries no later than two days before the effective date of the end of the coverage that their Medicare coverage will be ending.* The NOMNC informs beneficiaries on how to request an expedited determination from their Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and gives beneficiaries the opportunity to request an expedited determination from a BFCC-QIO. The BFCC-QIO will request medical records from the hospice.

The Detailed Notice of Hospice Non-Coverage (DN) and Advanced Beneficiary Notice (ABN) are issued together only when all covered care is being terminated and beneficiary is expected to continue receiving noncovered care. A Detailed Explanation of Non-Coverage (DENC) is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of covered service. Generally, the BFCC-QIO's review will be completed within 72 hours of the BFCC-QIO's receipt of the beneficiary's request for a review.

> ***NOTE:** If state regulations for discharge notice require more than 2 days' notice, the provider is required to follow the most stringent regulation. Hospice cannot bill Medicare for the longer discharge notice time if required by state regulations. State regulations are for licensure. NOMNC is for financial liability and related to payment.

Completing the NOMNC

Providers must use the OMB-approved NOMNC (CMS-10123). Providers must type or write the following information in the corresponding blanks of the NOMNC:

- Patient name
- Medicare patient number
- Type of coverage (SNF, Home Health, CORF, or Hospice)
- Effective date (last day of coverage)
  Note: The effective date is always the last day beneficiaries will receive coverage (payment by Medicare) for their services. Beneficiaries have no liability for services received on this date but may face charges for services received the day following the effective date of the NOMNC for home health, hospice, and CORF services.
- When reviewing the NOMNC, providers should inform the representative of the beneficiary about the right to appeal a coverage termination decision, and include the followinginformation:
  - The last day of covered services, and the date when the beneficiary's liability is expected tobegin;
  - 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.

260.3.3 – Provider Delivery of the NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per §260.2. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents. The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Electronic issuance of NOMNC: CMS does not prohibit this type of issuance. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of notice delivery.

Delivery timeframe: The NOMNC should be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. For example, if the last day of covered hospice care is a Friday, the NOMNC should be delivered no

later than the preceding Wednesday. Note: The two day advance requirement is NOT a 48 hour requirement. For example, if a patient's last covered hospice is at 10AM on Wednesday and the notice is delivered at 4PM on the prior Monday, it is considered timely.

The NOMNC may be delivered earlier than two days preceding the end of covered services. However, delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination.

260.3.5 - Refusal to Sign the NOMNC
(Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13)

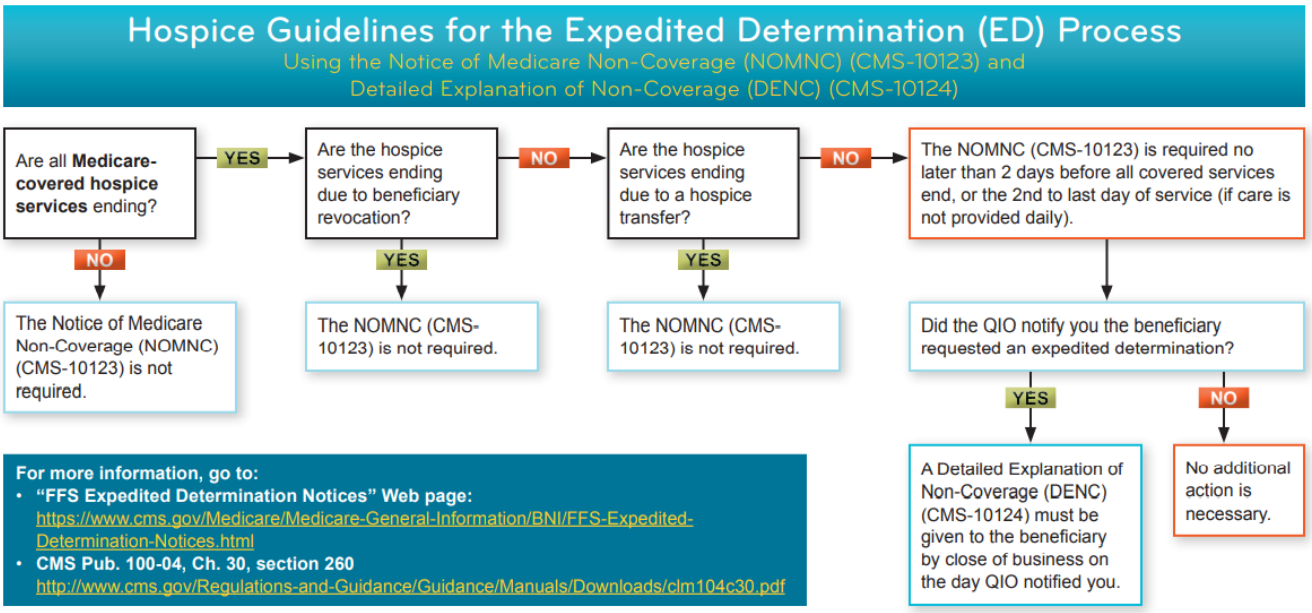
If the beneficiary refuses to sign the NOMNC the provider should annotate the notice to that effect and indicate the date of refusal on the notice. The date of refusal is considered to be the date of notice receipt. Beneficiaries who refuse to sign the NOMNC remain entitled to an expedited determination.

> **NOTE:** If state regulations for discharge notice require more than 2 days, the provider is required to follow the more stringent regulation. Hospice cannot bill Medicare for the longer discharge notice time if required by state regulations. State regulations are for licensure. NOMNC is for financial liability and related to payment.

Guidelines for the Expedited Review Process – Using the NOMNC and the DENC 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.

CGS has posted a very helpful flow chart for the use of the NOMNC and DENC



NOMNC Resources

Providers should use the CMS 10123 (Original Medicare notice) as the NOMNC issued tobeneficiaries.

- Beneficiary Notice Initiative
- Guidelines for issuing the Notice of Medicare Noncoverage, found beginning in Section 260.3 in the Medicare Claims Processing Manual, 100-4, Chapter 30 (PDF).
- Medlearn Matters article May 2021: Medicare Advance Written Notices of Non-coverage (cms.gov)

Detailed Explanation of Non-Coverage (DENC)

Quick Reference Guide

Detailed Explanation of Non-Coverage (follows issuance of NOMNC if beneficiary appeals)

Purpose	Gives a specific and detailed explanation of why services are no longer covered.
When use is required	After this issuance of a NOMNC, if the beneficiary appeals, the QIO When all hospice Medicare services are ending due to lack of terminality. Must be delivered even if beneficiary agrees with discharge
When not required	If beneficiary does not appeal (the QIO has not notified the hospice).
Timing	Must be given to the beneficiary by close of business on the day QIO notified you. May also choose to deliver the DENC with the NOMNC.
Who issues	Hospice
Form Required	CMS 10124-DENC
Signature	Does not require a signature.
What ifs?	Refuses to accept the notice upon delivery: should be annotated refused delivery.

DENC details:

- If the beneficiary does not agree that coverage should end after receiving the NOMNC, thebeneficiary 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 beneficiaryexplaining 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 submitthe 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 believesis 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, supplythe QIO with copies of the NOMNC and DENCs 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 thefirst 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 andbeneficiary 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

A QIO's decision cannot force a hospice to continue care if in the hospice physician's medical judgement, the patient does not meet Medicare hospice eligibility.

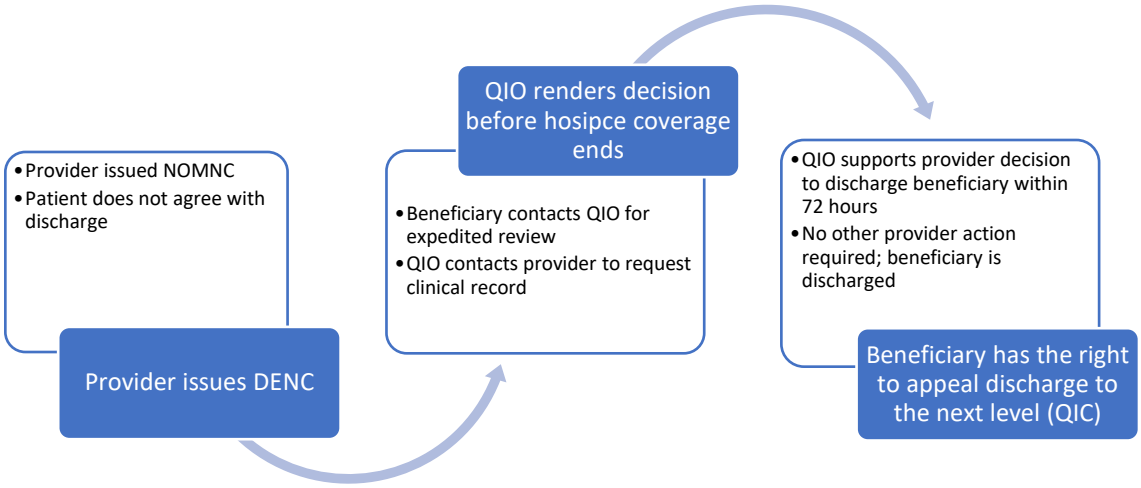
What is a hospice to do if medical director / hospice physician refuses to re-certify the beneficiary?

1. **If the QIO decision extends coverage to a period where a physician's orders do not exist, either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care, providers cannot deliver care.**
2. **In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue, and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider.**
3. **The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.**

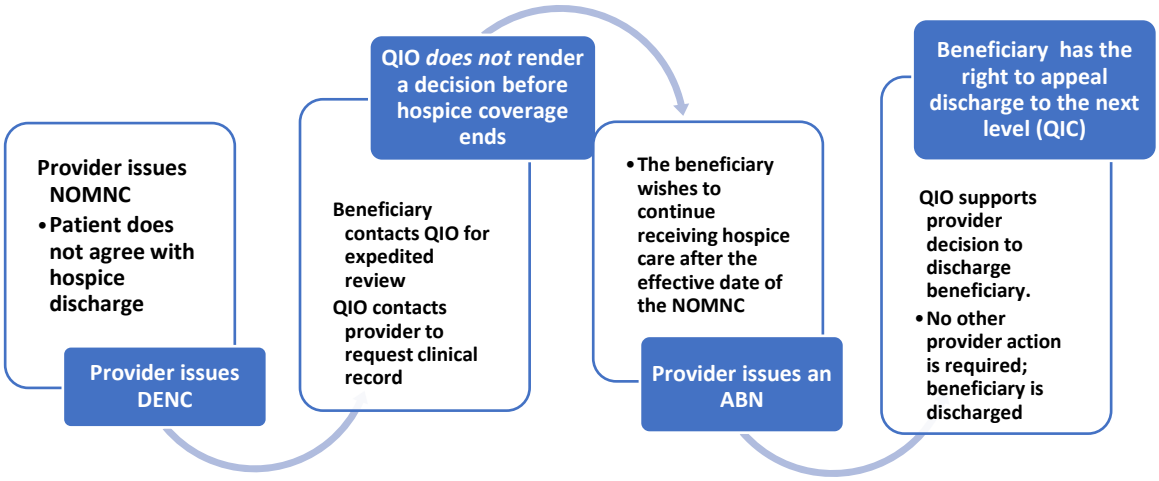
Source: **Section 260.6.2 - Effect of QIO Determination on Continuation of Care**

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 responsiblefor 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 responsiblefor continuing covered care until the effective date on the NOMNC.



DENC Resources:

- The DENC must contain the following information:
  - A specific and detailed explanation of why services are either no longer reasonable andnecessary or no longer covered;
  - A description of, and citations to, the Medicare coverage rule, instruction, or other policiesapplicable to the review; and
  - The facts specific to the beneficiary's discharge and provider's determination that coverageshould end.
  - Providers should use the most current Detailed Explanation of Non-Coverage, or DENC, with the form number CMS 10124.

Resources:

- CMS FFS & MA NOMNC/DENC | CMS – Forms available here
- FFS ABN | CMS
- CMS Medicare Claims Processing Manual, Chapter 30 - Financial Liability Protections Detailed Explanation of Non Coverage Section 260.4.5