CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 994	**Date: JUNE 30, 2006**
	Change Request 5117

SUBJECT: Special Issues Associated with the Advance Beneficiary Notice (ABN) for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs)

I. SUMMARY OF CHANGES: This CR updates part of section 50 of Chapter 30 regarding Hospice and CORF use of the ABN and Expedited Determination notices.

NEW / REVISED MATERIAL
EFFECTIVE DATE: September 29, 2006
IMPLEMENTATION DATE: **September 29, 2006**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	30/Table of Contents
R	30/50.9/Special Issues Associated with the Advance Beneficiary Notice (ABN) for Hospice Providers
R	30/50.9.1/Special Issues Associated with ABNs and Expedited Determinations for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs)
D	30/50.9.2/Denial Situations that Call for ABNs
D	30/50.9.3/Acceptable ABN Language

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 994	Date: June 30, 2006	Change Request 5117

SUBJECT: **Special Issues Associated with the Advance Beneficiary Notice (ABN) for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs).**

I. GENERAL INFORMATION

A. Background: Before July, 2005, the only limitation of liability (LOL) notice given to beneficiaries in Original Medicare in hospices was the ABN. This updated instruction offers more specific language for hospice providers to alert them of when an ABN is appropriate and it gives them model language to use for specific cases. It also provides clarification on ABN use by CORFs.

B. Policy: This language is authorized by §1879 of the Act, and specifically under regulations at 42 CFR 411-404. LOL notices are required under §1879 of the Social Security Act (the Act) in order to hold beneficiaries liable for certain noncovered services. Chapter 30 of the Medicare Claims Processing Manual provides basic information on LOL.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5117.1	Intermediaries shall review the instructions in the attachment and enforce ABN policy for hospice providers and CORFs accordingly.	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5117.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X							

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	N/A

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: No new impact

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: September 29, 2006 **Implementation Date:** September 29, 2006 **Pre-Implementation Contact(s):** Cyqwenthia Boyd Cyqwenthia.Boyd@cms.hhs.gov or 410-786-5875; Elizabeth Carmody, elizabeth.carmody@cms.hhs.gov or 410-786-7533. **Post-Implementation Contact(s):** Appropriate CMS Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

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(Rev.994, 06-30-06)

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50.9.1-Special Issues Associated with ABNs and Expedited Determinations for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs)

50.9 - Special Issues Associated with the Advance Beneficiary Notice (ABN) for Hospice Providers

(Rev.994, Issued: 06-30-06, Effective: 09-29-06, Implementation: 09-29-06)

I. General Use

Hospice providers issue the ABN, form CMS-R-131-G, according to the instructions given earlier in this section. The ABN will be given less frequently for the hospice benefit than in other settings, for reasons including bundled per-diem payment and less advent of discharges for coverage reasons and noncovered care.

There are three situations in which hospice services may be denied that could trigger liability protection under §1879.

- ***A.*** *Ineligibility because the beneficiary is not "terminally ill" as defined in §1879(g)(2) of the Act;*
- ***B.*** *Specific item(s) and/or service(s) that are billed separately from the hospice payment, such as physician services, were not reasonable and necessary defined in either §1862(a)(1)(A) or §1862(a)(1)(C) and;*
- ***C.*** *The level of hospice care is determined 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 related conditions.*

NOTE: *Regarding letter C above, CMS payment policy requires that the provider, not the beneficiary, absorb liability, if any, resulting from a change in level of care made during claim adjudication. Also, since providers are billing what they believe to be a covered level of care, there would be no anticipation of noncoverage in these cases. Therefore, this case would never involve delivery of an ABN to a hospice beneficiary.*

Examples of approved language for Box 1, "Items or Services" and Box 2, "Because," on the ABN under each of the other two conditions where an ABN would be required are:

A – Ineligibility for the Hospice Benefit:
Box 1: "The Medicare Hospice Benefit."
Box 2: "The documentation submitted does not support that your illness is terminal."

B – Item(s) or Service(s) not Medically Necessary:
Box 1: "Physician Services from Other than Your Attending Physician"

Box 2: "According to Medicare hospice requirements, this service is not covered because it was provided by a non-attending physician."

Box 1: "Surgical Removal of a Cataract"
Box 2: "This service is not covered because you are enrolled in a hospice."

II. Beneficiaries Who Have Elected the Hospice Benefit and Receive Care in Another Facility Not Authorized by the Hospice Provider.-

When a beneficiary who has elected the hospice benefit accesses an inpatient setting that has not been arranged by the hospice provider, it is the hospice's responsibility to inform the beneficiary of his liability with an ABN as required by these instructions. For example, if a hospice beneficiary is in a hospital under contract with the hospice for general inpatient care, and the beneficiary decides to stay in the hospital after the hospice provider tells the beneficiary this level of care is no longer required, but chooses not to revoke the hospice benefit, it is the hospice provider's responsibility to see that the beneficiary receives an ABN or comparable liability notice with notification of costs, such as room and board, for which the beneficiary will be financially liable. It is permissible for the hospice to arrange in advance that the hospital will give applicable notice in such cases, especially if the hospital will be billing for the noncovered care. Where hospices issue the ABN, HINNs (Hospital Issued Notices of Noncoverage) are issued by hospitals for inpatient hospitals stays.

If, however, the beneficiary revokes the hospice benefit while in an inpatient setting, it becomes that facility's responsibility alone as the rendering provider, subsequent to the end of hospice care, to give the appropriate liability notice. For example, if a hospice beneficiary enters a hospital and revokes the hospice benefit during the hospital stay, the hospital would then become responsible for notifying the beneficiary with a HINN if the hospital stay was not covered. The hospital is responsible for giving the HINN to the beneficiary according to applicable instructions since the facility has become the provider of care.

III. When ABNs Are Not Required for Hospice Services

A - Revocations

Hospice beneficiaries, or their representatives as defined by regulation, 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.

B - Respite Care

No mandatory notification is required when respite care exceeds five consecutive days, because payment for respite care is limited to this 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 Notice of Exclusions from Medicare Benefits

(NEMB) to notify patients of possible financial liability in such cases. See §90 of this chapter for NEMB instructions.

C - Transfers

A beneficiary is only allowed one transfer to another hospice during a benefit period. A second transfer is not allowed. In either case, an ABN is not required.

D - Noncovered Care Outside the Hospice Benefit

Hospice providers may choose to give services like palliative care that Medicare does not cover to beneficiaries who have not elected hospice. In such cases, Medicare does not require an ABN be issued. However, CMS encourages hospice providers to give advance voluntary notice to beneficiaries of possible financial liability when it exists in these cases. The NEMB may be used for this purpose.

50.9.1 - Special Issues Associated with ABNs and Expedited Determinations for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs)

(Rev.994, Issued: 06-30-06, Effective: 09-29-06, Implementation: 09-29-06)

Since July 2005, beneficiaries in Original Medicare whose Medicare-covered services are being terminated for reasons related to coverage in hospices, CORFs, home health agencies (HHAs), skilled nursing facilities (SNFs) and hospital swing beds have access to an expedited review process. This affects the use of ABNs for terminations of covered care. While HHAs, SNFs and swing beds use specialized ABNs discussed elsewhere in this chapter, hospice providers and CORFs use the general ABN.

In the past, hospice providers and CORFs would have only used the general ABN for all terminations where the beneficiary faced financial liability. Now hospice providers and CORFs will be required to issue the Notice of Medicare Provider Non-Coverage (Generic Notice) under the expedited review process for termination when covered care is ending for coverage reasons. Hospice providers and CORFs will also issue the ABN in addition to the expedited notice at terminations only when they continue to provide care to the beneficiary on a noncovered basis after the date Medicare coverage ends. For additional information on the expedited review process, please refer to CMS 2005 Transmittal 594, later to be manualized in this chapter.

NOTE: *Hospice providers and CORFs are not required to use the ABN to inform beneficiaries in Original Medicare of potential financial liability when terminations of covered care occur for reasons unrelated to coverage. An example is when care is terminated due to hospice staff safety issues in the beneficiary home. These providers may, however, use the NEMB for voluntary notification in such cases, and CMS recommends providers*

always take action to assure beneficiaries understand that care will be discontinued when this occurs.