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Implementation Date: September 29, 2006

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

Provider Types Affected

Hospices and CORFs billing Medicare fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs) for services

Background

Before July, 2005, the only limitation of liability (LOL) notice given to beneficiaries in Original Medicare in hospices was the ABN. The updated instructions in CR5117 offer more specific language for hospice providers to alert them when an ABN is appropriate and it gives them model language to use for specific cases. It also clarifies ABN use by CORFs.

This language is authorized by §1879 of the Social Security Act (the Act) and specifically under regulations at 42 CFR 411-404.

LOL notices are required under §1879 of the Act in order to hold beneficiaries liable for certain non-covered services.

The revised Sections 50.9 and 50.9.1 of Chapter 30 of the *Medicare Claims Processing Manual* - Financial Liability Protections - are attached to CR 5117 and the Centers for Medicare & Medicaid Services (CMS) web address for CR5117 is listed in the *Additional Information* section of this article.

Key Points

Section 1879 of the Social Security Act requires that providers give beneficiaries notice of their liability of non-covered care. The following information, excerpted from the revised *Medicare Claims Processing Manual* sections, helps guide hospice providers in fulfilling that requirement.

From Chapter 30, Section 50.9 - Special Issues Associated with the ABN for Hospices

I. General Use

There are three situations in which hospice services may be denied that could trigger liability protection under §1879 of the Act:

1. Ineligibility because the beneficiary is not "terminally ill" as defined in § 1879 (g)(2) of the Act;
2. Specific items (s) and/or services(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
3. 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 number three 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 non coverage in these cases. Therefore, this case would never involve delivery of an ABN to a hospice beneficiary.

Examples of Approved Language

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 the following:

- 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 the 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 and the beneficiary 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 non-covered care. Where hospices issue the ABN, HINNs (Hospital Issued Notices of Non-coverage) 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

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.

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. The *Medicare Claims Processing Manual, C*hapter 30, Section 90, provides NEMB instructions and states that: "NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions."

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.

Non-covered Care Outside the Hospice Benefit

Hospice providers may choose to give services such as palliative care that Medicare does not cover to beneficiaries who have not elected hospice. In such cases, Medicare does not require an ABN to 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.

Special Issues Associated with ABNs and Expedited Determinations for Hospices and CORFs

Since July 2005, beneficiaries in Original Medicare whose Medicare-covered services are being terminated for reasons related to coverage in hospices or CORFs have access to an expedited review process. This affects the use of ABNs for terminations of covered care.

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 non-covered basis after the date Medicare coverage ends.

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 that providers always ensure that beneficiaries understand that care will be discontinued when this occurs.

Implementation

The implementation date for the instruction is September 29, 2006.

Additional Information

The official instructions issued to your Medicare FI or RHHI regarding this change can be found at *http://www.cms.hhs.gov/Transmittals/downloads/R994CP.pdf* on the CMS website. The revised Section 50.9 and 50.9.1 of Chapter 30 of the *Medicare Claims Processing Manual* -Financial Liability Protections - are attached to CR5117.

If you have questions, please contact your Medicare FI or RHHI at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.