



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 6: Medicare Billing Issues

I. Outpatient Repetitive Services

A. What is a “Repetitive Service”

1. CMS defines repetitive services based on the revenue codes used to bill for the services. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>
 - a. The revenue codes that define repetitive services are listed in the *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2, included in the materials behind the outline.

B. Billing for Repetitive Services

1. Separate Monthly Claim

- a. Repetitive services must be billed monthly on a separate claim. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2; *Medicare Claims Processing Manual*, Chapter 4 § 170>

2. Services “in Support” of Repetitive Services

- a. Any items or services needed in the performance of the repetitive service should be reported on the same claim as the repetitive service, regardless of the revenue code those items or services are billed under. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

Examples of supporting items or services include disposable supplies, drugs or equipment used to furnish the repetitive service.

3. Other Services Provided During the Same Month as Repetitive Services

- a. Other services, except those provided in support of the repetitive services, may not be billed on the same claim as the repetitive services. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

- i. Occurrence Span Code 74
 - a) When an inpatient stay or non-repetitive outpatient hospital services paid under OPSS occurs during the same month as repetitive services, occurrence span code 74 and the dates encompassing the inpatient stay or outpatient service must be reported on the repetitive service bill. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

Case Study 1

Facts: A patient received cardiac rehab services on March 1, 5, 7 and 9. The patient was then admitted as an inpatient to the hospital on March 11-15 for pancreatitis unrelated to their cardiac condition. The patient returned to cardiac rehab on March 19 and received cardiac rehab services on March 19, 21, 23, 26, 28 and 30. How should the cardiac rehab services be billed?

II. Outpatient Non-repetitive and Recurring Services

A. Non-Repetitive Services on Different Dates

1. Multiple non-repetitive services provided on different dates in the same month may be billed on the same claim or separate claims. CMS sometimes refers to these services as “recurring services”. <*Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

Caution: Payment packaging is performed on a per claim basis. Billing services with different dates of service on the same claim may result in unintended packaging of unrelated services.

B. Non-Repetitive Services on the Same Date

1. Subject to the exceptions noted below, all services and supplies provided on the same day as a separately payable, non-repetitive outpatient service must be reported on the same claim. This will generally result in a single claim for all non-repetitive services provided on the same date of service. <*Medicare Claims Processing Manual*, Chapter 4 § 170>
 - a. MACs have been instructed to return claims with the same date of service to providers unless they are an exact duplicate, which are rejected, or contain condition codes 20, 21 or G0, discussed later in this module. <See Program Memorandum Intermediaries, Transmittal A-00-36, pg. 17; *Medicare Claims Processing Manual*, Chapter 1 § 120.2>

2. Exceptions

a. Exception for services subject to the pre-admission payment window

- i. Services subject to the one or three-day payment window must be reported on the inpatient claim, even if they are provided on the same date and associated with another non-repetitive outpatient service not subject to the payment window. The three-day payment window will be discussed later in this module. <Medicare Claims Processing Manual, Chapter 4 § 170>

b. Exception for multiple medical visits:

- i. Hospitals may report multiple medical visits provided on the same date on the same or separate claims. <Medicare Claims Processing Manual, Chapter 4 § 180.4>

ii. Condition Code G0

- a) Condition code G0 (G zero) is used to report distinct and independent visits billed on the same date in the same revenue center. <See IOCE Specifications, Sections 6.1.2 (Supplement); Medicare Claims Processing Manual, Chapter 4 § 180.4>

CMS has provided the following examples of distinct and independent visits:

- A visit to the ER in the morning for a broken arm and in the evening for chest pain
- Two visits to the ER for chest pain on the same day

- b) Hospitals must report condition code G0 whether the medical visits are reported on the same or separate claims. <See IOCE Specifications, Sections 6.1.2 (Supplement)>

- 1) If the visits are billed on separate claims, the G0 should be reported on the second claim. <Medicare Claims Processing Manual, Chapter 4 § 180.4>

iii. Modifier -27

- a) Modifier -27, “Multiple Outpatient Hospital E/M Encounters on the Same Date,” is reported for “separate and distinct” medical visits provided on the same date. <Program Memorandum A-01-80>

TIP: Modifier 27 is an NCCI modifier and may be used to override NCCI edits applicable to E/M codes. CMS has not provided a definition of “separate and distinct”, however, they refer to modifier 27 in conjunction with condition code -G0 indicating the definition for “distinct and independent” may apply.

iv. Condition Code -G0 with Modifier -27

- a) Condition Code -G0 must be applied, in addition to modifier -27, if the multiple medical visits occur in the same revenue center. <Program Memorandum A-01-80>

Case Study 2

Facts: A Medicare patient receiving chemotherapy treatments is registered as a “series” patient at the hospitals’ Cancer Center. The patient received chemotherapy treatments on November 1, 6, 11 and 18. On November 6, the patient is registered as an outpatient at the provider-based clinic where they see their family practitioner related to the flu. The visit was coded with E/M code G0463. Would it be permissible to bill the clinic visit separately from the chemotherapy treatments?

III. Preadmission (Three-Day) Payment Window

- A. Certain outpatient services provided prior to an inpatient admission are considered to be covered costs of the inpatient admission and are billed on the inpatient claim. <42 C.F.R. 412.2(c)(5); see *Medicare Claims Processing Manual*, Chapter 3 § 40.3>

1. Non-covered Inpatient Stay

- a. If the inpatient stay is not covered by Part A (e.g., exhaustion of benefits, lack of medical necessity) an inpatient Part B claim is submitted on a type of bill 012X and the outpatient services prior to the inpatient order are not combined to the inpatient claim but rather are billed to Part B as outpatient services on a type of bill 013X. <*Medicare Claims Processing Manual*, Chapter 4 § 10.12>

B. Overview

Factors to consider when determining the applicability of the preadmission payment window:

- The relationship between the inpatient and outpatient provider
- Services excluded from the rule
- The date the service was furnished

C. The Relationship Between the Inpatient and Outpatient Provider

1. An outpatient service is potentially subject to the preadmission payment window if:
 - a. The service was furnished by the same hospital where the patient was admitted, including at a provider-based department; or
 - b. The service was furnished by an entity that is “wholly owned or operated” by the hospital where the patient was admitted, including freestanding clinics. <42 C.F.R. 412.2(c)(5)(i); see 63 Fed. Reg. 6866; 76 Fed. Reg. 73281>
 - i. An entity is considered to be “wholly operated” by a hospital if the hospital has “exclusive responsibility for conducting and overseeing the entity’s routine operations.” <42 C.F.R. 412.2(c)(5)(i)>
 - ii. An entity that is “wholly sponsored” by a non-profit or not-for-profit admitting hospitals is treated the same as a wholly owned entity for purposes of the payment window. <See Medicare Claims Processing Manual, Chapter 3 § 40.3 B>
 - c. Although not stated in the regulations, according to the Medicare Claims Processing Manual, preadmission services furnished “by another entity under arrangements with the hospital” are also subject to packaging. <See Medicare Claims Processing Manual, Chapter 3 § 40.3(B)>

D. Outpatient Services Excluded from Application of the Rule

1. Ambulance services <42 C.F.R. 412.2(c)(5)(iii)> ;
2. Maintenance renal dialysis services <42 C.F.R. 412.2(c)(5)(iii)> ;
3. Physician professional services <See 63 Fed. Reg. 6866>;
4. Part A services furnished by skilled nursing facilities, home health agencies and hospices<See Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>; and

5. Visit services provided at a Rural Health Clinic (RHC) paid under their all-inclusive rate (AIR) or a Federally Qualified Health Center (FQHC) paid under the FQHC PPS rate that replaced the former AIR for FQHCs. <76 Fed. Reg. 73281; Medicare Benefit Policy Manual, Chapter 13 § 10.2>
 - a. Services provided at an RHC or FQHC paid under Part B rather than the AIR or FQHC PPS rate are subject to the payment window. <76 Fed. Reg. 73281-2>
6. Outpatient Services Not Covered or Payable under Part B
 - a. Services not covered or payable under Part B should not be bundled into a subsequent inpatient admission. <See Medicare Claims Processing Manual, Chapter 3 §40.3 C>

CMS provides the example of non-covered self-administered drugs provided before an inpatient admission (i.e., before the inpatient order) as an example of a non-covered item that should not be billed on the inpatient claim under the preadmission payment window rule.

E. The Date the Outpatient Services were Furnished

1. The day of admission:
 - a. An outpatient service provided by the hospital (or a wholly owned entity) on the same date as the patient's admission to the hospital is bundled into the inpatient admission, regardless of whether it is clinically related to the admission. <42 C.F.R. 412.2(c)(5)(ii) and (iv); 42 C.F.R. 412.405 (a)(2) and (3)>
2. Prior to admission:
 - a. Inpatient Prospective Payment System (IPPS) hospitals
 - i. An outpatient *diagnostic* service provided by the hospital (or a wholly owned entity) in the *three calendar days* prior to the patient's admission to the hospital is bundled into the inpatient admission, regardless of whether it is clinically related to the admission. <42 C.F.R. 412.2(c)(5)(ii)>
 - a) Definition of Diagnostic Services

- 1) CMS provides a list of revenue codes and HCPCS codes considered diagnostic for purposes of the rule in *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B, included in the materials behind the outline.

Caution: The list of diagnostic revenue codes and HCPCS codes provided in the Medicare Claims Processing Manual may not be exhaustive.

- ii. An outpatient *non-diagnostic* service provided by the hospital (or a wholly owned entity) in the three calendar days prior to the patient's admission to the hospital is bundled into the inpatient admission if it is related to the patient's admission. <42 C.F.R. 412.2(c)(5)(iv)>
 - a) Related is defined as being clinically associated with the reason for the patient's inpatient admission. <75 Fed. Reg. 50347>
- b. Non-IPPS hospitals, except Critical Access Hospitals
 - i. An outpatient *diagnostic* service is bundled into a subsequent inpatient admission if it is provided on the calendar day prior to the patient's admission to the hospital (and is furnished by the hospital or a wholly owned or operated entity and is not excluded from the rule as discussed above). <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3; *MLN Matters SE20024*>
 - ii. An outpatient *non-diagnostic* service is bundled into a subsequent inpatient admission if it is provided on the calendar day prior to the patient's admission to the hospital and it is related to the patient's admission (and is furnished by the hospital or a wholly owned or operated entity and is not excluded from the rule as discussed above). <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3>

Case Study 3

Facts: A patient comes to the emergency department of an IPPS hospital with syncope at 7pm on October 1. Diagnostic tests are performed on October 1 and the patient is placed in observation at 8pm. At 6am on October 2 additional diagnostic tests are performed and the patient is discharged home at 7 am. The patient is later admitted as an inpatient at the same hospital on October 5 for altered mental status and syncopal episodes. Are these services subject to the pre-admission payment window?

F. Billing Issues

1. Edits applied by Line-Item Date of Service (LIDOS)

- a. The payment window applies to outpatient services within three calendar days (or one calendar day for non-IPPS hospitals) prior to the patient's inpatient admission, even if the services are part of a continuous outpatient encounter that began prior to the payment window. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B and C>
- i. CMS pre-admission packaging edits are applied by line-item dates of service (LIDOS) for each service and not the "from" and "through" date of a claim. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B and D>
- ii. Application to Observation Services
 - a) Observation services are billed with the LIDOS that they began, rather than the date they are rendered. <*Medicare Claims Processing Manual*, Chapter 4 § 290.2.2>
 - b) Observation services with a LIDOS prior to the payment window will not trigger pre-admission packaging edits, even though some of the services may occur within the payment window and are presumably subject to packaging if they are related to the inpatient admission. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B and C>

2. Combining Outpatient Services on the Inpatient Claim

- a. The diagnosis codes, procedures, and charges for outpatient services subject to the payment window should be combined on to the inpatient claim. <See 63 *Fed. Reg.* 6866; see *Medicare Claims Processing Manual*, Chapter 3 § 40.3 C>
 - i. The HCPCS codes for outpatient procedures should be converted to ICD-10-PCS procedure codes for reporting on the inpatient claim. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 C>
 - ii. The ICD-10-PCS procedure codes for outpatient services occurring in the payment window should be reported with the date they were provided, even though this date precedes the inpatient admission date. <See CMS email notice to the HOSPITALS-ACUTE-L@LIST.NIH.GOV list on September 9, 2010>

3. Billing Clinically Distinct Services Separately

- a. Outpatient non-diagnostic services that are clinically distinct or independent from the reason for inpatient admission are considered unrelated and are separately billable. <42 C.F.R. 412.2(c)(5)(iv); 75 Fed. Reg. 50348>
 - i. The provider must report condition code 51 when separately billing unrelated outpatient non-diagnostic services provided in the payment window prior to an inpatient admission. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 C; *One Time Notification Transmittal 796*>
4. Billing by Freestanding (i.e., non-Provider Based) Wholly Owned or Operated Physician Practices and Entities
 - a. Technical services subject to the payment window are billed on the inpatient claim. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3; *MLN Matters SE20024*>
 - i. Although CMS has instructed providers to include charges for services subject to the payment window occurring in wholly owned or operated entities on the inpatient claim, it is unclear how to determine the amount of charge to be combined to the inpatient claim. <76 Fed. Reg. 73283>
 - b. Professional services associated with technical services subject to the payment window are billed separately on a supplier/1500 claim with modifier -PD. <*Medicare Claims Processing Manual*, Chapter 12 §§ 90.7 and 90.7.1; *MLN Matters SE20024*>
 - i. Services billed with modifier -PD that have a professional/technical component split (e.g., certain diagnostic services) will be paid at the professional component rate. <76 Fed. Reg. 73286; *Medicare Claims Processing Manual*, Chapter 12 § 90.7.1>
 - ii. Services billed with modifier -PD that do not have a professional/technical component split (e.g., E/M services) will be paid at the applicable facility rate. <76 Fed. Reg. 73286; *Medicare Claims Processing Manual*, Chapter 12 § 90.7.1>
 - c. Services provided in the payment window but not subject to bundling (i.e., unrelated non-diagnostic services) are billed as usual, with no special modifiers or other indicators. <*Medicare Claims Processing Manual*, Chapter 12 § 90.7>

Case Study 4

Facts: On September 13, a Medicare patient was seen in General Memorial Hospital's provider-based outpatient clinic for longstanding renal complications of their diabetes. The physician ordered laboratory tests and scheduled a follow-up visit for 2 days later. Later that same day, the patient presented to GMH's laboratory to have the tests ordered by the physician.

On September 15, the patient presented to GMH's provider-based outpatient clinic to review the laboratory tests with the physician. Later that day, the patient fell down the stairs in their home and was admitted to GMH for open reduction of multiple fractures. General Memorial Hospital is an IPPS hospital. Is the hospital entitled to separate payment for the clinic visit on September 13th? The laboratory test on September 13? The clinic visit on September 15?

IV. Medicare's Financial Liability Protections

- A. The Limitation on Liability ("LOL") statute is a Medicare law designed to protect beneficiaries from unexpected personal liability for a non-covered service if they are unaware the service is not covered by Medicare. <Medicare Claims Processing Manual, Chapter 30 § 10>

The beneficiary may not be charged for a non-covered service if:

- The service is denied for a reason specified in the "LOL" statute; AND
- The beneficiary did not have advance notice Medicare would not pay for it.

- B. Circumstances When Limitations on Liability Applies (and Advance Notice is Mandatory to Charge the Patient)

1. The item or service is not reasonable and necessary. <See Medicare Claims Processing Manual, Chapter 30 §§ 20, 20.1>
 - a. The item or service is considered by Medicare to be not medically necessary under the circumstances.
 - b. The service is a preventative service that is usually covered but will not be covered in this instance because frequency limitations have been exceeded.
2. The service is custodial care. <See Medicare Claims Processing Manual, Chapter 30 § 20.1>

3. The item or service is experimental (e.g., research use only or experimental use only laboratory tests). <See *Medicare Claims Processing Manual*, Chapter 30 §§ 20.1 and 40.2.2>

C. Circumstances When Limitations on Liability Does Not Apply (and Advance Notice is Voluntary, Beneficiary May be Charged Without Notice)

1. The LOL provisions do not apply to items or services that fail to meet a technical benefit requirement. <See *Medicare Claims Processing Manual*, Chapter 30 § 20.2>
 - a. “Technical denials” occur if coverage requirements for an item or service are not met or there is a failure to meet a condition of payment required by regulation. <See *Medicare Claims Processing Manual*, Chapter 30 § 20.2>

Example: Denial of a drug or biological because it is usually self-administered by the patient is considered a technical denial.

2. The LOL provisions do not apply to items or services that do not fit into a Medicare benefit (i.e., are statutorily excluded). <See *Medicare Claims Processing Manual*, Chapter 30 § 20.2>
 - a. “Categorical denials” occur when the denial is based on other statutory provisions not referenced in the LOL statute. <See *Medicare Claims Processing Manual*, Chapter 30 §§ 20.1 and 20.2>

Items or services excluded from Medicare coverage include:

- Routine physicals and most screening tests, except the Initial Preventative Physical Exam and Annual Wellness Visit
- Most vaccinations, except flu, pneumococcal, hepatitis B, COVID
- Routine eye care, examinations and most eyeglasses
- Hearing aids and hearing examinations
- Dental care and dentures
- Routine foot care and flat foot care
- Orthopedic shoes and orthotic foot supports
- Cosmetic surgery and surgery performed for cosmetic purposes

- b. Although ABNs are not required for services that are statutorily excluded from coverage or that fail to meet a technical benefit requirement, CMS “strongly encourages” providers to issue ABNs in these circumstances. <*Medicare Claims Processing Manual*, Chapter 30 § 50.2.1>

D. Limitations on Liability Notices

1. A properly prepared and delivered ABN form satisfies the Limitation on Liability notice requirement for outpatient services that are not considered reasonable and necessary or are custodial. <Medicare Claims Processing Manual, Chapter 30 §§ 20, 30, and 50>
2. A Hospital Issued Notice of Non-coverage (HINN) is the Limitation on Liability notice for hospital inpatients. The HINN will be discussed in a later module. <Medicare Claims Processing Manual Transmittal 982>

E. Handout 9 is a summary and comparison of Medicare notices.

V. Advance Beneficiary Notice (ABN)

A. The ABN Form

1. The Advance Beneficiary Notice (CMS-R-131 (Exp. 01/31/2026)), available in English, Spanish, and large print, is the required form for providing notice of non-coverage for outpatient services. Handout 10 is the ABN Form.
2. The ABN may not be modified except as specifically allowed in the completion instructions. <Medicare Claims Processing Manual, Chapter 30 § 50.5, C>

Link: Beneficiary Notice Initiative (MOON, IM, ABNs, HINNs) under Medicare-Related Sites – General
Use the links on the left navigation to go to the FFS ABN page.

B. Delivery of the ABN

1. The ABN should be delivered in person to the beneficiary or their representative and the provider must answer all inquiries of the beneficiary, including the basis for the determination that the service is not covered. <Medicare Claims Processing Manual, Chapter 30 § 50.8, 50.8.1>
 - a. If delivery in person is not possible, delivery may be by telephone, mail, secure fax, or email. <Medicare Claims Processing Manual, Chapter 30 § 50.8.1>
 - i. If notice is by telephone, a copy should be mailed, faxed or emailed to the beneficiary for them to sign and return to the provider. In order to be effective, the beneficiary must not dispute the contact. <Medicare Claims Processing Manual, Chapter 30 § 50.8.1>

2. Beneficiary Comprehension

- a. An ABN will not be considered effective unless the beneficiary, or their authorized representative, comprehends the notice. <Medicare Claims Processing Manual, Chapter 30 § 50.8>
 - b. The only printed versions of the form allowed are the OMB approved English and Spanish versions, and insertions should be made in the language of the printed form. <Medicare Claims Processing Manual, Chapter 30 § 50.5, A>
 - c. Oral assistance should be provided for languages other than English and Spanish and documented in the “Additional Information” section. <Medicare Claims Processing Manual, Chapter 30 § 50.5, A>
3. Beneficiary Representative
- a. If the patient is unable to comprehend the notice, notice must be provided to a known legal representative if the patient has one. < Medicare Claims Processing Manual, Chapter 30 § 50.3>
 - i. An authorized representative is an individual authorized under State or other applicable law to act on behalf of a beneficiary when the beneficiary is temporarily or permanently unable to act for themselves (e.g., a legally appointed representative or legal guardian). <Medicare Claims Processing Manual, Chapter 30 § 500>
 - ii. If the beneficiary does not have a representative, one may be appointed following CMS guidelines and as permitted by State and Local laws. <Medicare Claims Processing Manual, Chapter 30 § 50.3>
 - b. In states with health care consent statutes providing for health care decision making by surrogates for individuals who lack advance directives or guardians, it is permissible to rely on individuals designated under those statutes to act as authorized representatives. <Medicare Claims Processing Manual, Chapter 30 § 500>
 - c. If a representative signs on behalf of the beneficiary, the name of the representative should be printed on the form and the signature should be annotated with “rep” or “representative”. <Medicare Claims Processing Manual, Chapter 30 § 50.3>
4. Timing of Delivery
- a. The ABN must be provided far enough in advance of delivery of potentially non-covered items or services to allow the beneficiary time to consider all available options and make an informed decision without undue pressure. <Medicare Claims Processing Manual, Chapter 30 §§ 40.2.1, 50.8>

- i. The ABN is not effective if it is provided during an emergency, the beneficiary is under great duress, or the beneficiary is coerced or misled by the notifier, the notice, or the manner of delivery. <Medicare Claims Processing Manual, Chapter 30 § 40.2>
- b. A valid ABN remains effective as long as there has been no change in:
 - i. The care described on the original ABN;
 - ii. The beneficiary’s health status which would require a change in the treatment for the condition; and/or
 - iii. The Medicare coverage guidelines for the non-covered item or service (i.e., updates or changes to the coverage policy of the item or service). <Medicare Claims Processing Manual, Chapter 30 § 50.8, A>
- c. For items or services that are repetitive or continuous, a new ABN may be issued after one year, however, it is not required unless a change has occurred making the ABN no longer effective. <Medicare Claims Processing Manual, Chapter 30 § 50.8, A>

Caution: Medicare Claims Processing Manual, Chapter 30 § 40.2 continues to state that notice is not effective if delivered more than a year before the item or service is provided. This section was published in 2019 and is presumably superseded by the above guidance published in 2021.

5. Completion of the Form

Unless noted otherwise, information in this section is from the “Form Instructions, Advance Beneficiary Notice of Non-coverage (ABN), OMB Approval Number: 0938-0566” available on the FFS ABN webpage and included in the materials behind the outline.

- a. “Notifier(s)”
 - i. If the notifier in the header is an entity other than the billing entity, the notifier should annotate the Additional Information section of the ABN with information for contacting the billing entity for questions. <Medicare Claims Processing Manual, Chapter 30 § 50.3>

- ii. If multiple entities are involved in rendering or billing for the care (e.g., one entity provides the technical component and another entity provides the professional component), separate ABNs are not necessary. *<Medicare Claims Processing Manual, Chapter 30 § 50.3>*
- b. “Blank D”
- i. The “Blank D” field is filled in with one of the following general categories as applicable: Item, Service, Laboratory Test, Test, Procedure, Care, Equipment. All “Blank D” fields must be filled in for the ABN to valid.
 - ii. In the column under “Blank D”, describe the specific item or service that is non-covered, including the frequency or duration of repetitive or continuous services. Items can be grouped, e.g., “wound care supplies” or “observation services” rather than listed individually.
- c. “Reason Medicare May Not Pay:”
- i. Explain the reason the item may not be covered by Medicare.
 - ii. Simply stating “medically unnecessary” or the equivalent is not acceptable. *<Medicare Claims Processing Manual, Chapter 30 § 40.2.1, C>*

Tip: Be specific about the reason for denial, for example:

- “Medicare does not pay for custodial care, except for some hospice services”
- “Medicare does not pay for this test for your condition”.

d. “Estimated Cost”

- i. Provide a good faith estimate of the cost of the non-covered services to the patient. The cost to the patient is the provider’s usual and customary charge and is not limited by the Medicare allowable or payment amount.

Caution: The final amount billed to the patient may be affected by state laws requiring providers to give uninsured patients a discount, including discounts based on financial need or equal to the discount given to their largest payer.

- a) An estimate will be considered to be made in good faith if the estimate is within the greater of \$100 or 25% of the cost of the service to the patient (i.e., amount billed to the patient) and may be given as a range or may exceed the final amount billed.
- ii. Multiple services may be grouped together into a single cost estimate.
- iii. An average daily cost estimate may be provided for complex projections (i.e., observation services).

Examples of good faith cost estimates for a service with a \$1000 charge:

- Any estimate greater than \$750
- Between \$750 - \$1100
- No more than \$1200

iv. Unknown costs

- a) The hospital may not have a policy of routinely or frequently failing to provide a cost estimate, however, the patient may sign an ABN without a cost estimate in limited circumstances.
 - 1) If additional services may be required (i.e. reflexive testing), the cost of the initial services should be given, along with a notation that additional services may be provided.
 - 2) If the costs cannot be determined, make a notation in the cost estimate area that no cost estimate is available.

Case Study 5

Facts: A Medicare patient presented to a hospital for a nuclear medicine procedure that, under the applicable Medicare coverage policy, was not considered medically necessary for the patient's condition. The patient signed an ABN before the procedure was performed. The ABN was properly prepared and gave an estimated cost of \$2,000 - \$2,200 for the intended procedure.

The hospital provided the procedure; however, the patient required a more expensive radiopharmaceutical than normally used, resulting in a final total charge of \$2,400 for the procedure. The hospital billed Medicare and Medicare denied coverage. The hospital then sent the patient a bill for \$2,400.

The patient now says she is only going to pay \$850. She claims that the hospital is overcharging her because she found out from the Medicare beneficiary services hotline that Medicare typically only pays \$850 for the service. Assuming no state laws affect the amount collected by the provider, how much may the hospital collect from the patient?

- e. "Options"
 - i. The beneficiary or their representative must check one of the options or have the provider check the option if they are unable to do so.
 - a) The provider should make a note on the ABN if they checked the option at the request of the beneficiary.
 - ii. If the beneficiary refuses to choose an option, the ABN should be annotated with the refusal and the annotation should be witnessed.

<Medicare Claims Processing Manual, Chapter 30 § 40.2.2, B and 50.6, A.2.>
 - iii. Special Instructions for Dually Eligible Beneficiary
 - a) Dually eligible beneficiaries have both Medicare and Medicaid, including patients enrolled in a Qualified Medicare Beneficiary (QMB) Program.
 - b) For dually eligible beneficiaries, Option 1 must be modified by lining through certain language as designated in the "Form Instructions", included in the materials behind the outline. This is an exception to the general prohibition on modifying the ABN form.

- c) Dually eligible beneficiaries should be instructed to choose Option 1 in order for the claim to be submitted for Medicare adjudication and, if denied, submitted to Medicaid for a determination.
 - 1) If both Medicare and Medicaid deny coverage, refer to the “Form Instructions” or MLN Booklet *Dually Eligible Beneficiaries under Medicare and Medicaid*, available on the CMS website, for more information on potential beneficiary liability.
- iv. If there are multiple items on the ABN and the beneficiary wants to select different options for each of the items, more than one ABN should be used to accommodate the beneficiary’s choices.
- f. “Additional Information”
 - i. May be used for witness signatures or to make annotations, such as advising the beneficiary to notify their provider of tests or services that were ordered but not received. If items are added after the date of the ABN, they must be dated.
- g. “Signature”
 - i. The beneficiary or their representative should sign and date the notice.
 - ii. If the beneficiary refuses to sign but still desires to receive the item or service, the ABN should be annotated with the refusal and the annotation should be witnessed. <Medicare Claims Processing Manual, Chapter 30 § 40.2.2, B and 50.6, A.2.>

Case Study 6

Facts: A Medicare patient presented to the hospital for a minor non-cosmetic surgical procedure related to varicose veins. Under an applicable LCD, the procedure is not considered medically necessary for patients with a diagnosis of varicose veins. A properly prepared ABN was reviewed with the patient.

The patient refused to sign the ABN, but still wants to proceed with the procedure based on the recommendation of his physician. Two witnesses acknowledged in writing on the ABN form that the ABN had been reviewed with the patient, but that he refused to sign it. May the hospital bill the patient for the procedure, even though they did not sign the ABN?

6. Copy of the ABN

- a. The hospital should retain the original ABN and give a copy to the beneficiary. <Medicare Claims Processing Manual, Chapter 30 §§ 40.2.1 B and 50.5 C>
 - i. The ABN should be retained for 5 years, or longer as required by state law. <Medicare Claims Processing Manual, Chapter 30 § 50.7>

Caution: The ABN should be retained even if the beneficiary refuses the service or refuses to sign or choose an option.

- b. Carbon copies, fax copies, electronically scanned copies, and photocopies are all acceptable. <Medicare Claims Processing Manual, Chapter 30 §§ 40.2.1 B and 50.5 C>

C. Other Considerations for an Effective ABN

1. Interplay between the ABN and EMTALA requirements

a. EMTALA Requirements Take Priority over ABN Requirements

- i. Under the Emergency Medical Treatment and Active Labor Act (EMTALA) hospitals have an obligation to complete a medical screening examination (MSE) and stabilize a patient presenting to its emergency department, or in certain circumstance, presenting to other areas of the hospital. <Medicare Claims Processing Manual, Chapter 30 § 40.4>
 - a) CMS and the OIG take the position that where EMTALA applies, it is improper to present an ABN to a patient before completing the MSE and stabilizing the patient. <Medicare Claims Processing Manual, Chapter 30 § 40.4>

b. Contractor's Medical Necessity Determinations for EMTALA required care

- i. The MAC is required to make medical necessity determinations of EMTALA screening/stabilization services based on the "information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished". <Social Security Act § 1862 (d)>
- ii. The Intermediary should not apply frequency edits to EMTALA screening/stabilization services. <Social Security Act § 1862 (d)>

2. Medicare Advantage Plan Beneficiaries
 - a. The ABN form may not be used for services provided under Medicare Advantage Plans. <Medicare Claims Processes Manual, Chapter 30 § 50.1>
3. Prohibition on Routine, Blanket, and Generic ABNs
 - a. In general, “generic” ABNs (i.e., merely stating denial is possible”), “routine,” ABNs (i.e., no specific reason Medicare will not pay), and “blanket” ABNs (i.e., given for all claims) will not be considered to be effective. <Medicare Claims Processing Manual, Chapter 30 § 40.2.2 C>

Routine ABNs may be given for frequency limited service (e.g., screening mammography) if the ABN states the frequency limitation (e.g., “Medicare does not pay for this service more often than _____.”)

VI. Billing Outpatient Non-Covered Items or Services

- A. Handout 11 is an overview of billing for outpatient non-covered services, as discussed in this section.
- B. An Effective ABN was Issued
 1. Bill to the MAC with Occurrence Code 32
 - a. When an ABN is provided, the claim for the items or services for which the ABN was given must be filed with an occurrence code 32. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
 - b. The occurrence date should be the date that the ABN was given to the beneficiary. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
 2. Bill as Covered Charges
 - a. Items or services for which an ABN was given should be billed as “covered charges.” <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
 3. Other Covered or Non-covered Services Billed on the Same Claim
 - a. If other covered or non-covered items or services are billed on the same claim, modifier –GA should be used to identify those items or services for which an ABN was given. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>

4. Collecting Payment from the Beneficiary Upon Denial by the Intermediary
 - a. Where the MAC/FI denies payment for services, for which an effective ABN was provided, payment for the services may be collected from the Medicare beneficiary. <Medicare Claims Processing Manual, Chapter 30 § 50.12>
 - b. Medicare charge limits do not apply to services for which an effective ABN was given. <Medicare Claims Processing Manual, Chapter 30 § 50.12>

C. An ABN was Required but Not Issued

1. “Fully Non-Covered Claim”
 - a. A “fully non-covered claim” is billed without indicators of liability or only provider liability indicators and is used to bill entirely non-covered services for which the hospital is liable. “Fully non-covered claims” are allowed but not required for hospital liable services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
 - b. Indicators of Liability on “Fully Non-covered Claims”
 - i. No indicators of liability at the claim or line level (i.e., no condition code 21, a claim level indicator of beneficiary liability), or
 - ii. All indicators of liability at the claim or line level must indicate that the hospital, and not the beneficiary, is liable (i.e., no modifier -GY, a line level indicator of beneficiary liability). <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
2. Bill as Non-Covered Charges
 - a. Charges should be billed as non-covered. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
3. Other Covered or Non-covered Services Billed on the Same Claim
 - a. Modifier -GZ indicates a line item expected to be denied as not reasonable and necessary, but for which no ABN was given. The -GZ triggers automatic denial and hospital liability. <Medicare Claims Processing Manual, Chapter 1 §§ 60.1.3.1 and 60.4.2, Table 8; Medicare Program Integrity Manual, Chapter 3 § 3.3.1.1 (G)>

D. At Request of the Beneficiary (Demand Bill), a Voluntary ABN May Have Been Issued

1. Bill to the Intermediary with Condition Code 20
 - a. Where the hospital expects a service to be non-covered due to a categorical or technical denial, but the beneficiary requests that the claim be submitted to Medicare for a determination anyway, the claim should be submitted with condition code 20. This has traditionally been referred to as a “demand bill.” <Medicare Claims Processing Manual, Chapter 1 § 60.3.1>
 - i. The beneficiary has the right to have any service provided to them billed to Medicare for an official payment decision that they may appeal if they choose. <Medicare Claims Processing Manual, Chapter 1 § 60.3.1>
2. Bill as Non-Covered Charges
 - a. The charges for which coverage is “in dispute” must be submitted as non-covered charges. <Medicare Claims Processing Manual, Chapter 1 § 60.3.1>
3. Other Covered Services Billed on Same Claim
 - a. Covered services may, but are not required, to appear on the same claim as non-covered services billed with condition code 20. <Medicare Claims Processing Manual, Chapter 1 § 60.3.2>
4. Other Non-covered Services Billed on a Separate Claim
 - a. Other non-covered services (i.e., billed with occurrence code 32 or condition code 21) must be submitted on a separate claim from demand bill services. Claims with condition code 20 are exempt from same day billing rules. <Medicare Claims Processing Manual, Chapter 1 § 60.3.2>
5. Voluntary ABN Issued (Limitation on Liability does not apply)
 - a. Modifier –GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual Transmittal 1921 B>
 - i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual Transmittal 1921>

E. Billing for Denial Notices for Secondary Payors

1. Bill to the Intermediary with Condition Code 21
 - a. Where services are clearly non-covered (i.e., categorical or technical denials) but a claim is being submitted to Medicare for purposes of obtaining a denial notice that can be forwarded to secondary payers, the claim should be submitted with condition code 21. These types of claims are sometimes referred to as “no-pay bills.” <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
2. Bill as Non-Covered Charges
 - a. All charges on no-pay bills must be submitted as non-covered charges. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
3. Other Covered and Non-covered ABN Services Billed on Same Claim
 - a. Non-covered services being billed for a denial must be submitted with modifier -GY, rather than condition code 21, when they appear on the same claim as covered and other non-covered services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.2 (B)>
 - i. Modifier -GY indicates a line item that is statutorily excluded or does not meet the definition of any Medicare benefit (i.e., categorical and technical denial). Modifier -GY triggers beneficiary liability. <Medicare Claims Processing Manual, Chapter 1 § 60.4.2, Table 8>
4. Voluntary ABN Issued (Limitation on Liability does not apply)
 - a. Modifier –GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual, Transmittal 1921 B>
 - i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual, Transmittal 1921>

VII. Treatment of Conditions Arising During or From a Non-Covered Inpatient Stay

- A. Handout 12 is an overview of billing for inpatient non-covered services, as discussed in this section.
- B. Sometimes it is necessary for a hospital to treat conditions that arise during or from a non-covered stay such as a stay for cosmetic surgery, non-covered gastric bypass, etc.

1. Coverage depends on whether the treatment was “related to” the non-covered services and when the treatment was furnished. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - a. Related to
 - i. If the treatment was “related to” non-covered service and was provided during the non-covered stay, the treatment is not covered. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - a) Treatment of complications from non-covered services may be covered if the complications arise after the patient was discharged from the non-covered stay. <Medicare Benefit Policy Manual, Chapter 1 § 120>
 - b. Not related to
 - i. If the treatment or service is “not related to” the non-covered service then it is covered even if it was furnished during an otherwise non-covered stay. <Medicare Benefit Policy Manual, Chapter 1 § 120>
- C. Procedure for billing for covered services furnished during a non-covered stay. <Medicare Claims Processing Manual, Chapter 3 § 40.2.1>
1. Use the admission date for the entire stay, rather than the date the covered care started, in FL 6 (Statement From Date) and FL 12 (Admission Date)
 2. Occurrence Code 31 is used to indicate the date the hospital provided notice to the beneficiary of their liability for the non-covered portion of the stay (if applicable)
 - a. Presumably this would be the Preadmission/Admission HINN.
 3. Value Code 31 is used to report the amount of non-covered services charged to the patient and report non-covered services in the non-covered charges column.
 4. Occurrence span code 76 must be used to report the dates from admission to the day before the covered care started.
 5. The principal diagnosis is the diagnosis that “caused the covered level of care”.
 6. Only report covered procedures furnished during the covered period of care.
 - a. If non-covered procedures are furnished during the stay, they may not be reported on the same claim. <Medicare Claims Processing Manual, Chapter 1 § 60.2.1>

- i. Non-covered procedure may be reported (i.e., for a Medicare denial) on a separate claim with condition code 21 and the same Statement Covers Period – From/Through (FL 6). <Medicare Claims Processing Manual, Chapter 1 § 60.2.1>
7. When the patient is responsible for payment because non-covered services were furnished, the hospital may bill the patient its “customary” charge for the services. <42 C.F.R. 412.42(e)>

Case Study 7

Facts: A Medicare patient with BMI of 32 is admitted for bariatric surgery to assist in weight loss and control of their type 2 diabetes based on the recommendation of their endocrinologists. Medicare considers bariatric surgery reasonable and necessary only for patients with a BMI of 35 or greater. The hospital issued the patient an Admission HINN (Hospital Inpatient Notice of Non-coverage) upon admission to the hospital for the surgery on July 15. The patient was discharged from the hospital on July 20.

The patient returned to the hospital on July 27 with dizziness, weakness, and an irregular heartbeat. The patient experienced a severe hypoglycemic episode resulting in coma in the emergency department and was admitted to the hospital and diagnosed with “dumping syndrome”, a complication of bariatric surgery that prevents proper digestion. Is the admission for the “dumping syndrome” covered by Medicare, assuming the physician had a reasonable expectation of a two midnight stay?

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient received cardiac rehab services on March 1, 5, 7 and 9. The patient was then admitted as an inpatient to the hospital on March 11-15 for pancreatitis unrelated to their cardiac condition. The patient returned to cardiac rehab on March 19 and received cardiac rehab services on March 19, 21, 23, 26, 28 and 30. How should the cardiac rehab services be billed?

Analysis: Cardiac rehabilitation is categorized as a repetitive service and must be billed on a separate monthly claim. When an inpatient stay occurs during the same month as a repetitive service, occurrence span code 74 and the dates of the inpatient stay must be reported to prevent a duplicate claim edit. <Medicare Claims Processing Manual, Chapter 1 § 50.2.2>

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Case Study 2

Facts: A Medicare patient receiving chemotherapy treatments is registered as a “series” patient at the hospitals’ Cancer Center. The patient received chemotherapy treatments on November 1, 6, 11 and 18. On November 6, the patient is registered as an outpatient at the provider-based clinic where they see their family practitioner related to the flu. The visit was coded with E/M code G0463. Would it be permissible to bill the clinic visit separately from the chemotherapy treatments?

Analysis: The clinic visit must be billed on the same claim as the chemotherapy treatment on November 6. The provider may either include the clinic visit on the series account for the chemotherapy treatments or separate the chemotherapy treatments onto separate claims in order to bill the chemotherapy and clinic visit on November 6 on the same claim and the chemotherapy on November 1 and the chemotherapy on November 11 and 18 separately. <Medicare Claims Processing Manual, Chapter § 50.2.2>

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Case Study 3

Facts: A patient comes to the emergency department of an IPPS hospital with syncope at 7pm on October 1. Diagnostic tests are performed on October 1 and the patient is placed in observation at 8pm. At 6am on October 2 additional diagnostic tests are performed and the patient is discharged home at 7 am. The patient is later admitted as an inpatient at the same hospital on October 5 for altered mental status and syncopal episodes. Are these services subject to the pre-admission payment window?

Analysis: The emergency department visit, the 4 hours of observation and diagnostic tests performed on October 1 are not subject to the payment window and should be billed separately. The diagnostic tests and 7 hours of observation on October 2 are subject to the payment window and should be billed on the inpatient claim. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>

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Case Study 4

Facts: On September 13, a Medicare patient was seen in General Memorial Hospital's provider-based outpatient clinic for longstanding renal complications of their diabetes. The physician ordered laboratory tests and scheduled a follow-up visit for 2 days later. Later that same day, the patient presented to GMH's laboratory to have the tests ordered by the physician.

On September 15, the patient presented to GMH's provider-based outpatient clinic to review the laboratory tests with the physician. Later that day, the patient fell down the stairs in their home and was admitted to GMH for open reduction of multiple fractures. General Memorial Hospital is an IPPS hospital. Is the hospital entitled to separate payment for the clinic visit on September 13th? The laboratory test on September 13? The clinic visit on September 15?

Analysis: The hospital is entitled to separate payment for the clinic visit on September 13 because it is a non-diagnostic service and is not clinically related to the admission on September 15. The hospital must report condition code 51 on the outpatient claim for the clinic visit. The laboratory test on September 13 is bundled to the inpatient admission under the three-day payment window because all diagnostic services in the three days before an inpatient admission must be included on the inpatient claim, whether they are related or not. The hospital is also not entitled to separate payment for the clinic visit on September 15 because all services on the day of an inpatient admission must be included on the inpatient claim. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>

Case Study 5

Facts: A Medicare patient presented to a hospital for a nuclear medicine procedure that, under the applicable Medicare coverage policy, was not considered medically necessary for the patient's condition. The patient signed an ABN before the procedure was performed. The ABN was properly prepared and gave an estimated cost of \$2,000 - \$2,200 for the intended procedure.

The hospital provided the procedure, however the patient required a more expensive radiopharmaceutical than normally used, resulting in a final total charge of \$2,400 for the procedure. The hospital billed Medicare and Medicare denied coverage. The hospital then sent the patient a bill for \$2,400.

The patient now says she is only going to pay \$850. She claims that the hospital is overcharging her because she found out from the Medicare beneficiary services hotline that Medicare typically only pays \$850 for the service. Assuming no state laws affect the amount collected by the provider, how much may the hospital collect from the patient?

Analysis: The patient is liable for \$2400. The cost estimate is considered to be in good faith because it is within 25% of the final cost to the patient – 25% of the final cost of \$2400 would be \$600, meaning any estimate greater than \$1800 would be within 25% of the final cost. <“From Instructions, Advanced Beneficiary Notice of Non-Coverage (ABN)”>

Case Study 6

Facts: A Medicare patient presented to the hospital for a minor non-cosmetic surgical procedure related to varicose veins. Under an applicable LCD, the procedure is not considered medically necessary for patients with a diagnosis of varicose veins. A properly prepared ABN was reviewed with the patient.

The patient refused to sign the ABN, but still wants to proceed with the procedure based on the recommendation of his physician. Two witnesses acknowledged in writing on the ABN form that the ABN had been reviewed with the patient, but that he refused to sign it. May the hospital bill the patient for the procedure, even though they did not sign the ABN?

Analysis: Under the “LOL” provisions, an ABN does not need to be signed to be effective as long as the patient read and understood the notice. Two witnesses should document the patient’s refusal to sign, which was done in this case. <Medicare Claims Processing Manual, Chapter 30 § 40.2.2, B and 50.6, A.2.>

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Case Study 7

Facts: A Medicare patient with BMI of 32 is admitted for bariatric surgery to assist in weight loss and control of their type 2 diabetes based on the recommendation of their endocrinologists. Medicare considers bariatric surgery reasonable and necessary only for patients with a BMI of 35 or greater. The hospital issued the patient an Admission HINN (Hospital Inpatient Notice of Non-coverage) upon admission to the hospital for the surgery on July 15. The patient was discharged from the hospital on July 20.

The patient returned to the hospital on July 27 with dizziness, weakness and an irregular heartbeat. The patient experienced a severe hypoglycemic episode resulting in coma in the emergency department and was admitted to the hospital and diagnosed with “dumping syndrome”, a complication of bariatric surgery that prevents proper digestion. Is the admission for the “dumping syndrome” covered by Medicare, assuming the physician had a reasonable expectation of a two midnight stay?

Analysis: The second admission for treatment of complications from the non-covered bariatric surgery is covered by Medicare. Although the admission is related to the prior non-covered bariatric surgery, it occurred after the patient’s discharge, during a new hospitalization which was medically necessary for treatment of the patient’s condition. <Medicare Benefit Policy Manual, Chapter 1 § 120>

Excerpt from Medicare Claims Processing Manual, Chapter 1

code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

NOTE: For stays that necessitate the reporting of more than ten OSCs (i.e., more OSCs than the claim formats allow), Long Term Care Hospitals, Inpatient Psychiatric Facilities, and Inpatient Rehabilitation Facilities shall refer to instructions provided in Chapter 32, section 74.3 of this manual.

50.2.2 - Frequency of Billing for Providers Submitting Institutional Claims with Outpatient Services

(Rev. 2092, Issued: 11-12-10, Effective: 04-01-11, Implementation: 04-04-11)

Repetitive Part B services furnished to a single individual by providers that bill institutional claims shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply to hospice services billed under Part A, though they do not apply to home health services. Consolidating repetitive services into a single monthly claim reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

Type of Service	Revenue Code(s)
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech-Language Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Pulmonary Rehabilitation Services	0948

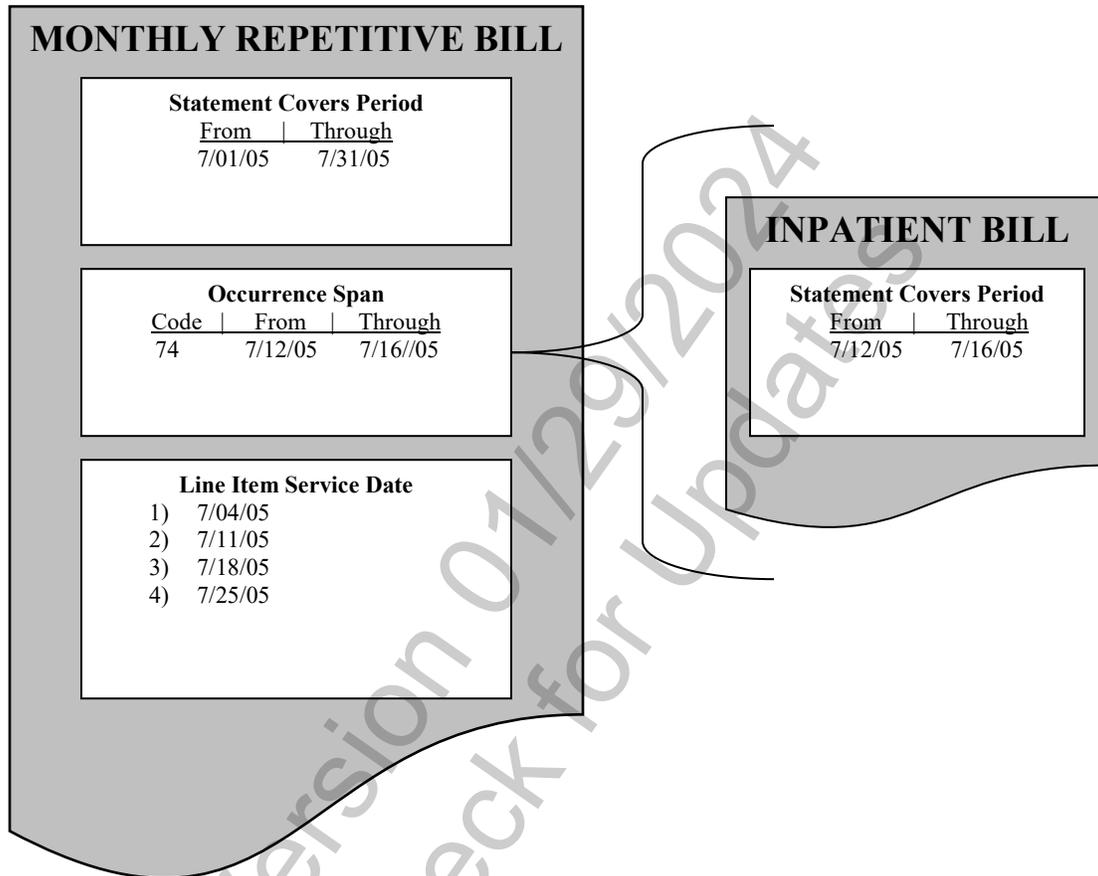
Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.



Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill for repetitive services shall nonetheless be submitted for the entire month as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive non-repetitive services while receiving repetitive services, and consequently, is

on leave of absence from the repetitive services. This permits submitting a single, monthly bill for repetitive services and simplifies Contractor review of these bills. The following is an illustration explaining this scenario:

Leave of Absence “Carve-Out” Example

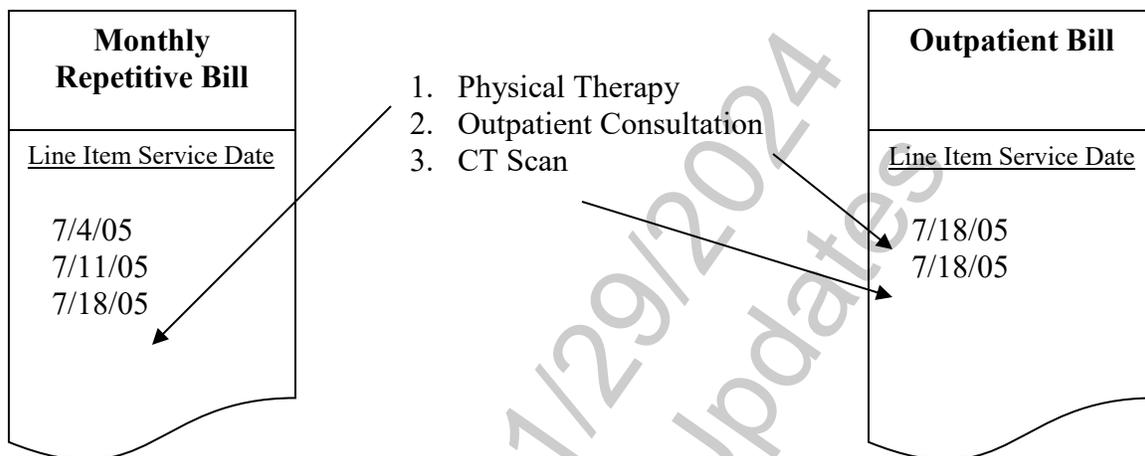


-  Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).
-  However, to facilitate APC recalibration, do not report unrelated one-time, non-repetitive services that have the same date of service as a repetitive service (even if both the non-repetitive service and the repetitive service are paid under OPSS). If a non-repetitive OPSS service is provided on the same date as a repetitive service, report the non-repetitive OPSS services, along with any packaged and/or services related to the non-repetitive OPSS service, on a separate OPSS claim. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, report the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the

monthly repetitive services claim. Similarly, as shown below in the illustration, “Example: Monthly Repetitive Billing Procedure,” a physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered on the same day an outpatient consultation and a CT scan are furnished, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month. Report the visit for the consultation and the CT scan on a separate claim.



Example: Monthly Repetitive Billing Procedure



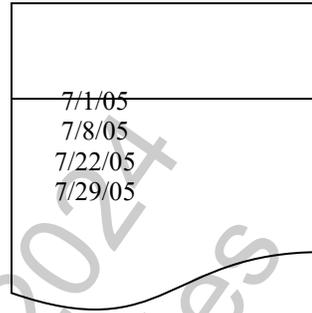
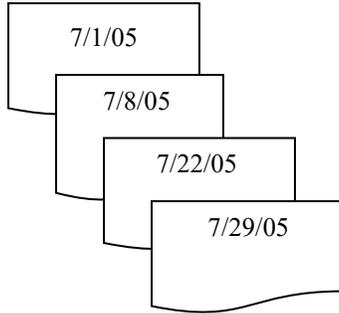
Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may all be reported on the same claim or billed separately by date of service as illustrated below:

Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):

OR

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):



Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-ASC services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

Contractors periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. Contractors may rely on informal communications from their medical review staff, and

Contractors should educate providers that bill improperly. Contractors shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.
- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

Medicare Program Memorandum Intermediaries, Transmittal A-00-36

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- o All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41, 13X without condition code 41 or 14X) with the exception of bills from hospitals in Maryland, Indian health service, CAHs, and hospitals located in Saipan, American Samoa, and Guam;
- o CMHC bills (bill type 76X);
- o CORF and HHA bills containing certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above (bill types 75X or 34X); and
- o Any bill containing a condition code 07 with certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above.

NOTE: For bill type 34X only vaccines and their administration, splints, casts, and antigens will be paid under OPSS. For bill type 75X only vaccines and their administration will be paid under OPSS. For bills containing condition code 07 only splints, casts, and antigens will be paid under OPSS.

Discontinuation of Bill Type 83X for Hospitals Subject to OPSS

Since bill type 83X "Ambulatory Surgical Center Services to Hospital Outpatients" will not be utilized under OPSS, hospitals are required, beginning with claims with dates of service on or after August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date services were rendered. As a result, pre-operative laboratory services will always have a line item date of service within the from and through dates on the claim. The instructions in §3626.4 of the MIM only apply to claims with dates of service prior to August 1, 2000.

Indian health service hospitals continue to bill for surgeries utilizing bill type 83X.

Discontinuation of Value Code 05 Reporting

With line item date of service reporting, there will be no way to correctly allocate professional component charges reported in value code 05 to specific line items on the claim. As a result, advise your hospitals that currently report professional component charges in value code 05 on outpatient claims to no longer include the professional component amount in their charges and to discontinue reporting the professional component in value code 05.

Provider Reporting Requirements

Advise your providers paid under OPSS not to include July 2000 and August 2000 dates of service on the same claim. Standard systems must edit to assure that a hospital or CMHC claim does not contain dates of service that span July 2000 and August 2000. In addition, advise your hospitals and CMHCs that every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPSS. Return claims submitted for the same date of service to the provider (except duplicates or those containing condition codes 20, 21 or G0) with a notification that an adjustment bill should be submitted. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

Procedures for Submitting Late Charges

Hospitals and CMHCs may not submit a late charge bill (Step 5 in the third position of the bill type) for bill types 12X, 13X, 14X, and 76X effective for claims with dates of service on or after August 1, 2000. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service by reporting a 7 in the third position of the bill type. Separate bills containing only late charges will not be permitted.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE and payment under OPSS.

Excerpt from Medicare Claims Processing Manual, Chapter 3

- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

A. - Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and A/B MACs (A) apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for A/B MAC (A) requirements for detecting duplicate claims in such cases.

B. - Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

- 🔑 Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, outpatient diagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

-  The technical portion of any outpatient diagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient diagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient diagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

-  An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the

same as a “for-profit” entity. Thus, outpatient diagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary’s inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary’s inpatient stay at the not-for-profit hospital.

 For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

Code	Description
0254	Drugs incident to other diagnostic services
0255	Drugs incident to radiology
030X	Laboratory
031X	Laboratory pathological
032X	Radiology diagnostic
0341, 0343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
035X	CT scan
0371	Anesthesia incident to Radiology
0372	Anesthesia incident to other diagnostic services
040X	Other imaging services
046X	Pulmonary function
0471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic
0482	Cardiology, Stress Test
0483	Cardiology, Echocardiology
053X	Osteopathic services
061X	MRT
062X	Medical/surgical supplies, incident to radiology or other diagnostic services
073X	EKG/ECG

Code	Description
074X	EEG
0918-	Testing- Behavioral Health
092X	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to an IPPS or IPPS-excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from IPPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For IPPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on the day of or any of the 3 days prior to admission. Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

C. - Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991 and Before June 25, 2010)

Nondiagnostic outpatient services that are related to a beneficiary's hospital admission and that are provided by the admitting hospital, or by an entity that is wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient payment. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay. Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The A/B MAC (A) shall assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services. If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the nondiagnostic preadmission services to Part B. This provision applies only when the beneficiary has Part A coverage. This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Hospitals must not include on a claim for an inpatient admission any outpatient nondiagnostic services that are not payable under Part B. For example, oral medications that are considered self-administered drugs under Part B are not payable under the outpatient prospective payment system (OPPS) and must not be bundled on an inpatient claim for purposes of the 3-day (or 1-day) payment window policy.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore, outpatient nondiagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, admission-related outpatient nondiagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any admission-related outpatient nondiagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient nondiagnostic services that are included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient nondiagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient nondiagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting

or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a “sponsorship” is treated the same as an “ownership”, and a “non-profit” or “not-for-profit” entity is treated the same as a “for-profit” entity. Thus, admission-related outpatient nondiagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary’s inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary’s inpatient stay at the not-for-profit hospital.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

Effective for dates of service on or after July 1, 2008 and before June 25, 2010, CWF will reject claims for nondiagnostic services when the following is met:

- 1) There is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay, and
- 2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPSS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPSS).

D. - Other Preadmission Services (Effective for Services Furnished On or After June 25, 2010)

Beginning on or after June 25, 2010, the definition of “other services related to the admission” (i.e., admission-related outpatient “nondiagnostic” services) is revised for purposes of the 3-day (or 1-day) payment window policy. Except for the following changes, the other requirements in section 40.3.C continue to be applicable.

-  For outpatient nondiagnostic services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary’s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPSS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary’s inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary’s admission) by adding a condition code 51 (definition “51 - Attestation of Unrelated Outpatient Non-diagnostic Services”) to the

separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

 Hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all preadmission outpatient diagnostic services and all preadmission outpatient nondiagnostic services that meet the above requirements. For purposes of the Present on Admission Indicator (POA), even if the outpatient services are bundled with the inpatient claim, hospitals shall code any conditions the patient has at the time of the order to admit as an inpatient as POA irrespective of whether or not the patient had the condition at the time of being registered as a hospital outpatient. In combining on the inpatient bill the diagnoses, procedures, and charges for the outpatient services, a hospital must convert CPT codes to ICD procedure codes and must only include outpatient diagnostic and admission-related nondiagnostic services that span the period of the payment window.

Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission and are covered by Part B may be separately billed to Part B. Hospitals must maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient nondiagnostic services are unrelated to the beneficiary's inpatient admission.

Effective for dates of service on or after June 25, 2010, CWF will reject outpatient claims for nondiagnostic services when the following occurs:

- 1) Condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") is not included on the outpatient claim, and
- 2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

40.3.1 - Billing Procedures to Avoid Duplicate Payments (Rev. 1, 10-01-03)

HO-400H

The hospital must install adequate billing procedures to avoid submission of duplicate claims. This includes duplicate claims for the same service and outpatient bills for nonphysician services considered included in the DRG for a related inpatient admission in the facility or in another hospital.

Where the hospital bills separately for nonphysician services provided to a patient either on the day before admission to a PPS hospital or during a patient's inpatient stay, the claim will be rejected by the A/B MAC (A) as a duplicate and the hospital may be subject to sanction penalties per §1128A of the Act.

Kimberly Hoy

From: Medicare Acute Care provider information [HOSPITALS-ACUTE-L@LIST.NIH.GOV] on behalf of CMS CMSPROVIDERRESOURCE [CMSPROVIDERRESOURCE@CMS.HHS.GOV]
Sent: Thursday, September 09, 2010 3:50 PM
To: HOSPITALS-ACUTE-L@LIST.NIH.GOV
Subject: Medicare's 3-Day/1-Day Payment Window Policy: Outpatient Services Treated as Inpatient
Medicare's 3-Day/1-Day Payment Window Policy: Outpatient Services Treated as Inpatient

During the Hospital Open Door Forum call on August 26th, 2010, hospitals expressed concerns regarding billing for procedures performed in the outpatient setting that must be bundled on the inpatient hospital bill in order to comply with the 3-day (or 1-day) payment window policy. CMS recently issued a memorandum to providers regarding a statutory change in the policy pertaining to admission-related outpatient non-diagnostic services (<http://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf>). Some hospitals were concerned that the Medicare claims processing systems may have edits that do not allow hospitals to bill the ICD-9-CM procedure code dates correctly for outpatient non-diagnostic services provided during the 3 calendar days (or 1 calendar day) immediately preceding the admission date on the inpatient claim.

CMS has verified that the Medicare claims processing system **does** allow the ICD-9-CM procedure code dates for non-diagnostic services provided up to 3 calendar days prior to the admission date on the inpatient claim. Therefore, hospitals are able to bill correctly for admission-related outpatient non-diagnostic services (that is, bundle the services on the inpatient hospital claim) without modifying dates on the inpatient claim. The CMS foresees no system issues that prevent hospitals from billing appropriately according to the 3-day (or 1-day) payment window policy. If providers encounter systems difficulties, they should contact their local contractor, CMS Regional Office, or CMS Central Office, accordingly.

Note: If you have problems accessing any hyperlink in this message, please copy and paste the URL into your Internet browser.

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other services provided under Part A, that is, services furnished by skilled nursing facilities and hospices. We have revised the regulations at §§ 412.2(c)(5) and 413.40(c)(2) to reflect this policy. We note that diagnostic services provided by these facilities that would be payable under Part B are subject to the window.

Comment: Three commenters requested that maintenance renal dialysis not be subject to the payment window. These commenters noted that patients must have dialysis on an ongoing basis. Because most patients receive dialysis three times a week, for any hospitalization, the patient will have at least one dialysis treatment falling in the payment window period. Regardless of the reason for the hospitalization, the patient would have received the dialysis treatment.

One of the commenters expressed the opinion that inclusion of dialysis services in the payment window provision would increase administrative costs for hospital-owned dialysis units because, prior to billing, they would have to research the diagnosis involved in every hospitalization and decide whether or not it is "related to dialysis." The commenter stated that, in such cases, dialysis units might seek payment or credit from the hospital rather than from Medicare, and that this would disrupt billing patterns and subject hospital-owned units to still greater fiscal constraints in the form of further administrative costs. Another commenter believes that excluding all outpatient chronic maintenance dialysis treatments would be easy to implement and administer. A simple directive could be issued to all Medicare contractors with instructions that dialysis services are not subject to the payment window provision.

Response: We agree with the commenters that outpatient chronic renal dialysis services are distinct from the type of hospital services that Congress designed the payment window provision to address. Maintenance dialysis must be provided to patients on a scheduled basis as long as they suffer from end-stage renal disease. Thus, it is not an inpatient service that hospitals have attempted to move outside the inpatient stay and corresponding hospital prospective payment. Therefore, in this rule, we are revising §§ 412.2(c) and 413.40(c) to exclude maintenance renal dialysis services from the preadmission services that are subject to the payment window.

Comment: Only one commenter responded to our request for comment on different approaches to defining "services related to the inpatient

admission." The commenter suggested that one possible approach would be to define certain preadmission services that are never considered to be related to the admission. The commenter provided the following list of preadmission services (in addition to maintenance renal dialysis) that should always be considered not related to the subsequent admission:

- Outpatient chemotherapy.
- Blood transfusions for chronic conditions (e.g., hemophilia and renal failure).
- Physical therapy, occupational therapy, speech therapy, other types of rehabilitative therapy, and respiratory therapy for chronic or long-term care conditions.
- Radiation therapy.

In addition, the commenter believed that any diagnostic tests associated with these services should also be excluded from the window.

Response: We agree with the commenter that certain services should not be subject to the provisions of the payment window. As noted above, we have determined that Part A services (such as home health, hospice, and skilled nursing facility services), ambulance services, and chronic maintenance renal dialysis should be excluded from the payment window.

With regard to the additional services requested by the commenter to be added to that list, we are not persuaded that these services should be excluded from the payment window. Outpatient chemotherapy and radiation therapy are time-limited treatments for specific medical conditions. This is also true of the rehabilitation services listed by the commenter. We do not believe that these services fall into the same category as maintenance dialysis. We are also not convinced that blood transfusions for chronic conditions should be excluded. These transfusions are often related to a change in condition or an injury; unlike dialysis, they are not generally provided to patients on a weekly schedule.

Therefore, we are not adding any of these services to our list of exclusions. We note that we have defined services as being related to the admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for both the preadmission services and the inpatient stay. Concerning the request to exclude diagnostic services associated with excluded services, we believe that the statute requires that all diagnostic services be included in the payment window.

Comment: One commenter stated that the hospital industry is making new arrangements for the provision of health care. Many hospitals are establishing

facilities licensed as free-standing clinics, owned and operated under a corporate umbrella, with a hospital responsible for conducting or overseeing the clinic's routine operations. The commenter requested that we address the difficulty of converting outpatient charges for preadmission testing from the HCFA-1500 to the UB-92 inpatient hospital billing form.

Response: We believe that the current procedures for billing Medicare for preadmission services, as set forth in section 415.6 of the Medicare Hospital Manual (HCFA-Pub. 10), are clear. When services are furnished within the 3-day payment window, they are included on the Part A bill, the HCFA-1450 (also known as the UB-92), for the inpatient stay. They are not separately billed under Part B. The charges, revenue codes, and ICD-9-CM diagnosis and procedure codes are all included on the HCFA-1450.

In the context of this comment concerning hospital arrangements, we would like to address the numerous telephone and written inquiries we have received concerning the definition of an entity "wholly owned or operated" by the hospital. The inquiries we have received include descriptions of various ownership/operation arrangements and requests to verify whether or not the 3-day payment window applies to each case. In general, if a hospital has direct ownership or control over another entity's operations, then services provided by that other entity are subject to the 3-day window. However, if a third organization owns or operates both the hospital and the entity, then the window provision does not apply. The following are examples of how this general policy is applied.

Arrangement: A hospital owns a physician clinic or a physician practice that performs preadmission testing for the hospital.

Policy: A hospital-owned or hospital-operated physician clinic or practice is subject to the payment window provision. The technical portion of preadmission diagnostic services performed by the physician clinic or practice must be included in the inpatient bill and may not be billed separately. A physician's professional service is not subject to the window.

Arrangement: Hospital A owns Hospital B, which in turn owns Hospital C. Does the payment window apply if preadmission services are performed at Hospital C and the patient is admitted to Hospital A?

Policy: Yes. We would consider that Hospital A owns both Hospital B and Hospital C, and the payment window would apply in this situation.

Medicare Claims Processing Manual, Chapter 30

2. Whether the beneficiary and/or the healthcare provider or supplier knew or could reasonably have been expected to know that the item or service was not covered.

Knowledge of the Non-covered Item/Service	Liability	Payment Responsibility
If the beneficiary knew, or should have known (e.g. a valid liability notice such as an ABN, Form CMS-R-131 was issued and the beneficiary consented to receiving the item or service).	Rests with the beneficiary	The beneficiary is responsible for making payment for the usual and customary charges to the healthcare provider or supplier for the denied item and/or service.
If the beneficiary did not know (and should not have known), and the healthcare provider or supplier knew, or should have known.	Rests with the healthcare provider or supplier	The beneficiary may not be charged for any costs related to the denied item and/or service, including copayments and deductibles.
If neither the beneficiary nor the healthcare provider or supplier knew, and could not reasonably be expected to have known.	Neither the beneficiary or the healthcare provider or supplier	The Medicare program makes payment for the assigned claim.

20.1 - LOL Coverage Denials (Rev. 1, 10-01-03) (Rev.:4197; Issued: 01-11-19; Effective: 04-15-19; Implementation: 04-15-19)

A. Statutory Basis

The following table provides examples of denials based on §1862(a)(1), §1862(a)(9), §1879(e), or §1879(g) of the Act:

Statutory Provision (section of the Act)	Description
§1862(a)(1)(A)	Items and services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
§1862(a)(1)(B) & §1861(s)(10)	Pneumococcal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration furnished to an individual at high or intermediate risk of contracting hepatitis B, that are not reasonable and necessary for the prevention of illness.
§1862(a)(1)(C)	In the case of hospice care, items and services that are not reasonable and necessary for the palliation or management of terminal illness.

Statutory Provision (section of the Act)	Description
§1862(a)(1)(E)	Items and services that, in the case of research conducted pursuant to §1142 of the Act, are not reasonable and necessary to carry out the purposes of that section (which concerns research on outcomes of health care services and procedures).
§1862(a)(1)(F)	Screening mammography that is performed more frequently than is covered under §1834(c)(2) of the Act or that is not conducted by a facility described in §1834(c)(1)(B) of the Act and screening pap smears and screening pelvic exams performed more frequently than is provided for under §1861(nn) of the Act.
§1862(a)(1)(F)	Screening for glaucoma, which is performed more frequently than is provided under §1861(uu) of the Act.
§1862(a)(1)(G)	Prostate cancer screening tests (as defined in §1861(oo) of the Act), which are performed more frequently than is covered under such section.
§1862(a)(1)(H)	Colorectal cancer screening tests, which are performed more frequently than is covered under §1834(d) of the Act.
§1862(a)(1)(I)	The frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation.
§1862(a)(1)(J)	Drugs or biologicals specified in §1847A(c)(6)(C) of the Act, for which payment is made under part B, furnished in a competitive area under §1847B of the Act, but not furnished by an entity under a contract under §1847(B) of the Act.
§1862(a)(1)(K)	An initial preventive physical examination, which is performed more than 1 year after the date the individual's first coverage period begins under Medicare Part B.
§1862(a)(1)(L)	Cardiovascular screening blood tests (as defined in §1861(xx)(1) of the Act), which are performed more frequently than is covered under §1861(xx)(2).
§1862(a)(1)(M)	A diabetes screening test (as defined in §1861(yy)(1) of the Act), which is performed more frequently than is covered under §1861(yy)(3) of the Act.
§1862(a)(1)(N)	An ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under §1861(s)(2)(AA) of the Act.
§1862(a)(1)(O)	Kidney disease education services (as defined in §1861(ggg)(1) of the Act) which are furnished in excess of the number of sessions covered under §1861(ggg)(4) of the Act.
§1861(dd)(3)(A)	Hospice care determined to be non-covered because the beneficiary was not "terminally ill," as referenced by §1879(g)(2) of the Act since the Balanced Budget Act of 1997.
§1862(a)(1)(O)	Personalized prevention plan services (as defined in § 1861(hhh)(1) of the Act), which are performed more frequently than is covered under such section.

Statutory Provision (section of the Act)	Description
§1814(a)(2)(C) & §1835(a)(2)(A) on or after July 1, 1987 §1879(g)(1) before December 31, 1995	Home health services determined to be non-covered because the beneficiary was not “homebound” or did not require “intermittent” skilled nursing care.
§1879(e)	Inpatient hospital services or extended care services if payment is denied solely because of an unintentional, inadvertent, or erroneous action that resulted in the beneficiary’s transfer from a certified bed (one that does not meet the requirements of §1861(e) or (j) of the Act) in a skilled nursing facility (SNF) or hospital.
§1862(a)(9)	Custodial care, unless otherwise permitted under paragraph §1862(a)(1)(C) of the Act.

 **20.2 - Denials When the LOL Provision Does Not Apply**
(Rev.: 4197; Issued: 01-11-19; Effective: 04-15-19; Implementation: 04-15-19)

Type of Denial	Description	Example(s)
Categorical	Categorical Denials are circumstances in which the LOL provision does not apply because the Medicare payment denial is based on a statutory provision not referenced in §1879 of the Act. Refer to §1862(a) of the Act for a complete listing.	<ul style="list-style-type: none"> • Personal comfort items (§1862(a)(6) of the Act). • Routine physicals and most screening tests (§1862(a)(7) of the Act). • Most immunizations (vaccinations) (§1862(a)(7) of the Act). • Routine eye care, most eyeglasses and examinations (§1862(a)(7) of the Act). • Hearing aids and hearing aid examinations (§1862(a)(7) of the Act). • Cosmetic surgery (§1862(a)(10) of the Act). • Orthopedic shoes and foot supports (orthotics) (§1862(a)(8) of the Act).

Type of Denial	Description	Example(s)
		<p>NOTE: §22.1 of this chapter provides a more expansive list of examples.</p>
Technical	<p>When coverage requirements are not met for a particular item or service, it is not a Medicare benefit; therefore, Medicare denies payment or when payment for a medically unreasonable or unnecessary item or service that is also barred because of failure to meet a condition of payment required by regulations.</p>	<ul style="list-style-type: none"> • Payment for the additional cost of a private room in a hospital or SNF is denied when the private accommodations are not required for medical reasons (§1861(v)(2) of the Act). • Payment for a dressing is denied because it does not meet the definition for “surgical dressings” (§1861(s)(5) of the Act). • Payment for SNF stays not preceded by the required 3-day hospital stay or Payment for SNF stay because the beneficiary did not meet the requirement for transfer to a SNF and for receiving covered services within 30 days after discharge from the hospital and because the special requirements for extension of the 30 days were not met (§1861(i) of the Act). • Drugs and biologicals which are usually self-administered by the patient. • Ambulance services denied because transportation by other means is not contraindicated or because regulatory criteria specified in 42 CFR 410.40, such as those relating to destination or nearest appropriate facility, are not met. (See the Medicare Benefit Policy Manual, Chapter 10) • Other items or services that must be denied under 42 CFR 410.12 through 410.105 of the Medicare regulations.

20.2.1 - Categorical Denials

(Rev.: 4197; Issued: 01-11-19; Effective: 04-15-19; Implementation: 04-15-19)

Below is a more expansive list of examples of categorical denials:

Statutory Provision (section of the Act)	Description
§1862(a)(12)	Dental care and dentures (in most cases).
§1862(a)(13)	Routine foot care and flat foot care.
§1862(a)(19)	Services under a physician's private contract.
§1862(a)(3)	Services paid for by a governmental entity that is not Medicare.
§1862(a)(4)	Health care received outside of the U. S. not covered by Medicare.
§1862(a)(11)	Services by immediate relatives.
§1862(a)(5)	Services required as a result of war.
§1862(a)(2)	Services for which there is no legal obligation to pay.
§1862(a)(21)	Home health services furnished under a plan of care, if the agency does not submit the claim.
§1862(a)(16)	Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
§1862(a)(17)	Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
§1862(a)(14)	Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangement with the hospital.
§1862(a)(18)	Items and services furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility, unless they are furnished under arrangements by the skilled nursing facility.
§1862(a)(15)	Services of an assistant at surgery without prior approval from the peer review organization.
§1862(a)(20)	Outpatient occupational and physical therapy services furnished incident to a physician's services.
§1862(a)(22)	Claims submitted other than in an electronic form specified by the Secretary, subject to the exceptions set forth in §1862(h) of the Act.

Statutory Provision (section of the Act)	Description
§1862(a)(23)	Claims for the technical component of advanced diagnostic imaging services described in §1834(e)(1)(B) of the Act for which payment is made under the fee schedule established under §1848(b) of the Act and that are furnished by a supplier (as defined in §1861(d) of the Act), if such supplier is not accredited by an accreditation organization designated by the Secretary under §1834(e)(2)(B) of the Act.
§1862(a)(24)	Claims for renal dialysis services (as defined in §1881(b)(14)(B) of the Act) for which payment is made under such section unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.

30 - Determining Liability for Disallowed Claims Under §1879
 (Rev.: 4197; Issued: 01-11-19; Effective: 04-15-19; Implementation: 04-15-19)

When a Medicare contractor determines that a review under the LOL provisions is appropriate under §20 of this chapter, the Medicare contractor must next determine who is liable, based on who knew, or should have known that Medicare was going to deny payment on the item or service. In order to make this determination, the contractor must take the following steps:

Version 01/20/2019
 Check for updates

Form Instructions
Advance Beneficiary Notice of Non-coverage (ABN)
OMB Approval Number: 0938-0566

Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. “Notifiers” include:

- Physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories);
- Hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A; and
- Home health agencies (HHAs) providing care under Part A or Part B.

All of the aforementioned healthcare providers and suppliers must complete the ABN as described below in order to transfer potential financial liability to the beneficiary, and deliver the notice prior to providing the items or services that are the subject of the notice.

Medicare inpatient hospitals and skilled nursing facilities (SNFs) use other approved notices for Part A items and services when notice is required in order to shift potential financial liability to the beneficiary; however, these facilities must use the ABN for Part B items and services.

The ABN must be reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain a copy of the ABN delivered to the beneficiary on file.

The ABN may also be used to provide notification of financial liability for items or services that Medicare never covers. When the ABN is used in this way, it is not necessary for the beneficiary to choose an option box or sign the notice.

ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. With the latest PRA submission, a change has been made to the ABN. In accordance with Title 18 of the Social Security Act, guidelines for Dual Eligible beneficiaries have been added to the ABN form instructions.

Completing the Notice

ABNs may be downloaded from the CMS website

at: <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

Instructions for completion of the form are set forth below:

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

There are 10 blanks for completion in this notice, labeled from (A) through (J). We recommend that notifiers remove the lettering labels from the blanks before issuing the ABN to beneficiaries. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The notifier must also insert the blank (D) header information into all of the blanks labeled (D) within the Option Box section, Blank (G). One of the check boxes in the Option Box section, Blank (G), must be selected by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

Header:

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

- 1. Blank (A) Notifier(s):** Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for billing questions.

- 2. Blank (B) Patient Name:** Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.
- 3. Blank (C) Identification Number:** Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may

be used. Medicare numbers (HICNs), Medicare beneficiary identifiers (MBIs), or Social Security numbers should not appear on the notice.

Body:

4. Blank (D): The following descriptors may be used in the Blank (D) fields:

Item
Service
Laboratory test
Test
Procedure
Care
Equipment

- The notifier must list the specific names of the items or services believed to be non-covered in the column directly under the header of Blank (D).
- In the case of partial denials, notifiers must list in the column under Blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous non-covered care, notifiers must specify the frequency and/or duration of the item or service.
- General descriptions of specifically grouped supplies are permitted in this column. For example, “wound care supplies” would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs, notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering “wound care supplies decreased from weekly to monthly” would be appropriate to describe a decrease in frequency for this category of supplies; just writing “wound care supplies decreased” is insufficient.
- Please note that there are a total of 7 Blank (D) fields that the notifier must complete on the ABN. Notifiers are encouraged to populate all of the Blank (D) fields in advance when a general descriptor such as “Item(s)/Service(s)” is used. All Blank (D) fields must be completed on the ABN in order for the notice to be considered valid.

- 5. Blank (E) Reason Medicare May Not Pay:** In the column under this header, notifiers must explain, in beneficiary friendly language, why they believe the items or services listed in the column under Blank (D) may not be covered by Medicare. Three commonly used reasons for non-coverage are:

“Medicare does not pay for this test for your condition.”

“Medicare does not pay for this test as often as this (denied as too frequent).”

“Medicare does not pay for experimental or research use tests.”

To be a valid ABN, there must be at least one reason applicable to each item or service listed in the column under Blank (D). The same reason for non-coverage may be applied to multiple items in Blank (D) when appropriate.

- 6. Blank (F) Estimated Cost:** Notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within \$100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted.

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

- 7. Blank (G) Options:** Blank (G) contains the following three options:

- **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. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed.

Suppliers and providers who don't accept Medicare assignment may make modifications to Option 1 only as specified below under "**H. Additional Information.**"

*** Special guidance for people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals (has a Qualified Medicare Beneficiary (QMB) Program and/or Medicaid coverage) ONLY:**

Dually Eligible beneficiaries must be instructed to check **Option Box 1** on the ABN in order for a claim to be submitted for Medicare adjudication.

Strike through **Option Box 1** as provided below:

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.~~

These edits are required because the provider cannot bill the dual eligible beneficiary when the ABN is furnished. Providers must refrain from billing the beneficiary pending adjudication by both Medicare and Medicaid in light of federal law affecting coverage and billing of dual eligible beneficiaries. If Medicare denies a claim where an ABN was needed in order to transfer financial liability to the beneficiary, the claim may be crossed over to Medicaid or submitted by the provider for adjudication based on State Medicaid coverage and payment policy. Medicaid will issue a Remittance Advice based on this determination.

Once the claim is adjudicated by both Medicare and Medicaid, providers may only charge the patient in the following circumstances:

- If the beneficiary has QMB coverage without full Medicaid coverage, the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy.
- If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or will not pay because the provider does not participate in Medicaid), the ABN could allow the provider to shift financial liability to the beneficiary per Medicare policy, subject to any state laws that limit beneficiary liability.

Note: These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances. More information on dual eligible beneficiaries may be found at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

- **OPTION 2.** I want the (D)_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

- **OPTION 3.** I don't want the (D)_____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided; thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Unless otherwise instructed to do so according to the specific guidance provided in these instructions, the notifier must not decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: "beneficiary refused to choose an option."

- 8. Blank (H) Additional Information:** Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable;
- An additional dated witness signature; or
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

***Special guidance for non-participating suppliers and providers (those who don't accept Medicare assignment) ONLY:**

Strike the last sentence in the Option 1 paragraph with a single line so that it appears like this: ~~If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.~~

This single line strike can be included on ABNs printed specifically for issuance when unassigned items and services are furnished. Alternatively, the line can be hand-penned on an already printed ABN. The sentence must be stricken and can't be entirely concealed or deleted. There is no CMS requirement for suppliers or the beneficiary to place initials next to the stricken sentence or date the annotations when the notifier makes the changes to the ABN before issuing the notice to the beneficiary.

When this sentence is stricken, the supplier should include the following CMS-approved unassigned claim statement in the (H) Additional Information section:

“This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge.”

This statement can be included on ABNs printed for unassigned items and services, or it can be handwritten in a legible 10 point or larger font.

An ABN with the Option 1 sentence stricken must contain the CMS-approved unassigned claim statement as written above to be considered valid notice. Similarly, when the unassigned claim statement is included in the “Additional Information” section, the last sentence in Option 1 should be stricken.

Signature Box:

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

- 9. Blank (I) Signature:** The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out “representative” in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.
- 10. Blank (J) Date:** The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

Disclosure Statement: The disclosure statements in the footer of the notice are required to be included on the document.

CMS will work with its contractors to ensure consistency when determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

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Check for Updates