Advanced Beneficiary Notice of Non-Coverage PC.A30

Regulation(s): Medicare Claims Processing Manual, Publication 100-04, Chapter 30
L-Tag(s): None

POLICY: Lifesong Hospice and Palliative Care provides Medicare beneficiaries (or their legal representatives) with an Advance Beneficiary Notice of Non-Coverage (ABN) when it is required to inform patients that Medicare will not pay for care or for a particular service.

PROCEDURE:

1. The correct, approved OMB form (CMS R-131) for the ABN is completed and cites the specific items or services for which payment will be or is likely to be denied and the expected reasons for the denial.

2. An ABN is required in the following three situations:
    a. when the beneficiary no longer meets Medicare's definition of terminally ill but the patient wants service to continue;
    b. the patient requests to remain at a level of care that is higher (for instance, the general inpatient level of care) than what is reasonable or medically necessary to manage the patient's terminal illness and related conditions; and
    c. items and services are billed separately from the hospice payment (for example, physician services) that are not reasonable or medically necessary.

3. The ABN form is given to Medicare beneficiaries or their legal representatives by the hospice nurse or social worker far enough in advance of furnishing items or services that are not likely to be covered so that the beneficiary or legal representative may make an informed decision regarding whether or not to assume the responsibility for financial liability if necessary.

4. The social worker or hospice nurse fully explains the ABN to the beneficiary or his/her legal representative to ensure comprehension.

5. The Medicare beneficiary's signature (or that of his/her legal representative) is obtained on two copies of the form. One copy of the form is left with the Medicare beneficiary (patient) and the second copy is returned to the hospice and filed in the patient's clinical record.

6. The ABN form is not given during emergencies or when the patient is under duress, and is only provided when there is a specific, identifiable reason to believe that Medicare will not pay for the items or services

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