Learn about these Medicare advance written notices of noncoverage topics:

- Types of advance written notices of noncoverage
- Issuing an advance written notice of noncoverage
- Prohibitions and frequency limits
- Completing an advance written notice of noncoverage
- Collecting payment from the beneficiary
- Financial liability
- Claim reporting modifiers associated with the ABN
- When you should not use an advance written notice of noncoverage
- Resources

TYPES OF ADVANCE WRITTEN NOTICES OF NONCOVERAGE

An advance written notice of noncoverage is a way for a Fee-For-Service (FFS) beneficiary to make an informed decision about items and services that are usually covered by Medicare but may not be expected to be paid in a specific instance for certain reasons, such as lack of medical necessity. These Centers for Medicare & Medicaid Services notices are approved for this purpose:

- **Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131,** is issued by all health care providers and suppliers when Medicare payment is expected to be denied, including:
  - Independent laboratories, Skilled Nursing Facilities (SNFs), and home health agencies (HHAs) providing Medicare Part B (outpatient) items and services
  - Hospice providers, HHAs, and Religious Nonmedical Health Care Institutions rendering Part A items and services

The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. If the beneficiary does not get written notice when it is required, he or she may not be held financially liable if Medicare denies payment, and the provider or supplier may be financially liable if Medicare does not pay.

- **Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN), Form CMS-10055,** is issued by SNFs before providing a Part A item or service to a FFS beneficiary that is usually paid by Medicare, but may not be paid in this particular instance because it is not medically reasonable and necessary or it is custodial care. SNFs may issue either the SNFABN or one of the five SNF Denial Letters as the liability notice for Part A items and services that are usually paid by Medicare, but may not be paid in this particular instance.

- **Hospital-Issued Notice of Noncoverage (HINN)** is issued by hospitals prior to admission, at admission, or at any point during an inpatient stay if hospitals determine that the care the beneficiary is receiving, or is about to receive, is not covered because it is:
  - Not medically necessary
  - Not delivered in the most appropriate setting
  - Custodial in nature

  The four HINNs hospitals issue are:
  - Preadmission/Admission HINN, also known as HINN 1–Use prior to an entirely non-covered stay
  - Notice of Hospital Requested Review (HRR), also known as HINN 10–Use for FFS and Medicare Advantage Program (Part C) beneficiaries when requesting Quality Improvement Organization review of a discharge decision without physician concurrence
  - HINN 11–Use for non-covered items and services provided during an otherwise covered stay
  - HINN 12–Use with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay
- **Home Health Change of Care Notice (HHCCN), Form CMS-10280,** is issued by HHAs to notify a FFS beneficiary who is receiving home health care benefits about plan of care (POC) changes. The beneficiary must receive written notification before HHAs may reduce or terminate an item and/or service.

ISSUING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

When You Must Issue an Advance Written Notice of Noncoverage

You must issue an advance written notice of noncoverage:

- When an item or service is not considered reasonable and necessary under Medicare Program standards. Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:
  - Experimental and investigational or considered “research only”
  - Not indicated for diagnosis and/or treatment in this case
  - Not considered safe and effective
  - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is furnished
- When outpatient therapy services exceed therapy cap amounts **and** do not qualify for a therapy cap exception
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES