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'Care Share

Beneficiary Notices in Original Medicare and Medicare Advantage

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Monique Thomas, with the Georgia, Louisiana, and Mississippi SMPs, recently asked the SMP National Resource Center if Medicare requires Medicare Advantage (MA) network providers to issue Advance Beneficiary Notices (ABNs) when they impose unexpected out-of-pocket costs on MA plan enrollees or propose to deliver services that the plan might not cover. Because other SMPs might be asking the same question, this article sets out to explore the use of non-coverage notices in Original Medicare and MA and how it may differ. Please note at the outset that some notices are used only in fee-for-service (FFS) Original Medicare, others in Original Medicare and MA, and that one is used only by MA plans. Providers are sometimes unaware that some notice forms are to be used with some beneficiaries and not others. Their indiscriminate use can cause confusion and may prevent beneficiaries from getting correct instructions for exercising their appeal rights.

Original Medicare Notices

FFS ABNs

The Advance Beneficiary Notice of Non-coverage (ABN, Form CMS-R-131) is exclusive to Original Medicare. Physicians, durable medical equipment (DME) suppliers, independent laboratories, home health agencies, and other providers – collectively called notifiers – must give ABNs to their patients in Original Medicare when they expect Medicare to deny a claim because medical necessity or other key coverage criteria won't be met. The ABN's purpose, according to the Medicare Claims Processing Manual, "is to inform a Medicare beneficiary, before he or she receives specified items or services that otherwise might be paid for, that Medicare certainly or probably will not pay for them on that particular occasion."

The law does not require notifiers to issue ABNs when Medicare never covers a service or item, such as cosmetic surgery, screening CT colonography (excluded by a National Coverage Determination), and home care equipment deemed as convenience items. In these situations, the Centers for Medicare & Medicaid Services (CMS) invites notifiers to issue ABNs voluntarily as a courtesy to forewarn their patients of impending out-of-pocket costs.

The Home Health Change of Care Notice (HHCCN, Form CMS-10280) and the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN, Form CMS-10055) should also be issued only to patients with Original Medicare. Home health agencies issue the HHCCN to inform patients of changes in care, including the type or frequency of services it provides, based on a doctor's order or its own assessment of a patient's changing condition. Skilled Beneficiary Notices in Original Medicare and Medicare Advantage The Sentinel, a publication of the SMP Resource Center www.smpresource.org

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November 2018 continued nursing facilities (SNFs) issue the SNF-ABN to transfer financial liability to beneficiaries before the facility provides an item or service that Medicare usually covers but may not be paid for in a particular case because it's not medically reasonable and necessary or is thought to be custodial care.

FFS HINNs
Three Hospital-Issued Notices of Non-coverage (HINNs) are sometimes given to beneficiaries with Original Medicare. HINN 1 notifies patients before a proposed inpatient admission that Medicare is not likely to cover the hospital stay due to lack of medical necessity or the sense that the services could be given safely in another, less costly, facility. HINN 1 also gives instructions for requesting an immediate review by the Quality Improvement Organization (QIO). HINN 11 tells patients that Medicare won't cover a specific service or item ordered for them during an otherwise covered inpatient stay. The HINN states that they will be financially liable for customary charges if they decide to receive the service or item anyway. HINN 12 notifies inpatients of the hospital's belief that Medicare won't pay for a continued stay. According to CMS, the HINN 12 should be used together with the Hospital Discharge Appeal Notices (addressed below) to inform beneficiaries of their potential financial liability for a non-covered continued stay.

Facility Fee Coinsurance Notice
In 2003, CMS released a Program Memorandum that informs hospital-based entities, including physician offices and clinics owned by hospitals, that they must provide written notice before delivering services that will potentially result in the beneficiary paying facility fees and must include an estimate of the cost. When patients receive services from a hospital-based doctor, the hospital bills Medicare for an outpatient visit (with a facility fee) and the physician visit, meaning that the beneficiary incurs coinsurance charges for both. CMS has not issued a model facility fee coinsurance notice so providers draft and deliver the notices in accord with CMS guidance. Though many providers apparently are unaware of this requirement, Monique Thomas reported that a hospital based clinic in Georgia recently issued a facility fee coinsurance notice to a client.

The guidance advises providers that the ABN for non-covered services (see above) does not meet the facility fee notice requirement. Providers need not issue the facility fee notice when beneficiaries have no deductible or coinsurance liability, as with Medicare's "free" prevention and screening benefits. Finally, rural health clinics are exempt from the facility fee notice obligation.

Notices Used in Original Medicare and Medicare Advantage

At least five CMS notices are given to people regardless of their Original Medicare or MA plan enrollment status. Beneficiaries who are admitted as hospital inpatients should receive the same Important Message from Medicare (IM, Form CMS-R-193), which explains discharge and appeal rights and gives instructions for requesting a QIO to review a premature discharge. Similarly, hospitals must deliver the same Medicare Outpatient Observation Notice (MOON, Form CMS-10611) to all beneficiaries who receive observation services as outpatients for more than 24 hours. The MOON explains how observation status may affect their cost-sharing charges and coverage for post-hospital skilled nursing facility care.

HINN 10
Hospitals deliver a Hospital-Issued Notice of Non-coverage (HINN 10) to beneficiaries when their doctors disagree with a hospital's discharge decision. In this situation, Medicare requires hospitals to initiate a QIO review of the case.

Expedited Determination Notices
Home health agencies, SNFs, hospices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs) must provide a Notice of Medicare Non-coverage (NOMNC Form CMS-10123) to beneficiaries when their Medicare covered service(s) are ending. The NOMNC tells

beneficiaries that their provider and/or health plan have determined that Medicare probably will not pay for current services after a specified date. The notice also explains how to request an expedited determination from the QIO. Providers issue a Detailed Explanation of Non-coverage (DENC, Form CSM-10124) after a beneficiary asks the QIO for an expedited determination about the need for ongoing care and coverage. Providers are to use the DENC to explain the specific reasons they're using to end covered services.

Hospital Discharge Appeal Notices

When a hospital inpatient or representative asks the QIO to review a hospital's discharge decision, hospitals are to issue a Detailed Notice of Discharge (DND, Form CMS- 10066) with information about the coverage rules and the patient's condition upon which the hospital is basing its discharge decision. The notice also reports the date on which Medicare coverage will end, pending the QIO's decision. The form contains a separate subsection where the hospital can insert specific information about managed care policies, if applicable.

Notices in Medicare Advantage

Integrated Denial Notice

The Notice of Denial of Medical Coverage form, also called the Integrated Denial Notice (IDN, Form CMS10003), is used exclusively in the MA program to give enrollees notice of a plan's decision to deny, stop, reduce, or suspend coverage of medical services or items that a physician or other prescriber has ordered. Medicare managed care plans typically use the IDN to explain denials for preauthorization requests for certain services, procedures, and items. Plans are to specify a rationale for their decision and refer to state or federal law and/or the terms in a plan's Evidence of Coverage (EOC) provisions to support the decision. These decisions are organization determinations that can be appealed. Thus, the IDN explains appeal rights and procedures and lists several agencies and organizations that can provide help, including the Medicare Rights Center, an SMP Resource Center partner.

The IDN does not specify, as does the ABN, that an enrollee who receives services and items is liable for their cost if Medicare doesn't cover them. This may be implied by reference to the EOC, where the model language for services not covered by the plan states, "If you get services that are excluded (not covered) you must pay for them yourself."

But does this mean that Medicare's limits on beneficiary liability don't apply to MA plans? No! When plan members receive covered services or items from a network provider and the plan later denies payment, they owe only the usual cost-sharing amounts unless the provider can show that the enrollee received prior notice that the item or service would only be covered if the beneficiary took further action. An IDN serves that purpose.

Keep in mind that MA plan enrollees always have a right to an advance determination of coverage prior to receiving services or items. Medicare law requires MA organizations to "have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization … is entitled to receive a health care service under this section." This procedure along with contact information should be plainly described in the EOC that each plan member receives when they first enroll or at the start of a new plan year.

Coverage Exclusions

As with Original Medicare, network providers have no statutory obligation to tell MA plan members that items or services are excluded from coverage, but they may do so as a courtesy. MA plans must, however, identify non-covered services in their EOC. The plans also may instruct network providers to deliver other informational notices to their patients as needed. When in doubt about coverage or costs, enrollees should refer to the EOC and call their plan's Member Services number.

Important Information for SMPs

Because the ABN and other notices often have serious implications for a beneficiary's financial liability for non-covered services or items, it's essential that providers complete them properly to enable people to make fully informed decisions about their health care. Beneficiary liability may be waived in some cases of inadequate or improper notice. SMPs can help beneficiaries in Original Medicare who receive flawed ABNs by calling 1-800- MEDICARE and asking them to escalate the case to the Medicare administrative contractor's provider education unit. MA plan members can ask their plans to review coverage denials when an IDN lacks key information. If you have questions or concerns about the misuse of advance notices, please let the Center know by contacting Sara Lauer at slauer@smpresource.org.

Most of Medicare's key beneficiary notices are available in English and Spanish on the Beneficiary Notices Initiative home page on CMS' website. Some are also available in large print formats. For more information on Medicare's rules for ABNs, see the article titled "Advance Beneficiary Notices: Protection or Problem?" in the February 2015 edition of The Sentinel available in the SMP Resource Library.

℘ **Editor's Note:** We learned as we went to press that the beneficiary who asked Monique Thomas for assistance was led to believe that he joined a Medicare Advantage plan with zero copayments for physician services. While the claim was true for some physician visits, the plan's Evidence of Coverage (EOC) document noted that patients who use hospital-based physicians are subject to copayments and facility fee charges. SMPs should encourage beneficiaries to read their EOCs and to report "no copay" marketing claims when they fail to tell MA plan members about out-of-pocket costs if they use facility-based providers.

Clip out and save

Who can I contact if I need more assistance?

You can call 1-800-MEDICARE (800-633-4227) if you have questions about what services are covered and at what cost under Original Medicare. You can also call to find providers who accept assignment in your area.

You can call your Medicare Advantage Plan/Part D plan directly with questions about your prescription drug formulary, in-network providers, and your plan's costs and restrictions for accessing care.

You can call your State Health Insurance Assistance Program (SHIP) 1-800-551-3191 in Montana, for information about how to find Original Medicare and Medicare Advantage providers that accept assignment or are in your plan's network. Your SHIP can also help you appeal service denials and find Medicare coverage that works well for you.

You can call your Senior Medicare Patrol (SMP) 1-800-551-3191 in Montana, if you believe you were a victim of Medicare fraud or abuse. Your SMP can help you identify cases of fraud or attempted fraud, such as having been pressured into signing something you didn't understand, a provider's refusal to bill Medicare without an explanation, or misleading plan marketing. Your SMP can also help you report cases of fraud or abuse to the proper authorities.

Information provided by the Medicare Rights Center

The Senior Medicare Patrol (SMP) helps to educate Medicare beneficiaries about ways to prevent, detect, and combat Medicare fraud. For more information about Medicare fraud, visit the Stop Medicare Fraud website at www.stopmedicarefraud.gov.