



Medicare Utilization Review Version

KEY CONCEPTS OUTLINE

Module 4: Medicare Outpatient Notices

I. Notice to Patients in Observation

A. A summary and comparison of Medicare notices, including inpatient and outpatient notices, is included as Handout 5. Inpatient notices will be discussed in a later module.

B. General Rule

1. Hospitals must provide oral and written notice, in the form of the Medicare Outpatient Observation Notice (MOON), regarding the outpatient nature of observation and its implications to Medicare patients who are in observation for more than 24 hours. <Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act; 81 *Fed. Reg.* 57038; *Medicare Claims Processing Manual*, Chapter 30 § 400.1>

C. Covered Individuals

1. Notice is required for patients receiving ordered observation for more than 24 hours who:
 - a. Are entitled to Medicare Part A or Part B, whether Medicare Part B pays for the observation services that are the subject of the notice; or
 - b. Are enrolled in Medicare Advantage plans or Medicare Health plans; or
 - c. Have Medicare Part A or Part B as a secondary payer. <81 *Fed. Reg.* 57038-041; *Medicare Claims Processing Manual*, Chapter 30 § 400.2>
2. For purposes of determining if a patient has received observation for more than 24 hours, observation time is started when care is initiated in accordance with the physician's order and is counted by elapsed time, without subtracting intervening procedures that require monitoring. <81 *Fed. Reg.* 57043-44; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4>

- a. This may result in a different number of hours of observation for purposes of application of the observation notice requirements and for billing. <81 Fed. Reg. 57043>
3. Notice is not required for:
 - a. Outpatients who do not receive ordered observation services for more than 24 hours, including patients who had less than 24 hours of medically necessary observation and remain in the hospital after all medical necessary observation has ended. <81 Fed. Reg. 57044>
 - b. Patients discharged or admitted before 24 hours have elapsed from the time observation services were ordered, (i.e., who did not have 24 hours of observation before they are admitted or discharged). <81 Fed. Reg. 57039, 57044>

Case Study 1

Facts: A Medicare patient presents to the emergency department at 3 p.m. on Monday with flu like symptoms. After diagnostic tests, the emergency department physician is concerned the patient may be developing pneumonia. She writes an order for observation, hydration and IV anti-biotics at 7 p.m.

The hospitalist sees the patient Tuesday morning in observation and orders repeat diagnostic tests. By afternoon, the patient is doing better. The hospitalist writes a discharge order, and the patient goes home with family members at 5 p.m.

What notice or notices, if any, is the hospital required to provide the patient? If a notice is required, what is the deadline for providing the notice?

D. Timing of the Notice

1. Notice may be provided prior to the 24th hour of observation and is required no later than 36 hours from the initiation of observation service. <81 Fed. Reg. 57047; *Medicare Claims Processing Manual*, Chapter 30 §§ 400.3.4, 400.3.8>; or
2. For patients who have received 24 hours of observation but are being transferred, discharged, or admitted prior to the 36th hour of observation, notice is required at the time of transfer, discharge, or admission. <81 Fed. Reg. 57041-44; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4>

- a. If the patient is admitted, the provider must include Part A cost share information and the implications of the three-day window (i.e., there is no separate Part B cost share for observation and other outpatient service provided in the three days before admission) in the additional information section of the MOON form. <81 Fed. Reg. 57040; Medicare Claims Processing Manual, Chapter 30 § 400.3.8>
- b. If the patient is admitted, and the MOON form is delivered after admission, the provider must note the date and time of admission. <81 Fed. Reg. 57047; Medicare Claims Processing Manual, Chapter 30 § 400.3.8>

Case Study 2

Facts: A Medicare patient presents to the emergency department at 3 p.m. on Monday with flu like symptoms. After diagnostic tests, the emergency department physician is concerned the patient may be developing pneumonia. She writes an order for observation, hydration and IV anti-biotics at 7 p.m.

Tuesday afternoon the hospitalist is concerned the pneumonia is continuing to develop and orders a different antibiotic and repeat testing. At 9 p.m. Tuesday evening, the hospitalist writes an admission order. By Wednesday morning, the patient is doing much better and is discharged with family at 2 p.m.

What notice or notices if any is the hospital required to provide the patient? If notice is required, what is the deadline for providing the notice?

E. Format and Content of the Notice

1. The Medicare Outpatient Observation Notice (MOON) is the required form for providing notice to Medicare beneficiaries under the NOTICE Act. Handout 6 is the MOON form. <81 Fed. Reg. 57044; Medicare Claims Processing Manual, Chapter 30 § 400.1>
 - a. The latest MOON form has an expiration date of 11/30/25 and can be downloaded from the Beneficiary Notice Initiative page. <cms.gov website, “Beneficiary Notice Initiative (BNI)” page, Medicare Outpatient Observation Notice (MOON)” page>

Link: Beneficiary Notice Initiative under Medicare-Related Sites - General

- b. CMS also published “Frequently Asked Questions” with the MOON form, which are included in the materials behind the outline.

2. Notice is required by providing both the written MOON form and oral explanation of the information on the MOON. <81 *Fed. Reg.* 57047-051; *Medicare Claims Processing Manual*, Chapter 30 § 400.1, 400.3.3>
 - a. Oral notice can be in the form of a video, provided a staff person is always available to answer questions about the written and oral explanation. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.3>
3. The MOON may be issued electronically, but the beneficiary must be given the option of a paper form and be provided a paper copy of the MOON after signing. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.3>
4. Content of the written notice and oral explanation
 - a. The notice must explain that the patient is receiving outpatient observation services, is not an inpatient and why. <Notice of Observation Treatment and Implication for Care Eligibility Act; 81 *Fed. Reg.* 57044-57048; Medicare Outpatient Observation Notice>
 - i. The clinical rationale for why the patient is receiving outpatient observation rather than inpatient services must be included in the “free text” field at the top of the MOON form. <Medicare Outpatient Observation Notice, Frequently Asked Questions, March 8, 2017>
 - ii. The information in the “free text” field should be reasonably understandable to the beneficiary and generally explain:
 - a) The physician has ordered outpatient observation services in order to evaluate the beneficiary’s symptoms and diagnosis; and
 - b) The beneficiary’s condition and symptoms will continue to be evaluated to assess whether they will need to be admitted as an inpatient or transferred or discharged from the hospital. <Medicare Outpatient Observation Notice, Frequently Asked Questions, March 8, 2017>

F. Delivery

1. Comprehension
 - a. Hospitals must use translators, interpreters, and assistive devices if necessary to ensure the patient understands the notice. <81 *Fed. Reg.* 5704; *Medicare Claims Processing Manual*, Chapter 30 § 400.3.7; Medicare Outpatient Observation Notice, Frequently Asked Questions, March 8, 2017>

2. Beneficiary Representative

- a. Notice may be delivered to a beneficiary's appointed representative designated by the beneficiary to act on their behalf or an authorized representative under state law (e.g., legal guardian or durable power of attorney). <Medicare Claims Processing Manual, Chapter 30 § 400.3.6>
- b. For patients who are temporarily or permanently incompetent, hospitals must provide notice to an authorized representative or a person the hospital has determined could reasonably represent the beneficiary, and acts in their best interests, in a manner protective of the beneficiary's rights and who has no conflict of interest. <Medicare Claims Processing Manual, Chapter 30 § 400.3.6>
- c. Notice to a Representative
 - i. When delivering notice to a representative, document the details in the "Additional Information" section. <Medicare Claims Processing Manual, Chapter 30 § 400.3.6>

For delivery to a representative, document:

- The name of the staff person initiating the contact;
- The name of the person contacted; and
- The date, time, and method of contact (e.g., in person or by telephone), including telephone number.

- ii. If telephone delivery is required, the information provided by telephone must include the entire contents of the MOON, which must be documented in the "Additional Information" section of the MOON. <Medicare Claims Processing Manual, Chapter 30 § 400.3.6>
- iii. The date and time of the contact, or good faith attempt to contact the representative, is considered the date and time of the receipt of the MOON. <Medicare Claims Processing Manual, Chapter 30 § 400.3.6>

3. Signature and Retention

- a. The MOON form should be signed by the patient or their authorized representative. <81 Fed. Reg. 57051, Medicare Claims Processing Manual, Chapter 30 § 400.3.3>
- b. If the patient or their representative refuse to sign the notice, the staff member who provided the notice must note the following in the "Additional Information" section:

- i. The date and time the notice was presented;
- ii. A certifying statement that the notice was presented and the patient or their representative refused to sign, including the name of the person who refused;
- iii. The name, title and signature of the staff member who presented the notice. <81 Fed. Reg. 57051, *Medicare Claims Processing Manual*, Chapter 30 § 400.3.5>

Example of documentation if patient refuses to sign MOON: I, John Doe, staff nurse, certify that this notice was presented and explained to the patient, Jane Smith, on 08/06/16 at 11:00 p.m. and the patient refused to sign the notice. Signed: John Doe, RN.

- c. The signed MOON must be retained in the patient's medical record, in hard copy or electronically. <*Medicare Claims Processing Manual*, Chapter 30 § 400.3.9>

II. Advance Beneficiary Notice (ABN)

A. General Rule

- 1. A properly prepared and delivered ABN form satisfies the Limitations 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>

B. The ABN Form

- 1. The Advance Beneficiary Notice (CMS-R-131 (Exp. 01/01/2026)), available in English, Spanish, and large print, is the required form for providing notice of non-coverage for outpatient services. Handout 7 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 under Medicare-Related Sites – General
Use the links on the left navigation to go to the FFS ABN page.

C. 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. 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>

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. The name, address, and phone number of the billing and/or notifying entity, which may appear as the entity’s logo.
- 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. The provider should provide a more specific reason.
<Medicare Claims Processing Manual, Chapter 30 § 40.2.1, C>

Tip: CMS previously published the following example of a specific reason, which would be applicable to non-covered observation:

- “Medicare does not pay for custodial care, except for some hospice services”

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 and may be an average daily cost (i.e., observation services).
 - 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.

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

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*, included in the materials behind the outline, for more information on potential beneficiary liability.

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.>

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, even if the beneficiary refused to sign or choose an option. <Medicare Claims Processing Manual, Chapter 30 § 50.7>

- 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>

D. 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>

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare patient presents to the emergency department at 3 p.m. on Monday with flu like symptoms. After diagnostic tests, the emergency department physician is concerned the patient may be developing pneumonia. She writes an order for observation, hydration and IV anti-biotics at 7 p.m.

The hospitalist sees the patient Tuesday morning in observation and orders repeat diagnostic tests. By afternoon, the patient is doing better. The hospitalist writes a discharge order and the patient goes home with family members at 5 p.m.

What notice or notices, if any, is the hospital required to provide the patient? If a notice is required, what is the deadline for providing the notice?

Analysis: No notice is required for this patient. The MOON would not be required because the patient was only in observation for 22 hours. Further, an ABN would not be required because the observation services were covered.

Refer to *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4.

Case Study 2

Facts: A Medicare patient presents to the emergency department at 3 p.m. on Monday with flu like symptoms. After diagnostic tests, the emergency department physician is concerned the patient may be developing pneumonia. She writes an order for observation, hydration and IV anti-biotics at 7 p.m.

Tuesday afternoon the hospitalist is concerned the pneumonia is continuing to develop and orders a different antibiotic and repeat testing. At 9 p.m. Tuesday evening, the hospitalist writes an admission order. By Wednesday morning, the patient is doing much better and is discharged with family at 2 p.m.

What notice or notices, if any is the hospital required to provide the patient? If notice is required, what is the deadline for providing the notice?

Analysis: The MOON is required because the patient had more than 24 hours of observation (26 hours), even though the patient was eventually admitted. The MOON must be delivered no later than 7 a.m. on Wednesday morning, 36 hours after observation was ordered on Monday evening.

The date and time of admission should be noted in the additional information section, along with information about the Part A cost share and the three-day payment window.

Note: The hospital should also deliver an Important Message from Medicare, discussed in a later module.

Refer to *Medicare Claims Processing Manual*, Chapter 30 § 400.3.4.

Excerpt from Medicare Claims Processing Manual, Chapter 30

Extensions. A beneficiary who requests an expedited reconsideration may request (either in writing or orally) that an IRE grant such additional time as the beneficiary specifies (not to exceed 14 days) for the reconsideration. If an extension is granted, the deadlines described above under notification, do not apply.

300.3 - The Responsibilities of the QIO

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When an IRE notifies the QIO that a beneficiary has requested an expedited reconsideration, the QIO must supply all information that the IRE needs to make its expedited reconsideration as soon as possible, but no later than by close of business of the day that the IRE notifies the QIO of the request for the reconsideration.

At the beneficiary's request, the QIO must furnish the beneficiary with a copy of, or access to, any documentation that it sends to the IRE. The QIO may charge the beneficiary a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the beneficiary. The QIO must accommodate the request by no later than close of business of the first day after the material is requested.

300.4 - The Responsibilities of the Provider

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

The provider may, but is not required to, submit evidence to be considered by an IRE in making its decision. If a provider fails to comply with an IRE's request for additional information beyond that furnished by the QIO for purposes of the expedited determination, the IRE makes its reconsideration decision based on the information available.

300.5 - Coverage During an Expedited Reconsideration

(Rev. 1257, Issued: 05-25-07; Effective: 07-01-07; Implementation: 07-02-07)

When a beneficiary makes a timely request for an expedited determination, the provider may not bill the beneficiary for any disputed services until the IRE makes its determination. Beneficiary liability for continued services is based on the QIO's decision.

400 - Part A Medicare Outpatient Observation Notice

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON informs all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or critical access hospital (CAH).

400.1 - Statutory Authority

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

On August 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) Public Law 114-42, amending Section 1866(a)(1) of the Social Security Act (the Act) (42 U.S.C. 1395cc(a)(1)), by adding a new subparagraph (Y). The NOTICE Act requires hospitals and CAHs to provide written and oral explanation of such written notification to individuals who receive observation services as outpatients for more than 24 hours.

The process for delivery of this notice, the Medicare Outpatient Observation Notice (MOON), was addressed in rulemaking, including a final rule, CMS-1655-F (81 FR 56761, 57037 through 57052, August 22, 2016), effective October 1, 2016. The resulting regulations are located at 42 CFR Part 489.20(y).

400.2 - Scope

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON must be delivered to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees who receive observation services as outpatients for more than 24 hours. The hospital or CAH must provide the MOON no later than 36 hours after observation services as an outpatient begin. This also includes beneficiaries in the following circumstances:

- Beneficiaries who do not have Part B coverage (as noted on the MOON, observation stays are covered under Medicare Part B).
- Beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON.
- Beneficiaries for whom Medicare is either the primary or secondary payer.

NOTES:

- For purposes of these instructions, the term “beneficiary” means either beneficiary or representative, when a representative is acting for a beneficiary.
- Please see Chapter 13 of the Medicare Managed Care Manual for Medicare Advantage instructions.

The statute expressly provides that the MOON be delivered to beneficiaries who receive observation services as an outpatient for more than 24 hours. In other words, the statute does not require hospitals to deliver the MOON to all beneficiaries receiving outpatient services. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients receiving observation services and not inpatients, and the reasons for such status, and must be delivered no later than 36 hours after observation services begin. However, hospitals and CAHs may deliver the MOON to an individual receiving observation services as an outpatient before such individual has received more than 24 hours of observation services. Allowing delivery of the MOON before an individual has received 24 hours of observation services affords

hospitals and CAHs the flexibility to deliver the MOON consistent with any applicable State law that requires notice to outpatients receiving observation services within 24 hours after observation services begin. The flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin also allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries.

Hospitals Affected by these Instructions. These instructions apply to hospitals as well as CAHs per section 1861(e) and section 1861(mm) of the Social Security Act.

400.3 - Medicare Outpatient Observation Notice

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON is subject to the Paperwork Reduction Act (PRA) process and approval by the Office of Management and Budget (OMB). The MOON may only be modified as per their accompanying instructions, as well as per guidance in this section. Unapproved modifications cannot be made to the OMB-approved, standardized MOON. The notice and accompanying instructions may be found online at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI>

400.3.1 - Alterations to the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

In general, the MOON must remain two pages, unless inclusion of additional information per section 400.3.8 or State-specific information per section 400.5 below results in additional page(s). Hospitals and CAHs subject to State law observation notice requirements may attach an additional page to the MOON to supplement the “Additional Information” section in order to communicate additional content required under State law, or may attach the notice required under State law to the MOON. The pages of the notice can be two sides of one page or one side of separate pages, but must not be condensed to one page.

Hospitals may include their business logo and contact information on the top of the MOON. Text may not be shifted from page 1 to page 2 to accommodate large logos, address headers, or any other information.

400.3.2 - Completing the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals must use the OMB-approved MOON (CMS-10611). Hospitals must type or write the following information in the corresponding blanks of the MOON:

- Patient name;
- Patient number; and
- Reason patient is an outpatient.

400.3.3 - Hospital Delivery of the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

Hospitals and CAHs must deliver the MOON to beneficiaries in accordance with section 400.2 above. Hospitals and CAHs must provide both the standardized written MOON, as well as oral notification.

Oral notification must consist of an explanation of the standardized written MOON. The format of such oral notification is at the discretion of the hospital or CAH, and may include, but is not limited to, a video format. However, a staff person must always be available to answer questions related to the MOON, both in its written and oral delivery formats.

The hospital or CAH must ensure that the beneficiary or representative signs and dates the MOON to demonstrate that the beneficiary or representative received the notice and understands its contents. Use of assistive devices may be used to obtain a signature.

Electronic issuance of the MOON is permitted. If a hospital or CAH elects to issue a MOON viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the MOON, as specified in 400.3.9, and the required beneficiary specific information inserted, at the time of notice delivery.

400.3.4 - Required Delivery Timeframes

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON must be delivered to a beneficiary who receives observation services as an outpatient for more than 24 hours, and must be delivered not later than 36 hours after observation services begin. The MOON must be delivered before 36 hours following initiation of observation services if the beneficiary is transferred, discharged, or admitted. The MOON may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.

The start time of observation services, for purposes of determining when more than 24 hours of observation services have been received, is the clock time observation services are initiated (furnished to the patient), as documented in the patient's medical record, in accordance with a physician's order. This follows the elapsed clock time, rather than the billed time, associated with the observation services.

400.3.5 - Refusal to Sign the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

If the beneficiary refuses to sign the MOON, and there is no representative to sign on behalf of the beneficiary, the notice must be signed by the staff member of the hospital or CAH who presented the written notification. The staff member's signature must include

the name and title of the staff member, a certification that the notification was presented, and the date and time the notification was presented. The staff member annotates the “Additional Information” section of the MOON to include the staff member’s signature and certification of delivery. The date and time of refusal is considered to be the date of notice receipt.

400.3.6 - MOON Delivery to Representatives

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The MOON may be delivered to a beneficiary’s appointed representative. Appointed representatives are individuals designated by beneficiaries to act on their behalf. A beneficiary may designate an appointed representative via the “Appointment of Representative” form, the CMS-1696. <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>. See Chapter 29 of the Medicare Claims Processing Manual, section 270.1, for more information on appointed representatives.

The MOON may also be delivered to an authorized representative. Generally, an authorized representative is an individual who, under State or other applicable law, may make health care decisions on a beneficiary’s behalf (e.g., the beneficiary’s legal guardian, or someone appointed in accordance with a properly executed durable medical power of attorney).

Notification to a beneficiary who has been deemed legally incompetent is typically made to an authorized representative of the beneficiary. However, if a beneficiary is temporarily incapacitated, a person (typically, a family member or close friend) whom the hospital or CAH has determined could reasonably represent the beneficiary, but who has not been named in any legally binding document, may be a representative for the purpose of receiving the MOON. Such a representative should act in the beneficiary’s best interests and in a manner that is protective of the beneficiary and the beneficiary’s rights. Therefore, a representative should have no relevant conflict of interest with the beneficiary.

In instances where the notice is delivered to a representative who has not been named in a legally binding document, the hospital or CAH annotates the MOON with the name of the staff person initiating the contact, the name of the person contacted, and the date, time, and method (in person or telephone) of the contact.

NOTE: There is an exception to the in-person notice delivery requirement. If the MOON must be delivered to a representative who is not physically present to receive delivery of the notice, the hospital or CAH is not required to make an off-site delivery to the representative. The hospital or CAH must complete the MOON as required and telephone the representative.

- The information provided telephonically includes all contents of the MOON;

- Note the date and time the hospital or CAH communicates (or makes a good faith attempt to communicate) this information telephonically, per 400.2 above, to the representative is considered the receipt date of the MOON;
- Annotate the “Additional Information” section to reflect that all of the information indicated above was communicated to the representative; and
- Annotate the “Additional Information” section with the name of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

Mail a copy of the annotated MOON to the representative the day telephone contact is made.

A hard copy of the MOON must be sent to the representative by certified mail, return receipt requested, or any other delivery method that can provide signed verification of delivery (e.g., FedEx, UPS). The burden is on the hospital or CAH to demonstrate that timely contact was attempted with the representative and that the notice was delivered.

If the hospital or CAH and the representative both agree, the hospital or CAH may send the notice by fax or e-mail; however, the hospital or CAH’s fax and e-mail systems must meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security requirements.

400.3.7 - Ensuring Beneficiary Comprehension

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The OMB-approved standardized MOON is available in English and Spanish. If the individual receiving the notice is unable to read its written contents and/or comprehend the required oral explanation, hospitals and CAHs must employ their usual procedures to ensure notice comprehension. Usual procedures may include, but are not limited to, the use of translators, interpreters, and assistive technologies. Hospitals and CAHs are reminded that recipients of Federal financial assistance have an independent obligation to provide language assistance services to individuals with limited English proficiency (LEP) consistent with section 1557 of the Affordable Care Act and Title VI of the Civil Rights Act of 1964. In addition, recipients of Federal financial assistance have an independent obligation to provide auxiliary aids and services to individuals with disabilities free of charge, consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973.

400.3.8 - Completing the Additional Information Field of the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

This section may be populated with any additional information a hospital wishes to convey to a beneficiary.

Such information may include, but is not limited to:

- Contact information for specific hospital departments or staff members.
- Additional content required under applicable State law related to notice of observation services.
- Part A cost-sharing responsibilities if a beneficiary is admitted as an inpatient before 36 hours following initiation of observation services.
- The date and time of the inpatient admission if a patient is admitted as an inpatient prior to delivery of the MOON.
- Medicare Accountable Care Organization information.
- Hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs.
- Any other information pertaining to the unique circumstances regarding the particular beneficiary.

If a hospital or CAH wishes to add information that cannot be fully included in the "Additional Information" section, an additional page may be attached to supplement the MOON.

400.3.9 - Notice Retention for the MOON

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

The hospital or CAH must retain the original signed MOON in the beneficiary's medical record. The beneficiary receives a paper copy of the MOON that includes all of the required information described in section 400.3.2 and, as applicable, sections 400.3.5, 400.3.6 and 400.3.8. Electronic notice retention is permitted.

400.4 - Intersection with State Observation Notices

(Rev. 3698, Issued: 01-27-17, Effective: 02-21-17; Implementation: 02-21-17)

As noted in sections 400.3.1 and 400.3.8 above, hospitals and CAHs in States that have State-specific observation notice requirements may add State-required information to the "Additional Information" field, attach an additional page, or attach the notice required under State law to the MOON.

500 - Glossary

(Rev. 10862; Issued: 07-14-21; Effective: 10-14-21; Implementation: 10-14-21)

The following terms are defined only for purposes of this Chapter 30 of the Medicare Claims Processing Manual.

Advance notice of non-coverage— 42 CFR 418.408(d)(2) states that if Medicare would

Medicare Outpatient Observation Notice
Frequently Asked Questions
March 8, 2017

Q1. How should hospitals and critical access hospitals (CAHs) complete the “You’re a hospital outpatient receiving observation services. You are not an inpatient because:” free-text field?

- A. The purpose of the MOON free-text field is to provide a clinical rationale for why the beneficiary is receiving observation services as an outpatient and is not an inpatient.

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

The language provided in the free-text field should be reasonably understandable to the beneficiary and generally explain that:

- The physician has ordered outpatient observation services in order to evaluate the beneficiary’s symptom(s) and diagnosis, if known; and
- The beneficiary’s condition and symptoms will continue to be evaluated to assess whether they will need to be admitted as an inpatient of the hospital or whether they may be transferred or discharged from the hospital.

Q2. Does CMS plan to provide specific language or examples for the free-text field?

- A. CMS does not plan to provide specific language or examples for the free-text field. We reiterate that hospitals and CAHs are responsible for populating the free-text field with a clinical rationale specific to each beneficiary’s circumstances, based on the treating physician’s clinical judgment. The clinical rationale should be reasonably understandable to the beneficiary.

Q3. Are hospitals and CAHs permitted to use pre-populated check boxes for the “You’re a hospital outpatient receiving observation services. You are not an inpatient because:” free-text field?

- A. Yes, hospitals and CAHs may develop and use pre-populated check boxes with common clinical explanations so long as a free-text field is retained for circumstances that do not fit within the pre-populated check boxes.

Q4. Are psychiatric hospitals subject to the NOTICE Act requirement to deliver the MOON?

- A. Yes.

Q5. Is the MOON available in an alternate language or format?

- A. The notice is available on the CMS website/Beneficiary Notices Initiative (BNI) webpage in both English and Spanish and pdf and Word formats.

With regard to translating the MOON into additional languages and presenting the MOON in alternate formats, such as braille, we believe –

- Based on hospitals’ and CAHs’ responsibility to provide language assistance to limited English proficiency (LEP) individuals, and consistent with section 1557 of the Affordable Care Act and section 504 of the Rehabilitation Act of 1973, hospitals and CAHs already have in place various procedures to ensure beneficiaries are able to understand Medicare notices.
- Hospitals and CAHs can further utilize those existing procedures to deliver the MOON.

Q6. Is it permissible to adjust or modify the format of the MOON?

- A. Because the language in the MOON has been approved by the Office of Management and Budget (OMB), providers may only modify the document text as per CMS guidance (e.g., the free text field). Providers also may not change standardized OMB-approved notice formatting, such as moving a signature line from the back to the front page of the MOON or continuing the MOON on a 3rd page.

Q7. Are hospitals and CAHs required to issue the MOON to Medicare Advantage enrollees?

- A. Yes, hospitals and CAHs must issue the MOON to beneficiaries in Original Medicare (fee-for-service) and Medicare Advantage enrollees, in accordance with CMS guidance.

Q8. What is the implementation date for the MOON?

- A. When CMS posted the finalized MOON and form instructions on the CMS website on January 8, 2017, hospitals and CAHs were directed to begin using the MOON, no later than **March 8, 2017**.

Please refer to the CMS BNI page for the latest MOON implementation information:

www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni.

Version 05/30/2023
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.

Version 05/30/2023
Check for Updates



Beneficiaries Dually Eligible for Medicare & Medicaid



What's Changed?

- Note: No substantive content updates

Medicare & Medicaid Programs

Medicare Program

Medicare is health insurance for people age 65 or older, certain people under age 65 with disabilities and entitled to Social Security disability or Railroad Retirement Board (RRB) benefits for 24 months (we waive the 24-month waiting period for people with amyotrophic lateral sclerosis [ALS], also known as Lou Gehrig's disease), and people of any age with ESRD.

Medicare has 4 parts:

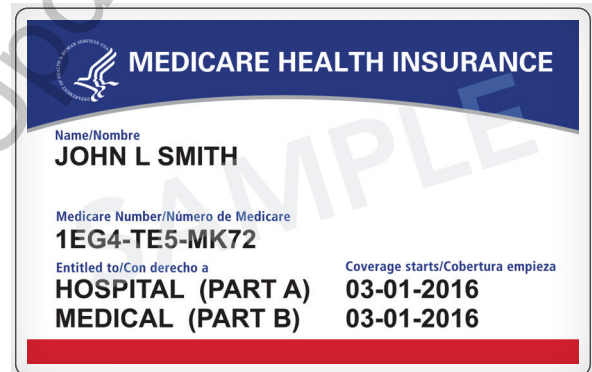
1. **Part A — Hospital Insurance** includes inpatient hospital, inpatient skilled nursing facility (SNF), hospice, and some home health services
2. **Part B — Medical Insurance** includes physician services, outpatient care, durable medical equipment (DME), lab and X-ray services, home health services, and many preventive services
3. **Part C — [Medicare Advantage \(MA\)](#) (for example, **Health Maintenance Organizations [HMOs]** or **Preferred Provider Organizations [PPOs]**):** Medicare-approved private insurance companies provide all Part A and Part B services and may provide prescription drug coverage and other supplemental benefits
4. **Part D — [Prescription Drug Benefit](#):** Medicare-approved private insurance companies provide prescription drug coverage

Beneficiaries may choose:

- Part A and Part B services through Original Medicare with optional Part D coverage through an approved stand-alone Medicare drug plan
- Part A and Part B services through an MA Plan if they live in its service area, with a drug plan included in some plans

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)



MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a	Coverage starts/Coertura empieza
HOSPITAL (PART A)	03-01-2016
MEDICAL (PART B)	03-01-2016

The [Extra Help Program](#) helps pay beneficiaries' Medicare drug plan monthly premiums, annual deductibles, and copayments for those who have or want Part D coverage and meet certain income and resource limits.

Medicaid Program

Medicaid is a joint federal and state program that provides health insurance for certain individuals with low income. Each state administers its own program, following broad national federal guidelines, statutes, regulations, and policies. Each state:

- Establishes eligibility standards
- Decides type, amount, duration, and scope of services
- Sets payment rates

Dually Eligible Beneficiaries

Dually eligible beneficiaries generally describe low-income beneficiaries enrolled in both Medicare and Medicaid. The term includes beneficiaries enrolled in Medicare Part A, Part B, or both, and getting full Medicaid benefits or only help with Medicare premiums or cost-sharing through 1 of these Medicare Savings Programs ([MSP](#)) eligibility groups:

- **Qualified Medicare Beneficiary (QMB) Program:** Pays Part A and Part B premiums, [deductibles, coinsurance, and copayments](#).
- **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Pays **only** the Part B premiums.
- **Qualifying Individual (QI) Program:** Pays **only** Part B premium (individuals enrolled in this program have no other Medicaid eligibility).
- **Qualified Disabled Working Individual (QDWI) Program:** Pays **only** Part A premium for certain individuals under age 65 with disabilities who have returned to work. Medicare pays covered dually eligible beneficiaries' medical services first because Medicare is the primary payer for items and services that both programs cover. Medicaid may cover medical costs that Medicare doesn't cover or partially covers (for example, nursing home care, personal care, and home- and community-based services). Beneficiaries' coverage can vary by state. Some [Medicaid Programs](#) pay care directly through Fee-for-Service (FFS) coverage. Others offer Medicaid through managed care or other integrated care models.

Note

Medicare providers **can't** bill QMB beneficiaries for Medicare cost-sharing. This includes Medicare [deductibles, coinsurance, and copayments](#). In some cases, a beneficiary may owe a small Medicaid copayment. Medicare and Medicaid payments (if any) (and any applicable Medicaid QMB copayment) are considered payment in full. You're subject to sanctions if you bill a QMB above the total Medicare and Medicaid payments (even when Medicaid pays nothing).

States **must** cover certain services through their Medicaid Programs, including:

- Doctor visits
- Inpatient and outpatient hospital services
- Mental health services
- Prescription drugs
- Prenatal care, maternity care, and family planning services (for example, contraceptives)
- Preventive care, like immunizations, mammograms, and colonoscopies

States **may** cover added services, including:

- Dental services
- Home- and community-based services
- Physical therapy
- Prosthetic devices
- Vision and eyeglasses
 - Very few children are dually eligible beneficiaries, but those who are can access vision, dental, hearing, and other services through the [Medicaid Early and Periodic Screening, Diagnostic, and Treatment \(EPSDT\) benefit](#)

Federal law defines Medicaid and MSP income and resource standards, but states can effectively raise those limits above the federal floor through the use of disregards (except for QDWIs). Annually, we release dually eligible beneficiary standards.

Tables 1–7 summarize the [dually eligible categories](#), including each category's benefits and basic qualifications.



Table 1. Full Medicaid (only)

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Full Medicaid coverage refers to the package of services beyond Medicare premiums coverage and cost-sharing certain beneficiaries get when they qualify for certain eligibility groups under a state's Medicaid Program. States must cover some of these groups (like Supplemental Security Income [SSI] recipients). States have the option to cover others, like the special income level institutionalized beneficiary group, home- and community-based waiver participants, and medically needy individuals. Dually eligible beneficiaries who get Medicaid only are enrolled in Part A and or Part B and qualify for full Medicaid benefits but not for MSP groups. States may pay their Part B premium.
Qualifications	<ul style="list-style-type: none"> States decide income and resource criteria. States can require Part A or B enrollment if they pay the beneficiary's premiums for these parts. Beneficiaries must show they need a certain level of care or meet state-specific medical criteria to qualify for certain categories.

Table 2. Qualified Medicare Beneficiary (QMB) Only Without Other Medicaid

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Medicaid pays Part A (if any) and Part B premiums. Medicaid is liable for Medicare deductibles, coinsurance, and copayments for Medicare-covered items and services. Even if Medicaid doesn't fully cover these charges, the QMB isn't liable for them.
Qualifications	<ul style="list-style-type: none"> Income can be up to 100% of the Federal Poverty Level (FPL). Resources can't be more than 3 times the SSI resource limit, increased annually by the Consumer Price Index (CPI). QMB qualifications include enrollment in Part A (or if uninsured for Part A, have filed for premium Part A on a conditional basis). Social Security Administration Program Operations Manual System section HI 00801.140 has more information.

Table 3. Qualified Medicare Beneficiary Plus (QMB+)

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Medicaid pays Part A (if any) and Part B premiums. Medicaid is liable for Medicare deductibles, coinsurance, and copayments for Medicare-covered items and services. Even if Medicaid doesn't fully cover these charges, the QMB+ isn't liable for them. Get full Medicaid coverage plus Medicare premiums and cost-sharing coverage (see Table 1 for a definition of full Medicaid coverage).
Qualifications	<ul style="list-style-type: none"> Meet QMB-related eligibility requirements described in Table 2 and full Medicaid eligibility requirements in Table 1.

Table 4. Specified Low-Income Medicare Beneficiary (SLMB) Only Without Other Medicaid

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Medicaid pays Part B premium.
Qualifications	<ul style="list-style-type: none"> Income between 100%–120% of FPL. Resources can't be more than 3 times the SSI resource limit, increased annually by the CPI. Enrolled in Part A.

Table 5. Specified Low-Income Medicare Beneficiary Plus (SLMB+)

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Medicaid pays Part B premium. Get full Medicaid coverage plus Medicare Part B premium coverage (see Table 1 for a definition of full Medicaid coverage).
Qualifications	<ul style="list-style-type: none"> Meet SLMB-related eligibility requirements described in Table 4 and full Medicaid eligibility requirements in Table 1.

Table 6. Qualifying Individual (QI)

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Medicaid pays Part B premium. Benefits limited to first-come, first-served.
Qualifications	<ul style="list-style-type: none"> Income between 120%–135% of FPL. Resources can't be more than 3 times the SSI resource limit, increased annually by the CPI. Enrolled in Part A. QI beneficiaries aren't eligible for any other Medicaid coverage.

Table 7. Qualified Disabled Working Individual (QDWI)

Benefits & Qualifications	Description
Benefits	<ul style="list-style-type: none"> Medicaid pays Part A premium.
Qualifications	<ul style="list-style-type: none"> Income up to 200% of FPL. Resources up to 2 times the SSI resource limit. Individuals under 65 with a qualifying disability who lost premium-free Part A coverage after returning to work and now must pay a premium to enroll in Part A. QDWI beneficiaries aren't eligible for any other Medicaid coverage.

Qualified Medicare Beneficiary (QMB) Billing Prohibitions

- No Original Medicare or MA providers or suppliers can charge QMBs Medicare Part A and Part B cost sharing for covered services. This prohibition applies even if the provider or supplier doesn't participate in Medicaid.
 - Note:** QMBs may have a small Medicaid copayment if 1 applies.
- Providers should use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS) and the [Medicare Remittance Advice](#) to identify if a beneficiary is a QMB and owes no Medicare cost-sharing.
- If you bill a QMB Medicare cost-sharing, or turn a bill over to collections, you **must** recall it. If you collect any QMB cost-sharing money, you **must** refund it.
- You may be subject to sanctions if you bill a QMB amounts above the total Medicare and Medicaid payments (even when Medicaid pays nothing).

Dually Eligible Beneficiary Billing Requirements

- You must accept assignment for Part B-covered services provided to dually eligible beneficiaries. Assignment means the Medicare Physician Fee Schedule (PFS) amount is payment in full. Special instructions apply when you provide an Advance Beneficiary Notice (ABN) to a dually eligible beneficiary, based on the expectation that Medicare will deny the item or service because it isn't medically reasonable and necessary or is custodial care.
- You can't bill the dually eligible beneficiary up front when you provide an ABN.
- Once Medicare and Medicaid adjudicate the claim, you may only charge the beneficiary in these circumstances:
 - If the beneficiary has QMB coverage without full Medicaid coverage and Medicare denies the claim, the ABN could allow you to shift financial responsibility to the beneficiary under Medicare policy.
 - If the beneficiary has full Medicaid coverage and Medicaid denies the claim (or won't pay because you don't participate in Medicaid), the ABN could allow you to shift financial responsibility to the beneficiary under Medicare policy, subject to state laws that limit beneficiary responsibility.

[ABN Form and Instructions](#) has more information.

Resources

- [Medicare Claims Processing Manual, Chapter 1](#)
- [Medicare General Information, Eligibility, and Entitlement, Chapter 2](#)
- [Medicare Patient Information](#)
- [Medicare & Medicaid Basics](#)
- [Medicare Managed Care Manual](#)
- [Medicare-Medicaid Coordination Office](#)
- [Medicare Prescription Drug Benefit Manual](#)
- [Social Security Administration's Role in MSP Applications](#)

[Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).