CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1587	**Date: September 5, 2008**
	Change Request 6136

SUBJECT: Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage

I. SUMMARY OF CHANGES: Prior to March 3, 2008, providers, practitioners, and suppliers paid under Part B as well as hospice providers and religious non-medical health care institutions paid under Part A were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act. Beginning on March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). The revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

NEW / REVISED MATERIAL
EFFECTIVE DATE: *March 3, 2008
IMPLEMENTATION DATE: March 1, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	30/Table of Contents
R	30/50/Form CMS-R-131 Advanced Beneficiary Notice of Noncoverage (ABN)
R	30/50.1/Introduction-General Information
D	30/50.1.1/Approved Standard Forms
D	30/50.1.2/User-Customizable Sections
D	30/50.1.3/Where to Obtain the ABN Forms
D	30/50.1.4/OMB Burden Notice for CMS-R-131
R	30/50.2/General Statutory Authority – Financial Liability Protections Provisions (FLP) of Title XVIII
R	30/50.2.1/Applicability to Limitation On Liability (LOL)

R	30/50.2.2/Compliance with Limitation on Liability Provisions
D	30/50.2.2.1/Non-Qualifying Categorical Exclusions
D	30/50.2.2.2/Non-Qualifying Technical Exclusions
D	30/50.2.2.3/When Services Will Not Be Furnished
D	30/50.2.2.4/M+C Enrollees and Non-Medicare Patients
D	30/50.2.3/Qualifying Categorical Exclusions
D	30/50.2.4/Qualifying Technical Exclusions
D	30/50.2.5/Routine ABNs
D	30/50.2.6/Qualified Recipients
R	30/50.3/ABN Scope
R	30/50.3.1/Mandatory ABN Uses
N	30/50.3.2/Voluntary ABN Uses
R	30/50.4/Issuance of the ABN
N	30/50.4.1/Issuers of ABNs (Notifiers)
N	30/50.4.2/Recipients of the ABN
N	30/50.4.3/Representatives of Beneficiaries
R	30/50.5/ABN Triggering Events
D	30/50.5.1/ Format of Insertions on ABN
D	30/50.5.2/Guidelines for Customizing the ABN Header
D	30/50.5.3/Patient Name Line
D	30/50.5.4/Medicare Health Insurance Claim Number (HICN) Line
D	30/50.5.5/ABN-G Customizable Boxes
D	30/50.5.6/ABN-L Customizable Boxes
D	30/50.5.7/Estimated Cost Line
D	30/50.5.8/Prohibition of Pre-Selection of an Option on ABNs
D	30/50.5.9/Date and Signature
R	30/50.6/ABN Standards
R	30/50.6.1/Proper Notice Documents
R	30/50.6.2/General Notice Preparation Requirements
R	30/50.6.3/Completing the ABN
N	30/50.6.4/Retention
N	30/50.6.5/Other Considerations During ABN Completion
R	30/50.7/ABN Delivery Requirements

R	30/50.7.1/Effective Delivery
R	30/50.7.2/Options for Delivery Other than In Person
R	30/50.7.3/Effects of Lack of Notification, Medicare Review and Claim Adjudication
D	30/50.7.3.4/ABNs for Unassigned Claims for Medical Equipment and Supplies Which Are Denied on the Basis of §1862(a)(1) of the Act, as Not Reasonable and Necessary
D	30/50.7.4/ABN Standards for Partial Denials on the Basis of Medical Necessity
D	30/50.7.5/ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
D	30/50.7.6/ABN Standards for Services in Skilled Nursing Facilities (SNFs)
D	30/50.7.7/Effect of Furnishing ABNs and Collection From Beneficiary
D	30/50.7.7.1/Providing a Proper ABN
D	30/50.7.7.2/Provider’s Exposure to Financial Liability
D	30/50.7.7.3/Financial Liability Resulting for Providing a Defective ABN
D	30/50.7.7.4/Collection From Liable Beneficiary
D	30/50.7.7.5/Receiving ABNs From Different Entities
D	30/50.7.7.6/ABNs and Bundled Payment
D	30/50.7.7.7/Health Insurance Portability and Accountability Act of 1996 (HIPAA) Sanctions and the Use of ABNs
D	30/50.7.8/Laboratory Issues with ABNs
R	30/50.8/ABN Standards for Upgraded Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
D	30/50.8.1/Incorporation by Reference of Section 50.1
D	30/50.8.2/ABNs for Part B Services Furnished in a Skilled Nursing Facility (SNF)
R	30/50.9/ABNs for Denials Under 1834(a)(17)(B) of the Act (Prohibition Against Unsolicited Telephone Contacts)
D	30/50.9.1/Special Issues Associated with ABNs and Expedited Determinations for Hospice Providers and Comprehensive Outpatient Rehabilitation Facilities (CORFs)
N	30/50.10/ABNs for Claims Denied Under §1834(j)(1) of the Act (Supplier Did Not Meet Supplier Number Requirements)
N	30/50.11/ABNs for Claims Denied in Advance Under §1834(a)(15) of the Act

N	30/50.11.1/Situations In Which Advance Determinations Are Mandatory
N	30/50.11.2/ Situations In Which Advance Determinations Are Optional
N	30/50.12/Collection of Funds and Refunds
N	30/50.12.1/Physicians' Services Refund Requirements
N	30/50.12.2/DMEPOS Refund Requirements (RR) Provision for Claims for Medical Equipment and Supplies
N	30/50.12.3/Time Limits and Penalties for Physicians and Suppliers in Making Refunds
N	30/50.12.4/Supplier's Right to Recover Resalable Items for Which Refund Has Been Made
N	30/50.13/CMS Regional Office (RO) Referral Procedures
N	50.14/Special Considerations
N	30/50.14.1/Obligation to Bill Medicare
N	30/50.14.2/ Emergencies or Urgent Situations
N	30/50.14.3/ Repetitive or Continuous Noncovered Care
N	30/50.14.4/Hospice and CORF
N	30/50.14.4.1/Special Issues Associated with the Advance Beneficiary Notice (ABN) Issued to Hospice Providers
N	30/50.14.5/Expedited Determination Notices
D	30/90/Form CMS-20007 - Notices of Exclusions From Medicare Benefits (NEMBs)
D	30/90.1/General Rules
D	30/90.1.1/Using NEMBs With Categorical Den
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D	30/90.1.3/Readability and Understandability
D	30/90.1.4/Modification of the Form CMS-20007
D	30/90.1.5/Using the Standard Form CMS-20007
D	30/90.2/Header
D	30/90.2.1/Options for Header
D	30/90.2.2/Customizing the Header
D	30/90.3/Explanation Box
D	30/90.4/Check-Off Boxes
D	30/90.5/Footer
R	30/140/Physician Refund Requirements (RR) Provision for Nonassigned Claims for Physicians Services Under §1842(l) - Instructions for

	Contractors
R	30/150/DMEPOS Refund Requirements (RR) Provisions for Claims for Medical Equipment and Supplies under §§ 1834(a)(18), 1834(j)(4), and 1879(h)-Instructions for Contractors
R	30/150.5.2.1/Denial of Payment in Advance
R	30/150.5.2.4/Presumption for Constructive Notice
R	30/150.5.2.5/Presumption When Advance Determination was Requested
R	30/150.5.2.9/Presumption about Beneficiary Knowledge
R	30/150.5.3/Knowledge Standards for §1834(a)(17)(B) Denials
R	30/150.5.4/Knowledge Standards for §1834(j)(1) Denials
R	30/150.5.5/Additional Knowledge Standards for All Medical Equipment and Supplies Denials
R	30/150.5.7/Appeal Rights
R	30/150.5.8/Processing Initial Denials
R	30/150.10.1/Appeal of the Denial of Payment
R	30/150.10.2/Beneficiary Given Advance Beneficiary Notice and Agreed to Pay
R	30/150.10.3/Supplier Knowledge
R	30/150.11/Guide Paragraghs for Inclusion in Appeal Determination
R	30/150.12/Supplier Fails to Make Refund
R	30/150.13/CMS Regional Office (RO) Referral Procedures
R	30/150.15/Supplier’s Right to Recover Resaleable Items for Which Refund Has Been Made
R	30/200.5.3/Length and Page Size

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1587	Date: September 5, 2008	Change Request: 6136

SUBJECT: Revised Form CMS R-131 Advance Beneficiary Notice of Noncoverage

EFFECTIVE DATE: March 3, 2008

IMPLEMENTATION DATE: March 1, 2009

I. GENERAL INFORMATION

A. Background:

Prior to March 3, 2008, providers, practitioners, and suppliers paid under Part B as well as hospice providers and religious non-medical health care institutions paid under Part A were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act. Beginning on March 3, 2008, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). The revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The revised notice incorporates suggestions for changes made by users of the ABN and by beneficiary advocates based on experience with the current form, refinements made to similar liability notices through consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. Additional changes made to the form were based on comments and suggestions made during the recent public comment period.

B. Policy: The authorization for these requirements are Sections 1879, 1834(a)(18), 1834(j)(4), 1842(l) of the Social Security Act, as well as 42 CFR 411.404(b) and (c), and 411.408(d)(2) and (f), which specify written notice requirements. These requirements are fulfilled by the ABN and subject to the Paperwork Reduction Act of 1995.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6136.1	Beginning March 3, 2008 and prior to March 1, 2009	X	X	X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Contractors shall accept the current ABN-G and ABN-L or the revised ABN as valid notification.										
6136.2	Beginning March 1, 2009, Contractors shall accept only a properly executed revised ABN (CMS R-131) as valid notification.	X	X	X	X						
6136.3	Contractors shall review the process associated with the revised ABN as indicated in the manual: 100-04/30.	X	X	X	X						
6136.4	Contractors shall perform additional individual provider education if alerted that a notifier is not complying with these instructions.	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6136.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Charlayne Van, charlayne.van@cms.hhs.gov , 410-786-8659/Evelyn Blaemire, evelyn.blaemire@cms.hhs.gov , 410-786-1803

Post-Implementation Contact(s): Charlayne Van, charlayne.van@cms.hhs.gov , 410-786-8659/Evelyn Blaemire, evelyn.blaemire@cms.hhs.gov , 410-786-1803

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):*

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

> The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (contractor contact, telephone number).

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply where the contractor automatically denies Part B services related to hospital inpatient services denied by the Quality Improvement Organization (QIO). In those cases, the QIO is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act and making the refund determination where appropriate.

150.10.1 - Appeal of the Denial of Payment

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

The first stage of the appeal is a new, independent, and critical reexamination of the facts regarding the denial of payment. If the *contractor* finds that the initial denial of payment was appropriate, go on to §150.10.2.

150.10.2 - Beneficiary Given Advance Beneficiary Notice and Agreed to Pay

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

A supplier which has given the beneficiary an ABN and has obtained the beneficiary's signed statement agreeing to pay, is not required to make a refund. If the supplier claims to have given an ABN to the beneficiary, the *contractor* will ask the supplier to furnish a copy of the ABN. Examine the ABN to determine whether it meets the standards in §40.3 and §50. In the absence of acceptable evidence of advance beneficiary notice, go on to §150.10.3.

150.10.3 - Supplier Knowledge

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

A supplier which did not know and could not reasonably have been expected to know that Medicare would not pay for the medical equipment or supplies is not required to make a refund. If the supplier claims not to have had any such knowledge, the *contractor* will determine whether the supplier knew, or could reasonably have been expected to know, that Medicare would not pay by applying the knowledge standards provided in §150.5.

150.11 - Guide Paragraphs for Inclusion in Appeal Determination

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Upon completion of the appeal, the *contractor* will send the supplier an appeal notice. Send a copy to the beneficiary. If the initial payment determination is reversed to payment, include in the appeal notice the supplier notice language required in §150.9. Otherwise, include one of the following paragraphs concerning refund.

Paragraph 1. Refund Not Required - Beneficiary Was Given Advance Beneficiary Notice and Agreed to Pay

> Under §1834(a)(18) and under §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1),

§1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not required if, prior to furnishing the items or services, the supplier notified the beneficiary in writing that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that you informed the beneficiary in advance that Medicare does not pay for the above items or services and the beneficiary agreed to pay for them. Therefore, you are not required to make a refund in this case. The beneficiary has been sent a copy of this notice.

Paragraph 2. Refund Not Required - Supplier Did Not Know That Medicare Would Not Pay For the Services

Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. However, a refund is not necessary if the supplier did not know, and could not reasonably have been expected to know, that Medicare does not pay for the items or services. After reviewing this claim, we find that you did not know, and could not reasonably have been expected to know, that Medicare would not pay for the above items or services. Therefore, you are not required to make a refund in this case. Upon your receipt of this notice, it is considered that you now have knowledge of the fact that Medicare does not pay for (description of item or service) similar conditions. The beneficiary has been sent a copy of this notice.

Paragraph 3. Adverse Action on Denial - Refund Required

Under §1834(a)(18) and §1834(j)(4) of the Social Security Act, a supplier which does not accept assignment and collects any amounts from a Medicare beneficiary for medical equipment and supplies for which Medicare does not pay on the basis of §1834(a)(17)(B), §1862(a)(1), §1834(j)(1), or §1834(a)(15) of the Social Security Act, must refund these amounts to the beneficiary. A refund is not required if (1) The supplier did not know, and could not reasonably have been expected to know, that Medicare would not pay for the items or services; or (2) The supplier notified the beneficiary in writing before furnishing the items or services that Medicare would not pay for the items or services and the beneficiary signed a statement agreeing to pay for them. After reviewing this claim, we have determined that neither of these conditions is met in this case. You must therefore refund any amount you collected for these items or services within 15 days from the date you receive this notice. A refund must be made within 15 days from receipt of this notice for you to be in compliance with the law. The beneficiary has been sent a copy of this notice.

Suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties (up to $10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program.

NOTE: For claims presented to the contractor prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

150.12 - Supplier Fails to Make Refund

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Under §1834(a)(18)(B) of the Act, a supplier which knowingly and willfully fails to make refund within the time limits in §150.4 may be subject to sanctions under §1128A the Act (i.e., civil money penalties (up to

$10,000 per item or service), assessments (three times the amount of the claim), and exclusion from the Medicare program).

NOTE: For claims presented to the contractor prior to January 1, 1997, the amount of the civil money penalty is up to $2,000 per item or service and the assessment is not more than twice the amount claimed.

Generally, the failure of a supplier to make a refund to a beneficiary comes to the *contractor*'s attention as a result of a beneficiary complaint or a referral from the Social Security Administration (SSA) or the CMS. Document beneficiary complaints and, if necessary, contact the beneficiary to clarify the information in the complaint and determine the amount the beneficiary paid the supplier for the denied items or services. If the *contractor* determines that a supplier failed to make a refund, the *contractor* will contact the supplier in person or by telephone (if that is not feasible, contact the supplier by letter) to discuss the facts of the case. The *contractor* will attempt to determine why the amounts collected have not been refunded. Explain that the law requires that the supplier make a refund to the beneficiary and that if it fails to do so, the Secretary may impose civil money penalties, assessments, and exclusion from the Medicare program. Make a dated report of contact. Include the information relayed to the supplier and the supplier's response. Re-contact the beneficiary in 15 days to determine whether the refund has been made. Do not make any referral to the CMS regional office until the supplier has been formally notified to refund the money and the supplier's appeal rights have been exhausted, or until the time limit for an appeal has passed.

150.13 - CMS Regional Office (RO) Referral Procedures

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

Prior to submitting any materials to the RO, the *contractor* will contact the RO to determine how to proceed in referring a potential sanction case. When referring a sanction case to the region, include in the sanction recommendation (to the extent appropriate) the following:

Background of the Subject

The subject's business name, address, Medicare Identification Number, owner's full name and Social Security Number, Tax Identification Number (if different), and a brief description of the subject's special field of medical equipment and supplies business.

Origin of the Case

A brief description of how the violations were discovered.

Statement of Facts

A statement of facts in chronological order describing each failure to comply with the refund requirements.

Documentation

Include copies of written correspondence and written summaries of any meetings or telephone contacts with the beneficiaries and the supplier regarding the supplier's failure to make refunds. Include a listing of the following for each item or service not refunded to the beneficiary by the supplier (grouped by beneficiary):

- Beneficiary Name and Health Insurance Claim Number;
- Claim Control Number;

- Procedure Code (CPT-4 or HCPCS) of nonrefunded item or service;
- Procedure Code modifier;
- Date of Service;
- Place of Service Code;
- Submitted Charge;
- Units (quantity) of Item or Service; and
- Amount Requested to be Refunded.

Other Significant Issues

Include any information that may be of value to the RO while they review and possibly develop a case to impose sanctions.

150.15 - Supplier's Right to Recover Resaleable Items for Which Refund Has Been Made

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

If the *contractor* denies Part B payment for an item of medical equipment or supplies on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, and the beneficiary is relieved of liability for payment for that item under §1834(a)(18) of the Act, the effect of the denial, subject to State law, cancels the contract for the sale or rental of the item and, if the item is resaleable or re-rentable, permits the supplier to repossess that item for resale or re-rental. In the case of consumable items or any other items which are not fit for resale or re-rental and which cannot be made fit for resale or re-rental, suppliers are strongly discouraged from recovering these items since such actions reasonably could be viewed as purely punitive in nature. If a supplier makes proper refund under §1834(a)(18) of the Act, Medicare rules do not prohibit the supplier from recovering from the beneficiary items which are resalable or re-rentable.

Alternatively, when the contract of sale or rental is cancelled on the basis described above, whether or not the supplier physically repossesses the resaleable or re-rentable item, the supplier may enter into a new sale or rental transaction with the beneficiary with respect to that item as long as the beneficiary has been informed of their liability. If the circumstances which preclude payment for the item have been removed, e.g., the supplier has now obtained a supplier number, the supplier may submit to the *contractor* a new Part B claim based on the resale or re-rental of the item to the beneficiary. If Part B payment is still precluded, the supplier can establish the beneficiary's liability for payment for the denied resold or re-rented item by giving the beneficiary an ABN notifying the beneficiary of the likelihood that Medicare will not pay for the item and obtaining the beneficiary's signed agreement to pay for the item. The resale or re-rental of the item to the beneficiary does not change the fact that the beneficiary is relieved of liability in connection with the original transaction.

Under the capped-rental method, if the *contractor* determines that the supplier is obligated to make a refund, the supplier must repay Medicare those rental payments that the supplier has received for the item. However, the Medicare beneficiary must return the item to the supplier.

200.5.3 - Length and Page Size

(Rev.1587, Issued: 09-05-08, Effective: 03-03-08, Implementation: 03-01-09)

The Important Message from Medicare: The IM must NOT exceed two sides of a page in length. The IM is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information hospitals insert in the notice.

The Detailed Notice: The Detailed Notice must NOT exceed one side of a page in length. The Detailed Notice is designed as a letter-sized form. If necessary, it may be expanded to a legal-sized page to accommodate information hospitals may insert in the notice. Hospitals may attach applicable Medicare policies to the notice.