



Medicare Advance Written Notices of Non-coverage



Table of Contents

What’s Changed?	3
Introduction.....	4
Types of Advance Written Notices of Non-coverage	4
Issuing an Advance Written Notice of Non-coverage	5
Prohibitions & Frequency Limits	7
Completing an Advance Written Notice of Non-coverage	8
Collecting Patient Payment	10
Financial Liability	10
ABN Claim Reporting Modifiers	10
When Not to Use an Advance Written Notice of Non-coverage	11
Resources	11

What's Changed?

- Defined notifier
- Added modifiers GK and GL and explained their use

You'll find substantive content updates in dark red font.

Introduction

An advance written notice of non-coverage helps Medicare Fee-for-Service (FFS) patients choose items and services Medicare usually covers but may not pay because they're medically unnecessary or custodial in nature. The Advance Beneficiary Notice helps patients decide whether to get the item or service Medicare may not cover and accept financial responsibility. If you don't provide the patient with required written notices, Medicare may hold you financially liable if they deny payment. This booklet explains the Advance Beneficiary Notice-issued notice types, uses, and timing.

Types of Advance Written Notices of Non-coverage

CMS approved these notices:

- All health care providers and suppliers must issue an [Advance Beneficiary Notice of Non-coverage \(ABN\) \(Form CMS-R-131\)](#) when they expect a Medicare payment denial that transfers financial liability to the patient. This includes:
 - Independent laboratories, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs) providing Medicare Part B (outpatient) items and services
 - Hospice providers, HHAs, and religious non-medical health care institutions providing Part A items and services
- SNFs must issue a [Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage \(SNFABN\) \(Form CMS-10055\)](#) to transfer financial liability to the patient before providing a Part A item or service that Medicare usually pays, but may not because it's medically unnecessary or custodial care.
- Hospitals must issue a [Hospital-Issued Notice of Non-coverage \(HINN\)](#) before or at admission, or during an inpatient stay if they determine the patient's care isn't covered because it's:
 - Medically unnecessary
 - Not delivered in the most appropriate setting
 - Custodial in nature

“Notifiers” are entities who issue ABNs. These entities can include physicians, practitioners, providers (including laboratories), and suppliers, and utilization review committees for the care provider.

Hospitals issue 4 different HINNs:

1. **HINN 1—Pre-admission/Admission HINN:** Use before an entirely non-covered stay.
2. **HINN 10—Notice of Hospital Requested Review (HRR):** Use for FFS and Medicare Advantage Program (Part C) patients when requesting Quality Improvement Organization (QIO) discharge decision review without provider agreement.
3. **HINN 11—Non-covered Service(s) during Covered Stay:** Use for non-covered items and services during an otherwise covered stay.
4. **HINN 12—Non-covered Continued Stay:** Use with the Hospital Discharge Appeal Notices to inform patients of their non-covered continued stay potential liability.

- HHAs must issue a [Home Health Change of Care Notice \(HHCCN\) \(Form CMS-10280\)](#) to notify a patient getting home health care benefits about Plan of Care (POC) changes. HHAs must notify the patient in writing before they reduce or terminate an item or service. The HHCCN isn't a liability notice, but a change-in-care notice. Find more information on [completing the HHCCN](#).

Issuing an Advance Written Notice of Non-coverage

When to Issue an Advance Written Notice of Non-coverage

Advance written notice of non-coverage recipients include patients who have Medicare and Medicaid coverage (that is, dual eligible). To transfer financial liability to the patient, you must issue an advance written notice of non-coverage:

- When an item or service isn't reasonable or necessary under Medicare Program standards. Common reasons we deny an item or service as not medically reasonable or necessary include:
 - Experimental and investigational or considered "research only"
 - Not indicated for the case's diagnosis or treatment
 - Not considered safe and effective
 - More services than Medicare allows in a specific period for the corresponding diagnosis
- When patients get custodial care
- Before caring for a patient who isn't terminally ill (hospice providers)
 - Specific items or services billed separately from the hospice per diem payment, such as physician services, that aren't reasonable or necessary
 - Level of hospice care isn't reasonable or medically necessary
- Before caring for a patient who isn't confined to the home or doesn't need intermittent SNF care (HHA providers)
- When outpatient therapy services exceed therapy cap amounts and don't qualify for a therapy cap exception
- Before providing a preventive service usually covered but we won't cover in this instance because of frequency limitations
- Before providing an item or service we won't pay because (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS] suppliers):
 - Provider used prohibited unsolicited phone contacts
 - Supplier hasn't met supplier number requirements
 - Non-contract supplier provides an item listed in a competitive bidding area
 - The patient wants the item or service before we get the advance coverage determination

Non-Contract DMEPOS Suppliers

An ABN is valid if a patient understands what the notice means. An exception applies when patients have no financial liability to a non-contract supplier of an item from the Competitive Bidding Program unless they sign an ABN indicating Medicare won't pay for the item because they got it from a non-contract supplier and they agree to accept financial liability.

Services must meet specific medical necessity requirements in the statute, regulations, guidance, and criteria defined by [National Coverage Determinations](#) (NCDs) and [Local Coverage Determinations](#) (LCDs) (if any exist for the service reported). Every service you bill must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

NCDs or LCDs may limit coverage. NCDs limit Medicare specific services, procedures, or technologies coverage on a national basis. The HHS Secretary determines reasonable and necessary NCDs. Medicare Administrative Contractors (MACs) may develop an LCD to further define an NCD or if there's no specific NCD. This coverage decision gives guidance to the public and medical community within a specified geographic area. In most cases, this information's availability indicates you knew, or should've known, we would deny the item or service as medically unnecessary.

Issuing an Advance Written Notice of Non-coverage as a Courtesy

Medicare doesn't require you to notify the patient before you provide an item or service we never cover or isn't a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the patient about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the patient isn't required to check an option box or sign and date the notice. Find more information about non-covered services in the [Items & Services Not Covered Under Medicare](#) booklet.

Events Prompting an Advance Written Notice of Non-coverage

These 3 triggering events may prompt an advance written notice of non-coverage:

1. Initiations
2. Reductions
3. Terminations

Initiations

Initiations happen at the beginning of a new patient encounter, start of a POC, or when treatment begins. If you believe at initiation Medicare won't cover certain items or services because they're not reasonable and necessary, you must issue the notice before the patient gets the non-covered care in order to transfer financial liability.

Reductions

Reductions happen when a component of care decreases (for example, frequency or service duration). Don't issue the notice every time there's a care reduction. If a reduction happens and the patient wants to continue getting care no longer considered medically reasonable or necessary, you must issue the notice before the patient gets the non-covered care in order to transfer financial liability.

For the HHCCN, POC reductions happen when an HHA reduces or stops items or services during a spell of illness while continuing others, including when 1 home health discipline ends but others continue.

Terminations

Terminations stop all or certain items or services. If you terminate services and the patient wants to continue getting care no longer considered medically reasonable or necessary, you must issue the notice before the patient gets the non-covered care in order to transfer financial liability.

For the HHCCN, the POC ends when an HHA stops delivering all services.

Issuing an Advance Written Notice of Non-coverage When Multiple Entities Provide Care

When multiple entities provide care, Medicare doesn't require separate advance written notices of non-coverage. Any notifier involved in delivering care can issue the notice when:

- There are separate ordering and delivering providers (for example, a provider orders a laboratory test and an independent laboratory delivers it)
- A provider delivers the technical component and another delivers the professional component of the same service (for example, a radiological test from an independent diagnostic testing facility, and another provider interprets the results)
- The entity that gets the signature on the notice isn't the same entity billing the service (for example, a laboratory refers a specimen to another laboratory and the second laboratory bills Medicare)

In these situations, you may enter more than 1 notifier in the form's header, space **A. Notifier**, if the patient can clearly identify who to contact with billing questions.

We hold the **billing** notifier responsible for issuing the notice.

Prohibitions & Frequency Limits

Routine Notice Prohibition

There's no reason to issue an advance written notice of non-coverage on a routine basis, except:

- Experimental items and services
- Items and services with frequency coverage limitations

- Medical equipment and supplies denied because the supplier had no supplier number, or the supplier made an unsolicited phone contact
- Medically unnecessary services always denied

Other Prohibitions

You can't issue an advance written notice of non-coverage to:

- Shift liability and bill the patient for the services denied due to a Medically Unlikely Edit.
- Compel or coerce patients in a medical emergency or under great duress. Using an advance written notice of non-coverage in the emergency room or during ambulance transports may be appropriate in some cases (for example, a patient who's medically stable and not under duress).
- Charge a patient part of a service when Medicare fully pays through a bundled payment.
- Transfer liability to the patient when we would otherwise pay for items and services.

Frequency Limits

Some Medicare-covered services have frequency limits. We pay only a certain amount of a specific item or service in each diagnosis period. If you believe an item or service may exceed frequency limits, issue the notice before providing the item or service to the patient.

If you don't know the number of times the patient got a service within a specific period, get this information from the patient or other providers involved in their care. Find your [MAC](#) website or [check Medicare eligibility](#) to determine if a patient met the frequency limits from another provider during the calendar year.

Extended Treatment

You may issue a single notice to cover extended treatment if it lists all items and services and the duration of treatment when you believe Medicare won't pay. If the patient gets an item or service during the treatment that you didn't list on the notice and we may not cover it, you must issue a separate notice.

Completing an Advance Written Notice of Non-coverage

An advance written notice of non-coverage should be:

- Issued (preferably in person) and understood by the patient or their representative.
- Completed on the approved, standardized notice format (when applicable), with all required blanks completed. It can't exceed 1 page in length. You may include attachments listing additional items and services. If you use attachment sheets, they must clearly match the items or services in question with the reason a denial is expected and cost estimate information. The print should be readable to the patient. We permit limited customization of the advance written notice of non-coverage, such as pre-printing information in certain blanks.

- Issued far enough in advance for potentially non-covered items or services so the patient can consider available options.
- Explained in its entirety, answering all questions related to the notice.
- Signed and dated by the patient or their representative after they select 1 option. If you issue the notice electronically, offer the patient a paper copy and keep a copy for your records (whether the notice is signed on paper or electronically). If you maintain electronic medical records, you may scan the signed hard copy.
- Kept for 5 years from the date-of-care delivery when no other requirements under state law apply. We require you to keep all notice records, including when the patient declined the care, refused an option, or refused to sign the notice.

If you can't issue the notice in person, you may issue it via direct phone, email, mail, or secure fax machine (according to HIPAA policy). The patient shouldn't dispute the contact. You should document the contact in the patient's records and keep a copy of the unsigned notice on file while you wait for the signed notice.

You must follow phone contacts immediately by a hand-delivered, mailed, emailed, or faxed advance written notice of non-coverage. The patient or the patient's representative must sign and keep the notice and send you a signed copy for their medical record. If the patient fails to return a signed copy, document the initial contact and subsequent attempts to get a patient's signature.

Find detailed instructions on how to complete an ABN in the [Advance Beneficiary Notice of Non-Coverage Interactive Tutorial](#).

When Patients Change Their Minds

If a patient changes their mind after completing and signing the notice, ask them to add explanatory notes to the completed notice. They must sign and date the notes and clearly indicate their new selection. If you can't provide the notice in person, you may add explanatory notes to the form that show the patient's new selection and immediately forward a copy to the patient to sign, date, and return. You must provide the patient a copy of the revised notice as soon as possible.

Patient Refusal to Choose Option or Sign Advance Written Notice of Non-coverage

If the patient or their representative refuses to choose an option or sign the notice, you should add notes to the original copy indicating their refusal. You may list any refusal witnesses (a witness isn't required). If a patient refuses to sign a properly issued notice, consider not providing the item or service unless the consequences prevent it (health and safety of the patient or civil liability in case of harm).

Collecting Patient Payment

When Medicare requires an advance written notice of non-coverage, if you properly notify patients we may not cover the item or service and they sign the notice, you may seek payment from them. If we pay all or part of the items or services claim the patient paid, you must refund the patient the proper amount in a timely manner. We consider refunds timely within 30 days after you get the Remittance Advice or within 15 days after an appeal determination, if you or the patient file an appeal.

Note: We don't allow SNFs to collect Part A services money until the MAC makes an official claim payment decision. Distinct dual eligible billing limitations apply, including Qualified Medicare Beneficiaries (QMBs).

Financial Liability

If you don't issue a required notice or your MAC finds the notice invalid and you knew, or should have known, we won't pay for a usually covered item or service, and we may hold you financially liable. You can't collect payment from the patient. If you previously collected the patient's payment, refund the proper amount in a timely manner.

ABN Claim Reporting Modifiers

Using Modifiers for ABN Claim Reporting

Modifier	When to Use Modifier
-GA Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case	Report when you issue a mandatory ABN for a service as required and keep it on file. You don't need to submit a copy of the ABN, but you must make it available on request. Use the -GA modifier when both covered and non-covered services appear on an ABN-related claim.
-GX Notice of Liability Issued, Voluntary Under Payer Policy	Report when you issue a voluntary ABN for a service Medicare never covers because it's statutorily excluded or isn't a Medicare benefit. Use this modifier combined with modifier -GY.
-GY Notice of Liability Not Issued, Not Required Under Payer Policy	Report Medicare statutorily excludes the item or service, or the item or service doesn't meet the definition of a Medicare benefit. Use this modifier combined with modifier -GX.
-GZ Expect Item or Service Denied as Not Reasonable and Necessary	Report when you expect Medicare to deny payment of the item or service because it's medically unnecessary and you didn't issue an ABN.

Using Modifiers for ABN Claim Reporting (cont.)

Modifier	When to Use Modifier
–GK Reasonable and Necessary Item/Service Associated with GA or GZ Modifier	Report when upgrading a piece of equipment. If you have an ABN, bill with –GA. If you don't have an ABN, bill with –GZ.
–GL Medically Unnecessary Upgrade Provided Instead of Non-Upgraded Item, No Charge, No ABN	Report when you provide an upgraded item, but don't charge Medicare or the patient for the non-upgraded item, and you didn't issue an ABN.

When Not to Use an Advance Written Notice of Non-coverage

Don't use an advance written notice of non-coverage for items and services you provide under Medicare Advantage (Part C) or the Medicare Prescription Drug Plans (Part D).

Under these coverages, we don't require you to notify the patient before you provide items or services that aren't a Medicare benefit or that we never cover.

Get a list of Medicare non-covered items and services in [Medicare Claims Processing Manual, Chapter 30, Section 20.1](#).

Resources

- [Beneficiary Notices Initiative \(BNI\)](#)
- [Email Your ABN Questions](#)
- [Medicare Claims Processing Manual, Chapter 1, Section 60.4.2](#)
- [Medicare Claims Processing Manual, Chapter 30](#)

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