



## Medicare Advance Written Notices of Non-coverage



## Table of Contents

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What’s Changed? .....	3
Types of Advance Written Notices of Non-coverage .....	4
Issuing an Advance Written Notice of Non-coverage .....	5
Prohibitions & Frequency Limits .....	8
Repetitive or Continuous Non-covered Care.....	9
Completing an Advance Written Notice of Non-coverage .....	9
Collecting Patient Payment .....	10
Financial Liability .....	11
ABN Claim Reporting Modifiers .....	11
When Not to Use an Advance Written Notice of Non-coverage .....	12
Resources .....	12

## What's Changed?

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We added language about repetitive or continuous non-covered care (page 9).

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

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 not medically necessary or custodial in nature. You communicate these financial liabilities and appeal rights and protections through notices you give your patients. If you don't provide your patients with the required written notices, we may hold you financially liable if we deny payment. This booklet explains the advance written notice types, uses, and timing.

"You" refers to the health care provider or supplier.

## Types of Advance Written Notices of Non-coverage

CMS uses these notices:

- [Advance Beneficiary Notice of Non-coverage \(ABN\) \(CMS-R-131\)](#) — All health care providers and suppliers must issue an ABN when they expect a payment denial that transfers financial liability to the patient. This includes:
  - **Part B (outpatient)** items and services provided in independent labs, skilled nursing facilities (SNFs), and home health agencies (HHAs)
  - **Part A (inpatient)** items and services provided by hospice providers, HHAs, and religious non-medical health care institutions (RNHCIs)
- [Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage \(SNF ABN\) \(CMS-10055\)](#) — SNFs must issue a SNF ABN to transfer financial liability to the patient before providing a Part A item or service that we usually pay, but may not because it's medically unnecessary or custodial care.
- [Hospital-Issued Notices of Non-coverage \(HINN\)](#) — Hospitals must issue a 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, health care providers (including labs), suppliers, and utilization review committees for the care provider.

Sections 220 and 240 of [Medicare Claims Processing Manual, Chapter 30](#) has more HINN information.

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

[Beneficiary Notices Initiative \(BNI\)](#) webpage has copies of the HINNs.

[Medicare Outpatient Observation Notice \(MOON\) \(CMS-10611\)](#) — The MOON informs patients when they're an outpatient getting observation services and aren't a hospital or CAH inpatient. Section 400 of [Medicare Claims Processing Manual, Chapter 30](#) has more information.

## 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 Original Medicare FFS coverage. To transfer financial liability to the patient, you must issue an advance written notice of non-coverage:

- When a Medicare item or service isn't reasonable or necessary under Program standards, including care that's:
  - Not indicated for the diagnosis, treatment of illness, injury, or to improve the functioning of a malformed body member
  - Experimental and investigational or considered research only
  - More than the number of services allowed in a specific period for that diagnosis
- When providing custodial care
- When outpatient therapy services exceed therapy threshold amounts
- Before caring for a patient who isn't terminally ill (hospice providers)
  - Specific items or services billed separately from the hospice per diem payment (for example, 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)
- Before providing a preventive service we usually cover but won't cover in specific situations when services exceed frequency limits

- Before providing a Medicare item or service we cover (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS] suppliers) because:
  - Provider accepted prohibited unsolicited phone contacts
  - Supplier hasn't met supplier number requirements
  - Non-contract supplier provides an item listed in a competitive bidding area
  - Patient wants the item or service before 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-contracted 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 specific Medicare service, procedure, or technology 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

We don'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 doesn't affect financial liability, and the patient isn't required to check an option box or sign and date the notice. [Items & Services Not Covered Under Medicare](#) booklet has more information about non-covered services.

## 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 plan of care (POC), or when treatment begins. If you believe at initiation we 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 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 to transfer financial liability.

## 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 to transfer financial liability.

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

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

- There's separate ordering and delivering providers (for example, a provider orders a lab test and an independent lab delivers it)
- A provider delivers the technical component, and another delivers the same service's professional component (for example, a radiology 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 lab refers a specimen to another lab and the second lab bills us)

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

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### Routine Notice Prohibition

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

- 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 services denied due to a Medically Unlikely Edit ([MUE](#))
- 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 for part of a service when we fully pay 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 it 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 them or other providers involved in their care. [Find your MAC's website](#) or [check for eligibility](#) to determine if a patient met the frequency limits from another provider during the calendar year.

[Medicare Preventive Services](#) educational tool has more information on Medicare-covered services that have frequency limits.

### 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 we 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.

## Repetitive or Continuous Non-covered Care

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An ABN remains effective after delivery if there's no change in:

- Care described on the original ABN
- Patient's health status
- Medicare coverage guidelines for the items or services in question (for example, updates or changes to the policy of an item or service)

**Note:** If any bullets above change during treatment, issue a new ABN.

For repetitive or continuous items or services, you may issue the patient another ABN after 1 year for subsequent treatment of the non-covered condition. This isn't required unless any conditions above apply to the situation.

You may give a patient a single ABN describing an extended or repetitive non-covered treatment course if the ABN lists all items and services you believe we won't cover. If applicable, the ABN must also specify the treatment duration.

If a patient is getting repetitive non-covered care but you failed to issue an ABN before providing the first episodes of care, you may issue the ABN at any time during treatment. However, if you issued the ABN after initiating repetitive treatment, the ABN can't be retroactively dated or used to shift liability to the patient for care provided before you issued the ABN. In these cases, care provided before ABN delivery is the health care provider's or supplier's financial responsibility.

## Completing an Advance Written Notice of Non-coverage

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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. 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 patient should be able to read it. We permit limited advance written notice of non-coverage customization, 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, with you answering all notice-related questions.
- Signed and dated by the patient or their representative after they select an option. If you issue the notice electronically, offer the patient a paper copy and keep a copy for your records (whether 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 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 the unsigned notice copy on file while you wait for the signed notice.

You must follow phone contacts immediately with 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 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 their 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 them 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 even though 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 we require an advance written notice of non-coverage, if you properly notify patients that 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 item or service claim the patient paid, you must refund them 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 dually 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've known, we won't pay for a usually covered item or service, 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
<b>–GA</b> <b>Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case</b>	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.
<b>–GX</b> <b>Notice of Liability Issued, Voluntary Under Payer Policy</b>	Report when you issue a voluntary ABN for a service we never cover because it's statutorily excluded or isn't a Medicare benefit. Use this modifier combined with modifier –GY.
<b>–GY</b> <b>Notice of Liability Not Issued, Not Required Under Payer Policy</b>	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.
<b>–GZ</b> <b>Expect Item or Service Denied as Not Reasonable and Necessary</b>	Report when you expect we'll deny payment of the item or service because it's medically unnecessary and you didn't issue an ABN.
<b>–GK</b> <b>Reasonable and Necessary Item/Service Associated with GA or GZ Modifier</b>	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.
<b>–GL</b> <b>Medically Unnecessary Upgrade Provided Instead of Non-Upgraded Item, No Charge, No ABN</b>	Report when you provide an upgraded item, but don't charge us or the patient for the non-upgraded item, and you didn't issue an ABN.

Section 60.4.2 of [Medicare Claims Processing Manual, Chapter 1](#) has more ABN modifier information.

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

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

You don't need to notify the patient before you provide items or services that aren't a benefit or never covered.

Section 20.2.1 of [Medicare Claims Processing Manual, Chapter 30](#) has a list of Medicare non-covered items and services.

## Resources

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- [Email Your ABN Questions](#)
- [Medicare Claims Processing Manual, Chapter 30](#)

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