Advanced Beneficiary Notice (ABN)

What is an ABN?

An Advanced Beneficiary Notice of Noncoverage (CMS-R-131) is issued to Medicare patients by a medical provider when the care planned for a patient is not expected to be covered by Medicare. The ABN allows a patient to make an informed decision about whether to proceed with the item or service, and understand the costs of their care if it is not covered by Medicare.

When must an ABN be obtained?

ABNs must be provided to a patient prior to an item or service being rendered, when it is reasonable to anticipate that Medicare will not pay for it. There must be a specific reason that coverage is not expected, such as not meeting medical necessity policy guidelines, being subject to frequency limitations, being considered experimental, etc.

What if an ABN is not obtained?

If an ABN is not obtained prior to service delivery and Medicare subsequently denies payment, a provider may not charge the patient for the care provided.

When is an ABN optional?

For items and services that are never covered by Medicare (cosmetic surgery for example), it is not necessary to provide an ABN to the patient. However, it is considered a best practice to use an ABN form or a provider's own similar form to convey and document financial responsibility information to a patient.

What if a patient refuses to sign the ABN?

Review the ABN with the patient and have a witness sign as to the patient's refusal.

Can we use our own ABN form to notify the patient?

CMS does not allow providers to create their own versions of the ABN form. The exact CMS-R-131 must be used. The completed form must include the name, address and telephone number of the provider, in the header, which may also include the provider's logo.

What if we don't know what the service will cost?

A cost estimate must be provided, or the ABN will be deemed invalid. Although some services may vary in cost, the ABN must be accurate within 25% of the actual billed charges.

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How do we bill Medicare and the patient after an ABN is obtained?

Follow the choice of the patient on the ABN. The patient may choose to pay but still have Medicare billed for a final coverage decision (and/or to submit to secondary coverage). The patient may choose to pay and choose that no bill is submitted to Medicare. Or the patient may elect to not have the service provided, in which case no bill would be appropriate.

What modifiers should be reported?

Providers should choose the most appropriate modifier when a claim is submitted for a service that is expected to be denied.

- GA - ABN was required, and an ABN was issued.
- GZ - ABN was required, but an ABN was not issued.

- GX - ABN was not required for a non-covered service, optional ABN was issued.
- GY - ABN was not required for a non-covered service, no ABN was issued.

Resources:

Medicare Advance Beneficiary Notices information booklet:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf

Sample ABN forms in English and Spanish:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish.zip

Instructions for completing an ABN form:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-Instructions.pdf

Statutory guidelines for mandatory and voluntary ABN use:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-CMS-Manual-Instructions.pdf

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