

Department:	Ambulatory Services
Policy Number:	AMB-03-043
Initial Approval Date:	December 2000
Review Responsibility:	Maryann C. Palmeter
Review Date:	December 2017
Revised Date:	September 2025

Page 1 of 5

TITLE: ADVANCE BENEFICIARY NOTICE

PURPOSE:

To ensure fee-for-service Medicare patients are issued a valid Advance Beneficiary Notice (ABN) when a procedure/service may not be considered medically reasonable and necessary according to Medicare Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs).

DEFINITIONS:

Advance Beneficiary Notice (ABN) – A written notice issued to a fee-for-service Medicare beneficiary before furnishing an outpatient procedure/service/test (the “Service”) that is usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity.

Custodial Care - Nonmedical care (for example, bathing, assistance going to the bathroom) that can be performed safely by someone without medical, nursing, or other professional training.

Local Coverage Determination (LCD) – A coverage decision made by a Medicare Administrative Contractor under Medicare Part A or Part B on whether a particular Service is medically reasonable and necessary based on the patient’s signs, symptoms, or diagnosis.

Maintenance Program – Care provided to prevent or slow further worsening of a patient’s condition that can be performed safely by someone without medical, nursing, or other professional training.

National Coverage Determination (NCD) – A nationwide determination of whether Medicare will cover a Service. Medicare coverage is limited to Services that are considered “medically reasonable and necessary” for the diagnosis or treatment of an illness or injury (and is a Medicare benefit).

Notifier – Provider or staff who discusses ABN form with patient and completes task as identified below.

Representative - An individual who may make health care and financial decisions for a patient. For example, the patient’s legal guardian or “durable medical power of attorney” are authorized representatives. If the patient has a known, legally authorized representative, the ABN must be issued to the existing representative.

Department:	Ambulatory Services
Policy Number:	AMB-03-043
Initial Approval Date:	December 2000
Review Responsibility:	Maryann C. Palmeter
Review Date:	December 2017
Revised Date:	September 2025

Page 2 of 5

Voluntary ABN – An ABN issued to a patient for a Service that Medicare never pays for (statutorily excluded), or does not fall under a Medicare benefit category.

Valid Reasons for Medicare Denial – An ABN must be issued when one or more of the following reasons exists before an outpatient Service is performed:

- “Medicare does not pay for this test/service for your condition.”
- “Medicare does not pay for this test/service as often as this (denied as too frequent)” (for example screening mammograms, Annual Wellness Visits, screening colonoscopies).
- “Medicare does not pay for experimental or research use tests/services.”

Services provided as a medical emergency (example: Emergency Department, Trauma Center, Urgent Care Center, Operating Room, etc.) are excluded from this requirement.

PROCEDURE:

1. When a Service is ordered for a Medicare Part B patient and the diagnosis does not meet medical necessity according to Medicare’s guidelines, the EPIC system will alert the provider.
 - A. The alert box will allow the provider to view the LCD reference information which lists diagnoses that would meet medical necessity for the Service.

Note: The diagnosis may not be the only requirement for coverage.

- B. From the LCD lists, the provider can choose an acceptable diagnosis that meets medical necessity and is supported in the medical record documentation or choose to print an ABN form if there is not a covered diagnosis.
2. If the provider chooses not to change the diagnosis and prints an ABN form, the Notifier will inform the patient that the ordered Service does not meet Medicare’s medical necessity guidelines and the patient needs to decide whether or not he/she wants the Service.
 3. The Notifier provides the patient with a completed ABN form before the Service is performed. When completing the ABN, the following items must be included:
 - Notifier’s name
 - Ordering clinic name, address and telephone number
 - Patient’s name
 - Patient’s medical record number

Department:	Ambulatory Services
Policy Number:	AMB-03-043
Initial Approval Date:	December 2000
Review Responsibility:	Maryann C. Palmetter
Review Date:	December 2017
Revised Date:	September 2025

Page 3 of 5

- Include in the “Items or Services” box the CPT code and description
 - Include in the “Reason Medicare May Not Pay” box the reason why the Service may be denied. Refer to the “Valid Reasons for Medicare Denial” section of this policy for the appropriate language to include in this box.
 - In the “Estimated Cost” box, include the charge for the service.
4. The Notifier will review the ABN with the patient. If an interpreter is needed to communicate with the patient, utilize the standard procedure to obtain interpreter services.
 5. If the patient has further questions concerning the reason the Service was ordered, the Notifier will contact the ordering provider prior to asking the patient to sign the ABN form. It is a Medicare requirement that the patient understand that the Service may not be covered and why before signing the ABN.
 6. The Notifier will instruct the patient to select one of the following options on the ABN and place a checkmark in the corresponding box:
 - Option 1 – I want the service, bill Medicare;
 - Option 2 – I want the service, do not bill Medicare; or
 - Option 3 – I do not want the service.

Note: If the patient needs a Medicare claim denial for a secondary insurance plan to cover the service, the Notifier may advise the patient to select Option 1.

Special guidance for people who are dually enrolled in both Medicare and Medicaid. These instructions should only be used when the ABN is used to transfer potential financial liability to the beneficiary and not in voluntary instances. 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.

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 and to strike through the wording as indicated below:

[] **OPTION 1.** I want the (D) listed above. I want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN).

Once the claim is adjudicated by both Medicare and Medicaid, we 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.

Department:	Ambulatory Services
Policy Number:	AMB-03-043
Initial Approval Date:	December 2000
Review Responsibility:	Maryann C. Palmeter
Review Date:	December 2017
Revised Date:	September 2025

- 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.

7. The patient or the patient's representative must sign and date the appropriate boxes at the bottom of the form. If the ABN is unsigned and not dated, it is not valid. If a representative signs on behalf of a patient, the representative should write out "representative" or "Rep" in parentheses after his or her signature. The representative's name should be clearly legible or noted in print.
8. The Notifier distributes the completed/signed ABN as follows:
 - A. Signed original is scanned into the official medical record.
 - B. Give the patient two (2) copies.
 - C. Instruct patient to present one of the copies at the time of the ordered/scheduled service.
 - D. Instruct patient to keep one copy for his/her own records.
9. Copy of the ABN must go with diagnostic specimens.
10. When scheduling the Service, inform the scheduler that the patient has signed an ABN and has been instructed to bring the signed copy to the appointment.
11. If the patient refuses to have the Service or refuses to sign the ABN, document on the ABN the person(s) and circumstances involved and ensure that the ABN is scanned into the official medical record. Inform the provider of the patient's choice.
12. Procedures that will not be covered by Medicare, as determined by the LCD or NCD, should not be ordered without a signed ABN. Contact your department supervisor to discuss with the patient and the ordering provider.
13. Billing Instructions
 - A. Physician bill – If the patient selects Option 1, a "GA" modifier must be appended to each procedure code listed on the signed ABN.
 - B. If the patient selects Option 2, enter the provider's charge in Self-Pay, select the "Edit" button and click the check box labeled "Do Not Bill Insurance." If the patient pays at the time of service, the Self-Pay Discount policy (EA-06-07-001) will apply.

Department:	Ambulatory Services
Policy Number:	AMB-03-043
Initial Approval Date:	December 2000
Review Responsibility:	Maryann C. Palmeter
Review Date:	December 2017
Revised Date:	September 2025

Page 5 of 5

- C. For diagnostic laboratory tests, when the integrity of the specimen is at risk, the laboratory personnel may perform the test(s) ordered even if medical necessity guidelines for the diagnosis, sign, symptom or ICD-10-CM code provided does not meet medical necessity requirements and an ABN is not present. When an ABN has not been issued and the laboratory test is being performed, make sure to choose "NO" in EPIC when prompted if the ABN has been signed. The physician's office must forward the original ABN when ordering a non-covered test. If the patient presents without an ABN, the physician ordering the test will be contacted to determine if an ABN was obtained. If an ABN was obtained, proceed to register the specimen indicating that an ABN has been obtained. If an ABN was not obtained and the test is performed, the charge must be billed with a "GZ" modifier to indicate that the laboratory test is expected to be denied by Medicare due to lack of medical necessity but an ABN was not issued.

14. A Voluntary ABN may be issued to the patient as a courtesy for Services that are statutorily excluded or do not fall under a Medicare benefit category. Follow the prior instructions for completing the ABN but append the "GY" modifier to the charge if the patient elects to have the Service.

REFERENCES:

CMS. *Medicare Claims Processing Manual* Pub. # 100-04, Ch. 1, § § 20 and 50.
CMS. Medicare Learning Network Booklet "Medicare Advance Written Notices of Noncoverage." May 2025.

APPROVED BY: Maryann C. Palmeter