



MEDICARE ADVANCE WRITTEN NOTICES OF NONCOVERAGE



Target Audience: Medicare Fee-For-Service Providers
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Learn about these Medicare advance written notices of noncoverage topics:

- Types of advance written notices of noncoverage
- Issuing an advance written notice of noncoverage
- Prohibitions and frequency limits
- Completing an advance written notice of noncoverage
- Collecting beneficiary payment
- Financial liability
- ABN claim reporting modifiers
- When not to use an advance written notice of noncoverage
- Resources

TYPES OF ADVANCE WRITTEN NOTICES OF NONCOVERAGE

An advance written notice of noncoverage helps a Medicare Fee-For-Service (FFS) beneficiary make an informed decision about items and services Medicare usually covers but may not pay because they are medically unnecessary. These Centers for Medicare & Medicaid Services (CMS) notices are approved for this purpose:

- All health care providers and suppliers must deliver an [Advance Beneficiary Notice of Noncoverage \(ABN\)](#), Form CMS-R-131, when a Medicare payment denial is expected in order to transfer financial liability to the beneficiary. 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 Nonmedical Health Care Institutions providing Part A items and services

The ABN helps the beneficiary decide whether to get the item or service Medicare may not cover and accept financial responsibility to pay for it. **If the beneficiary does not get written notice when it is required, they may not be financially liable if Medicare denies payment, and the provider or supplier may be financially liable instead.**

- SNFs, to transfer financial liability to the beneficiary, must issue a [Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage \(SNFABN\)](#), Form CMS-10055, before providing a Part A item or service to a beneficiary Medicare usually pays, but may not pay because it's medically unnecessary, or it is custodial care.

- Hospitals issue a [Hospital-Issued Notice of Noncoverage \(HINN\)](#) prior to admission, at admission, or at any point during an inpatient stay if hospitals determine the beneficiary's care is not covered because it is:
 - Medically unnecessary
 - Not delivered in the most appropriate setting
 - Custodial in nature

The four HINNs hospitals issue are:

- Preadmission/Admission HINN, also known as HINN 1: Use prior to an entirely noncovered stay
 - Notice of Hospital Requested Review (HRR), also known as HINN 10: Use for FFS and Medicare Advantage Program (Part C) beneficiaries when requesting Quality Improvement Organization review of a discharge decision without physician concurrence
 - HINN 11: Use for noncovered items and services during an otherwise covered stay
 - HINN 12: Use with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a noncovered continued stay
- Home Health Agencies issue [Home Health Change of Care Notice \(HHCCN\)](#), Form CMS-10280 to notify a beneficiary receiving home health care benefits about plan of care (POC) changes. The beneficiary must receive written notification before HHAs may reduce or terminate an item or service. It is important to note that the HHCCN is not a liability notice rather a change in care notice.

ISSUING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

When You Must Issue an Advance Written Notice of Noncoverage

To transfer financial liability to the beneficiary, the provider must issue an advance written notice of noncoverage (the notice):

- When an item or service is not reasonable and necessary under Medicare Program standards. Common reasons for Medicare to deny an item or service as not medically reasonable and necessary include care that is:
 - Experimental and investigational or considered “research only”
 - Not indicated for diagnosis or treatment in this case
 - Not considered safe and effective
 - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is furnished
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)

- Before furnishing an item or service Medicare will not pay because (durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers):
 - The provider violated the prohibition against unsolicited telephone contacts
 - The supplier has not met supplier number requirements
 - The supplier is a non-contract supplier furnishing an item listed in a competitive bidding area
 - The beneficiary wants the item or service before Medicare receives the advance coverage determination

NON-CONTRACT DMEPOS SUPPLIERS

An ABN is valid if beneficiaries understand the meaning of the notice. Where an exception applies, beneficiaries have no financial liability to a non-contract supplier furnishing an item included in the Competitive Bidding Program unless they sign an ABN indicating Medicare will not pay for the item because they received it from a non-contract supplier and they agree to accept financial liability. For more information about non-contract DMEPOS supplier requirements, refer to the [DMEPOS Competitive Bidding Program Non-Contract Supplier](#) fact sheet.

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 billed must indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

Limited coverage may result from NCDs or LCDs. NCDs limit Medicare coverage for specific services, procedures, or technologies on a national basis. The Secretary of the U.S. Department of Health & Human Services determines reasonable and necessary NCDs. Medicare Administrative Contractors (MACs) may develop an LCD to further define an NCD or in the absence of a specific NCD. This is a coverage decision made at their discretion to provide guidance to the public and the medical community within a specified geographic area. In most cases, the availability of this information indicates you knew, or should have known, Medicare would deny the item or service as medically unnecessary.

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

You are not required to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. For more information about noncovered services, refer to the [Items and Services Not Covered Under Medicare](#) booklet.

Three Events That Prompt Issuance of an Advance Written Notice of Noncoverage

These three “triggering events” may prompt an advance written notice of noncoverage:

- Initiations
- Reductions
- Terminations

Initiations

Initiations occur at the beginning of a new patient encounter, start of a POC, or when treatment begins. If you believe at initiation Medicare will not cover certain items or services because they are not reasonable and necessary, you must issue the notice prior to the beneficiary receiving the noncovered care.

Reductions

Reductions occur when a component of care decreases (for example, frequency or duration of a service). Do not issue the notice every time there is a reduction in care. If a reduction occurs and the beneficiary wants to continue receiving the care no longer considered medically reasonable and necessary, you must issue the notice prior to furnishing noncovered care.

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

Terminations

Terminations discontinue all or certain items or services. If services are terminated and the beneficiary wants to continue receiving care no longer considered medically reasonable and necessary, you must issue the notice prior to furnishing noncovered care.

For the HHCCN, terminations to the POC occur when an HHA ends delivery of all services.

Issuing an Advance Written Notice of Noncoverage When Multiple Entities Provide Care

When multiple entities provide care, Medicare does not require separate advance written notices of noncoverage. Any party involved in delivering care can issue the notice when:

- There are separate ordering and furnishing providers (for example, a physician orders a laboratory test and an independent laboratory delivers the ordered test)

- One health care provider delivers the technical component and another provider delivers the professional component of the same service (for example, a radiological test an independent diagnostic testing facility provides, and a physician interprets)
- The entity that obtains the signature on the notice is not the same entity billing the service (for example, one laboratory refers a specimen to another laboratory and the second laboratory bills Medicare for the test)

In these situations, you may enter the names of more than one entity in the header of the notice if the beneficiary can clearly identify whom to contact with billing questions.

Note: Regardless of who issues the notice, Medicare holds the billing entity responsible for effective issuance.

PROHIBITIONS AND FREQUENCY LIMITS

Routine Notice Prohibition

There is no reason to issue an advance written notice of noncoverage 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 telephone contact
- Services always denied for medical necessity

Other Prohibitions

You cannot issue an advance written notice of noncoverage to:

- Shift liability and bill the beneficiary for the services denied due to a Medically Unlikely Edit (MUE).
- A beneficiary in a medical emergency or under great duress (compelling or coercive circumstances). Advance written notice of noncoverage use in the emergency room or during ambulance transports may be appropriate in some cases (for example, a beneficiary who is medically stable and not under duress).
- Charge a beneficiary for a component of a service when Medicare makes full payment through a bundled payment.
- Transfer liability to the beneficiary when Medicare would otherwise pay for items and services.

Frequency Limits

Some Medicare-covered services have frequency limits. Medicare only pays for a certain quantity of a specific item or service in a given period for a diagnosis. If you believe an item or service may exceed frequency limits, issue the notice before furnishing the item or service to the beneficiary.

If you do not know the number of times the beneficiary got a service within a specific period, get this information from the beneficiary or other providers involved in their care. Contact your MAC or use the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) (270/271) to determine if a Medicare beneficiary 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 will not pay. If the beneficiary receives an item or service during the treatment that you did not list on the notice and Medicare may not cover it, you must issue a separate notice. A single notice for an extended course of treatment is only valid for 1 year. If the extended course of treatment continues after 1 year, issue a new notice.

COMPLETING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

An advance written notice of noncoverage should be:

- Issued (preferably in person) to, and understood by, the Medicare beneficiary or their representative.
- Completed on the approved, standardized notice format (when applicable), with all required blanks completed. It cannot exceed one 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. Use a visually high-contrast combination of dark ink on a pale background. The print should be readable to the beneficiary. Medicare permits limited customization of the advance written notice of noncoverage, such as preprinting information in certain blanks.
- Issued far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options.
- Explained in its entirety, answering all questions related to the notice.
- Signed and dated by the beneficiary or their representative after they select one of the options. If you issue the notice on an electronic screen, offer a paper copy to the beneficiary 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 for retention.
- Kept for 5 years from the date-of-care delivery when no other requirements under State law apply. Medicare requires you to keep a record of the notice in all cases, including when the beneficiary 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 telephone, email, mail, or secure fax machine (according to HIPAA policy). The beneficiary should not dispute the contact. You should document the contact in the beneficiary's records and keep a copy of the unsigned notice on file while you wait for the signed notice.

Telephone contacts must be immediately followed by either a hand-delivered, mailed, emailed, or faxed advance written notice of noncoverage. The beneficiary or the beneficiary's representative must sign and retain the notice and send you a signed copy to keep in the beneficiary's record. If the beneficiary fails to return a signed copy, document the initial contact and subsequent attempts to obtain a signature in the beneficiary's records or on the notice.

For detailed instructions on completing an ABN, refer to the [Advance Beneficiary Notice of Noncoverage Interactive Tutorial](#).

When the Beneficiary Changes Their Mind

If the beneficiary changes their mind after completing and signing the notice, you should request they annotate the completed notice. They must sign and date the annotation and include a clear indication of their new option selection. If you cannot provide the notice in person, you may annotate the form to reflect the beneficiary's new option selection and immediately forward a copy to the beneficiary to sign, date, and return. You must provide a copy of the annotated notice to the beneficiary as soon as possible.

Beneficiary Refusal to Choose an Option or Sign the Advance Written Notice of Noncoverage

If the beneficiary or the beneficiary's representative refuses to choose an option or sign the notice, you should annotate the original copy indicating the refusal to choose an option or sign the notice. You may list any witnesses to the refusal, although a witness is not required. If a beneficiary refuses to sign a properly issued notice, consider not furnishing the item or service unless the consequences (health and safety of the beneficiary or civil liability in case of harm) prevent this option.

COLLECTING BENEFICIARY PAYMENT

When an advance written notice of noncoverage is required, if you properly notify the beneficiary the item or service may not be covered, and they sign the notice, you may seek payment from them. If Medicare pays all or part of the claim for items or services previously paid by the beneficiary, you must refund the beneficiary the proper amount in a timely manner. Refunds are considered timely within 30 days after you receive the Remittance Advice from Medicare or within 15 days after a determination on an appeal if you or the beneficiary file an appeal.

Note: SNFs are not permitted to collect money for Part A services until Medicare makes an official payment decision on the claim. For dual eligible beneficiaries, including Qualified Medicare Beneficiaries (QMBs), distinct billing limitations apply.

FINANCIAL LIABILITY

If you do not issue a required notice or Medicare finds the notice is invalid and you knew, or should have known, Medicare will not pay for a usually covered item or service, you may be financially liable. You cannot collect funds from the beneficiary. If you previously collected payment from the beneficiary, you must refund the beneficiary the proper amount in a timely manner.

ABN CLAIM REPORTING MODIFIERS

Table 1. Using Modifiers for ABN Claim Reporting

Modifier	When to Use the 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 it is on file. You do not need to submit a copy of the ABN, but you must have it available on request.
GX Notice of Liability Issued, Voluntary Under Payer Policy	Report when you issue a voluntary ABN for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.
GY Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit	Report that Medicare statutorily excludes the item or service, or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.
GZ Item or Service Expected to Be Denied as Not Reasonable and Necessary	Report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

WHEN NOT TO USE AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

Do not use an advance written notice of noncoverage for items and services you furnish under Medicare Advantage (Part C) or the Medicare Prescription Drug Benefit (Part D). You are not required to notify the beneficiary before you furnish items or services that are not a Medicare benefit or that Medicare never covers, such as:

- Services when there is no legal obligation to pay
- Services authorized or paid by a government entity other than Medicare (this exclusion does not include services paid by Medicaid on behalf of dual eligibles)

- Services required because of war
- Personal comfort items such as radios and televisions
- Eye examinations for prescribing, fitting, or changing eyeglasses
- Hearing aids

RESOURCES

Table 2. Medicare Advance Written Notices of Noncoverage Resources

For More Information About...	Resource
Beneficiary Notices Initiative (BNI)	CMS.gov/Medicare/Medicare-General-Information/BNI
Contact Your MAC	CMS.gov/MAC-website-list
DME Supplier Requirements	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf (Sections 50.7.3.1–50.12)
Email Your Questions	RevisedABN_ODF@cms.hhs.gov
Forms and Instructions, Rules, and Financial Liability Protections	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf (Section 60.4.1) CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
HETS	CMS.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp
HHCCN Form Instructions	CMS.gov/Medicare/Medicare-General-Information/BNI/Downloads/HHCCN-Form-Instructions.pdf
Medicare Coverage	CMS.gov/Medicare-Coverage-Database CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html CMS.gov/Medicare/Coverage/CoverageGenInfo
Medicare Learning Network® Catalog of Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MUEs	CMS.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Advance Beneficiary Notice of Noncoverage (ABN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Forms-English-and-Spanish-Incl-Large-Print.zip
Advance Beneficiary Notice of Noncoverage Interactive Tutorial	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909183.html
DMEPOS Competitive Bidding Program Non-Contract Supplier	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243505.html
Home Health Change of Care Notice (HHCCN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/HHCCN-Forms-English-and-Spanish.zip
Hospital-Issued Notice of Noncoverage (HINN)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/HINNs.zip
Items and Services Not Covered Under Medicare	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1253078.html
Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNFABN)	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS019508.html

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