Does this exam need an ABN?

Advance Beneficiary Notice of Non-coverage, form CMS-R-131
Current version: **Exp. 03/31/2029**

Ask these four questions in order for every Medicare patient, booked or walk-in, before the exam. Stop at the first answer that sends you right.

1 Is Original Medicare (Part B) primary or secondary?

Check eligibility: fee-for-service Medicare or Railroad Medicare. Not a Medicare Advantage plan.

NO → **No ABN**
Medicare Advantage or no Medicare: follow the plan's pre-service determination process.

YES ↓

2 Is this an emergency, or is the patient in acute distress?

An ABN given under duress is not valid.

YES → **Don't give an ABN**
Care for the patient. An ABN can't be used here.

NO ↓

3 Does Medicare never cover this service by law?

For example: an X-ray ordered by a chiropractor, or an elective screening Medicare doesn't cover, such as a coronary calcium score.

YES → **ABN optional, strongly encouraged**
Tell the patient before the exam that they'll pay, and quote the self-pay price. Usually billed GY, with GX if an ABN was given.

NO ↓

4 Do you genuinely expect Medicare to deny this exam for this patient?

The diagnosis doesn't meet the NCD or your MAC's LCD · a screening exam repeated too soon (mammogram under 11 full months, DEXA under 24 months without a qualifying condition, lung screening under 12 months) · a pre-op test with only a pre-op diagnosis.

YES → **ABN required before the exam**
Use the current form, fill in the exam, reason and cost, and let the patient choose and sign. Bill GA.

NO ↓

No ABN needed
Bill Medicare as usual. Never hand out "just in case" ABNs: a blanket ABN is invalid.

Ordering provider not enrolled in PECOS? That's not an ABN situation: Medicare rejects the claim for enrollment, not medical necessity. Check PECOS at booking and ask for an order from an enrolled provider. If the patient goes ahead anyway, treat it as self-pay with a written financial agreement, and confirm the approach with your MAC.

If you give an ABN, fill in every field right

Field	Do	Don't
Identification number	Your MRN or account number (optional)	Never the MBI or Social Security number
Item, test or service	The specific exam: "MRI lumbar spine without contrast"	"Imaging" or "radiology services"
Reason Medicare may not pay	Plain words for every exam listed	"May not be covered"
Estimated cost	A good-faith figure; an overestimate is fine	A blank, or a guess from nowhere
Options 1, 2, 3	Left for the patient to choose	Pre-check a box

Sources: CMS ABN form instructions (CMS-R-131); Medicare Claims Processing Manual, Ch. 30, §50.

Before the exam: the ABN checklist

Keep at the check-in desk and the booking desk

Every Medicare fee-for-service patient

- [ ] **1** Confirm Original Medicare, not a Medicare Advantage plan.
- [ ] **2** Check the ordering provider: PECOS-enrolled and eligible to order imaging? A chiropractor?
- [ ] **3** Check the diagnosis against the exam and your MAC's coverage policy.
- [ ] **4** For a screening exam, confirm the date of the last one, including outside priors.
- [ ] **5** If a trigger applies, print the current form (Exp. 03/31/2029) and fill in the exam, reason and estimated cost.
- [ ] **6** Explain the three options, answer questions, and let the patient choose and sign before the exam.
- [ ] **7** Give the patient a copy, scan the original, and flag the claim for the right modifier.

Walk-ins and same-day add-ons

They skip the pre-visit billing review, so run steps 1 to 4 before the patient goes back. If they want time to decide or to ask their doctor for a better diagnosis, reschedule. Don't push a signature in the waiting room.

If the patient refuses to sign or choose

Write "patient refused to choose an option" or "refused to sign" on the form, add a witness if you can, give the patient a copy and keep the original. Then consider not performing the exam, unless the patient's health or safety requires it.

11 mistakes that void an ABN

1. **Outdated form:** any version but "Exp. 03/31/2029".
2. **Blanket ABNs:** one for every Medicare patient "just in case".
3. **Generic wording:** "radiology services", "may not be covered".
4. **Signed blank:** signature first, exam or cost filled in later.
5. **Staff-selected option:** a box checked without the patient asking, or without a note saying so.
6. **Too late:** on the exam table, after the exam, or with no time to decide.
7. **Under duress:** during an emergency or acute distress.
8. **Missing reason or cost** for an exam listed.
9. **Wrong program:** a Medicare Advantage patient.
10. **Too old:** signed more than a year before the exam.
11. **Unanswered questions:** not answering, or not pointing the patient to 1-800-MEDICARE.

Modifiers on the claim

GA	Required ABN given and signed. Patient liable if denied.
GZ	Denial expected, no valid ABN. Provider liable.
GY	Statutorily excluded service. Patient liable.
GX	Voluntary ABN given for an excluded service; usually with GY.

Option 2 chosen: no claim goes to Medicare. Option 1: submit the claim even though you expect a denial. Dual eligibles choose Option 1. Confirm GX and GY combinations with your MAC.

Keep it

The signed ABN, or a scan, for at least **5 years** after the exam, longer if state law requires. Copy to the patient, and to the billing entity if someone else bills.

Sources: CMS ABN form instructions (CMS-R-131); Medicare Claims Processing Manual, Ch. 30, §50.