



Getting Medicare right

# Case Studies

HIICAP Regional Training  
Fall 2025

# Case study topics

- Advanced Beneficiary Notice (ABN)
- Delayed claim submission
- Never enrolled provider issues

# **Advanced Beneficiary Notice (ABN)**

# Meet Margaret

Margaret, 72, was asked to get some lab work done by her doctor. In addition to regular patient paperwork, she was given a form titled Advance Beneficiary Notice (ABN) right before receiving the service. Margaret didn't have much time to look it over and signed the ABN without fully understanding what it meant. A few weeks later, she received a bill for the full cost of the service. She called the provider, who said Medicare had denied coverage. Margaret is very confused and anxious about the bill; she can't afford it.



**Why was Margaret billed  
and what are her options  
now?**



# Discussion

Consider these questions:

- Why did Medicare deny payment?
- How can Margaret address the misunderstanding with Medicare?
- What steps should Margaret take to make sure she is not liable for the cost?

# Advance Beneficiary Notice (ABN)

- **Advance Beneficiary Notice (ABN):** notices a provider should give beneficiaries, if based on Medicare coverage rules, the provider believes Medicare will deny payment for the service
  - Only provided to Original Medicare beneficiaries
  - The notice must list the reason why the provider believes Medicare will deny payment.
    - For example: "Medicare only pays for this test once every three years."

# Advance Beneficiary Notice(ABN)

- ABNs allow the beneficiary to decide whether to get the care, and if Medicare denies payment, they accept responsibility for the full cost of the service
- Providers are not required to give an ABN for services that are never covered by Medicare, such as hearing aids or routine footcare
- Providers are not permitted to give a blanket ABN for all services

# Advance Beneficiary Notice(ABN)

- ABN serves as a warning that Medicare may not pay for the service, it is possible that Medicare will pay for the service.
- To get an official decision from Medicare:
  - Beneficiaries must sign the ABN, agreeing to pay if Medicare does not, and receive the care.
  - Beneficiaries must make sure to request that their provider bills Medicare for the service before billing them
    - Otherwise, the provider is not required to submit the claim, and Medicare will not provide coverage

# ABN appeals

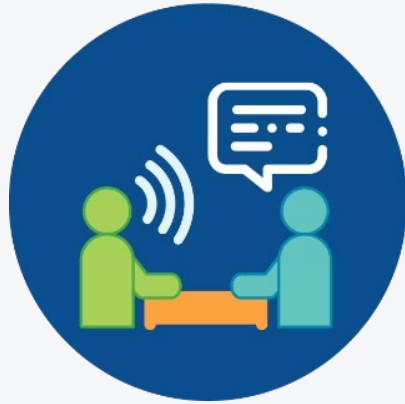
- If Medicare rules about **when beneficiaries should receive** an ABN and **how it should look** are not followed, beneficiaries may not be responsible for the cost of the care
- Beneficiaries have to file an appeal to prove this.





## ABN appeals

- Beneficiaries may not be responsible for denied charges if the ABN:
  - Is difficult to read or hard to understand
  - Is given by the provider (except a lab) to every patient with no specific reason as to why a claim may be denied
  - Does not list the actual service provided, or is signed after the date the service was provided
  - **Is given to beneficiaries during an emergency or is given just prior to receiving a service (for instance, immediately before an MRI)**
  - ABN was not provided when it should have been



## Advice for Margaret

- Since Margaret signed the ABN given to her, she acknowledged liability for the cost if Medicare didn't cover the lab tests
- Margaret should check her Medicare Summary Notice (MSN) for denial reason
- She should also review ABN to ensure it meets all the requirements
- Margaret can file an appeal arguing that she given the ABN right before the service with little time to go over the information and was not informed by signing she would be responsible for payment

# Meet Gary

Gary, 68, was referred by his primary care physician for an imaging test to evaluate persistent joint pain. After the test, he received an MSN stating that Medicare will not pay for the service because it is not medically necessary.

Gary is confused. He contacts his doctor to learn more, and his doctor says that Gary did not meet the Medicare coverage criteria for the service, but that he ordered the tests anyway because he thought Gary needed them. Gary is sure he was not informed beforehand that Medicare might not cover the imaging test. He doesn't know if he's responsible for the full cost now.



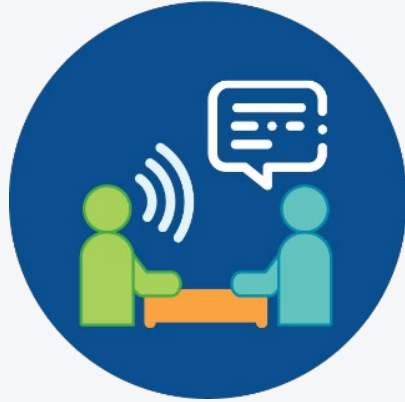
**Should Gary have been given an ABN, and what can he do now?**



# Discussion

Consider these questions:

- Why did Medicare deny payment?
- Does Gary's situation meet the requirements for an ABN?
- What steps should Gary take to make sure he is not liable for the cost?



## Advice for Gary

- Medicare denied payment because services Gary's physician ordered were not medically necessary
- Gary should have been given an ABN explaining why Medicare might not cover the service and that if he signs the ABN he might be liable for any cost if Medicare denies payment
- Gary can file an appeal arguing that he was not given ABN when he should have been or explained that Medicare might deny the services his physician recommended

**Claim filed late**

# Meet Nancy

Claim  
filed late

Nancy, 70, received outpatient services at a local clinic in July 2024.

Due to internal delays, the provider did not submit her claim until August 2025. Medicare denied the claim because it was filed after the filing deadline. The provider then billed Nancy directly for the full cost of the service, making her responsible since Medicare denied payment. Nancy is confused and doesn't want to be held responsible for the cost.



**What should Nancy do now?**



# Discussion

Consider these questions:

- Can the provider bill Nancy?
- What is the filing deadline for providers to submit claims?
- What steps should Nancy take to make sure she is not liable for the cost?

# Medicare's timely filing rules

- Providers must submit claim within **12 months**
- Beneficiaries can't be held responsible for payment of the provider failed to meet the filing deadline
  - Provider or supplier must accept responsibility for the late filing
- The provider can't bill the beneficiary for denied claim if they filed the claim late
  - Provider can still charge the beneficiary a 20% coinsurance and any applicable deductible amount



## Advice for Nancy

- Nancy's provider cannot bill her for the denied claim
- Provider failed to file the claim timely and should accept responsibility
- Nancy can contact her provider and explain the Medicare rule around timely filing
- If provider continues to bill Nancy for the services, she can try contacting Medicare to report this

# **Navigating claims with never-enrolled provider**

# Meet Jean

Never-  
enrolled  
provider

Jean, a 74-year-old Medicare beneficiary, visited a local wellness clinic for a diagnostic test recommended by her doctor. Weeks later, she received a bill for the full cost of the service. When she contacted the clinic, she was told they were not enrolled in Medicare and could not submit a claim on her behalf. Jean feels the service should have been covered and doesn't know how to submit a claim herself or whether that is even possible.



**What should Jean do now?**



# Discussion

Consider these questions:

- What are Medicare's rules for never-enrolled providers?
- How can beneficiaries file a claim themselves?
- What should be Jean's next steps?

# Medicare provider categories


- **Participating providers:** accept Medicare and always takes assignment
- **Non-participating providers:** accept Medicare but does not agree to take assignment in all cases
- **Opt-out providers:** do not accept Medicare payment and have signed agreement to be excluded from Medicare program

# Never-enrolled providers

- These providers have never formally enrolled in Medicare nor formally opted out
- These providers should be encouraged to register their status with Medicare
- If beneficiary sees a provider that has no status with Medicare, they should not be held liable for any charges from that provider
  - If the provider bills them, the beneficiary can try filing a claim with Medicare for the services they receive
  - This will likely generate a denial, which they can then appeal and make the argument that they should not be held liable for charges from a provider who failed to properly opt out or enroll in Medicare



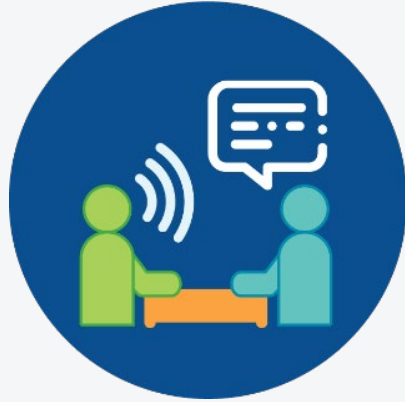
## **Consequence of seeing a Never-enrolled provider**

- Beneficiary pays out-of-pocket at time of service
  - Beneficiaries would usually submit CMS-1490S for reimbursement
    - The claim may be denied because provider is not eligible to receive payment from Medicare
    - The claim may be paid then recouped by MAC
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# Strategy for resolution

- Appeal to Medicare with the goal to have Medicare rule beneficiary not liable for cost (except deductible/coinsurance)
  - Base the appeal on provider's failure to properly opt out
- If appeal is successful:
  - Send letter explaining Medicare policy
  - Request reimbursement to client





## Advice for Jean

- Since the provider is not enrolled, Jean can submit a claim directly to Medicare using the CMS-1490S form
  - The form allows beneficiaries to request reimbursement for covered services when the provider cannot bill Medicare.
- In the case of Jean being denied reimbursement or claim being recouped, Jean can appeal asking Medicare to determine she is not liable for full cost
  - If appeal is successful, she should then request reimbursement from the provider



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**Thank you!**