

MEDICARE BILLING GUIDE 2026

Updated Regulations, ABN Rules, and Compliance Modifiers

MEDICARE PART B BASICS

Medicare Part B covers outpatient medical services, preventive care, and durable medical equipment. Billing Medicare requires close adherence to yearly updates, national medical necessity definitions, and strict compliance documentation.

THE ADVANCED BENEFICIARY NOTICE (ABN) RULE

An Advanced Beneficiary Notice (Form CMS-R-131) is a written notice given to a traditional Medicare patient *before* a service is provided, if the doctor believes Medicare will deny payment based on medical necessity or frequency limits. To manage who is financially responsible, you must append one of these four modifiers to the claim:

MODIFIER	OFFICIAL DEFINITION	BILLING OUTCOME & FINANCIAL RESPONSIBILITY
GA	Waiver of liability issued as required by policy	A signed, valid ABN is on file. If Medicare denies the claim, responsibility shifts to the patient. You can bill the patient directly for the allowed amount.
GX	Notice of voluntary ABN issued for excluded items	Used when a service is naturally excluded by law (like cosmetic procedures). It speeds up processing, and the patient is fully responsible.
GY	Item/service is statutorily excluded by Medicare	Used to get an official denial notice from Medicare, which is often required before a secondary insurance will review the claim. Patient is responsible.
GZ	Item/service expected to be denied; no ABN obtained	The provider expected a denial but forgot to get an ABN signed. If Medicare denies the claim, the provider must write off the charge. It is illegal to bill the patient.

TIMELY FILING RULE

Medicare claims must be filed within one full calendar year from the original date of service. Any claim sent after the 365-day mark will be rejected permanently with zero patient recourse.