Internal Medicine Coding Alert

Get ABNs, or Risk Picking Up Patient Tabs

Without ABNs, unpaid Medicare bills may become your problem

If you aren't obtaining advance beneficiary notices (ABNs) from patients who undergo treatments that Medicare may not deem medically necessary, your office could have to pick up the tab on scads of uncovered or partially covered services.

"An ABN is a form that an office treating a Medicare patient has the patient sign if the office is unsure whether Medicare will pay for a certain service," says **Kathryn Cianciolo, RHIA, CCS, CCS-P**, a Waukesha, Wis., coding consultant for more than 20 years.

Cianciolo says that with the information provided on an ABN, the patient can make a more informed decision on whether he wants to have the procedure performed, given the fact that it's likely he will have to pay for it.

Example. An internist excises a benign lesion of less than 0.5 centimeters from a patient's kneecap. You report the procedure as 11400 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere], trunk, arms or legs; excised diameter 0.5 cm or less) and list 686.1 (Pyogenic granuloma) as the diagnosis, but you are unsure if Medicare will accept 686.1 as an appropriate diagnosis code to justify 11400.

Before he performs the incision, the physician should inform the patient that she may be responsible for the remainder of the bill if Medicare refuses payment. That's where an ABN comes in, Cianciolo says.

When Do You Need an ABN?

Medicare accepts the general ABN form (also called the ABN-G) in all situations. Cianciolo recommends obtaining ABNs each time a diagnostic procedure may not match up with the proper diagnosis code. If the patient has a diagnosis not listed on your local medical review policy (LMRP) for the procedure, but the physician still thinks the patient should have the procedure performed, you should get the patient to sign an ABN preprocedure.

Also, obtain ABNs when a patient is coming in for a screening procedure but the office is unsure if the procedure will violate Medicare's frequency-period rules.
"For example, Medicare will only cover an annual physical once every 365 days, or it will only cover a blood test or a mammogram every so many days," Cianciolo says. If the doctor sees reason for another screening procedure before Medicare allows you to bill for the procedure again, get an ABN on file.

Smart idea: "You definitely want to make sure you have an ABN if you are unsure about Medicare payment on any service," Cianciolo says.

Medicare does not mandate that you must use ABNs, but it does prohibit billing a Medicare beneficiary for a denied claim unless the doctor's office has a signed ABN on file.

"If you don't have an ABN and Medicare refuses the claim, you're pretty much out the money," she says. "You're not allowed to bill the patient for it."

With a signed ABN on file, however, your office is justified in billing the patient for any part of the bill Medicare won't pay for. The ABN proves to Medicare that the patient understood that he might be responsible for the bill before the procedure was performed, Cianciolo says.

It may be helpful to have a blank ABN in front of you while reading this section. A copy of Form No. CMS-R-131-G, the general ABN form, is available online at http://www.cms.hhs.gov/medicare/bni/CMSR131G_June2002.pdf.

Be Thorough

Explaining to the patient what services you think Medicare will deny and why is the primary function of the ABN, **Thomas Bartrum, JD**, attorney at Baker, Donelson, Bearman & Caldwell in Nashville, Tenn., said at the American Health Lawyers Association's 2003 Institute on Medicare and Medicaid Payment Issues. Merely writing that Medicare might deem the procedure "medically unnecessary" is not enough, he said. In the "Items or Services" box on the form, list all services the physician thinks Medicare may deny. In the "Because" box, list all evidence the doctor has to support his stance.

Bartrum recommended including everything pertaining to why Medicare may deny the service in the ABN: details from Medicare's coverage plans, examples of similar cases in which payment was refused, specific details about the patient's individual claim, etc. Be as specific as possible when explaining why Medicare might deny the claim: The patient will appreciate it, and it will keep you from drawing the ire of CMS' Routine Notice Prohibition police.

Duplicate, Duplicate

Be sure each ABN you file is filled out in duplicate; you'll need one copy for your records and one copy for the patient. These forms must be identical. If there is an inconsistency in the similarity of the two documents and the patient complains about it, your office will most likely be the one with the headache, Bartrum said.

Be Proactive

Except under extremely rare circumstances, the physician should give the patient the ABN **before performing the service**. This allows the patient to make an informed choice on treatment in a relatively low-stress environment. Inform patients at the time they schedule appointments that Medicare may or may not cover the service. Then, deliver the ABN ASAP. (For examples of other acceptable forms of ABN delivery, see "Reader Question: Follow the CMS Definition of 'Deliver' " .)