Internal Medicine Coding Alert

Medicare Revises the ABN To Create a Standard

CMS' release of a program memorandum on June 27, 2001, introduces medical providers to a new, abbreviated and more efficient advance beneficiary notice (ABN) aimed at becoming an industry standard. The memo also reiterates the guidelines required in issuing an ABN to Medicare patients.

According to the CMS transmittal, "The latest version of the Office of Management and Budget (OMB)-approved ABN for Part B services (OMB Approval No. 0938-0566, Form No. HCFA-R-131) satisfies the requirements for the provider's ABN and the beneficiary's agreement to pay." The approved notice language now serves as the standard for the revised ABN form.

"The memo's clarification on the guidelines for using an ABN lists all the things we should have been doing but were not specifically stated," says **Carol Pohlig, BSN, RN, CPC,** reimbursement specialist for the department of medicine at the hospital of the University of Pennsylvania in Philadelphia. "This memo makes it clear about how an ABN should be executed."

The ABN form has been shortened from two pages to one. "It appears as if Medicare is trying to make this form function much like the 1500 claim form in an effort to streamline the process (of preparing ABNs) for all providers," says **Jim Stephenson,** president of Northcentral Medical Management Consulting and Billing Service in Elyria, Ohio.

Note: Link to the Coding Institute's Web site at http://codinginstitute.com/news/article9.html for a copy of the new form.

A signed ABN provides Medicare patients with advance notice that a particular service may be reduced or denied because it is considered not reasonable or medically necessary under Section 1862 (1) (A) of the Social Security Act.

"A physician should request a patient sign an ABN whenever there is a good reason to believe a service may not be covered," Stephenson says. "Practices should review their carrier's policy guidelines before performing any procedures to ensure that the patient's condition will be reimbursed by Medicare. If you are still unsure whether Medicare will reimburse a procedure, an ABN ensures that either Medicare or the patient will be responsible for payment."

Make Sure Patient Signs Form Prior to Procedure

For example, a 65-year-old new patient presents to her internist for a pelvic/breast exam (G0101). She recalls having a physical two years ago, but she cannot remember if the gynecological exam was part of the service. Medicare allows claims for G0101 once every two years. But if the patient were unsure as to the date of the exam, the visit would warrant an ABN. Inform her before the pelvic exam that Medicare will pay for the service only every two years and that if this visit falls outside of Medicare's frequency limit, the service may not be covered. If the patient chooses to proceed with the examination, explain the ABN, inform her that she may be responsible for payment and ask her to sign the form.

If, however, the internist performs the pelvic/breast exam without an ABN, the physician cannot ask the patient to come back to the office and sign a waiver after the claim has been denied. "The patient has to be told at the time of the service that Medicare may not cover it," Stephenson says. "But internists need to be careful not to request ABNs for services Medicare never covers."

Avoid "Blanket" ABNs

According to Nationwide Medicare, the local Medicare carrier for Ohio and West Virginia, "Statutorily excluded service and service denied for reasons other than the determination of medical necessity (i.e., routine foot care, hearing aids)

are always the responsibility of the patient and do not require an ABN."

Pohlig says that before the release of the June 27 CMS memo, there was improper use of the ABN particularly as a blanket tool. Physicians used to believe one ABN would suffice for the coverage of one procedure performed several times during the year, she said.

For instance, if a patient presents with a systemic condition such as diabetes and the internist wants to monitor the patient for any systemic effects, certain electrocardiogram (EKG) tests will need to be performed to check the patient's diabetes and to check for cardiac abnormalities. "If the patient is asymptomatic [i.e., the EKG shows no abnormalities], the only diagnosis submitted on the claim would be diabetes. Because diabetes is not part of the list of medically necessary diagnoses of Medicare policy, an ABN would be required," Pohlig says. "If the patient has to have this screening performed every six months, the ABN would need to be signed and submitted for each service performed. One ABN for the year would not be proper."

Some medical offices ask patients to sign a waiver even for noncovered services if the beneficiary requests the claim in hopes of receiving additional reimbursement from a secondary insurer. In these cases, use modifier -GX (service not covered by Medicare) to indicate the claim is being filed solely for denial purposes. Medicare will issue a denial notice so the patient may seek payment through other insurance.

Note: Two modifiers will take the place of modifier -GX on Jan. 1, 2002. Modifier -GY will be used to report an item or service statutorily noncovered, while modifier -GZ will describe an item or service not reasonable and necessary. More information on this policy can be found at www.codinginstitute.com/news/article11.html.

Stephenson says internists usually don't get reimbursed by Medicare for services such as a screening colonoscopy for low-risk patients (although Medicare recently approved coverage for colonoscopy every 10 years) and screening bone density tests (check with local Medicare carriers to determine coverage for this service).

"However, if a patient is concerned about osteoporosis but shows no symptoms or is perhaps postmenopausal, an ABN can protect both the patient and the internist," Stephenson says.

Dual-energy x-ray absorptiometry (DEXA) bone scans (76075, 76076) are frequently used to screen for osteoporosis. "DEXA claims are often perceived as 'preventive' or 'screening' even though some carriers accept claims submitted with diagnoses listed as 781.91 (loss of height) or 781.92 (abnormal posture)," Stephenson says. "But not all carriers recognize these new 2001 ICD-9 codes as medically necessary. If the internist suspects the patient may have osteoporosis based on past or family history but a diagnosis cannot be determined until the test is complete, the patient should sign an ABN. "There's no hard and fast rule that says you can't ask patients to sign a waiver in situations where you truly don't know if Medicare will pay," he says. If a provider notifies the patient that Medicare is likely to deny payment for the service, the ABN is serving its purpose.

What To Do if a Patient Refuses To Sign

A patient may refuse to sign the ABN and choose not to have the test performed. However, if the patient chooses not to have the test performed, he or she would be going against the medical advice of the internist.

If a patient refuses to sign for a treatment the physician deems as necessary but possibly not covered, Nationwide Medicare suggests the physician review the ABN verbally with the patient. The physician may refuse to provide the service if the patient still refuses to sign. Or, if the patient insists on the test but refuses to sign an ABN, the physician should have a witness sign the ABN to indicate that the patient was advised of the ABN, refused to sign it, but still wants the test performed. Under Medicare guidelines, the local carrier will directly bill the
patient for the test if it deems the procedure not medically necessary. Document the situation with witnesses' signatures and retain as part of the patient's record.

Although the ABN is filed in the patient record for those procedures or services that Medicare is not expected to cover, practices must still submit the claim to their local carrier. The claims should include the applicable CPT procedure code

with modifier -GA (waiver of liability statement on file), which alerts Medicare to notify on the explanation of benefits that the patient is responsible for payment. Also, always give the patient a copy of the signed waiver for his or her records.