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BY AAPC

Internal Medicine Coding Alert

Save Time and Trouble by Using ABN Correctly

Learn the basics of this common document

An advance beneficiary notice is a written notice that informs the beneficiary (that is, the patient) that Medicare might not cover a particular service or procedure. By signing the waiver, the patient acknowledges that he may have to pay for the procedure or service if Medicare does not.

Why Won't Medicare Pay?

Medicare only allows for a finite number of certain procedures per patient per time period. For example, Medicare covers an ob-gyn physical including a pelvic exam every two years for low-risk women.

Also, there are some procedures that Medicare doesn't cover -- namely routine physician checkups including the lab tests associated with the routine physical exam and elective procedures such as cosmetic surgery. In these cases, you won't need a signed notification unless a secondary insurer is willing to pay.

Note: In these instances, a provider would use an NEMB (see below) rather than an ABN Medicare coverage varies from state to state and county to county, so be sure to check with your local carriers for guidance on covered procedures and ABN policies.

Why an ABN?

There are two main reasons to obtain a signed ABN from patients:

1. to ensure reimbursement for services provided but deemed not covered by Medicare, and

2. to reduce the risk of compliance implications associated with ABNs.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay for it. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare refuses to pay.

Without a valid ABN, you cannot hold a Medicare patient responsible for the denied charges, leaving the bill in the physician's lap.

What Should an ABN Contain?

A valid ABN must be Medicare-approved and must include:

1. Patient name and Medicare identification number

2. Name of items or services (prior to signature of patient)

3. Statement of provider's belief that Medicare won't cover the service

4. Statement of provider's specific reason(s) for believing Medicare will deny the claim as procedure not reasonable or medically necessary (writing "medically unnecessary" is insufficient)

5. Patient's mark of one of the two boxes on the mandatory Medicare ABN form indicating that he either wants to receive

the items/services or not

6. Patient's dated signature.

In addition, providers should -- but are not required to -- provide the patient with estimated costs of potentially noncovered items/services.

You should obtain a signed ABN for each recommended procedure or service that might not be covered by Medicare. There is no such thing as a blanket ABN that will cover all the procedures or services in a given visit -- this will not hold up to Medicare's scrutiny.

After you submit a claim for services for which the patient has signed an ABN, the patient receives an Explanation of Benefits (EOB) from Medicare stating that payment for the procedure(s) in question was denied and why and that the patient is responsible for the cost of the items/services. Patients can then contact their local Medicare carrier for more information.

ABNs Protect Patients, Too

ABNs help the patient understand his options. Once you have completed the ABN and discussed it with the patient, he can: 1) sign the ABN and assume financial responsibility for the procedure in question; 2) cancel the procedure; 3) reschedule the procedure or service for a future date when he can afford it, or when Medicare may cover the procedure; or 4) refuse to sign the ABN and request that the physician perform the procedure anyway.

How to Move Forward -- Without a Signature

What if the patient refuses to sign? The physician's obligation under Medicare is to notify the patient that a procedure might not be covered. Reviewing the ABN with the patient fulfills this obligation. Therefore, the physician can still bill the patient for any procedures Medicare denies.

Documentation is key in this situation. Even if the patient refuses to sign the ABN, the provider should indicate on the ABN that he addressed the issue with the patient but that the patient refused to sign and still requested the procedure. Have two witnesses among the physician's staff sign and date the refusal, and keep this document in the patient's file. Submit a claim to Medicare as if you had a signed ABN to continue the reimbursement process.

ABNs for Nonmainstream Procedures

Medicare will not cover a procedure just because it has a CPT code. Physicians should obtain a signed ABN for such "nonmainstream" procedures.

For example, the Stretta procedure is gaining acceptance as a treatment for gastroesophageal reflux disease (GERD) and has been assigned CPT code 43257. But it is still not considered mainstream, and many Medicare carriers still consider it to be "not proven effective" and won't pay for the procedure. Having the patient sign an ABN before the procedure lets the patient know that he will be liable for payment.

Modifiers Explain ABN Status

You should accompany any ABN claim with the correct code modifier so Medicare's EOB will properly outline when the patient has to pay. Use the following descriptions to guide your modifier choice:

• **GA** -- Waiver of liability statement on file

Use modifier GA when you've issued an ABN because you expect Medicare to deny the service as not medically necessary. This might include tests ordered without a payable diagnosis code or those ordered more frequently than covered.

Example: A physician orders a screening Pap smear (P3000), but the patient does not remember when she last had the test. Because Medicare only covers one Pap test every three years unless the physician suspects cervical abnormalities, you should get the patient to sign an ABN acknowledging that she will have to pay for the test if she has had a Pap smear within the last three years.

- **GY** -- Item or service statutorily excluded or does not meet the definition of any Medicare benefit

By law, Medicare excludes some medical treatments, such as many screening tests, and you might want to inform patients of this fact. Although you're not required to issue a notification (NEMB, Notice of Exclusions from Medicare Benefits) for excluded procedures, doing so is a courtesy to the patient and may help you get paid. When you report modifier GY in these cases, Medicare will generate a denial notice that the patient can use to seek payment from secondary insurance -- helping the physician avoid unpaid claims.

Example: A patient requests a hearing aid (for example, V5244). Medicare does not pay for hearing aids, but the patient's secondary insurer provides coverage. The physician has the patient sign an NEMB and appends modifier GY to V5244 to demonstrate that he is aware Medicare does not cover the service.

- **GZ** -- Item or service expected to be denied as not reasonable and necessary

Modifier GZ is bad news -- it indicates that an ABN wasn't issued when it should have been. Therefore, you cannot bill the patient when Medicare denies payment. So why use GZ if you still won't get paid? Because you'll reduce the risk of fraud or abuse allegations when filing claims that are not medically necessary.

Example: A physician orders prothrombin time (PT) testing (85610, Prothrombin time) for a patient with a diagnosis of unspecified Gram-negative septicemia (038.40). The lab doesn't issue an ABN but discovers before billing that Medicare's PT National Coverage Determination only covers the test for unspecified septicemia (038.9). Expecting a denial, the lab bills 85610-GZ.

ABN Use in Emergency Departments

You may think that discussing ABNs with ED patients violates patient anti-dumping laws, but this is a common misconception. Although the Emergency Medical Treatment and Labor Act (EMTALA) requires that physicians screen and stabilize patients prior to inquiring about insurance coverage, the policy doesn't bar payment questions altogether. After the physician completes the medical screening exam (MSE) and stabilizes the emergency patient, he has met the EMTALA requirements and can then ask the patient about payment for noncovered services -- and to sign an ABN if appropriate.

Warning: The Centers for Medicare & Medicaid Services policy prohibits giving an ABN to a patient who is "under duress," including patients who need ED services before stabilization.

There are instances when patients receive scheduled treatment in the ED. For example, a patient comes to the ED weekly to receive Procrit injections. His diagnosis is myeloid metaplasia (289.89), which isn't listed as a payable diagnosis on the Medicare local medical review policy for Procrit.

The first question you need to answer is whether this patient meets the medical-necessity requirements for an evaluation and management service by the physician. The patient might not require an E/M service at all. Some hospitals, however, require all patients presenting to the ED undergo a formal triage process and an MSE at minimum. Hospital legal counsel most often provides guidance regarding these issues, so you should seek legal guidance from the attorney at your facility about ABNs.

Exception: If the patient presents to the ED because you do not have a separate outpatient injection/infusion services area, and the patient is "scheduled" and registered as an outpatient, then the emergency department EMTALA MSE/ABN rules do not apply. In this case, you should obtain an ABN.

Request an ABN for Consults, Second Opinions

You should obtain an ABN from a patient prior to rendering a service if you know that the patient is seeking a second opinion or confirmation of a diagnosis or treatment plan. For example, a patient recently diagnosed with intestinal cancer (153.x) seeks a second opinion before undergoing surgery to remove the affected tissue. Your surgeon provides a full workup and discusses possible outcomes with the patient. The ABN lets the patient know that he may be responsible for payment if the insurer deems the service unnecessary.

Many payers, including Medicare, have previously not covered confirmatory consultations because the insurers considered such second opinions -- especially when generated by the patient or patient's family -- a "duplication of services."

This problem may continue to haunt physicians who provide second opinions for patients. Because another physician has already examined the patient and provided an opinion, the payer may deem any attempt to re-examine the patient a duplication of services -- even if you bill the care as an office visit or inpatient or outpatient consultation.

Keep It Proper

When issuing an ABN, be sure to advise the patient that he will be personally and fully responsible for payment of all procedures identified on the ABN if Medicare denies the claim. Be aware that ABNs issued under the following circumstances are considered improper:

• When the physician refuses to answer inquiries from a patient or his authorized representative.

• When an ABN was used to shift liability to the beneficiary for procedures when full payment for those procedures is bundled into other payment.

When to Use ABNs

Following are examples of when and how to properly use ABNs.

• Because of personal concerns, a patient asks that a urologist perform a second screening prostate-specific antigen (PSA) determination, although he had one within the last year.

By statute, Medicare will only reimburse one screening PSA (G0103) annually. Medicare most likely won't pay on this second repeat study. You should have the patient sign an ABN to ensure that he understands that he will most likely be financially responsible for this second screening PSA.

• A patient with laryngeal spasm (478.75) requests a botulinum injection to combat his symptoms (for instance, 64613). This patient has already received one chemodenervation injection in the past two months. Medicare often limits the frequency of botulinum treatments and will not pay for additional injections during a given time period without evidence of extenuating circumstances.

Because you are unsure whether Medicare will cover the procedure, you ask the patient to sign an ABN. The ABN outlines the service the physician will provide (laryngoscopy with Botox injection) and the reason Medicare may reject payment (excessive frequency). You would report 64613 with modifier GA appended.

• A patient with chronic lower-back pain requests an epidural injection (62311). This patient has already received six such injections in the past 12 months -- the maximum number his Medicare carrier will reimburse in a one-year period without extenuating circumstances.

Because you are unsure if Medicare will cover the procedure, you ask the patient to sign an ABN. The surgeon provides the injection, and you report the service using 62311 with modifier GA appended. In this case, because the patient has exceeded the frequency guidelines, Medicare denies the claim and sends the patient an EOB.

ABN vs. NEMB

An ABN isn't always the most appropriate document for procedures not covered by Medicare. Because ABNs are only for procedures that Medicare might not cover, you should not use them for procedures that are excluded from Medicare benefits. The Notice of Exclusions from Medicare Benefits (NEMB) states clearly that a procedure is definitely not covered regardless of the physician's specialty, and you should use it for services such as routine eye care or cosmetic surgery. Unlike the mandatory ABN form, providers may use notices of their own design rather than the Medicare NEMB form.

For example, an elderly man visits a podiatrist for routine nail trimming and filing because he is unable to do this himself. The podiatrist knows that the procedure does not qualify for Medicare coverage because the patient doesn't have a systematic condition such as peripheral neuropathy due to diabetes required for this type of routine foot care.

CMS recommends NEMBs as a courtesy to the patient, even though Medicare does not require them. Having the patient sign the NEMB will remind him that Medicare will not cover the procedure, and he will be billed for it.

Suppose the ABN is signed, the procedure is done, and Medicare refuses payment. So now what?

You might be in the habit of obtaining ABNs for noncovered services, but having that piece of paper doesn't ensure your practice's compensation. Here are two processes that help streamline the steps between ABNs and money in the bank.

1. Know Who's Liable

In addition to understanding the regulations dictating how to get ABNs from patients, you need to know how these regulations translate into payments -- or don't.

Pitfall: Don't make the mistake of assuming that once a patient signs an ABN, you're going to get paid. Depending on the type of liability provision the patient falls under, the ABN may not mean anything other than notification of noncovered services. Make sure you're familiar with these two provisions:

Limitation on liability (LOL). LOL is provided under the Social Security Act §1879(a)-(g) for all Part A services and all assigned claims for Part B services. This kind of provision applies to providers participating in Medicare, and it requires only that you notify the beneficiary of noncoverage. A signed ABN is not an explicit agreement to pay; it is merely a notice of noncoverage.

Refund requirements (RR). RR is provided under the Social Security Act §1879(h) for assigned claims for medical equipment and supplies. RR is also provided for unassigned claims for medical equipment and supplies under §§1834(a)(18) and 1834(j)(4) of the act and for unassigned claims for physicians' services under §1842(l) of the act.

For a beneficiary to be held liable under RR, the beneficiary must sign the ABN. All the RR provisions require not only that the beneficiary be notified but also that the beneficiary agree to pay in order for the beneficiary to be held liable. Consequently, you cannot use an unsigned ABN to shift liability to a beneficiary when RR applies.

Under LOL, a beneficiary signature is not an absolute requirement. The LOL provision requires only that the beneficiary be properly notified; there is no explicit requirement for an agreement to pay. Therefore, these instructions provide for the situation in which a beneficiary receives an ABN, refuses to sign it, but still demands to receive the services specified on the ABN. In that case, the provider, physician, practitioner or supplier can annotate the form, with the signature of a witness, that the beneficiary received notice but refused to sign the form, and can submit the claim with an indication that an ABN was given.

2. Lock in Necessity

Deciding what meets medical-necessity requirements for an ABN service isn't always easy. CMS defines medical necessity as "the determination of a service that is reasonable and necessary for the diagnosis of illness or injury, or treatment of a malformed body member."

And once the services meet that condition, you might still have to navigate through a maze of other regulations, such as local coverage determinations (LCDs) and national coverage determinations (NCDs).

Use these steps to decide whether the service fits the insurer's rules on medical necessity:

• Look at the physician's order or patient's prescription to find out whether that test or service has an NCD and/or LCD. If there are no limitations on coverage, the patient doesn't need an ABN, and you're in the clear.

• If you find a relevant NCD and/or LCD and discover that the service or test does have limited coverage, review the diagnosis or signs and symptoms that prompted the physician to order the test, and decide whether the policy covers that indication.

• If you find that the service does not meet the medical-necessity requirements, and the signs and symptoms or diagnosis is not on the covered list, you should have the patient complete an ABN.

Some common tests that require ABNs include blood tests for cholesterol checks, Pap smears, prostate cancer screenings, and prophylactic tetanus vaccines.

Tip: Be sure to check for frequency limitations on tests. If an LCD places a limitation on a service and the patient exceeds it, you'll need to issue an ABN. Mammographies, Pap smears, glaucoma tests, and screenings for prostate and colorectal cancer have these frequency requirements.

Hint: Keep in mind that Medicare usually relies on the primary diagnosis code to make the appropriate medical-necessity determination.