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Part B Insider (Multispecialty) Coding Alert

ABNs: Game of Musical Diagnoses Leaves Patient Without Chair

A signed advance beneficiary notice gives you the right to tell a patient, "I told you so" after a denial. It doesn't guarantee, however, that your Medicare woes are over when that bill bounces back unpaid.

Physician offices are still naive when it comes to ABNs, which they've only recently started using in force, according to experts. Physicians lose out on significant rightful reimbursement because they are hesitant to encourage patients to sign ABNs where appropriate, or fail to use the forms properly, experts say.

But even if you use ABNs immaculately, you still can run into problems with upset patients, as one practice discovered recently. **Windsong Radiology Group** in Williamsville, N.Y., admitted a patient for a bone densitometry (76075). Because the scan didn't turn up anything and the patient history form didn't show any signs of medical necessity, Windsong billed Medicare using ICD-9 code V82.81 (Osteoporosis). The practice added the -GA modifier and obtained an ABN, says billing specialist **Lucia Yang**.

Medicare denied the claim, and Windsong in turn billed the patient's secondary insurance, which applied the claim toward the patient's deductible. Then Windsong billed the patient for the bone density scan, and the patient complained to the referring physician, Yang says. And that's where the troubles really began.

The referring office insisted Windsong should rebill Medicare with diagnosis code 733.00 (Osteoporosis, unspecified), which is covered for 76075, unlike the original diagnosis. The referral source promised to send some medical documentation or a letter of medical necessity, but failed to do so. Finally, the referring doctor sent a letter saying the patient has a family history of osteoporosis, which Windsong didn't feel was enough to change the diagnosis to 733.00.

The referral source decided that no further documentation was necessary and that Medicare should pay the claim with the revised diagnosis. But Windsong, fearing a Medicare audit, continued to ask for proof of medical necessity. By this time, Windsong had passed the 120-day limit to appeal to Medicare, Yang says.

After many more exchanges, the referring doctor called Windsong's head physician and complained about an "unprofessional" billing staff and offered yet another new diagnosis, 672.x (Pyrexia of unknown origin during the puerperi-um). "Obviously, we have no way of preventing physicians from just picking any ICD-9 that is payable for a particular service," Yang complains, but they should at least provide documentation for it.

Windsong agreed to file an appeal with Medicare despite the filing limits and instructed the carrier to contact the referring physician directly. The carrier denied the appeal for lateness, as expected. These situations have come up more often recently with referral sources and are a cause for concern at Windsong.

Because Medicare doesn't require details on a referral, such as the diagnosis the referring physician gave, it should be irrelevant to a specialist what diagnosis the referring doctor used originally, insists **Jennifer Darling**, insurance and collection specialist with the **Center for Oncology Research & Treatment** in Dallas.

"The referring physician should have no impact on how you are billing your claims," Darling says. "As the specialist, the physician sees the patient, makes a diagnosis on his or her own, and bills accordingly." And if a patient has signed a waiver stating that he or she understands the liability should Medicare not cover a service, then the patient must pay no matter what, she says. Whether the patient pays has nothing to do with the primary-care physician, says Darling, owner of **BBC Medical Management Services**.

In such a situation, Darling would ask the referral source to have the patient contact her directly. "I would not deal with the other office," she says. "I would insist on working directly with the patient, as they are the one who accepted the

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services and financial responsibility."

If a practice recognizes that it is billing incorrectly, even if it's at the behest of another practice, it's committing fraud, Darling warns.

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