Part B Insider (Multispecialty) Coding Alert

Compliance: Review 4 Tips to Ace ABN Quandaries

Tip: Follow Medicare's rules to avoid ABN issues.

Now and again, your practice may perform a service or furnish items that Medicare doesn't cover for beneficiaries because it deems the care medically unnecessary or unreasonable. That's when you must implement an advance beneficiary notice (ABN), both to alert your patients of the issue and to protect yourself from liability.

Read on to make sure you know how to properly use an ABN, so you can submit clean claims every time.

Tip 1: Define and Explain ABNs for Clarity

Providers issue an ABN - form CMS-R-131 - to "beneficiaries in situations where Medicare payment is expected to be denied," says CMS. ABNs are primarily furnished "to transfer potential financial liability to the Medicare beneficiary in certain instances," agency guidance reminds.

And practices should have patients sign the ABN if Medicare might not completely cover a service or item, or at all.

You can bill the patient for the service if you have a signed ABN, but you must also append the correct modifier to the service when the claim is submitted, says **Lynn Radecky,** office manager in Franklin Lakes, New Jersey.

When issuing an ABN, you must advise the Medicare beneficiary that she will be personally and fully responsible for payment of all items and services specified on the ABN if Medicare denies the claim. According to Medicare guidance, you should give this information to the patient before you take her back to the room.

Moreover, you must ensure that your ABN language is clear to patients and in layman's terms. "The explanation must be easy for the patient to understand, and the form should be shared and explained prior to the service actually being provided," reiterates **Mike Granovsky, MD, FACEP, CPC,** president of LogixHealth, a national coding and billing company in Bedford, Massachusetts.

Tip 2: Don't Forget the Modifiers

You should append modifier GA (Waiver of liability statement issued as required by payer policy, individual case) to a procedure code when you think Medicare won't cover the service and you have a signed ABN. In this case, you are indicating that while the service is covered by Medicare, it may not be covered at the time of service due to timing or perhaps the diagnostic reason for doing it. When Medicare sees modifier GA, it will send an explanation of benefits (EOB) to the patient confirming that she is responsible for payment because, in essence, the patient has agreed to pay if Medicare denies. If you don't append the modifier, Medicare will not inform the patient of her responsibility.

Second, when you know Medicare never covers a service, you should report the appropriate CPT® code for the surgeon's services appended with modifier GY (Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit) or GX (Notice of liability issued, voluntary under payer policy). Medicare will generate a denial notice for the claim, which the patient may use to seek payment from secondary insurance. You append GY if the patient has not signed an ABN for the noncovered service, but GX if they have.

Finally, if you believe that Medicare will reject your claim for a reason other than it not being a covered service but you failed to have the patient sign an ABN, you should append modifier GZ (Item or service expected to be denied as not reasonable and necessary) to the CPT® code describing the noncovered service the physician provided. You don't want to be in a position to use modifier GZ because it means that you probably won't get paid for the service. However, by notifying Medicare using modifier GZ, you reduce the risk of allegations of fraud or abuse when filing claims that are not

medically necessary, experts say.

Example: In a physician's opinion, a Medicare patient requires transthoracic echocardiography to assist with diagnosis. However, the patient's record does not support reporting any of the codes indicating medical necessity listed in the payer's local coverage determination (LCD) for the test. You issue the patient a standard CMS ABN to allow her to make an informed decision about having a service Medicare is unlikely to consider medically necessary. You keep a copy of the ABN in the patient's record and give her a copy of the signed form. You submit a claim for the service with modifier GA appended to the test code.

Tip 3: Sometimes ABNs Are Improperly Issued

You've already put the patient on notice that Medicare coverage is unlikely. With this information, the patient is then in a better position as a healthcare consumer to make an informed decision about which services he may have to pay for out of pocket or through other insurance.

And patients should be given this information up front - before they go back to the exam room and before services are rendered. Because these issues do arise, it's critical that a signed ABN is on file.

"Anytime there's suspicion that Medicare may not cover a procedure that they ordinarily would, it's important to get an ABN when possible," explains **Leslie Johnson, CPC, CSFAC,** chief coding officer at PRN Advisors in Palm Coast, Florida.

An ABN is improperly issued under the following circumstances:

- When the provider refuses to answer inquiries from a patient or the patient's authorized representative.
- When you used an ABN to shift liability to the beneficiary for items/services when you should consider full payment for those items/services already bundled into other payments.

Important: Your failure to provide a proper ABN in situations when you need one may result in your practice being found liable.

In most situations, however, you should simply remind the patient that she has signed the ABN and that you explained at that time that she must pay if Medicare doesn't. Suggest that the patient contact Medicare if she has further questions. You might also want to review your protocol with all staff who will be dealing with ABN signatures to ensure that everyone is giving the patient information in a clear, straightforward manner.

Tip 4: Observe Payer Preferences

Private payers often have their own rules, and those frequently differ from CMS. For patients who are not covered by Medicare, you should check with the payers for any ABN requirements.

"Medicare Advantage or private payers may have their own ABN forms, so you should be aware of any updates from any payer with whom you contract," Granovsky warns.

Johnson agrees, saying ABNs are good practice "not just for Medicare, but actually, other payers are requesting similar [ABN-type documents]. It's a good habit for a practice to work into their routine, even if it seems difficult to obtain."

Resource: Review CMS-R-131 form details and instructions at www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-InstructionS.pdf.