Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Coding Quiz--How Much Do Your Really Know About ABNs?

Demystify modifiers GA, GY and GZ

You use advance beneficiary notices (ABNs) to let beneficiaries know of services that Medicare may not cover. But if you think ABNs are a piece of cake, you might be in for a surprise. Take this three-question quiz to see whether you can determine how to use ABNs.

Patient Didn't Understand ABN

Question 1: We have a patient with generalized hyperhidrosis (780.8) who signed an ABN for Botulinum administration, and, as we suspected, her Medicare carrier won't pay for the services. Now the patient is saying that she didn't understand what the ABN meant and she is refusing to pay. What should I doin this situation?

Answer 1: The patient is responsible, says **Heather Corcoran**, coding manager at **CGH Billing Services** in Louisville, Ky. An ABN is a written notice a provider gives a Medicare beneficiary before furnishing items or services when the provider believes that Medicare will not pay on the basis of medical reasonableness or medical necessity. Remember these additional factors:

Making informed decisions: 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.

Mistake: When issuing an ABN, you must advise the Medicare beneficiary that he will be personally and fully responsible for payment of all items and services specified on the ABN if Medicare denies the claim.

Be aware that Medicare considers an ABN improperly issued under the following circumstances:

- When the provider refuses to answer inquiries from a patient or the patient's authorized representative.

- When a practice uses an ABN to shift liability to the beneficiary for items/services when full payment for those items/services is already bundled into other payments.
Your failure to provide a proper ABN when one is required may result in your provider being found liable. In most situations, however, you should simply remind the patient that he agreed to have the services provided and signed the ABN. And you should point out that you explained at that time that he must pay if Medicare doesn't cover the services. Suggest that the patient contact Medicare if he has further questions.

ABN or NEMB?

Question 2: If I provide a service that I know Medicare won't cover (such as personal comfort items, orthotics, preventive medicine/routine physical exams/cosmetic surgery), am I required to offer the patient a notice of exclusion from Medicare benefits (NEMB)?

Answer 2: No law requires you to offer an NEMB, but it's a good proactive measure for any Medicare provider. An NEMB alerts the patient that Medicare doesn't cover certain items and services, says **Rick Gawenda**, PT, director of physical medicine and rehabilitation at **Detroit Receiving Hospital**.

Give the NEMB to the patient before you perform the procedure and document it in the patient's chart. You should date the form and provide a copy for both yourself and the patient.

-The NEMB is used to inform Medicare beneficiaries that the services they may receive are never covered by Medicare, whereas the ABN is used when normally Medicare covers the service to be provided but, under the circumstance, the provider feels that Medicare may deny the service,- Gawenda says.

Reminder: Typically, therapists use an ABN when the patient has either plateaued in his therapy or has achieved all of his goals but wants to keep coming for therapy anyway. The NEMB would be more likely in a situation like an annual physical exam, in which Medicare categorically denies all claims for that service.

The NEMB should include an estimate of the cost of the noncovered services and tell the patient he is responsible for the cost, either privately or through a secondary payer.

Resource: You can print an NEMB (Form 20007) from http:// new.cms.hhs.gov/BNI/Downloads/ CMS20007English.pdf. The form even includes a check box for PT services that therapists perform -incident-to- a physician's services. If you have provided the patient with an NEMB, you only have to file with Medicare at the patient's request. Note this request in the patient's chart.

Master Modifiers GA, GY and GZ

Question 3: I-m confused about when to use modifiers GA, GY, and GZ. How should I use them with an ABN?

Answer 3: You should append modifier GA (Waiver of liability statement on file) to a service/procedure code when you think Medicare won't cover the service and you have a signed ABN. When Medicare sees modifier GA, it will transfer the responsibility to the patient. Medicare will also send an EOB to the patient confirming that he is responsible for payment. If you don't append the modifier, Medicare will hold the provider responsible for the service or procedure, not the patient.

Example: A patient with chronic lower-back pain requests an epidural injection (62311, Injection, single [not via indwelling catheter], not including neurolytic substances, with or without contrast [for either localization or epidurography], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; lumbar, sacral [caudal]).

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 ABN outlines the procedure the provider will provide (epidural injection) and the reason Medicare may reject payment (excessive frequency).

The physiatrist provides the injection, and you report the service as 62311-GA. In this case, because the patient has exceeded the frequency guidelines, Medicare denies the claim, transfers the responsibility to the patient and sends the patient an EOB.

When you know that Medicare never covers a service, you should report the appropriate CPT code for the physiatrist's services with modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) appended. Medicare will generate a denial notice for the claim, which the patient may use to seek payment from secondary insurance.

If you think that Medicare will reject your claim 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 the position to use modifier GZ because it means that you probably won't get paid for the

service,- says **Joyce Ludwick**, compliance consultant with **Park City Solutions Group in** Ann Arbor, Mich. -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.-

Want more? For complete instructions on using ABNs, go online to www.cms.hhs.gov/manuals/downloads/clm104c30.pdf.