Eli's Rehab Report

Billing: Heads Up: New ABN May Cut Need for NEMB

CMS' updated, revised ABN was effective March 3

If you still struggle with understanding the difference between the ABN and the NEMB forms, your prayers have been answered.

Earlier this month, CMS unveiled its new advance beneficiary notice (ABN), and the new form not only replaces both the previous ABN-G (for physicians and therapists) and ABN-L (for laboratories) but also incorporates the notice of exclusions from Medicare benefits (NEMB) form. CMS expects this new, combined form to "eliminate any widespread need for the NEMB in voluntary notification situations," according to the new ABN Form Instructions document.

The NEMB's previous purpose: In case you weren't familiar with exactly when you were supposed to use the ABN rather than the NEMB, keep in mind that in the past, ABNs were only for procedures that Medicare might not cover but didn't apply to procedures that were statutorily excluded from Medicare benefits. That was where the NEMB came in -- you were able to use it for services such as therapy services beyond the therapy caps (that didn't fall under an exception) because Medicare never covered them.

Now CMS will accept the new ABN form for either purpose, noting in its ABN instructions that "the revised version of the ABN may also be used to provide voluntary notification of financial liability."

Don't worry: Although Medicare contractors began accepting the new ABN form on March 3, CMS has implemented a six-month transition period. Therefore, you aren't required to submit the new form until Sept. 1.

Important note for SNFs: You're not required to use the revised ABN form for Part B supplies and services. Instead, watch for a revision of the current SNF ABN that CMS plans to release before Sept. 1, 2008.

4 ABN Tips to Remember

Although the ABN form has changed, many of the previous ABN "best practices" remain the same. The following is a quick look at four important ABN facts.

1. Understand the function of the ABN. If you discover that a patient's upcoming therapy may not be payable by Medicare, but the patient still wants you to perform the service, the ABN will let the patient know that he may be responsible for paying the noncovered portion, and you're required to issue an ABN in this case.

If, however, the service you're providing is statutorily noncovered by CMS, you can choose to voluntarily provide the patient with the revised ABN, notifying her that this service is not covered by Medicare and that she is responsible for payment -- in other words, exactly how you would have handled using an NEMB form.

Remember: 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 your clinic 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, says **Kara Hawes, CPC-A,** with Advanced Professional Billing in Tulsa, Okla.

2. Keep fresh copies of the ABN close by. "The patient has to sign the ABN form at the time of service, otherwise the form is not valid," Hawes says. "When the claim is denied without an ABN, Medicare will not allow you to be reimbursed for the service or collect money from the patient."

3. Explain the ABN to the patient. 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 therapy services in question; 2) cancel the therapy; or 3) reschedule the therapy for future dates when he can afford it, or when Medicare may cover the procedure.

4. Know your billing modifiers. When you expect Medicare to deny all or part of a service, you should append the correct modifier to the service code so Medicare's explanation of benefits (EOB) will properly outline when the patient has to pay. Use the following descriptions to guide your modifier choice:

• "Modifier GA (Waiver of liability statement on file) is used when the service provider believes the service is not covered, and the office has a signed ABN on file," says **Dena Rumisek,** a biller in Grand Rapids, Mich.

For example, you have a Medicare patient who has reached all of her therapy goals and wants to continue therapy for a few maintenance sessions.

• **Modifier GY** (Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, it is not a contract benefit) applies when Medicare excludes the service and you're using the new ABN as you would have used the NEMB in the past.

• **Modifier GZ** (Item or service expected to be denied as not reasonable and necessary) means that you didn't issue an ABN when you probably should have, and you cannot bill the patient if Medicare denies the service.