Eli's Rehab Report

Performing Joint Injections Too Often? Prepare an ABN

Don't write off the $50-80 that Medicare allots for 20600-20610

If you research payable diagnoses and double-check your joint injection claims before sending them to Medicare, you're on track to getting paid -- but don't
stop there.

PM&R practices often concentrate so carefully on payable diagnoses for joint arthrocentesis and aspiration that they forget to ensure that the patients meet frequency guidelines. And without an ABN on file, you can't even attempt to collect payment from a Medicare patient for these procedures:

1. **CPT 20600** -- Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)
2. **CPT 20605** -- ... intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
3. **CPT 20610** -- ... major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa).

Wait a Month for Another Injection

Most payers won't reimburse joint arthrocentesis or aspiration to the same joint unless 30 days have passed since the patient's last injection. According to the policy of HGSAdministrators (a Pennsylvania Part B carrier), "More frequent treatments are usually not within the acceptable standard of practice."

PM&R practices are usually careful to double-check whether the allotted time has elapsed before they schedule a patient's injection. Problems generally occur when patients come from other physicians and don't recall when they had their most recent injection.

Try this: If you are unable to locate the patient's prior records, you should ask the patient to sign an ABN just in case a month hasn't passed since her last injection. Some patients will sign the ABN and go ahead with the procedure, says **Jeff Fulkerson, BA, CPC, CMC**, certified coder at The Emory Clinic in Atlanta, either because they are confident that 30 days have passed since their last procedure or because they simply don't want to reschedule the appointment and come back another day.

And, you should append modifier -GA (Waiver of liability statement on file) to your injection code. This modifier tells the carrier that the patient has signed an ABN and knows that Medicare might deny the claim.

In some cases, your physiatrist knows that the patient doesn't meet frequency guidelines but feels that another injection is medically necessary and injects the patient anyway. In this case, your physician should send a letter of medical necessity along with your claim, explaining why he performed another injection within the 30-day period. Most carriers are willing to bend the 30-day rule if the physician makes a clear case.

The policy of First Coast Service Options (a Part B carrier in Florida) states, "Claims submitted for arthrocentesis performed at unusually frequent intervals will be reviewed by Medicare to make certain that the services were medically reasonable."

But don't put all of your faith in the carrier's claim review committee. The payer may disregard your physician's letter, or it may determine that despite the letter your claim does not meet medical-necessity guidelines. Because of this, if you

believe your patient exceeds medical-necessity guidelines, ask him to sign an ABN even if the physiatrist submits a letter of medical necessity to the insurer.

Medicare's ABN Policy

Medicare does not mandate that you use ABNs, but it does prohibit billing a Medicare beneficiary for a denied claim unless your office has a signed ABN on file. The ABN proves to Medicare that the patient understands that she might be responsible for the bill. Be sure each ABN you file is filled out in duplicate; you'll need one copy for your records and one copy for the patient.

Deliver it: Not only must you make sure the patient has a copy of the ABN; CMS doesn't consider an ABN "delivered" unless the patient understands the form and its contents. If the patient has a condition that affects her awareness, such as Alzheimer's disease (331.0), or doesn't seem to understand why you're asking her to sign the form, you should ask the patient's guardian to sign it.

"Since you are also required to have the patient and/or guardian sign a consent form for treatment and assignment of benefits, you should also ask the guardian to sign the ABN," says **Sandi Scott, CPC, CORT**, director of audits and training in the law department of InSight Health Corp., and an AAPC PMCC licensed instructor.