

# Outpatient Facility Coding Alert

## Rehab Services: Don't Skip the ABN, or You Could Be Stuck With the Therapy Bill

**Exception: Steer clear of an ABN when modifier KX applies.**

If you haven't heard the latest changes regarding Advance Beneficiary Notices (ABNs), it's time to get the scoop. A denied claim that was once your patient's financial responsibility could become yours.

**Background:** The American Taxpayer Relief Act of 2012 gave Medicare beneficiaries limitation of liability protections, starting Jan. 1, 2013, for therapy services that don't qualify for an exception to the therapy caps.

"At that point it was mandated that the therapist issue an ABN prior to delivering services over the cap, if there is no qualifying exception, to transfer financial liability to the patient," says **Mary R. Daulong, PT, CHC, CHP**, president and CEO of Business and Clinical Management Services, Inc., in Spring, Tx.

**More details:** The ABN has always been mandated when a particular service, that would otherwise be covered, is likely to be denied due to lack of medical necessity. Therapy services over the cap did not originally require an ABN because they were statutorily excluded as a Medicare benefit, Daulong explains. After March of 2009, the Centers for Medicare and Medicaid Services (CMS) only recommended the ABN for advising patients of financial liability for therapy services when a cap exception could not be justified. Now the rules have tightened.

Use the ABN ☐ But Don't Go Overboard

CMS released new ABN clarifications, in light of the new limitations of liability protections.

Basically, you must issue an ABN to patients before providing any service that is not medically reasonable and necessary whether above or below the therapy caps. Then, if you file a claim, you must append a GA modifier (Waiver of liability statement issued as required by payer policy, individual case). This is a change from the past, when you previously appended 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) to signify that an ABN has been provided.

**The kicker:** If Medicare denies the claim, without a signed ABN and GA modifier, financial liability falls on you, the provider.

Do not, however, issue an ABN just because the patient exceeds the cap.

"CMS prohibits therapists from routinely providing blanket or generic ABNs," Daulong points out. "Unless there is a specific, identifiable reason to believe Medicare will not pay for services, bill for them with the KX modifier (Requirements specified in the medical policy have been met)."

"Attaching a KX modifier automatically attests that the claim is medically necessary," explains **Rick Gawenda, PT**, president and CEO of Gawenda Seminars and Consulting. So, issuing an ABN at the same time you submit the claim with modifier KX would be contradictory.

**This still stands:** "An ABN is not required to transfer financial liability to the patient when the services are never covered by Medicare, such as accent reduction services," notes **Mark Kander**, director of health care regulatory analysis for the American Speech-Language-Hearing Association. In these cases, you can use a voluntary ABN or

alternative notice as a courtesy, he explains.

**Safeguards:** Whether the patient is above or below the cap, solid documentation supporting medical necessity is key, according to Gawenda. "Outcome tools can also help support a patient's progress and why you are choosing to continue therapy," he says. "If you encounter a denial and for a claim with a KX modifier, then you can appeal the claim."

To view CMS' ABN clarifications and to read examples of appropriate situations for issuing an ABN, see <http://tinyurl.com/aefym8p>.