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Health Information Compliance Alert

Advanced Beneficiary Notice: Analyze Your ABN Know-How With This 3 Part Challenge

Confused by modifiers GA, GY, and GZ? Here are your solutions.

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 quiz to see whether you can determine how to deal with the following scenarios.

Patient Didn't Understand ABN

Question 1: We have a patient who came for her yearly well-woman exam and signed an advance beneficiary notice. As we suspected, her Medicare carrier won't pay for the services because these visits are only covered once every two years. Now the patient is saying she didn't understand what the ABN meant and is refusing to pay. What should I do?

Answer 1: The patient must pay. An ABN is a written notice a provider gives a Medicare beneficiary before furnishing items or services when the provider thinks 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 she may have to pay for out of pocket or through other insurance.

Mistake: 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.

Notice: According to Medicare's Web site, you should give this information to the patient before you take her back to the room.

Avoid These Improper Circumstances

Question 2: What circumstances should you consider an ABN improperly issued?

Answer 2: 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.

Your failure to provide a proper ABN in situations when you need one you 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.

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 procedure code when you think Medicare won't cover the service and you have a signed ABN. When Medicare sees modifier GA, it will send an explanation of benefits (EOB) to the patient confirming that she is responsible for payment. If you don't append the

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modifier, Medicare will not inform the patient of her responsibility.

Example: A patient with breast cancer sees her oncologist, who suggests that she have a hysterectomy. You know that Medicare only pays for surgery that is medically indicated to restore normal function and that you'll have an uphill battle with it for this diagnosis. You have peer-reviewed articles at the ready, however, to help you get it covered.

Because you are unsure if Medicare will cover the procedure, you ask the patient to sign an ABN. The ABN outlines the service the surgeon will provide (a laparoscopic-assisted transvaginal hysterectomy) and the reason Medicare may reject payment (not on the list of covered diagnoses).

The surgeon performs the hysterectomy, and you report the service using a laparoscopic-assisted transvaginal hysterectomy code (58550-58554, depending on the weight of the uterus and whether the ob-gyn removes the tubes and ovaries) with modifier GA appended. In this case, because the breast cancer diagnosis doesn't support the hysterectomy's medical necessity, Medicare denies the claim and sends the patient an EOB.

Second, when you know Medicare never covers a service, you should report the appropriate CPT code for the ob-gyn's services appended with modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit). Medicare will generate a denial notice for the claim, which the patient may use to seek payment from secondary insurance. For instance, the ob-gyn provides a preventive medicine service to the patient and bills 99387-GY to Medicare to get a denial so her secondary insurance will pay.

Finally, if you believe 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 non-covered service the physician provided.

Experts say 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. 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 to www.cms.hhs.gov/manuals/downloads/clm104c30.pdf.

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