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# Optometry Coding & Billing Alert

## News You Can Use: Eliminate NEMB Jumble With New ABN

Update now if you-re not already using the revised form for refractions

If your practice is like most optometry offices, every day you perform services, like refractions, that Medicare does not cover. If you-ve never quite understood when you should provide a patient with an ABN rather than an NEMB for a noncovered service, CMS has just made your life easier.

Medicare has unveiled its new advance beneficiary notice. This new form not only replaces the previous advance beneficiary notice (ABN-G for physician services) 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 old way:** Previously, you would use an ABN only for procedures that Medicare might not cover. The ABN did not apply to procedures that CMS statutorily excluded from Medicare benefits -- that's where the NEMB came in.

**The new way:** Now, CMS will accept the new ABN form for either a "potentially noncovered" service or for a statutorily excluded service. "The revised version of the ABN may also be used to provide voluntary notification of financial liability," CMS says.

**Get ready for the change now:** Medicare carriers began accepting the new ABN on March 3, but CMS has implemented a six-month transition period. Although you aren't required to submit the new form until Sept. 1, you may find making the change immediately a little easier.

**How to get it:** You can view a sample copy of the revised ABN, as well as CMS- complete instructions for implementing and using the form, on the CMS Web site at http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp.

Although the ABN form has changed, many previous ABN "best practices" remain (mostly) the same. Here are four guidelines to follow anytime you use the form.

1. Provide the ABN Up-Front

If you discover that Medicare won't pay for a patient's upcoming procedure but the patient still wants you to perform the service, the ABN will inform the patient that he may be responsible for paying the noncovered portion.

ABNs help patients decide whether they want to proceed with a service even though they might have to pay. A signed ABN ensures that the physician will receive payment directly from the patient if Medicare won't pay. Without a valid ABN, you cannot hold a Medicare patient responsible for denied charges, says **Kara Hawes, CPC-A,** with Advanced Professional Billing in Tulsa, Okla.

"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."

2. 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 service or procedure in question; 2) cancel the service or procedure; or 3) reschedule the procedure or service for a future date when he can afford it, or when Medicare may cover the procedure.

3. Give the Patient an Estimate

"Medicare is going to require that the estimated cost be included on the form starting in September. That's a big change," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-OBGYN, CPC-CARDIO,** manager of compliance education for the University of Washington Physicians and Children's University Medical Group Compliance Program.

4. Apply Modifiers to Explain ABN Status

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.

"You should use modifier GA (Waiver of liability statement on file) when the service provider believes the service is not covered and the office has a signed ABN on file," says **Dena Rumisek,** practice biller in Grand Rapids, Mich. This might include tests ordered without a payable diagnosis code or ordered more frequently than covered.

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) applies when Medicare excludes the service and you-re using the new ABN as you previously would have used the NEMB.

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 when Medicare denies the service.