Eli's Rehab Report

Outpatient Outlook: Forget the ABN and YOU Could Foot Your Patient's Therapy Bill

But take care not to use an ABN with a KX modifier.

If you haven't heard the latest on the Advance Beneficiary Notice (ABN), get in the loop now. A denied claim that was once your patient's financial responsibility could become yours.

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 & CEO of **Business & Clinical Management Services, Inc.** in Spring, TX.

Flashback: 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 recalls. After March of 2009, the **Centers for Medicare & 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, But Don't Overuse the ABN

CMS released new ABN clarifications, in light of the new limitations of liability protections. In summary, 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 (no longer a GY modifier) 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".

"Attaching a KX modifier automatically attests that the claim is medically necessary," explains **Rick Gawenda, PT,** president & CEO of **Gawenda Seminars & Consulting**. So, issuing an ABN at the same time 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, Gawenda says. "Outcome tools can also help support a patient's progress and why you are choosing to continue therapy." If you encounter a denial and for a claim with a KX modifier, then you can appeal the claim, he adds.

To view CMS' ABN clarifications and to read examples of appropriate situations for issuing an ABN, see

http://tinyurl.com/aefym8p.