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BY AAPC

Eli's Rehab Report

READER QUESTIONS: Absolutely Get That ABN or Face a Failed Appeal

Question: We recently performed biofeedback training and reported 90911. The insurer denied our claim and stated that we exceeded frequency guidelines. But the patient insisted that we perform just one more session (over and above the insurer's recommendations) because she felt that we were close to fixing her incontinence problem. Should we appeal?

Wisconsin Subscriber

Answer: You can certainly appeal the claim, but your chances of collecting may be slim unless you asked the patient to sign an advance beneficiary notice (ABN) before you performed her final biofeedback service.

Insurance carriers publish varying frequency limits for 90911 (Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry), but most carriers limit biofeedback sessions to six treatments over a four-week period, or variations of that. In the future, if you know that your carrier only allows a limited number of biofeedback treatments, but your patient insists on additional treatment sessions, ask her to sign an ABN and advise her that she might have to pay you the amount due for the session.

Because you already performed the service and the insurer denied it, you should appeal the claim with a letter indicating why the additional session was medically necessary. If you think that the patient's condition would have regressed without the final session, you should submit your notes to that effect with your appeal.

Make sure that you linked an appropriate diagnosis code to your biofeedback training claim. Acceptable diagnoses for 90911 vary among payers, but most include 625.6 (Stress incontinence, female), 788.32 (Stress incontinence, male) and 788.30 (Urinary incontinence, unspecified), among others. Make sure you use the diagnosis your provider documents.

Remember: You only have 120 days to request the first level of appeals when dealing with Medicare payers.