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Pain Management Coding Alert

Compliance: Use These Pointers to Sharpen ABN Smarts

Remember modifiers, or payer might forget about ABN.

At times, pain management practices need to use advance beneficiary notices (ABNs) - written notices 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.

Sounds like a mouthful, right? Well, once you know the basics, ABNs aren't so confusing.

Read on to make sure you know how to properly issue an ABN so you can submit clean claims to your Medicare payers and ensure a minimum amount of confusion with patients.

Know the Whats and Whens of ABNs

An ABN is a form that you should get a patient to sign when your practice performs a service that Medicare might not cover completely, or at all. You can bill the patient for the service if you have a signed ABN, but you must also append the correct modifier to the service when the claim is submitted, says **Lynn Radecky**, office manager in Franklin Lakes, New Jersey.

Specifics: According to **Steve Verno, CMBSI, CEMCS, CMSCS, CPM-MCS**, an independent medical coding and billing instructor in Yalaha, Florida, you must issue the ABN when:

- You believe Medicare may not pay for an item or service;
- Medicare usually covers the item or service, but it might not in this case; and
- Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.

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

Important: Your failure to provide a proper ABN in situations when you need one you may result in your practice being found liable.

Be Careful not to Improperly Issue ABNs

There are certain circumstances under which an ABN would be considered improperly issued. These include the following:

- 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.

In addition to improperly issued ABNs, "there are also instances where you are not required to issue an ABN, but it's not improper to do so," says **Cynthia A. Swanson, RN, CPC, CEMC, CHC, CPMA**, senior manager of healthcare consulting for Seim Johnson in Omaha, Nebraska.

"For services Medicare does not routinely cover - for example acupuncture services - an ABN is not required to be given to a Medicare beneficiary," continues Swanson. "Many practices do, however, provide ABN or related information to the

patient to advise the patient of their options for having the service and understanding any related financial obligations. "

Remember the Modifiers

You should append modifier GA (Waiver of liability statement issued as required by payer policy, individual case) to a procedure code when you think Medicare won't cover the service and you have a signed ABN. In this case, you are indicating that while the service is covered by Medicare, it may not be covered at the time of service due to timing or perhaps the diagnostic reason for doing it. When Medicare sees modifier GA, it will send an explanation of benefits (EOB) to the patient confirming that she is responsible for payment because in essence the patient has agreed to pay if Medicare denies. If you don't append the modifier, Medicare will not inform the patient of her responsibility.

Second, when you know Medicare never covers a service, you should report the appropriate CPT® code for the surgeon's services appended with 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) or GX (Notice of liability issued, voluntary under payer policy). Medicare will generate a denial notice for the claim, which the patient may use to seek payment from secondary insurance. You append GY if the patient has not signed an ABN for the noncovered service, but GX if they have.

Finally, if you believe that Medicare will reject your claim for a reason other than it not being a covered service 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 noncovered service the physician provided. 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, experts say.

"CMS has provided communications regarding the use of G modifiers. These modifiers are recommended to be used to help ensure the proper processing of the claim," says Swanson. "The G modifiers additionally allow Medicare to provide the applicable Medicare remittance advice notice comments and corresponding patient financial responsibility or provider responsibility information."