



# Don't Give It Away

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**In today's environment it is hard enough to collect money from the payers, much less the patients, for services your clients render. Physician practices should not make this task any harder by giving away free services to Medicare patients because they are non-covered services.**

An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice that the provider gives to the patient when the provider believes that Medicare will deny payment for a service because it is not medically necessary. The ABN gives the patient the opportunity to choose whether to receive the service. If the patient chooses to receive the service and Medicare does not pay, the patient is responsible for payment. On the other hand, if the provider does not give the patient an ABN, the provider cannot bill the patient for any services that are denied by Medicare due to medical necessity.

Proper use of ABNs is very important and impacts many specialties. Many imaging facilities and radiologists experience high rates of medical necessity denials related to imaging exams that were performed for non-covered diagnoses. Other examples of procedures that are typically denied coverage by Medicare are preventive and cosmetic services.

## Uses for ABNs

ABNs are used by a variety of healthcare providers, including physicians, hospitals, independent diagnostic testing facilities (IDTFs), and others. The ABN is used for patients enrolled in traditional Medicare. CMS has instructed that the ABN should not be used for Medicare Advantage (Medicare managed care) patients. Also, unless the payer instructs otherwise, an ABN should not be issued to a non-Medicare patient.

ABNs must be issued on the official CMS ABN form (CMS-R-131). Homemade ABN forms were permitted in the past but are no longer allowed. The form is available in both English and Spanish. The ABN form and instructions for its use can be downloaded from the CMS website at [www.cms.gov/bni](http://www.cms.gov/bni).

ABNs can also be issued for services that are excluded from Medicare coverage by law. Examples of these statutorily excluded services include routine physical exams, most screening tests (other than covered tests like screening mammograms), cosmetic services, routine dental and vision services, etc.

Providers are not required to issue ABNs for statutorily excluded services. Every beneficiary has already been notified at the time of Medicare enrollment that these services will not be covered. However, providers are permitted to issue an ABN for a statutorily excluded service on a voluntary basis, to remind the patient that Medicare will not pay. By using the ABN, the provider can make sure the patient understands that the service will need to be paid out of pocket or by a secondary payer.

## Inappropriate Uses of ABNs

An ABN should not be issued if the provider does not have a specific reason to believe the service will be denied. Providers are not permitted to issue "blanket" ABNs to all of their Medicare patients. However, ABNs can be issued to all patients who are receiving services with frequency limitations, like screening mammograms and Pap smears, because there is no way to know for certain when the patient had her last exam.

An ABN cannot be issued after the exam has already been performed, or when the patient has already been prepped and is about to begin the exam. The ABN must be provided far enough in advance that the patient has time to consider the options.

An ABN cannot be used to make the patient pay for a bundled service. Payment for the bundled service is already included in the Medicare payment for another associated service, so the provider cannot collect an additional payment. For example, it would be inappropriate to ask a patient to sign an ABN for intravenous injection of a radiopharmaceutical (code 96374) for a diagnostic nuclear medicine exam, since the injection is included in the code for the diagnostic study.

An ABN cannot be issued in an emergency situation. However, an ABN can be issued for a service provided to an emergency department patient, provided that the patient is stable.

Finally, a patient cannot be asked to sign an ABN if the patient is unable to read and understand the form. For example, ABNs should not be given to patients who are blind, illiterate, or demented.

## Shared ABNs

Any facility (hospital, clinic, etc.) can issue an ABN that covers both the technical component and the professional component of a non-covered service. For example, (*continued on next page*)

a hospital can issue an ABN that also covers the radiologist, pathologist, etc., even though the physician's professional services are not billed by the hospital. In this situation the physician's contact information should be included on the ABN. Also, an ABN can be issued by the referring physician if the physician is aware that the service for which he is referring the patient is likely to be non-covered.

### Completion of the ABN

The CMS website contains detailed instructions for completing the ABN. Please review those instructions for complete information.

The provider must enter in field E (Reason Medicare May Not

options listed on the ABN. The provider may never choose an option for the patient. It is a serious compliance violation to ask a patient to sign an ABN with a choice already checked.

The ABN can be signed by the Medicare beneficiary or his representative. CMS defines a **representative** as "an individual who may make health care and financial decisions on a beneficiary's behalf." Examples include a person who holds a durable medical power of attorney for the patient, or the patient's guardian.

If the patient or representative refuses to choose an option and/or refuses to sign, the provider should make a note of this on the original copy of the ABN. The provider must give a copy of the annotated form to the patient or representative. According

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The ABN must be **provided far enough in advance** that the patient has time to consider the options.

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Pay) the reason why the service may not be covered. Three common examples are:

1. Medicare does not pay for this test for your condition.
2. Medicare does not pay for this test as often as this (denied as too frequent).
3. Medicare does not pay for experimental or research use tests.

Reason #1 is appropriate for a patient whose diagnosis is not covered under the Medicare LCD for a diagnostic exam. Reason #2 is appropriate for a service with frequency limitations, like a screening mammogram or glaucoma screening.

The ABN gives the patient three choices:

- **Option 1:** The patient wants to receive the service and also wants the service to be submitted to Medicare. The provider may collect payment from the patient at the time of service, but if Medicare decides to pay, the patient's payment must be refunded.
- **Option 2:** The patient wants to receive the service but does not want it to be submitted to Medicare. The provider is not required to submit a claim when this option is selected.
- **Option 3:** The patient does not want the service.

These are the only three choices. The patient cannot choose to have the service but not pay for it.

The patient or representative must choose one of the three

to CMS, the provider should consider not performing the service unless the consequences would be such that refusal is not an option (for example, possible risk to the patient or possible civil liability for the provider if the service is not performed).

The patient or representative must be given a copy of the signed ABN form. The provider must keep the original ABN or a legible copy on file for five years or longer if required by state law. All ABNs must be retained, even if the patient decided not to have the service or refused to sign.

If the ABN is obtained by a provider other than the billing provider, a copy of the signed ABN must be furnished to the billing provider. For example, if a hospital obtains an ABN that also covers the radiologist, the hospital must provide a copy of the ABN to the radiologist.

### Billing Modifiers

Obtaining the signed ABN is only the first step in the process. The billing company must submit the proper modifier on the claim or it is as if the ABN was never obtained.

#### MODIFIER GA

Providers are to report modifier GA (Waiver of liability statement issued as required by payer policy) on the claim when:

- The provider has issued an ABN because the provider believes the service will be denied as not medically necessary

- The patient has signed the ABN
- The patient has requested the service to be submitted to Medicare (option 1)

Modifier GA should not be applied when the provider voluntarily issues an ABN for a statutorily excluded service (for example, a calcium scoring test in a patient without signs or symptoms of heart disease).

When a hospital or physician claim with modifier GA is denied as not medically necessary, the patient's explanation of benefits will indicate that the patient is financially responsible because he received advance notice of non-coverage. The patient has the right to appeal the coverage decision.

When the patient has accepted financial responsibility by signing an ABN, the provider is allowed to bill the patient for the provider's usual charge for the service. The provider is not limited to collecting only the Medicare allowable from the patient, although some providers choose to do so.

#### MODIFIER GX

Effective April 1, 2010, providers should use modifier GX (Notice of liability issued, voluntary under payer policy) when they voluntarily issue an ABN for a service that is statutorily excluded from Medicare coverage (for example, a routine or screening exam other than those covered by the Medicare preventive benefit). Medicare will automatically deny services submitted with modifier GX.

Providers can submit modifier GX together with modifier GY. Modifier GX indicates that the patient signed an ABN, and modifier GY indicates that the service is not a Medicare benefit.

#### MODIFIER GY

Providers should not normally submit claims to Medicare for services that are statutorily excluded from Medicare coverage (for example, routine screening exams other than those covered by

Medicare) or services that are not a Medicare benefit. However, the patient may ask the provider to submit a claim for such a service by checking option #1 on the ABN. The patient may choose this option because he or she needs a Medicare denial in order to obtain payment for the service from a secondary payer.

These services should be submitted with modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit). This applies even if the provider did not issue an ABN for the service.

Services submitted with modifier GY will be automatically denied.

#### MODIFIER GZ

A provider may not realize that a service does not meet Medicare medical necessity criteria until after the service has been performed. For example, scheduling staff may forget to check the Medicare LCD until after the exam has been completed. An ABN can be obtained only prior to the service. Once the exam has been done, it is too late. In this situation the claim should be submitted to Medicare with modifier GZ (Item or service expected to be denied as not reasonable and necessary).

Modifier GZ tells the Medicare contractor that the provider knows the exam is likely to be non-covered, but an ABN was not obtained. Claims submitted with modifier GZ will be evaluated by the Medicare contractor on an individual basis. If the service is denied, the patient's explanation of Medicare benefits will indicate that the patient is not financially responsible for the service. The provider cannot bill the patient for the service in this situation.

Detailed instructions for the use of ABNs are available on the Beneficiary Notice Initiative page of the CMS website ([www.cms.gov/bni](http://www.cms.gov/bni)). All of this information should be carefully reviewed to ensure compliance with Medicare requirements. ■

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