

Revenue Cycle Strategist



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Coding Q&A

By Jennifer Swindle, RHIT, CCS-P

When is it necessary to obtain an advance beneficiary notice (ABN) from a Medicare beneficiary? What must an ABN include to be valid, and how do you report it for accurate processing by CMS?

A: An ABN should be obtained from a Medicare beneficiary when you believe a planned service may not be covered by Medicare for a specific reason, such as it does not meet medical necessity requirements or it falls outside the normal frequency limits for the service. To be valid, the ABN must specify a particular patient, a particular test or service, and a particular reason why it may not be covered. "Blanket" ABNs obtained from all patients for a particular service are not appropriate, nor are ABNs obtained "just in case" with no reason specified.

ABNs must be obtained using the standard government form CMS-R-131. To be valid, this form must be completed prior to the service being

rendered. However, it may not be obtained while the patient is under duress, such as in need of emergency treatment. It must indicate the particular service that may not be covered, why it may not be covered, and the estimated cost to the patient if it is not covered. This information allows the patient to make an informed decision on whether to proceed.

When an accurate and appropriate ABN is obtained, the claim should be submitted with a GA modifier, which shows that the ABN was completed. The GA modifier will not automatically cause Medicare to deny a claim. However, if the claim is denied, the GA modifier will allow the provider to submit the claim as "patient responsibility." A GA modifier is not needed for services that are statutorily excluded from coverage, as these services are never paid. However, you may still file a Medicare claim to obtain a denial on a noncovered service, which the beneficiary may need to file a claim with a secondary

insurer. In these cases, a GY modifier should be attached. This modifier indicates to Medicare that you know the service is excluded, but you need a denial.

If a service has limitations and an ABN should have been obtained but was not, modifier GZ should be attached. This modifier indicates you understand that the service may be denied but you did not obtain an ABN. The reason may be due to a patient refusing to sign an ABN, or because a service was provided in an emergency where it was not permissible to obtain an ABN. In most cases, the provider will be held financially responsible for these claims, but adding the GZ modifier may avoid a potential violation of billing rules.

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