Physicians' FAQ for Medicare Compliance Issues

ABN's

What is an ABN?
ABN is the acronym for Advance Beneficiary Notice. The ABN is a mechanism devised by HCFA almost 10 years ago to protect beneficiaries from receiving and being billed for services that are not covered by Medicare, without the beneficiary being warned that they may be liable for the charges.

What is a local medical review policy (LMRP)?
Medicare does not pay for screening or routine tests. They only pay for tests used for treatment and diagnosis of disease. Since many tests can be used in either case, HCFA needed a way to define screening versus diagnostic use of these tests. The LMRP defines the Medicare approved use of a test by specifically indicating what clinical circumstances justify the use of the test. These policies contain a list of ICD-9 codes that the Carrier or Fiscal Intermediary (FI) will accept for payment. The diagnosis information must be included on the claim form. Everything else is considered not "reasonable and necessary" use of the test and the claims are rejected as not being medically necessary. LMRPs are usually developed by the Carrier Advisory Committees and can be different from state to state, carrier to carrier. Because of the Balanced Budget Act of 1997 however, a national list is being discussed to decrease variation from state to state.

What is a limited coverage test?
A limited coverage test is a test that has a published LMRP. There are about 20 of them in Utah at the present time.

How do I know when to get an ABN and when not to?
A provider should only use an ABN when there is reason to believe that payment for a test will be denied. Some common examples are:

* The physician wants to order a limited coverage test but does not have a diagnosis that fits within the LMRP.
- A patient wants to have a limited coverage test done but does not have signs, symptoms or clinical history that fits the LMRP for the test.
- A physician wants to order a test that is not FDA approved. Medicare does not pay for non FDA approved tests.
- Limited coverage tests are ordered as part of a routine physical examination.
- The physician is screening for disease.

Who is the best person to talk to the patient about the ABN?
The physician is the best person. Only she or he knows why the test is being ordered even though it is outside of the Medicare guidelines. The physician can explain to the patient why she or he thinks they need the test done. Informed consent to allow the patient to make a choice about having a test done is one of the purposes of the ABN. The reason for testing can come only from the physician ordering the test. Once the patient reaches the laboratory, the only information we can give them is that they are most likely going to get billed if they have the test done. The laboratory should not speculate on why a physician ordered a test (such as saying this is a screening test) unless the physician has stated that on the requisition.

I have my own lab in my office. Do these ABNs and limited coverage test issues apply to that lab also?
Yes. The same rules and cautions apply to testing performed in your office and billed through your practice.

What are the consequences of not doing these ABNs or giving ICD-9 codes to my in office lab for my in-office testing?
Your laboratory will not be able to get paid for the testing it is doing. They will receive denials from Medicare. If there is no ABN signed by the patient, the laboratory will have to write off the charges. If the ABNs are not properly used (i.e. routine or blanket ABNs are used etc.), the provider may have to refund money to Medicare beneficiaries. <u>Just as you can't run your practice if you don't get paid for your services, the laboratories cannot keep financially viable by writing off a large portion of their work due to a lack of an ABN.</u>

MEDICAL NECESSITY

When the government says a test must be "medically necessary," what does that mean?
The government's interpretation of medical necessity is based on language contained in the Social Security Act rather than a clinical definition. That means it is a test necessary for the diagnosis and/or treatment of disease. It means that the test is essential to diagnosing and/or treating the patient for the reason the patient is seeing the physician at the time the test is ordered. Routine tests and tests used to screen for disease in the absence of signs, symptoms or histories are not considered medically necessary by Medicare.

How does Medicare determine if a test is medically necessary?
The inclusion of the ICD-9 diagnosis code on the claim form (HCFA 1500 or UB 92) tells the Medicare Carrier or FI the medical reason or justification for the test.

Am I required by law to provide an ICD-9 code or diagnosis narrative to the laboratory for every test that I order to establish the medical necessity?
The Balanced Budget Act of 1997 (BBA) requires an ordering physician to provide diagnosis information to the laboratory when he or she is ordering a test for which that information is required for payment by the Medicare Program. That essentially covers any test for which an LMRP has been published.

Why does the laboratory ask me to provide ICD-9 codes or diagnosis information for all tests that I order when it is not required by law beyond the LMRP tests?
HCFA gives the Carriers and FIs a lot of flexibility in the area of medical necessity requirements and in many cases the local Carrier or FI is requiring the laboratory to include an ICD-9 code on the claim for all laboratory claims submitted. There is an imitative at HCFA to use its computers to verify the medical necessity of orders in an attempt to determine whether the claims submitted by labs reflect the physician's actual orders and documentation. Some Carriers and FIs are actually starting to cross reference lab claims to physician claims for the same date of service as a means to monitor this. In this case it is necessary for the lab claim to contain diagnosis information. Beyond the Medicare Program requirements, many managed care companies require the inclusion of ICD-9 codes on the lab claim submissions.

I'm a small physician office with few Medicare patients. How concerned should I be with these issues?
Medicare monitors these problems through analysis of claims information. Screens and edits are set up in their computer systems to detect certain patterns of test ordering, , diagnosis codes used and other issues. The computer does not discriminate based on size of the provider, number of claims submitted or anything else. If violations of the edits occur, they are flagged for review by a person. If there seems to be a problem, you could be audited, regardless of your size. Because it is computer monitored, even a small provider can be detected. Regardless of your size, these issues should be taken seriously and attention should be given to your Medicare billing and coding practices to insure you are in compliance with all rules and regulations.

What documentation am I responsible to keep and how long must I keep it?
Most actions being taken against providers today are under the provisions of the False Claim Act. This act has a statute of limitations of six years. In order to be able to defend yourself and your actions, it is appropriate to keep records associated with the ordering, billing and results of testing for six years. In Utah all medical records must be retained for seven years as result of a state law. In a Medicare audit of the laboratory they can request the medical necessity justification for the laboratory testing that resides in the patient's chart. The physician is a part of the laboratory Medicare audit, because that is where the laboratory test order originated.

For more information about medical necessity you can reread the Utah Medicare Carrier's Medicare Updates. The following issues may be useful to enhance your understanding of Medicare medical necessity regulations.

Issue	Topic
July 1997, Issue 97:05	Advance Notice Form, pg. 47
Nov. 1997, Issue 98:01	Waiver of liability pg. 5
Jan. 1998, Issue 98:02	Medically reasonable and necessary pg. 13
March 1998, Issue 98:03	Diagnostic information required of the ordering physician pg. 7
Nov. 1998, Issue 98:06	Waiver of liability and the GA modifier pg. 21