Blockchain for Beginners

Do you know what blockchain is?

Everyone has heard of blockchain, but not many people understand what it really is – myself included. I went looking for an approachable introduction to the technology and found this excellent **Wired video** (posted below) that describes blockchain for five different levels of understanding:

- Five Year Old
- Pre-Teen
- College Student
- Grad Student
- Expert (at about 10 minutes in if you want to skip ahead)

I found that listening to each segment helped me grasp the concept and increase my understanding as the levels progressed.

What does blockchain have to do with healthcare?

Although I found varying degrees of optimism about the blockchain's ability to solve healthcare's interoperability problem, I did find a wishlist on **happiest minds blog** that highlights some of the most promising uses for the technology.

Features of a "Health Wallet" Owned By Patients*

1. Block Chain contains the complete health and billing

history of the patient
2. The transaction is updated into the Block Chain only when there is consensus between the parties involved, and there is no option to update a previously written record
3. Patients permit the stakeholder to access the historical data, which is always in read-only mode; Patients will always know who had access to their data.

Benefits of a "Health Wallet" Owned by Patients*

1. Comprehensive and trusted view of the Patient record
2. Could avoid any new integration system to be created to communicate to different systems
3. Administrative task and claims can be made easier

*Parents, Families, Caregivers, Guardians

Other possibilities suggested by posts on **HealthITAnalytics:**

Diagnosis Mistakes

> *"…The patient could be put in complete control of who accesses the record and who can make changes. The patient could monitor the accuracy of edits such as new diagnoses, or even limit which providers are allowed to access sensitive information such as mental health data."*

Access to Sensitive Information

> *"Patients could receive automated notifications when a party asks permission to access a certain piece of data or requests a change, giving individuals more control over how, when, and for what purpose their data is shared."*

Universal Credentialing Relief

> *"Blockchain would allow a provider to make his or her current certificate of attestation of licensure available on the blockchain, where organizations can query for the data and ensure that it is trustworthy and up to date."*

Care Coordination

> *"…Chilmark Research envisions that blockchain could improve care coordination by connecting patient data across multiple providers, or simplify the process of revenue cycle management by strengthening bonds within provider networks, streamlining the eligibility verification process, and automating claims adjudication."*

Medication Mistakes and Prescription Fraud

> *"If one provider writes a prescription that is identical to the recommendations of another clinician, the blockchain could flag the duplication and prevent the patient from doubling up on the same medication."*

How to Ask for Advice

A question I recently answered on Quora was:

How would you go about asking a business professional that you admire, for advice on starting up a business?

My answer could just as easily apply to asking someone to mentor you.

Here's what I said:

Asking someone for advice means you have to adhere to their timeline – meet or talk when they can meet or talk. Offer them email questions as an alternative.

Treat them, if they are willing, to a meal or beverage – breakfast, coffee, lunch, drinks, or dinner and don't be cheap about it if you pick the place.

If you want to stand out, **write them a letter** to ask for their time to give you advice. When meeting, take notes. After the meeting, call or email or write to them to thank them for their time.

Don't make the meeting or call all about you. Ask questions about them, not just what they can share about your situation.

Don't think of this connection as a one-time thing. It could potentially grow into a professional relationship that benefits both parties. You are just starting our and willing to learn, they are willing to share – how can you help each other?

New Medicare Card and Reason Code N793

If you've seen new reason code N793 on your Medicare remittance advice lately and wonder what it is, you now know it relates to the new Medicare card.

The description for N793 is:

> ***Alert:** CMS is changing from the Medicare Health Insurance Claim Number (HICN aka "hickin") to the new Medicare Beneficiary Identifier (MBI). You can use either the HICN or MBI during this transition period.*

You've probably been bombarded with Medicare news releases and Open Door Forums describing the change and the timeline, but if not, here are some helpful links:

CMS Page on the New Card **here.**

FAQs updated April 4th **here.**

Signs and widgets for your office and website **here.**

Timeline for state by state rollout **here.** (Hint: most states are described only as "After June 2018")

Electronic Remittance Advice Example **here.**

Important Dates for the New Medicare Card

- Transition Period ends December 31, 2019.
- CMS accepts MBIs only regardless of the date of service January 1, 2020

Webinar: Reduce Costly Patient No-Shows

There are a million reasons a patient no-shows for an appointment, or calls right before their scheduled appointment to cancel. Some of the reasons are unavoidable, but all of them cost you money.

Regardless of your specialty, location or patient population, no-shows and late cancels are a costly nightmare. They can lead to revenue losses for your practice of hundreds of thousands of dollars a year – not to mention the management, scheduling, and patient care challenges they cause.

Researching online how to best resolve patient no-shows and late cancels will make your head spin. You'll find thousands of recommendations, with no idea if you can trust the source. The best way to combat this costly problem is to get advice from a leading practice management expert like **– me!**

> ***BONUS!*** *As a reader of Manage My Practice, use this code to get 10% off the webinar price:* ***MANAGEMYPRACTICE10OFF***

On **Wednesday, April 11th at 1pm ET**, during a 60-minute online training session, you can receive my proven no-show and late cancel resolution tactics. I'll walk you through how you can reduce your no-show and late cancel rates, and stop the hemorrhage of revenue that occurs with them.

Here are just a few of the practical, step-by-step tactics you'll receive by attending this upcoming, 60-minute online training:

- Find out how much **money you're really losing** with proven measuring protocols
- Uncover the **real reasons behind** patient no-shows and late cancels so you can fix them
- Tools to **create a no-show/late cancel policy** that will work
- Effectively **communicate** your no-show/late cancel policy to your patients
- Figure out how to **charge for no-shows and late cancels** and not lose patients
- Expert **scheduling strategies** to mitigate no-shows and late cancels and avoid revenue losses
- Track **benchmarks** and determine if your specialty has unique data to watch
- Identify **repeat offender** patient types and learn how to handle them
- Using your **website** to improve patient understanding of your policies
- Develop no-show and late-cancel **scripts for face-to-face/phone interaction** with patients
- Address **chronic late cancel/no-show patients** without losing them (if you don't want to)
- And so much more…

Who should attend? Anyone in a practice with an interest in reducing patient no-shows and late cancels should attend this expert-led online training. This includes, but isn't limited to: Practice/Clinic Managers, Administrators, Surgery Center Administrators, Front Desk Managers, Scheduling Managers, Providers, etc.

The AAPC has awarded 1 CEU for this 60-minute program.

Unfortunately, you're never going to be able to completely stop all patient no-shows and late cancels. However, there are proven techniques that will help you significantly get more of your patients to their appointments on time, and help you avoid the massive losses that no-shows and late cancels create.

Patient no-shows and late cancels is a chronic problem. A variety of sources report that they cost US physician practices approximately **$150 BILLION** a year. But you can seriously reduce your losses with the proven tactics you'll receive from this expert-led online training. **Don't wait, reserve your access today.**

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25 Principles for Adult Behavior in Healthcare

This month **John Perry Barlow** died.

Described by **Stephen Levy of Wired** as a "cowboy, poet, romantic, family man, philosopher, and ultimately, the bard of the digital revolution", Barlow penned a list he called the

“25 Principles of Adult Behavior,” as a series of instructions for life.

I see it as a series of turn signals and it inspired me to create the “25 Principles of Adult Behavior in Healthcare.”

I stole 9 of his principles (those in italics) and added a bunch of my own.

1. Don’t assume you know what a patient is going through.
2. Don’t think the patient owes you respect for caring for them.
3. Don’t think anyone owes you respect because you’re in charge.
4. Be patient with every patient. Be patient with everyone. *Be patient. No matter what.*
5. *Don’t badmouth: Assign responsibility, not blame.*
6. *Say nothing of another you wouldn’t say to him.*
7. Put nothing in writing that you are not willing to repeat in a court of law or have printed on the front of the local newspaper.
8. *Laugh at yourself frequently. Just laugh, but not at others.*
9. *Concern yourself with what is right rather than who is right.*
10. *Expect no more of anyone than you can deliver yourself.*
11. *Never forget that, no matter how certain, you might be wrong.*
12. *Praise at least as often as you disparage.*
13. *Admit your errors freely and soon.*
14. Knock before entering.
15. All people deserve dignity. Offer it.
16. Everyone is frightened in healthcare, even if they don’t act like it – patients and admins alike.
17. Leave it at the office.
18. Address patients and others by their formal titles until they give you permission to do otherwise.
19. Keep your hands away from your eyes, your nose and your

mouth regardless of what your job is.

20. Wash your hands frequently, regardless of what your job is.
21. Listen more than you talk. Especially listen to patients even if you are sure you know what they are going to say.
22. Let people finish their sentences and pause before answering.
23. Start conversations with questions. You might be surprised at what you learn.
24. If you're the boss: sit at every workstation in the office once every three months and observe.
25. Bring cookies to work once in awhile.

Photo Credit: eamoncurry123 Flickr via Compfight cc

Credit Card Signatures: Bye Bye

What follows is an article adapted from one published in the Infintech News January 30, 2018. Infintech is my **Credit Card on File** gateway and credit card processor for my consulting business. It is also a company I recommend to clients. I've been working with my rep, **Michael Gutlove** for 6 years implementing Credit Card on File in medical and dental practices, and can honestly say his customer service is unparalleled.

****

The rise of mobile payments such as Apple Pay and Google

Wallet have set the stage for consumers to have an improved shopping experience when purchasing goods or services. With the influx of convenient payment methods, credit cards companies are continually taken to task on improving overall purchasing practices.

The major credit card brands – MasterCard, Visa, American Express and Discover – have found a way to do just that. These brands recently announced that as of April 2018, **they will no longer require a signature on debit or credit card purchases**, so buyers can have a faster and more convenient shopping experience. This will also help reduce merchants' operating expenses associated with retaining these signatures.

Here is a quick recap of the statements from the card networks according to creditcards.com:

- **Mastercard**, which announced in October that it would make signatures optional in April, says more than 80 percent of the in-store transactions it processes now don't need a signature.
- **Discover** said on Dec. 6, that it, too, would abandon the signature requirement. "With the rise in new payment security capabilities, like chip technology and tokenization, the time is right to remove this step from the checkout experience," Discover's Jasma Ghai, vice president of global products innovation, says.
- **American Express** announced Dec. 11 that it will drop the signature requirement globally in April. "The payments landscape has evolved to the point where we can now eliminate this pain point for our merchants," said Jaromir Divilek, Executive Vice President, Global Network Business, American Express.
- **Visa** said in a blog post that it will make "the signature requirement optional for all EMV contact or contactless chip-enabled merchants in North America, beginning April 2018."

Credit Card Signatures No Longer Fight Fraud

In the past, signatures were perceived as an added layer of protection to prevent customers and merchants from fraudulent transactions. Initially, retail stores could use the signature on the receipt and match it to the signature on the back of the customer's card, but merchants rarely do this making the need for a signature less impactful. Although it isn't mandatory to collect a signature from a customer, merchants can still do so if they wish.

The need for signatures has also declined around the world due to many advancements in the payments industry such as contactless payment options, the global adoption of EMV chip technology and the ever-growing world of online commerce. According to pymnts.com, in the two years since EMV chip cards launched in the United States, fraud at the physical point of sale has declined by 66 percent. This is attributed to the deployment of EMV technology at the in-store point of sale and consumers' use of chip cards. Signatures as an added measure of authentication is unlikely to create risk for chip card transactions.

Credit Card Security Isn't Compromised

According to macrumors.com, credit card companies eliminating signatures for in-store transactions will not have any impact on customer security. In fact, security is better than ever due to the move towards a more digital payment world.

"Our secure network and state-of-the art systems combined with new digital payment methods that include chip, tokenization, biometrics, and specialized digital platforms use newer and more secure methods to prove identity," said Linda

Kirkpatrick, an Executive Vice President at Mastercard.

Both Merchants and Customers Are Okay with this Change

According to usatoday.com, Kirkpatrick says that "eliminating the need for signature is another step in the digital evolution of payments and payment security."

Since security is not an issue, both merchants and customers are looking forward to saying goodbye to signatures. Payments will become easier and more convenient, checkout lines will move faster and merchants will be able to push more customers through lines in a timely manner. It's a win-win for everyone.

Photo Credit: torbakhopper Flickr via Compfight cc

So You Want to Be a Practice Management Consultant?

I recently was asked how to start consulting in the medical practice management space. I love consulting, but it's not nearly as glamorous and freewheeling as it might look.

Don't Quit Your Day Job

Unless you have an amazing referral stream or money to put into marketing, you cannot expect to be able to support yourself initially. I consulted informally on the side for

years before starting my actual consulting practice, and after 6 years of pure consulting, I've gone back to having a day job managing a practice and consulting on the side.

Write Every Day

Consultants write reports. Every day. It's our product. If you don't write well or have trouble with spelling or grammar, get help. If you're not sure if you can write well, get help.

Consultants Have to Market Themselves

As an independent consultant you have to wear every hat. You have to:

- Market yourself.
- Get consulting agreements.
- Collect deposits.
- Consult and write a report on your findings and recommendations.
- Bill and collect your fee.

I started my blog in 2008 with the idea that I might someday leverage it into an income stream. I was told then, and believe it holds true today that producing good-quality content is the best form of advertisement for consultants. I get 90% of my business through my blog which ranks well because I've been writing faithfully for 10 years.

Independent Consultant Advice

- **Start or continue consulting** if opportunities are available and give more than you get in service and value to help build word-of-mouth. Get testimonials and clients willing to act as referrals.
- **Get a website.** Everyone who considers hiring you wants

to see that you are “real” and a website is one measure of real. If you teach yourself how to create a website, you will save money and not have to rely on anyone else to correct mistakes or publish a post when you want it published.

- **Develop your voice** by producing content for your website – don’t be afraid that by writing content you are giving away your secrets. Your secret sauce is who you are and the skill you bring to the table.
- **Troll listservs** for problems practices are talking about. Don’t be afraid to answer questions on listservs (your state MGMA listserv, for instance) and build your reputation as a go-to consultant.
- Make sure to **offer email subscriptions** to your website so you are pushing content to your audience.
- **Pay attention to what content does well** (Google Analytics is free) and adjust your writing appropriately.
- **Make one article or blog post work three times** – where else can you publish it? LinkedIn? Facebook? A practice management newsletter? Expand it into a white paper or eBook? A webinar?
- **Consider offering something for free** – a free 30-minute consultation is a great way to introduce potential clients to you.

Be a Consultant With a Firm

Many consultants “pay their dues” by joining an established consulting company for two or more years. This gives you great experience and can be great money, but you don’t get paid if there’s no work and the traveling is tough after awhile. You have to be a real road warrior to travel every Monday and Thursday and only be home on the weekends.

I am at the point in my consulting career that I don’t travel. Clients prefer the face-to-face, but once I point out how much

money I save them by not traveling to their location, they are fine with it. Put a recording or a video on your website to introduce yourself so potential clients can see and hear you and get a feel for who you are.

Blog Monetization

I've tried every possible way to monetize my blog (ads, products, sponsored content and campaigns, affiliate marketing) and once you have eyeballs on your site they will produce small income streams but not significant ones unless your website is drawing thousands of visitors per day. I even considered a paywall at one time, but after market research decided that practice managers and practices would not be willing to pay even a small amount per month for exclusive content.

Create a Product

Because medical practices – especially small and non-surgical/procedural practices – are really hurting financially you may want to develop products to sell as well as your time and expertise. One of my niches is implementing Credit Card on File. Practices may have the resources to implement the program themselves, so I also sell an Action Pack of templates and worksheets so they can DIY.

Develop Your Specialty

Think about your experience and skills, and research who is filling a niche that you'd like to develop. Do your homework and see if you can either emulate what they're doing, or provide something different or better. Think about how you can distinguish yourself in that niche and write, write, write about it so you can be found.

How to See Patients When the Physician Isn’t Credentialed Yet

Credentialing new physicians is the definition of Catch-22.

You can’t start the process too early as payers won’t accept the application (especially if the physician doesn’t have their malpractice in place), and by the time payers will accept the application to begin credentialing, the provider is already onboard and ready to see patients.

Credentialing typically takes 3 to 6 months and sometimes longer as insurance plans are not motivated to put more physicians on their networks and increase their payment exposure.

One of the strategies many practices employ is to bill for the new physician’s services as if an existing physician provided them, but you don’t want to do that. Ever.

You might get away with it, but the risk is too great.

First, if you are billing under an enrolled physician’s NPI as rendering and supervising, the enrolled physician’s utilization is going to spike – that’s a red flag.

Second, if a patient sees the enrolled physician’s name on their EOB, they might call the insurance plan and say “I never

saw that doctor.” Another red flag. Don’t forget that patients are increasingly attuned to the possibility of fraud, and they should be!

Third, a payer might request your appointment schedule, which will tell the tale of who actually saw the patient.

These red flags can trigger an audit – something to avoid at all costs.

What can you do while waiting for credentialing to be complete?

Ask for a Statement of Supervision

Some plans will officially let you bill under a supervising physician once the credentialing of the new physician is underway. Ask every plan if they will accept a Statement of Supervision from a physician enrolled in the plan, so the new physician can start seeing patients.

Divert Self-Pay and Medicare Patients to the New Physician

Physicians can see Medicare patients right away. Medicare will let physicians retro-bill back 30 days from the date their Medicare application was received at the Medicare Administrative Contractor’s (MAC’s) office. This is why I prefer to enroll physicians in Medicare the old fashioned way – on paper – because I can always prove the delivery with a Return Receipt Requested response. You won’t be able to bill until you get the “Welcome to Medicare” letter with the physician’s PTAN, but you will get paid.

Check With Medicaid

If you are enrolling the new physician in Medicaid, check on

your state's rules (each state is different). They are usually so hungry for physicians taking Medicaid that they will allow retro-billing as well.

Schedule Patient Meet and Greets

Offer complimentary Meet and Greets (no medical care provided) to potential patients who might want to see the new physician when credentialing is complete. This is not appropriate for every specialty, but works well for many.

Put the New Physician on the Speaking Circuit

If you can't fill the physician's schedule due to credentialing, get the physician out to meet other physicians and the community. Marketing a new physician is never a waste a time – make a plan long before the physician arrives to have speaking engagements set up – so many organizations are looking for free speakers! Contact TV, radio stations, newspapers and local magazines to see if they'd like to interview the new physician. Also connect the new physician with other new physicians starting around the same time – they'll often start to refer.

Work With Your Web Team

Have the physician write for your blog, or have your social media folks work with the physician to produce articles.

See Some Patients for Free

Sometimes it's worth it to see a patient for free to get the new practice moving along and to spread the good word!

Photo Credit: Diari La Veu Flickr via Compfight cc

Bad Online Reviews and How to Respond to Them

It is important to address **every** online review – good or bad – publicly so that others reading the review will know you are responsive to patient communication and concerns.

Here's How to Respond

Here are some simple steps to addressing a bad review, potentially resolving the patient's complaint and showing possible future patients how you deal with patient concerns.

Don't get bent out of shape.

As much as we want to think that we do the best we can for every patient, we do make mistakes. I spoke with a patient recently and told her the practice had failed to send her prescription in and she was dumbfounded. "You mean you are actually admitting you made a mistake?" she said "That's so refreshing." We will all make mistakes, and we all must own them.

Read it. Go away. Come back and read it again.

First blush reads can be deceiving because we are instantly on the defensive. All healthcare is under the microscope and we are all peddling so hard to keep up that it's easy to feel that we are doing everything we can and resent anyone who thinks we could do better. If you let it go for 24 hours, when you come back and read it a again, it could read differently and may be not as harsh as we originally perceived it to be.

Address the online review and include:

- An **apology** acknowledging that the patient was dissatisfied – regardless of the specifics or what you cautioned them about, you want patients to know you do not want them to be dissatisfied. This is not necessarily to admit that you did something "wrong", but that if the patient feels something went wrong, you want to acknowledge their feelings and address them. This is not the forum to say "we told you this might happen…"
- **Reassurance** that patient care is the top priority in your practice.
- An **invitation** to contact the practice administrator to discuss the issue in more detail and review if anything could have been done differently. Include a phone number and email.
- **Edit, edit, edit.** Write it, let it sit for awhile, and come back and see if it reads the way you want it to. Have others read it and give their opinions. Less is often more when responding to a bad review.

Keep a copy of the online review and your response

Share with employees at a staff meeting. Make it a customer service teaching moment.

Contact the Patient

If you know who wrote the online review, contact the patient with an offer to discuss over the phone or face-to-face.

Keep in mind that the most important thing is to take the public sting out of the review by responding in an open, calm and compassionate way.

Photo Credit: sergiosantos9 Flickr via Compfight cc

Getting Paid: Master the ABN Advance Beneficiary Notice

One of the most popular topics I've written about over the past 10 years, and the one I get the most email on, is the ins and outs of using the Medicare Advance Beneficiary Notice of Noncoverage – the ABN – also known as form CMS-R-131.

Why is getting an ABN so important?

The answer to this question is simple. If you supply a service to a Medicare patient and Medicare does not pay for it, you can only collect payment from the patient if you've communicated to the patient what the cost is and that the cost will be their responsibility AND the patient has agreed. If you routinely supply services to patients that Medicare does not cover and do not use the ABN, your practice will be missing income that is rightfully yours. Read on for more information on the appropriate times to issue ABNs for Medicare (and non-Medicare patients).

Why do practices find it difficult to use ABNs?

The ABN is a collection tool that many medical practices do not know how to implement. It is particularly difficult to determine who has ownership of this process, because the form must be completed and signed by the patient before the service is provided. The patient is in the exam room or the lab, ready for the service or test, and a knowledgeable staff

person must step in, explain the rules and pricing and obtain the patient's signature.

Which insurance plans require the ABN?

Although you can use the ABN for Medicare Advantage Plans (commercial insurance plans that offer Medicare replacement coverage) only original/traditional Medicare (sometimes referred to as the "red, white and blue card" Medicare) **REQUIRES** the ABN.

Commercial non-Medicare plans have also started asking physicians to issue ABNs when a service will not be covered by the plan and the patient will be paying for the service out-of-pocket. I've developed a non-Medicare ABN that you are welcome to have a copy of – just drop me an email (marypat@managemypractice.com) and request it. I think ABNs are not a bad idea at all to give to non-Medicare patients as it formalizes the process and drives home to the patient what the cost for something they ask for will be and that they've agreed to pay for it.

The ABN is not a replacement for a good financial policy

Please don't use a blanket ABN in place of a solid financial policy. Your financial policy should state that patients agree to be responsible for payments for services their plans don't cover. The ABN is meant for specific individual services or series of services that the insurance plan is not going to cover, not as a catch-all for whatever insurance does not pay for. **Note that the ABN is not meant to cover any dollars for which you are contractually obligated to write-off.**

What version of the ABN is current?

As of last summer (6/21/2017), there is an updated ABN. You should be using the one that has the date of 03/2020 in the

lower left-hand corner. In accordance with Section 504 of the Rehabilitation Act of 1973 (Section 504), the form has been revised to include language informing beneficiaries of their rights to CMS nondiscrimination practices and how to request the ABN in an alternative format if needed.

Copies of the current ABN are available in English and Spanish here.

Who uses the ABN?

The ABN is to be used by all providers, practitioners, and suppliers paid under **Medicare Part B**, as well as hospice providers and religious non-medical healthcare institutions (RNHCIs) paid exclusively under **Medicare Part A.** Since 2013, home health agencies (HHAs) providing care under Part A or Part B issue the ABN instead of the Home Health Advance Beneficiary Notice (HHABN) Option Box 1 to inform beneficiaries of potential liability. The HHABN has been discontinued.

When should the ABN be used?

The ABN's purpose is to allow the physician practice to collect from the patient for services that the patient wants but are not covered by Medicare. Practices are not expected to give ABNs to patients to cover services that are never covered (called statutory exclusions), however, many practices find that supplying this form to patients helps patients understand why they are responsible for the paying for the service. Practices may collect in full at time of service for services that are never covered by Medicare, but if you are not sure if Medicare will or will not pay, you may want to wait for Medicare to adjudicate the claim before collecting from the patient.

Note that the ABN must be completed and signed **BEFORE** providing the items or services that are the subject of the

notice.

Also note when the ABN is used as a voluntary notice (i.e. for statutory services), the beneficiary is not required to choose an option box or sign the notice.

The four broad categories of items and services not covered under Medicare are:

1. Services and supplies that are not medically reasonable and necessary
2. Non-covered items and services (statutory exclusions)
3. Services and supplies denied as bundled or included in the basic allowance of another service
4. Items and services reimbursable by other organizations or furnished without charge

The brochure that describes in-depth of what Medicare does not cover is available here.

Can you give an example of when to use an ABN?

A Medicare patient wants an EKG even though she does not have any symptoms or diagnoses that would point to an EKG being medically necessary. She is not in her first 12 months of Medicare coverage, therefore she does not qualify for an EKG as a part of her Welcome to Medicare Visit (not an exam.) She believes there may be something wrong with her heart, even though she cannot name any symptoms that would warrant a diagnostic EKG. In this case, without a diagnosis to support the EKG, an ABN would be appropriate. You would advise the patient that Medicare may not pay for the EKG, in fact probably won't pay for the EKG, and you complete the ABN, showing the patient what she will be paying out of pocket for the test. In the case of Medicare not covering the test, you may charge the patient your full rate for an EKG and are not restricted by the Medicare allowable. If the patient agrees to

have the test and signs the ABN stating she understands she will be responsible for the cost of the test if Medicare does not pay, you will provide the patient with a copy of the signed form and will will attach the completed form to the patient's encounter form or somehow note in the EMR that an ABN has been obtained so the EKG will be billed with the modifier "GA" which indicates an ABN was executed for a service that might not be covered by Medicare. In the case where a service is never covered (i.e. statutory exclusions) you may append a modifier "GY" to the service to indicate an ABN is on file.

The ABN can be scanned with the encounter form or any other financial paperwork from the visit so it can be retrieved if requested by Medicare during an audit. If you do not archive your paperwork electronically, you can file the ABNs alphabetically by patient name by month. You can also scan the ABN into your EMR if you choose.

What are statutory exclusions (services that are never covered) under Part B?

- Oral drugs and medicines from either a physician or a pharmacy. **Exceptions: oral cancer drugs, oral antiemetic cancer drugs and inhalation solutions.**
- Routine eyeglasses, eye examinations, and refractions for prescribing, fitting, or changing eye glasses. **Exceptions: post cataract surgery. Refer to benefits under DME prosthetic category.**
- Hearing aids and hearing evaluations for prescribing, fitting, or changing hearing aids.
- Routine dental services, including dentures.
- Routine foot care without evidence of a systemic condition.
- Injections which can be self-administered. **Exceptions: EPO, and clotting factors.**
- Naturopath's services.

- Nursing care on a full-time basis in the home and private duty nursing. (Refer to benefits under Medicare Part A).
- Services performed by immediate relatives or members of the household. Services payable under another government program.
- Services for which neither the patient nor another party on his or her behalf has a legal obligation to pay.
- Immunizations. **Exceptions: Influenza, Pneumovax and Hepatitis B.**
- Wheelchair van ambulance services.
- Cosmetic surgery.
- "Annual Physicals" best described by codes 99387 or 99397. This is a long discussion for another post, but note that Medicare does not pay for annual preventive EXAMINATIONS, although they pay for annual wellness visits, which are not physical examinations. They do, however, pay for screening pelvic and breast exams and pap test collection at specific intervals.

How do you complete the "Estimated Cost" Section F of the ABN?

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). CMS expects that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

For a service that costs $250:

- Any dollar estimate equal to or greater than $150
- "Between $150-300"

- “No more than $500”

For a service that costs $500:

- Any dollar estimate equal to or greater than $375
- “Between $400-600”
- “No more than $700”

What about estimating the costs for a series of services?

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices,but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

How do I use modifiers to indicate

the ABN is present?

The modifiers can be confusing! Focus on using the GA and GX modifiers as best practice.

GA Modifier – Waiver of Liability Statement Issued as Required by Payer Policy, Individual Case – ABN Needed and Obtained

Use this modifier to report that an advance written notice was provided to the beneficiary of the likelihood of denial of service as being not reasonable and necessary under Medicare guidelines.

- Report when you issue a mandatory ABN for service as required and is on file.
- You do not need to submit a copy of the ABN but it must be available upon request.
- The most common example of these situations would be services adjudicated under a Local Coverage Decision (LCD).
- The presence or absence of this modifier does not influence Medicare's determination for payment.
- Line item is submitted as covered and Medicare will make the determination for payment.
- If it's determined that the service is not payable, the claim denial is under "medical necessity denial."
- It is inappropriate to use the GA modifier when the provider/supplier has no expectation that an item or service will be denied.
- Do not use on a routine basis for all services performed by a provider/supplier.

GX Modifier – Notice of Liability Issued, Voluntary Under Payer Policy – No ABN Needed But Was Issued Nonetheless

Use this modifier to report when you issue a voluntary ABN for a service that Medicare never covers because it is statutorily excluded or is not a Medicare benefit.

- Line items submitted as non-covered will be denied as beneficiary liable.
- You may use this modifier in combination with the GY modifier.

GY Modifier – Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit – No ABN Needed and None Issued

Use this modifier to report that Medicare statutorily excludes the item or service or the item or service does not meet the definition of any Medicare benefit. Use this modifier to notify Medicare that you know this service is excluded.

- Services provided under statutory exclusion from the Medicare Program; the claim would deny whether or not the modifier is present on the claim.
- It is not necessary to provide the patient with an ABN for these situations.
- Situations excluded based on a section of the Social Security Act.
- Modifier GY will cause the claim to deny with the patient liable for the charges.
- Do not use on bundled procedure or on add-on codes.
- Line items submitted as non-covered and will be denied as Patient Responsibility
- You may use this modifier in combination with the GX

modifier.

GZ Modifier – Item or Service Expected to Be Denied as Not Reasonable and Necessary – ABN Needed But Not Obtained

Use this modifier to report when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

- This modifier is an informational modifier only.
- Medicare will adjudicate the service just like any other claim.
- If Medicare determines that the service is not payable, denial is under "medical necessity." The denial message will indicate that the patient is not responsible for payment.
- If either the beneficiary or provider requests a review, the modifier tells us an ABN was not given, and this could help in completing the review quickly.
- Medicare will auto-deny services submitted with a GZ modifier. The denial message indicates that the patient is not responsible for payment; deny provider liable.
- If either beneficiary or provider requests a review, the modifier tells us that an ABN was not given.

For in-depth instruction from Medicare on completing the ABN, click here.

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