Avoid Paying for Hospital’s Mistake: Get Right to Review Chargemaster

Radiology practices that offer services in hospitals often leave themselves vulnerable to potential billing and compliance problems. That’s because even if they handle their own billing for professional services, they’re dependent to some extent on the accuracy of the hospital’s chargemaster, says radiology coding and compliance expert Jackie Miller. An incorrect chargemaster can lead to improper coding or even billing for services that weren’t performed, Miller warns.

We’ll explain how problems can arise with the chargemaster and tell you why all practices that perform services in hospitals should get periodic access to their hospital’s chargemaster. And we’ll give you Model Language that you can insert into your contract with your hospital to get some protection from chargemaster problems. [RACRI8006]

How Hospital Chargemaster Can Cause Problems for You

The chargemaster (also known as a charge description master, or CDM) is the name for a utility file that translates the hospital’s internal charge code into a CPT or HCPCS code for billing, Miller explains. Typically a hospital creates its own chargemaster that’s unique to that facility, she adds. Because codes and coding rules change so frequently, chargemasters quickly become obsolete if not updated regularly. So anyone using hospital data for billing purposes runs the risk of errors if the hospital’s chargemaster has not been well maintained, Miller notes.

Obviously, hospital-based radiology practices that rely on the hospital to handle billing for them are most vulnerable to errors in the chargemaster, Miller remarks. Those practices should be sure that their contract with the hospital allows them access to data in the chargemaster and protects them from the hospital’s billing errors (see “Get Key Protections if You Delegate Billing Function to the Hospital,” Insider, June 2003, p. 8). But even practices that handle their own billing for professional services can get into trouble if a hospital chargemaster isn’t accurate or up-to-date, Miller explains.

Example: A radiology practice performs interventional services at the hospital, using the hospital’s equipment, but bills for its own professional services. The practice does a TIPS (transvenous intrahepatic portosystemic shunt) procedure on a hospital patient and submits a correct claim with CPT code 37182. But the hospital’s chargemaster has the charge code for TIPS linked to CPT code 37140, which is used for open (surgical) shunts, and the hospital submits this code for the technical service. If the payor catches the discrepancy, both the hospital and the radiology practice are like-
**GET RIGHT TO REVIEW CHARGEMASTER (continued from p. 1)**

ly to be asked to provide proof of the service they provided. Although the radiology practice did nothing wrong, the practice will have to cope with the administrative hassle of proving that it provided the services it billed for, Miller points out.

**OIG Concerned About Professional/Technical Component Discrepancies**

Having to prove to a payor that you’ve billed correctly, and the hospital hasn’t, isn’t the only risk associated with incorrect chargemasters, points out Virginia health care attorney Thomas W. Greeson. There are legal risks, too. In its work plans for the last several years, the OIG has repeatedly mentioned discrepancies between technical component and professional component billing as a concern, he notes. In Greeson’s opinion, obsolete or incorrect hospital chargemasters are frequently the cause of discrepancies between claims for professional component and technical component services provided in the hospital. And even though you might be able to prove that the hospital—not you—made the error, having to do so can create bad feelings between you and the hospital. Plus, defending these audits is expensive and time consuming.

**Get Hospital to Share Chargemaster Information with You**

When a hospital is performing the billing on your behalf, it’s usually not too difficult to get the hospital to share its data with you, Greeson remarks. But if you bill your professional services, the hospital may be reluctant to allow your practice to access its chargemaster because the chargemaster information is considered proprietary to the hospital. And even if the hospital agrees to let you review it, says Miller, it may be difficult for anyone from your practice to make sense of it. There are two ways around this problem:

*Get right to see auditor reviews.* As part of their compliance plans, most hospitals have outside auditors review their chargemasters periodically, which means they must share the “keys” to the chargemasters with the auditors. So instead of demanding the right to see the chargemaster, it’s more beneficial to get the hospital to agree to share the auditor’s findings with you, Greeson advises.

To persuade the hospital to share this information with you, use the OIG’s concern about discrepancies between technology and professional component billing. Tell the hospital that you need access to the auditor’s review of the chargemaster to ensure that your coding matches up with the hospital’s, he suggests.

When demanding the right to review the auditor’s findings, you should try to get the hospital to agree to conduct the audits at least annually. Also try to get the hospital to agree to let you know when the auditor suggests revisions to the chargemaster. That way, you can review your own records to see if the hospital billed the technical component of any services you provided with codes the auditor thought should be revised.
To get the right to see the auditor’s reviews, here’s some Model Language you could use in your hospital contract.

**Model Language**
Hospital shall hire an independent auditor to conduct a full audit of the hospital’s chargemaster at least annually. Hospital agrees to provide Practice with a copy of the auditor’s findings and to notify Practice of any revisions to the chargemaster that the auditor suggests.

**Get right to use your own auditor.** A hospital typically will include in your contract a provision that allows it to review your professional fees or approve your fee schedule, Greeson says. In return for giving the hospital this right, you should get the right to have your own auditor inspect the hospital’s chargemaster to make sure that it’s consistent with your fees, especially if you suspect a problem that may affect your billing, Greeseon says. And since the chargemaster will be Greek to anyone who isn’t familiar with it, it’s important that the hospital agree to cooperate with and assist your auditor as necessary, he points out. Here’s contract language that would give you that right.

**Model Language**
Hospital shall permit Practice or its authorized representative to audit the Hospital’sradiology services’ chargemaster if the Practice, in good faith, deems such audit necessary to ensure consistency in billing for radiological services provided at hospital or to investigate or respond to allegations or evidence of wrongdoing in the Hospital’s coding of radiology services. Hospital shall cooperate with such auditor to the full extent necessary to ensure a thorough and complete audit.

**Get Indemnification for Problems Hospital Chargemaster Causes**
If you’re billing for your own professional services, clearly the hospital won’t agree to be on the hook for your billing errors. And though the hospital may resist indemnifying you for errors its chargemaster causes, you should fight for an indemnification clause, Greeson says, because resolving a hospital’s chargemaster error can cause you a lot of trouble. Try to add the following indemnification language to your contract.

**Model Language**
Hospital agrees to indemnify Practice and hold it harmless from and against any claims, losses, damages, causes of action, attorney’s fees, and all other costs associated with and arising directly from Hospital’s actions in coding and submitting claims for the technical component of radiology services for which Practice provided the professional component.

**Insider Sources**
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**Dos & Don’ts**

**✓ Document Actions Taken to Correct MQSA Deficiency Notice**

If your mammography facility gets a deficiency notice from a Mammography Quality Standards Act (MQSA) inspector, be sure to thoroughly document any corrective action you take to remedy the deficiency. It’s extremely important to document corrective actions because failure to do so can result in a higher level deficiency at the next inspection.

Mammography facilities must undergo annual inspections to maintain their accreditation in compliance with the MQSA. Because mammography facilities are subject to stringent quality control (QC) and record-keeping requirements, it’s not unusual for an inspector to find deficiencies when performing these inspections. In fact, about 40 percent of mammography facilities have some reported deficiency at their annual inspection, according to the most recent statistics posted on the FDA Web site. Most of the reported Level 1 (the most serious on a scale of 1 to 3) and Level 2 deficiencies are related to a failure to document the daily processor QC test and the weekly phantom image QC test. And many of the Level 3 deficiencies are related to inadequate documentation of the quarterly QC tests. If the tests aren’t documented, the inspector must assume they weren’t done and write a deficiency finding, according to the FDA’s mammography inspection guidance.

This problem is compounded if a facility fixes the problem but doesn’t document how the problem was fixed and when. Failure to thoroughly document corrective action is in itself a violation. And if an inspector makes such a citation, he’ll assign a level of deficiency one level higher than the original deficiency. So failure to document fixing a Level 3 deficiency becomes a Level 2 deficiency at the next inspection—even if the Level 3 deficiency has been corrected.

**Insider Says:** You can read the FDA’s guidance on mammography inspections, see recent facility scorecards, and review articles that will assist you in the facility inspection process, at the FDA’s mammography Web page. Go to www.FDA.gov and click on “A-Z index,” in the upper left corner. Go to “M” and click on “mammography.”
CCI version 10.1 goes into effect on April 1, 2004, for physician services. According to a recent announcement by the American College of Radiology (ACR), this version of the CCI unbundles several sets of codes that had been bundled under CCI 10.0—the previous version of the CCI used for professional medical services. We'll tell you about the changes and what they mean to radiology practices.

CCI 10.0 Bundled Some Common Radiological Services

The following services had been bundled under version 10.0:

- 75998 (fluoroscopic guidance for central venous access device placement or replacement) with 76937 (ultrasound guidance for venous access);
- 76856 (non-obstetric pelvic ultrasound) with 76830 (non-obstetric transvaginal ultrasound); and
- 76857 (limited or follow-up non-obstetric pelvic ultrasound) and 76830 (non-obstetric transvaginal ultrasound).

Under CCI 10.0, if claims for both services in any of the above pairs were submitted with the same date of service by the same physician, only the Column 1 code (the first code listed above for each pair) would be paid. For example, if a radiologist billed for both fluoroscopic (75998) and ultrasound (76937) guidance for venous access, only the fluoroscopy would be paid. But if there was documentation that the services were separate, the edits could be bypassed by appending the -59 modifier to the Column 2 code, says Atlanta radiology coding and compliance expert Jackie Miller. But since frequent use of this modifier can target a practice for audits, many practices declined to use the -59 modifier. Instead, they would submit a claim for just the Column 1 service and absorb the cost of the other.

CCI 10.1Eliminates Bundles

In good news for radiology practices, the ACR has announced that the code pairs listed above will be eliminated from version 10.1 of the CCI, which takes effect on April 1, 2004, for physician services. Medically necessary and appropriately documented claims for the previously bundled services listed above—if performed on or after April 1—will be paid separately, Miller explains. So there's no longer a need to use the -59 modifier to avoid the edits, and there's no payment reduction for the services, even when performed together.

But keep in mind that the date of service is key, Miller remarks. Claims for services that were bundled under CCI 10.0 will still be bundled if they were performed before April 1, 2004. So if your radiologist performed a non-obstetric pelvic ultrasound and a transvaginal ultrasound on March 30 and you want to get paid for both services, you must append the -59 modifier to the transvaginal ultrasound code to avoid the CCI edits—even if you don't submit the claim until after April 1, Miller says.

Insider Says: Hospital claims aren’t affected by this change, Miller notes. That’s because the CCI edits applied to hospital claims are always one version behind those applied to physician claims. So if services are provided to a hospital outpatient prior to April 1, the radiologist’s claim will be subject to version 10.0 of the CCI edits, while the hospital’s claim will be subject to version 9.3.

Insider Source


CMS Introduces Plan for New NPI

In January 2004, CMS announced that it had published a final rule adopting the National Provider Identifier (NPI) as the unique identifier that all health care providers must use when submitting electronic claims or engaging in other transactions that are governed by HIPAA. The NPI will replace the other identifiers—like the Unique Provider Identification Number (UPIN) and Medicare provider numbers—that health care providers must currently use. The final rule goes into effect on May 23, 2005, so you have some time before you need to get and use an NPI. We’ll answer some questions you may have about the NPI so that you’ll be ready for its introduction in May next year.

What Is an NPI?

An NPI is a new, unique 10-digit identification number that will be
issued to each health care provider by the National Provider System (NPS) based on information, known as “enumerators,” that organizations enter into the NPS.

Why Is the NPI Needed?
HIPAA requires that all “covered entities” have a unique identifying number for the purpose of submitting health care claims electronically, and CMS is developing the NPI to be that unique identifying number, explains New York health care attorney Jay Silverman. Currently, physicians must use and keep track of several identifying numbers, like a UPIN, Medicare provider number, Medicaid provider number, and/or other identifiers assigned by health plans. Once the NPI is introduced, health care providers will use the NPI number with every health plan to which they submit electronic claims. In addition, the NPI will belong to a specific provider forever and won’t change, absent some problem like fraudulent use or identity theft, Silverman says. For example, the NPI can be used:
- To identify the physician on prescriptions;
- In patient medical record systems in hospitals and health plans; and
- For purposes of coordinating benefits between health plans.

Who Must Get an NPI?
All HIPAA covered entities must get an NPI, so that means that all physicians and physician practices that submit claims electronically, as well as hospitals and health plans, must get an NPI. Providers that aren’t covered entities are eligible to get an NPI but aren’t required to get one, Silverman points out.

How Will the NPI Be Used?
The NPI will be used to identify health care providers in “standard transactions” under HIPAA—for most physicians, that means that the number will be used to identify their electronic claims for health care services. But the NPI may be used in other ways, too, Silverman says. For example, the NPI can be used:
- To identify the physician on prescriptions;
- In patient medical record systems in hospitals and health plans; and
- For purposes of coordinating benefits between health plans.

When Do You Need an NPI?
The final rule takes effect on May 23, 2005, and according to CMS, the process for applying for the NPI begins on that date. In FAQs about the NPI that CMS has posted on its Web site, CMS says that NPI applications may be submitted either electronically or through the mail, but not until May 23, 2005.

When Must You Use the NPI?
The compliance date for all covered entities except small health plans is May 23, 2007. (Small health plans will have until May 23, 2008, to comply.) So physicians who are covered entities under HIPAA—that is, those physicians who, either individually or through their practices, submit claims for professional services electronically—aren’t required to use the NPI until then, Silverman says. But he’s suggesting that his clients obtain their NPIs as soon as the application process is established in May 2005. If you do, you’ll be assured of having your NPI in plenty of time to meet the compliance date. And you’ll have some experience with using it before the compliance date, so that if there are problems with your NPI or with implementing the NPI system, your claims won’t get delayed in the last minute rush.

Insider Says: To view a copy of the final rule, go to www.cms.gov/hipaa/hipaa2/default.asp. Click on the link “National Provider Identifier (NPI) Final Rule Published” under “Latest News.” You can find the FAQs about the NPI by going to the CMS Web site at www.cms.hhs.gov. On the first page, click on FAQs at the top. Under “Category,” choose HIPAA; under “Topic,” choose HIPAA Administrative Simplification Act; and under “Search Text,” type NPI.

Insider Source
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Watch Out for Six Problems When Health Plans Amend Contracts to Comply with HIPAA

It’s likely that you’ve been receiving a new contract or contract amendment from every health plan you contract with. The reason: compliance with HIPAA, which requires both providers and plans to keep members’ protected health information (PHI) confidential and to take specific steps to safeguard PHI.

But be wary of what a plan’s new contract or amendment says about HIPAA. It may include HIPAA requirements that don’t apply to you, are unnecessarily harsh, or increase your risk of being sued by plan members.

To protect yourself from problems like these, experts recommend that you not sign any contract or contract amendment dealing with HIPAA until you learn to recognize and fix contract clauses that can hurt you. We’ll point out six problems to look for and tell you what to do if you find them.

**HIPAA Regulations Impose Tough Requirements**

Under HIPAA, both providers and plans are “covered entities” and must comply with the regulations. HIPAA requires covered entities to create and use many new policies, procedures, and forms and make significant changes to their contracts and operations, notes Washington, D.C., attorney Kirk Nahra. If you improperly use or disclose PHI, you or your organization may face stiff penalties for violating HIPAA. These penalties include fines ranging from $100 per accidental violation to $250,000 for malicious violations, as well as prison sentences for selling PHI or using it to harm someone.

But that doesn’t mean the contract (or contract amendment) the plan asks you to sign in order to comply with HIPAA applies to you, best protects your rights, or defines your obligations. “Since HIPAA is so new and complex, people may interpret provisions differently or use a general amendment for all providers when they shouldn’t,” says New York City attorney Anne Maltz.

**SIX CONTRACT PROBLEMS**

Here are six problems to look for in new contracts or amendments and what you can do if you find them. If you know what to look for and point out potential problems or errors to the plan, the plan is likely to correct them, notes Washington, D.C., attorney Keith Lind.

**Problem #1: Plan Imposes Policies and Procedures Meant for Plan or Larger Provider**

HIPAA doesn’t require a smaller organization to adopt or implement policies and procedures with the same level of detail as a larger one, says Maltz. “HIPAA is flexible and recognizes that a larger, more sophisticated covered entity will have more responsibilities and obligations to comply with HIPAA than a smaller one,” she explains. This means that unless your practice or facility is very large, the compliance obligations HIPAA imposes on you won’t be as burdensome as those it imposes on the plans you contract with. For example, HIPAA may require that plan to have a full-time privacy official who’s responsible for developing, implementing, and overseeing its privacy policies, while your medical practice needs someone only part-time.

But we’ve heard about some proposed contract amendments that require providers to adopt HIPAA policies and procedures as strict as the plan’s. In other cases, they require the provider to comply with the plan’s policies and procedures. “That’s too much for a smaller provider, and HIPAA doesn’t require it,” says Maltz. Also, some procedures a plan may want a provider to use may be more than a provider can realistically do, says Lind.

**What to do.** Check any new contract or contract amendment to make sure it doesn’t obligate you to comply with requirements beyond what the law requires of you. If you don’t yet know what your HIPAA obligations are, you’ll have to work with your attorney to find out. If the contract or amendment goes too far, ask the plan to change it.

**Insider Says:** No matter how familiar you are with reading contracts, you may want to show new HIPAA contract language or amendments to your attorney. It’s hard to predict exactly what language plans will use or what surprises they’ll have in store.

**Problem #2: Overly Burdensome or Unnecessary ‘Business Associate’ Contracts**

Some plans may send you a “business associate” contract to sign, in addition to your regular plan contract. That’s because HIPAA requires organizations that disclose PHI to a business associate to ensure that the business associate will safeguard that information. The regulations require the organization and the business associate to sign a detailed contract to protect the privacy of PHI. And they impose additional requirements on business associates that don’t apply to covered entities, such as reporting...
unauthorized disclosures of PHI to the covered entity.

A provider can be both a covered entity and a plan’s business associate and be required to sign a business associate contract. But you’re not a business associate simply because you have a provider contract with a plan or treat a plan member, warns Nahra. “You’re only a business associate if you’re doing work on the plan’s behalf—say, if the plan has delegated quality assurance or credentialing functions to you,” he explains. So you don’t want to sign a business associate contract and take on additional responsibilities unless you have to, recommends Maltz.

**What to do.** Determine whether you’re a business associate of any plan. To do that, review your contract and relationship with the plan to see if you’re performing any activity for the plan (not on your own behalf) that involves PHI. If you’re not, don’t sign any business associate contract that the plan sends you. Get your attorney’s help if you’re not sure whether you qualify as a business associate.

If you determine that you’re a plan’s business associate, check the business associate contract before you sign it to make sure it doesn’t go too far. For instance, it may require business associates to use certain procedures to handle PHI. But you may already safeguard PHI appropriately, says Lind. “If your standards are already adequate, don’t automatically agree to more or different ones. This is negotiable,” he adds.

**Problem #3: Plan Requires More than ‘Minimum Necessary’ Disclosure**

HIPAA requires that your disclosures of PHI be kept to only the “minimum necessary.” So if a plan denies a claim for services you provided to a plan member and you want to appeal, the plan can’t insist that you submit the member’s whole medical record unless that’s the minimum necessary disclosure needed for the particular appeal, warns Maltz. But your existing contract is unlikely to limit disclosures in this way. And there’s no guarantee that any new contract or contract amendment won’t also require you to submit more than the minimum amount of information needed for the plan to review claims, conduct retrospective reviews, audit your records, or otherwise use PHI, without getting specific authorizations from plan members. “Some plans may even need to change how they define a clean claim,” says Maltz.

**What to do.** Review any new contract or amendment to make sure it doesn’t require you to provide more PHI than is minimally necessary for the plan to perform its functions. If it does, point out that it should be changed to comply with HIPAA.

Also, the regulations allow providers to reasonably determine what’s minimally necessary to share with the plan. So make sure the contract gives you the right, as the holder of the PHI, to reasonably determine what’s minimally necessary.

**Insider Says:** Also review your existing contracts to make sure they don’t require you to act in ways that could violate HIPAA. For instance, an existing contract may give the plan more access to your information than HIPAA allows, and the plan’s contract amendment may not change that. You’ll have to point that out to the plan and get it fixed. “You don’t want to be stuck in a situation down the road where you either violate HIPAA or violate your contract,” Lind says.

**Problem #4: Plan Demands PHI Without Member Authorization**

If a plan wants to use any PHI for purposes other than treatment, payment, or health care operations, such as marketing, the member must give written authorization permitting the plan to use the PHI for that purpose. And some disclosures for treatment purposes—such as a psychiatrist’s session notes—require a more stringent authorization says Maltz.

But some existing plan contracts may require providers to hand over PHI for any reason, without getting an authorization, even if one is needed. And any new contract or contract amendment may not change this.

**What to do.** Make sure you’re not obligated by any new contract or amendment (or by an existing contract that an amendment doesn’t correct) to turn over PHI to a plan just because the plan asks for it. Instead, the plan should be required to ask the member—or ask you to ask the member—to sign an authorization if an authorization is required, says Maltz. And there should be no penalty against you or the member if the member refuses to sign an authorization.

**Problem #5: Members Get Contract Right to Sue You for HIPAA Violations**

Some older plan contracts say that members are third-party beneficiaries to the contract. That means if you violate the contract, both the plan and the member can sue you. But HIPAA doesn’t give members a right to sue providers for violating HIPAA, and while the proposed HIPAA privacy regulations included that right, it was dropped from the current regulations. You’re giving away more than you have to if your contract continues to give members the right to sue you if

(continued on p. 8)
you accidentally disclose PHI in violation of HIPAA, says Lind.

**What to do.** Check any new contracts or amendments you get from plans now—or any you may have signed after the proposed regulations were issued—and any existing contracts to make sure no language names members as third-party beneficiaries of the contract. If you find any such language, ask the plan to remove it. “Most plans will drop this language because they don’t want to be sued by members for violating HIPAA, either,” says Lind.

**Problem #6: You’re Liable for PHI Changes**

The HIPAA privacy regulations give patients the right to request amendments to their PHI to correct mistakes. For example, a patient may ask a hospital to change a piece of incorrect, incomplete, or outdated information about him or his test results. If you amend a member’s PHI in response to such a request, HIPAA requires you to tell the plan about the amendment if the plan may need or rely on that information. This lets the plan update its own records.

But some plans may want to penalize you for making a mistake and forcing them to go through the administrative hassle of changing their records, warns Maltz. For instance, a plan may want to include a financial penalty in the contract or require you to cover its costs if the member later sues because of the mistake. But that’s overreaching, she says. “HIPAA is looking for cooperation in these situations, not penalties,” she explains.

**What to do.** Watch out for new contract language that penalizes you for amendments to correct mistakes in PHI. If you see such language, ask the plan to remove it. “This is a reasonable request, especially since it probably won’t happen all that often,” says Maltz.

**Insider Says:** There may be further changes to HIPAA down the road, warns Lind. In August 2002, HHS published some changes to the final regulations, and it hasn’t yet issued all the final regulations needed to implement HIPAA. One change extends the compliance date for business associate contracts for up to one additional year. These modifications also exempt from the minimum necessary standard all uses and disclosures made pursuant to a signed authorization by a patient or enrollee.

Several provider associations have also sued the government to try to get the HIPAA privacy regulations changed or thrown out. With this in mind, you may want some protection in your contracts in case the HIPAA requirements are scaled back but the plan doesn’t revise its contracts accordingly, Lind says. For example, you may want the new contract or amendment to contain a general statement that “in no event shall Provider comply with any provision of HIPAA beyond what the law requires of Provider,” suggests Lind.

**Insider Sources**

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**Educate Staff About Use, Misuse of ABNs**

Sometimes a treating physician orders a service for a Medicare patient, which Medicare won’t cover. Depending on the circumstances, you may need to give the patient an Advance Beneficiary Notice (ABN) before providing the uncovered service. The ABN allows you to bill the patient for the uncovered service.

The problem, says New York health care attorney Matthew Kupferberg, is that some practices give out an ABN any time they don’t expect to get paid by Medicare. And that’s an improper use of an ABN—something that CMS and the OIG have expressed concern about.

We’ll review the proper use of an ABN and explain what its purpose is. And we’ll tell you about another form—the Notice of Exclusion From Medicare Benefits (NEMB)—that you can use when you provide services that Medicare never pays for. We’ll also give you a Model Memo (see p. 9) that you can adapt and give to your staff so that everyone in your practice is clear about how and when to use an ABN.

**ABNs Explain Service May Not Be Covered**

Medicare beneficiaries typically expect that Medicare will pay the tab when they get any medical services—and they don’t expect to be out-of-pocket for more than their copayment, Kupferberg remarks. But sometimes a physician will believe that a service is appropriate for the patient, even though Medicare rules may deem that service “not medically necessary.” In those cases, and only those cases, you must give the patient an ABN.
Example: A surgeon orders a preoperative chest X-ray for a patient with mild hypertension. Medicare will sometimes pay for preoperative chest X-rays if the patient has a certain underlying disease, but in this case, you feel the carrier will most likely deny the claim for lack of medical necessity. The practice should give the patient an ABN, which explains that the procedure the physician recommends may not be covered and that if not covered, the patient will be responsible for payment.

ABNs Allow Patient to Make Informed Decision
In addition to informing the patient that she’ll be responsible for payment for a particular service, the ABN has another purpose, Kupferberg explains. It explains that the patient has the option of refusing that service. CMS doesn’t want elderly people to feel that they’re obligated to receive any service the physician wishes to provide. The ABN is supposed to act as an impetus for dialogue between the patient and the physician, so that the patient can make an intelligent decision about whether to get the service the physician recommends, he remarks.

Insider Says: You can print and use the ABN form available on the CMS Web site, at www.cms.hhs.gov/medicare/bni/CMSR1312.pdf. But note that CMS rules bar you from altering it in any way, except to fill in your practice’s information and the blanks on the form. The Web site also has an ABN form available in Spanish.

Misuse of ABNs on Regulators’ Radar Screen
Misusing ABNs is something that CMS is increasingly concerned about, as indicated by recent statements in testimony before Congress and in addresses to industry groups, says Kupferberg. CMS’s perception is that some practices routinely distribute ABNs to secure additional payment from patients for services that Medicare doesn’t deem medically necessary.

Practices can’t use an ABN to “paper over” the provision of medically unnecessary services to Medicare beneficiaries, he emphasizes. Kupferberg says CMS and the OIG would consider that an abusive practice—even if the patient understood that the additional service wasn’t covered by Medicare and agreed to pay for it. Rather, an ABN should be given only if the physician has some documented reason for wanting to provide the additional service, but feels that the carrier is unlikely to approve it—for example, if the patient’s diagnosis doesn’t come within the carrier’s LMRP for the service, Kupferberg explains. Ideally, the treating physician will explain to the patient that Medicare won’t cover the service she’s ordering. But because you’re providing the service, the burden of obtaining the ABN falls on you, Kupferberg cautions.

Use NEMB When Service Isn’t Covered Benefit
Another way practices misuse ABNs is by giving them even when Medicare.

Give Staff Memo Explaining Use of ABN, NEMB
Here’s a Model Memo that you can adapt and distribute to your staff, reviewing proper ABN usage and explaining the difference between the ABN and the NEMB forms. Attach copies of the ABN and NEMB forms to this memo. RACR10007

TO: Staff of XYZ Radiology
FROM: Julie Jones, Practice Administrator
RE: Proper Use of ABNs, NEMB

Medicare rules require us to give Medicare patients an Advance Beneficiary Notice (ABN) when a service we recommend may not be covered by Medicare. It is crucial that we abide by Medicare rules and use ABNs appropriately, and it is important that our patients be informed of their financial responsibility regarding the services they receive. Accordingly, all staff members are responsible for knowing the following information and adhering to the practices set forth below:

1. An ABN informs the patient that his or her Medicare benefits may not cover a service the physician recommends, because Medicare may not consider the service medically necessary. The ABN explains that the patient may refuse the recommended service and that if the patient opts to receive the recommended service, the patient is responsible for payment.
2. An ABN must be given to the patient for signature before the patient receives the recommended service.
3. ABNs are to be distributed on a case-by-case basis, and may not be given routinely, so give an ABN only when the physician recommends an additional visit or other service for a specific reason.
4. If the service the physician recommends is NEVER covered by Medicare, the patient should not receive an ABN. Instead, you may give the patient a Notice of Exclusion from Medicare Benefits (NEMB) that explains that the service is not a covered benefit under the Medicare program.
5. Use of the NEMB form is not mandatory, but is recommended. I have attached a copy of each form to the memo for your review. Please see me with any questions.
USE, MISUSE OF ABNs (continued from p. 9)  

Care never covers the service in question. In general, the reason for this misuse isn’t economic exploitation of the patient, but just laziness, Kupferberg remarks. For example, say a treating physician orders a screening exam that Medicare never covers. Rather than explain to the patient that he has other options, and answer his questions about his Medicare benefits, some practices just have the patient sign an ABN. This is an improper use of an ABN, Kupferberg says.

Medicare provides a different form that you can use if the service you’re providing to a Medicare patient is never covered—it’s called the Notice of Exclusion From Medicare Benefits (NEMB), and it explains to patients that the service the physician is recommending isn’t covered by Medicare. Unlike the ABN form, use of the NEMB isn’t mandatory. But it’s helpful if your practice performs non-covered services for Medicare beneficiaries, Kupferberg says.

Insider Says: You can print and use the NEMB form on the CMS Web site at www.cms.hhs.gov/medicare/bni. Scroll down the page to find the links to the NEMB form, in both English and Spanish.

Send Memo to Staff  
To make sure everyone in your practice knows how and when to use the ABN and NEMB forms, give your staff an explanatory memo. Like our Model Memo, your memo should:

- Explain what an ABN says [Memo, par. 1];
- Emphasize that the patient must receive and sign an ABN before getting the service [Memo, par. 2];
- Caution that ABNs are to be distributed on a case-by-case basis and not given out routinely [Memo, par. 3];
- Point out that the NEMB is to be used when Medicare never covers the service the physician recommends [Memo, par. 4]; and
- Explain that using the NEMB isn’t mandatory but may be helpful to staff and patients [Memo, par. 5].

Insider Says: It’s a good idea to attach copies of the ABN and NEMB forms to the memo. This will help your staff grasp the difference between the two forms. And proper use of ABNs should be part of your compliance plan, Kupferberg advises. So you can use the memo as part of your ongoing compliance training, too.

Insider Source  
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SHOW YOUR LAWYER  
For more information about the cases and/or laws referred to in this issue, show your lawyer the legal citations listed below: