Dynamic Chiropractic

BILLING / FEES / INSURANCE

Medicare Advanced Beneficiary Notice and Maintenance Services

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Q I have heard that with the new Medicare Advanced Beneficiary Notice (ABN), chiropractors no longer have to bill for services that are maintenance. Is that true?

A Yes, it's true. As of March 3, 2008, chiropractors are no longer required to bill for services that are considered maintenance. Therefore, the use of modifier GA is no longer necessary when the chiropractor determines services are maintenance. The new ABN is now called the "Advance Beneficiary Notice of Noncoverage." Although it's not mandatory for use until Sept. 1, 2008, it can be used now. The new form and instructions for use can be downloaded directly from the Centers for Medicare and Medicaid Services (CMS) Web site at www.cms.hhs.gov/BNI/02_ABNGABNL.asp. (If you have difficulty with the link, I will be glad to forward the documents via e-mail to those who request it.)

The new form also allows customization for local practitioner use. This means you can personalize and modify the form to fit the specific needs of your practice pertaining to maintenance care. For the most part, this means you may have the form preconfigured for maintenance care and only need to update the dollar amount to have it ready for the patient's signature.

However, if you believe Medicare may indeed still pay for services, as you are able to demonstrate that the patient is getting functionally better, the form still can be used to denote that Medicare "may not" pay for services. In that scenario, the patient still is taking responsibility should Medicare deny for medical necessity.

However, Medicare still will be billed to make a determination of necessity. In that case, the modifier GA will be used in conjunction with modifier AT. By using these combinations, you are detailing to Medicare that the patient has accepted responsibility for payment should Medicare decide care was not medically necessary. In that case the EOB will denote "patient responsibility." Thus the patient can be billed directly for those services. If Medicare determines care is medically necessary by using the AT with the GA, Medicare still will make payment to the provider or patient.

It seems Medicare has realized that receiving billing for pure maintenance care, by default, is a waste of resources when the patient already has agreed to be responsible. Imagine the labor and time involved to process, review, print and mail claims that are for maintenance but are never considered for payment. Maybe this savings will allow an increase in the reimbursement.

No, I must be dreaming.

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