Test Your Knowledge of the Medicare Advanced Beneficiary Notification (ABN) Form and the Therapeutic Shoe Program

It's important to know the answers to these common questions.

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1. It is smart office policy to have an ABN signed when a patient presents the first time to the office and is eligible for covered at-risk foot care. T or F?

True. Since there is a screen of 61 days for at-risk foot care, regardless of the provider, it is prudent practice for all new patients to complete an ABN. There are many instances of podiatric patients being less than truthful about the timing of their last visit to a podiatrist, especially new patients that may have been dissatisfied with treatment by another podiatrist. When at-risk foot care services have been provided by your office in a time frame considered "too frequent" by the Medicare rules, a properly executed ABN is required to bill the patient for services rendered.

2. Completion of a new ABN is required each time a patient presents for "too frequently provided" at-risk foot care. T or F?

False. The ABN instructions by CMS state that a single form is acceptable for a course of treatment of the same condition when the reason for a possible denial remains the same. Since the reason for denial would be "too many services" in each instance, one waiver form is all that is needed. However, the instructions also state that an ABN expires if a course of treatment continues beyond one year when a new ABN must be completed.

3. An ABN must be on file in order to charge patients cash for mycotic nail debridement which has never caused pain or who do not exhibit a systemic disease that meets class findings. T or F?

False. For services that are excluded from Medicare coverage due to statute or regulation, an ABN need not be on file. However, to avoid patient misunderstanding, it may be good office protocol to have this class of patients also execute an ABN.

4. When Medicare is billed for covered at-risk foot care services more often than the 61 day screen allows, the service does not require submission of a claim to Medicare unless the patient insists. T or F?

False. When services are likely to be denied due to medical necessity (for example, those provided too frequently) the claim must be submitted to Medicare to allow the program to determine the service is medically unnecessary. In these cases, a valid ABN must be also on file. The patient also may be charged your usual and customary fee, rather than the limiting fee for this service, and can be asked to pay at the time the service is provided.

5. 11721 is submitted to Medicare with a –GY modifier to tell the Medicare Carrier that the service provided exceeds the frequency allowed by the program. T or F?

False. The proper modifier is –GA, which informs the carrier that "a signed ABN is on file in this patient's medical record."

6. When a patient receives services which are excluded by regulation or statute such as routine foot care, claims must be submitted to Medicare for the patient, an ABN executed, and the modifier –GY appended to the service. T or F?

False. For services excluded by statute, claims are filed to Medicare only at the request of the patient, an ABN is not required, and a –GY is appended to the service. A -GY modifier denotes the service is not covered by Medicare or does not meet the requirements of a Medicare benefit. By appending –GY to the service, it is clear exactly what type of service was provided to the patient. allowing a secondary insurer to elect to cover the service.

7. It is acceptable to provide an English version of the ABN form to an exclusively Spanish speaking patient. T or F?

False. There are both English and Spanish versions of this form available from CMS. Practices are expected to use whichever is appropriate.

8. The ABN form may be modified by a practice in any way it desires. T or F?

False. There are 50 pages of instructions for using this one page CMS form. It may not be modified by the practice.

9. It is problematic if an ABN form is not signed in the treatment room before certain procedures – those that may not be covered due to medical necessity - may be performed. T or F?

False. If a physician has explained the reasons a specific treatment may not be covered, has explained the cost to the patient, and offers the ability to "opt out" of the treatment before the procedure is performed, the ABN form may be signed on the way out of the office, as not to interrupt the flow of patient care.

10. If a service is expected to be denied by medical necessity, such as too frequent covered at risk foot care, a physician may not collect any money from the patient until the claim is adjudicated by Medicare. T or F?

False. The ABN specifically states this doctor may collect the fee, and that should Medicare allow the service, the doctor will promptly refund to the patient any money collected in error.

11. Patients who present for treatment of non-painful mycotic nails or treatment of painful mycotic nails too frequently can be charged the usual and customary fee for services. T or F?

True. If Medicare is not paying for a service for any reason, the Medicare fee schedule does not apply and the usual and customary fee may be charged to any patient.

12. Since trimming of nails for a diabetic (CPT 11719) reimburses less than CPT 99211 (which does not require a physician to be in the treatment room), it is

perfectly acceptable to enter into a private contract with the patient explaining they will pay more than the Medicare fee schedule allows. T or F?

False. Wishful thinking! One may not enter into a private contract that violates Medicare rules. In addition, podiatrists do not have the option to "opt out" of Medicare completely as plenary physicians have. APMA is working on a technical correction to allow podiatrists to opt out.

13. It is appropriate to charge a Medicare patient a fee for providing a three minute whirlpool bath prior to palliative foot care. In addition, this has no relevance to the Medicare program and an ABN is not required. T or F?

True. One may bill for this service without Medicare concerns. This type of whirlpool treatment does not meet the definition of hydrotherapy that is a covered Medicare service under certain situations. This type of whirlpool treatment is provided for the convenience of the doctor and the patient, and is not of sufficient duration to be considered hydrotherapy nor is it part of a written treatment plan for physical therapy.

14. It would be acceptable to charge a Medicare patient a fee for supplying adhesive foam pads which they take home and use as needed. T or F?

True. As long as these items are used at home they are not considered incident (bundled) into the physician service. If the pads are single use and are applied in the office they would considered dressing and incident to the professional service.

15. It is considered acceptable for a podiatrist to spend time in an orthopedic shoe store to screen Medicare patients in the store for eligibility of therapeutic shoes. The podiatrist prescribes shoes and inserts and bills these encounters as evaluation and management services using CPT 99XXX series codes since the service supplied is considered "office and other outpatient location." The shoe store bills for the shoes and inserts after obtaining a certification form from the family doctor. T or F?

False. A prescriber may not bill for an E/M visit when the sole purpose of the encounter is for prescribing and fitting shoes. In addition, other aspects of this arrangement should be reviewed by a qualified healthcare attorney who will supply a written opinion!

16. Podiatrists may elect to dispense custom dual density inserts or heat molded dual density inserts to patients without dispensing the shoes themselves - provided the patient already has a shoe which fits the requirements of the diabetic shoe program. T or F?

True. The DMERC policy specifically allows for this. I believe this may be the simplest route for some practices to take that do not want to deal with shoe fitting. Documentation in the medical record should include the brand and size of the shoe the patient wears, that the shoes meet the requirements of the program, that they are in serviceable condition, and the specific reason dual density innersoles are required. The remainder of the usual paperwork must be on file and follow the usual DMERC rules. This includes a letter from the MD/DO certifying the patient has a foot condition allowing for shoe coverage and that the patient is under their care for diabetes. The patient must also have one of the six clinical conditions required. The number of innersoles and specific size and brand of innersole dispensed should be documented in the medical record.

One additional point. Every corner store is a DMERC supplier involved in the therapeutic shoe program. I believe podiatrists should take the high road and dispense custom inserts to all our patients. The $50.00 additional cost per

patient is balanced by the overhead and time required to heat mold 6 inserts! We are also supplying a better product!

17. A low-level office visit may be billed to Medicare for the visit in which therapeutic shoes and innersoles are dispensed. T or F?

False. The medical policy specifically disallows an office visit if the sole purpose of the visit was not the fitting or dispensing of therapeutic shoes. Consider getting on the bandwagon of those podiatrists who have begun providing annual or semi-annual comprehensive diabetic foot exams as recommended by Diabetic Practice Guidelines written by ACFAS/ACFOAM. These guidelines may be downloaded and viewed on the www.acfaom.org web site. This exam includes a history and physical exam, a review of shoe gear, a plantar pressure assessment using PressureStat or a similar device, and time for counseling. Along with PressureStat mats, the Footlogic Corporation supplies comprehensive diabetic foot exam (CDFE) forms designed by this author which allow a CPT 99213 when completed.

18. Cam walkers and similar devices are not bundled into the fracture codes and may be separately reimbursable. T or F?

True. Pneumatic walkers are billed to DMERC under HCPCS L 4360 and non-pneumatic devices are billed under the new 2003 HCPCS code L4386 (thanks to Paul Kesselman, DPM and Codingline for bringing this new code to my attention). Non-DMERC providers may not dispense these devices to Medicare patients and collect for them as though they were non-covered services.

19. Physicians may charge patients a travel allowance when performing home visits as long as they have them sign an ABN form which states they understand that Medicare will not reimburse them for this travel allowance. T or F?

False. According to Medicare, this practice is prohibited and that the site of service was considered when calculating relative values for at-risk foot care CPT codes.

20. Post op shoes are bundled by Medicare into the fracture codes and cannot be billed to a patient. T or F?

False. Post-op shoes are not a covered service of the Medicare program and can be billed at your usual and customary charge to the patient. No ABN is required.

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