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SunSolutions SPOTLIGHT News Break

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Therapy Caps and Advance Beneficiary Notice of Non-coverage (ABN) Form CMS-R-131, FAQs

CMS has released a Frequently Asked Questions (FAQ) document on Therapy Caps and the use of the Advance Beneficiary Notice of Non coverage **(ABN)**, **Form CMS-R-131**:

Q1: How did the American Taxpayer Relief Act (ATRA) of 2012 (PL 112-240, January 3, 2013) affect liability provisions for services above the therapy cap?

- A1: Prior to the ATRA, original (fee-for-service) Medicare claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS encouraged suppliers and providers to issue a voluntary Advance Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, as a courtesy, to alert beneficiaries to potential financial liability. However, issuance of an ABN wasn't required for the beneficiary to be held financially liable. Section 603 (c) of the ATRA amended §1833(g)(5) of the Social Security Act (the Act) to provide limitation of liability (LOL) protections (See §1879 of the Act) to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable. The ABN informs the beneficiary why Medicare may not or won't pay for a specific item or service and allows the beneficiary to choose whether or not to get the item or service and accept financial responsibility. ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges.

Q2: When are therapists required to issue the mandatory ABN for therapy services?

- A2: Therapists are required to issue the ABN to original (fee-for-service) Medicare beneficiaries prior to providing therapy that is not medically reasonable and necessary regardless of the therapy cap.

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1. **Example 1 – Therapy cap is not met - ABN Mandatory** Mr. X has been receiving physical therapy (PT) three times per week, and currently, he has achieved all his PT goals established in the plan of care (POC). The total amount applied to his therapy cap this year is $780. Mr. X requests continued PT services two times per week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that won't be covered by Medicare because they are no longer medically necessary.
2. **Example 2 – Therapy cap has been met - ABN Mandatory** Ms. Z has recently been receiving physical therapy (PT) three times per week, and she has achieved all her PT goals established in the POC. The total amount applied towards her therapy cap this year is $1900. Ms. Z. requests continued PT services two times a week even though PT is no longer medically necessary. In this example, the ABN must be issued prior to providing the services that are not medically necessary and exceed the cap in order for the therapist to transfer liability and charge the beneficiary. **Sample wording for ABN completion in either Example 1 or 2:** 1st column of ABN table labeled "D". (Remove "D" and all other lettering on the ABN prior to issuance and insert "Services" in all blanks labeled "D".) "Physical therapy services two times per week for three weeks." Under column labeled "Reason Medicare May Not Pay": "You have met your physical therapy goals, and physical therapy is no longer medically necessary. Medicare doesn't pay for physical therapy services that aren't medically reasonable and necessary." In cases such as these, if Medicare denies the claim and a valid ABN was issued, financial liability shifts to the beneficiary. If the provider fails to issue an ABN for therapy that is not medically necessary, the provider will be held financially liable if Medicare denies the claim.
3. **Example 3 – Therapy cap met - No ABN required** Mr. A has been receiving PT three times a week and has not met his PT goals. Mr. A has met his therapy cap of $1900, but additional PT above the cap is medically reasonable and necessary. Since Mr. A qualifies for a therapy cap exception, his continued therapy above the cap will be covered by Medicare. When the therapist submits claims for the necessary therapy that exceeds the cap amount, the – KX modifier is used to attest that therapy beyond the cap amount is medically reasonable and necessary. In this example, an ABN is not issued to Mr. A. since the ABN is only issued for therapy above the cap that is not medically reasonable and necessary. Providers/ suppliers must not issue the ABN to all beneficiaries who receive services that exceed the cap amount.

Q3: When I provide services that aren't medically reasonable and necessary and a valid ABN was issued, how do I indicate this on the claim?

- **A3:** Add the –GA modifier to the claim to indicate that an ABN has been issued as required per payer policy.

Q4: Which modifier do I need to use when filing claims above the cap that are not medically reasonable and necessary? Do I still use the –GY modifier?

- A4: Prior to January 1, 2013, the –GY modifier was applied to claims for therapy services above the cap that were not medically reasonable and necessary when the provider was billing the non-covered services to receive a denial. The –GY indicates that a service is statutorily excluded or does not meet the definition of any Medicare benefit and results in a Medicare payment denial and beneficiary liability. If such services were billed with

coverage charges and no modifier, the claim also resulted in a payment denial and beneficiary liability. Section 603(c) of the ATRA included statutory changes in liability protections (see A1 above) that disallows use of the—GY modifier when filing claims for therapy services above the cap amount that are not medically reasonable and necessary. When a waiver of liability statement in the form of an ABN has been issued as required per payer policy (see A2 above) for therapy services above the cap that are not medically reasonable and necessary, a -GA modifier is applied to the claim. If the provider/supplier did not issue an ABN for therapy services above the cap that are not medically reasonable and necessary, the -GA modifier can't be used on the claim. The provider would be liable for the charges above the cap.

Q5: What is a voluntary ABN and when should one be provided to the beneficiary?

- A5: When a provider/supplier provides a service that Medicare never covers, such as a service that fails to meet the definition of a Medicare benefit or a service that is explicitly excluded from coverage under §1862 of the Act, the limitation of liability protections in §1879 of the Act don't apply. So, there is no requirement for suppliers/providers to alert beneficiaries to forthcoming financial liability prior to providing a never covered service. However, suppliers/providers may issue the ABN, Form CMS-R-131 as an optional notice to alert the beneficiary to liability. When the ABN is used as an optional notice it is called a voluntary ABN. The requirements for valid completion of the mandatory ABN don't apply to the voluntary ABN. For example, the beneficiary does not need to sign the voluntary ABN or check off an option box on the notice. The voluntary ABN serves as a courtesy to the beneficiary so that s/he is aware that a service 4 won't be covered by Medicare. Alternatively, provider/suppliers may construct their own notice to give to beneficiaries for services that Medicare never covers. With the afore-mentioned ATRA changes to liability protections for therapy services, a provider/supplier will seldom encounter situations for using a voluntary ABN or an optional notification for non-covered therapy services. An example of therapy services that are never covered by Medicare are physical therapy services rendered by a chiropractor. So, a chiropractor offering physical therapy services as allowed by his/her state's scope of practice could issue a voluntary ABN to the beneficiary.

Q6: For services above the cap that are medically reasonable and necessary, can a provider transfer liability to a beneficiary?

- **A6**: No, Medicare covers therapy services above the cap that are medically reasonable and necessary. The beneficiary would be liable for applicable co-pays and deductibles.

Q7: Where can I get more information on the ABN or a copy of the ABN?

- **A7:** Information on the ABN and the form and form instructions can be downloaded from http://cms.gov/Medicare/Medicare-General-Information/BNI/index.html .

If you have any ABN specific questions that aren't answered by reviewing our webpage documents, you can send an email to: RevisedABN_ODF@cms.hhs.gov

Visit us @ www.sunsolutionsconsulting.com

Contact Info

Contact SunSolutions Consulting at GRS-BusDev@genesishcc.com or toll free - 800-728-8808 for a listing of products, services or to schedule an educational seminar teleconference.