New Medicare ABN Is Here!

What should you do now?

The new Medicare ABN is here and is attached to this email in both English and Spanish, in case that is helpful. The current ABN expires on June 30, 2023. Any patients that are on a current ABN (you are billing adjustments with modifier GA) can begin to sign the new ABN now.

As many of you know, I routinely state that the ABN is likely the single most misunderstood and misused piece of documentation in chiropractic. There are a whole host of ways practices have developed habits in using it and, unfortunately, it is these habits that have made it incredibly easy for auditors to claw back refunds from well-meaning doctors simply because using the ABN improperly often has the effect of rendering it null and void.

What NOT to do:

Do NOT have your patients sign the ABN on the first visit, unless they are initiating care as a wellness/maintenance patient.

Do NOT have your patients sign the ABN on the first visit but leave the date of the signature blank! I should hope that this does not require further explanation as to why!

Do NOT have your patients sign the ABN on every visit. This will render the ABN void.

What you SHOULD do:

Have your patients sign the ABN on the day they start wellness/maintenance care. This ABN is now valid until the new ABN expires (January 2026) or until the patient presents with a condition (new or exacerbation of previous) that qualifies as active treatment where you will submit services with modifier AT. Once the patient returns to wellness/maintenance status and is ready to go back to a GA modifier, the patient should sign a new ABN. Note, ABN's no longer need to be signed one year after the date of signature. Theoretically, they can be used indefinitely as long as the patient remains on wellness/maintenance and the ABN has not expired as noted in the lower left corner of the form.

What CPT Codes should be listed on the ABN?

The ABN is only to list codes that are normally covered by Medicare. This means that for chiropractic-only practices, only the CMT codes (98940, 98941, and 98942) should appear in Box D. The reason in Box E should read "Medicare will likely consider this to be maintenance and is not considered medically necessary and may not pay." Box F should have the fees that you will be charging. If you are credentialed as a participating provider ("par"), then you can charge the patient the fee schedule for your area for the appropriate level of service provided. If you are non-participating ("non-par"), then you can charge up to 115% of the Medicare allowable. This is also known as the Limiting Charge.

Note, since the ABN is only to address services that are normally covered by Medicare, any services that are never covered by Medicare should not appear on the ABN anywhere. This means that you should not be listing exams, x-rays, or passive and active therapies on the ABN. These services should be made clear to your patient that, in chiropractic-only practices, these services are never covered when performed by a chiropractor. These can be disclosed to the patient on their first visit on the "Voluntary Notice" and you may collect your regular fees for these services. I have attached the Voluntary Notice to this email. As this is not an official Medicare form, you may make modifications to this so that it is congruent with your office's financial policies.

If you or your team need further assistance or clarification on this information, please feel free to reach out to me at drjefflewin@gmail.com or call me at 954-205-3479.

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