Glaucoma represents a family of diseases commonly associated with optic nerve damage and visual field changes. Studies have shown that the early detection and treatment of glaucoma is the best way to control the disease before it causes major vision loss. Medicare allows annual screenings to check for intraocular pressure (IOP), which is common with glaucoma. This screening is provided as a covered benefit under Medicare Part B and subject to the current deductible and coinsurance rules; however, for screenings to be covered, we have to ensure that certain guidelines are met.

First, at least 11 months must have passed following the month in which the last Medicare-covered screening was performed and completed, and the patient must fall into a high-risk category. High-risk individuals are those who have been diagnosed with diabetes mellitus or who have a family history of glaucoma, Hispanic Americans, age 65 and over, and African Americans, age 50 and over. Documentation must support that the patient is considered “high risk.” Finally, Medicare will pay for glaucoma screening exams when provided by or performed under the direct supervision of an optometrist or ophthalmologist legally authorized to perform the services under state law. The screening must be performed in the office setting and billed with HCPCS Code G0117 or G0118.

If the above criteria are not met or the patient does not fall within the high-risk categories, you would need to use Form CMS-R-131, also known as the Advance Beneficiary Notice of Non-Coverage (ABN). This ABN can be used to notify patients of exclusion from coverage and requires that the cost estimate be completed on the form. It also has a third option for patients who indicate that they want to receive the item or service but do not want Medicare billed, as illustrated in Figure 1.

If you determine that the form is needed for a screening that is about to be provided, you must complete your portion of the form before—NOT AFTER—asking the patient to sign and before providing the service, thus the name, “Advance Beneficiary Notice.” The patient’s name should also be filled out at the
The Medicare number is no longer used, but you may include an account number or some other identification for your personal office use. Be sure to complete the various blanks on the form, describing what services will be provided. You will also need to include why you believe the service or procedure to be non-covered and write down the cost estimate associated with the procedure or service. Further, you should use language the patient can understand. You may add CPT, ICD-9, or HCPCS codes but would also need to add descriptions to accompany these codes. You must list the reason(s) for the possible denial and they must be specific to the particular patient. You should not use broad statements such as “not considered medically necessary for coverage”; this is not an acceptable statement. You might re-phrase with wording such as this: “Medicare does not pay for this glaucoma screening due to the time frame from the last covered glaucoma screening.”

When the paperwork is completed properly, the cost can be collected from the patient because having this form in place shows that you have provided the patient with the appropriate information. This not only protects the practice but also protects the patient’s interests.

A sample ABN (effective March 1, 2009), along with complete instructions for its use, may be found in the Chapter 30, Section 50 of the Medicare Claims Processing Manual (www.cms.hhs.gov/manuals/downloads/clm104c30.pdf). The same instruction and sample form may be found in CMS Transmittal 1587, CR 6136 (www.cms.hhs.gov/Transmittals/Downloads/R1587CP.pdf).