

ABN and medical necessity quiz

Circle the correct answer:

1. Medicare considers medical necessity to be a determination of whether a service is reasonable and necessary to diagnose or treat an illness or injury or to improve the functioning of a malformed body member.
a. True b. False
2. Which of the following is a financial-liability provision that does not require a beneficiary signature on the advance beneficiary notice (ABN)?
a. NCD b. RR c. LMRP d. LOL
3. Third parties may reimburse a service designated as noncovered under certain circumstances.
a. True b. False
4. Which of the following are referring physicians required to do?
a. Include actual ICD-9-CM codes on a test order
b. List actual CPT codes on a test order
c. Provide a narrative description of signs/symptoms or diagnosis
d. Both a and c
5. Which of the following does CMS consider to be a test order?
a. A written document signed by the treating physician that may be hand-delivered, mailed, or faxed to the testing facility
b. A telephone call by the treating physician or his or her office to the testing facility
c. E-mail by the treating physician or his or her office to the testing facility
d. All of the above
6. What is an LMRP?
a. Low medical reimbursement policy
b. Local medical review policy
c. Last-minute refusal to pay
d. Local medical reimbursement policy
7. Which of the following will Medicare contractors begin issuing by October 2005?
a. NCDs b. ABNs c. LCDs d. LMRPs
8. Providers can submit requests for reconsideration to have LMRP content modified.
a. True b. False
9. Facilities can obtain ABNs after a patient has received a diagnostic test.
a. True b. False
10. In the absence of signs or symptoms, how does Medicare describe a diagnostic exam?
a. Preventive b. Screening c. Diagnostic d. None of the above

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For the manager:

Providers are seeing an increase in denials related to medical necessity, even for legitimate services. Because appealing claims is often burdensome, many organizations choose to write off these denials. However, doing so results in a loss of revenue and can put the organization at risk for fraud and abuse charges.

Consistent denials for a single test could cost a facility millions of dollars each year. But to provide patients with the highest quality of care and add new services/equipment to treat them, hospitals and testing facilities must remain financially viable—and those lost dollars can prevent that from being so.

In addition, if such medical-necessity denials are received but the facility consistently fails to obtain an ABN and to bill the beneficiary, the government could cite the facility for offering patients inappropriate incentives by providing free care.

Therefore, facilities should use effective medical-necessity screening processes to maintain compliance and reimbursement. This will allow you to determine when Medicare is likely to deny payment for a test or service so your facility can obtain an ABN.

Part of your job is to ensure that your facility only bills Medicare for medically necessary services, so your staff must understand medical necessity. Once they do, they can help your facility by ensuring that physician orders meet Medicare's medical-necessity requirements.

Although physicians may order any tests that they feel are necessary to appropriately diagnose and treat a patient, Medicare will only pay for those that meet its definition of medical necessity. In other words, what physicians consider medically necessary from a clinical perspective may not match what Medicare considers medically necessary from a reimbursement perspective, and your staff need to know the difference.

Answer key:

1. a. True
2. d. LOL
3. b. False
4. c. Provide a narrative description of signs/symptoms or diagnosis
5. d. All of the above
6. b. Local medical review policy
7. c: LCDs
8. a. True
9. b. False
10. b. Screening

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