

**ABN Training Handbook
for Hospital Staff
and Physicians**

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Contents

About the contributing editoriv
Introduction	1
What is medical necessity?	1
Beneficiary Notices Initiative	2
Why can't providers bill denied medical-necessity charges?	2
Who explains coverage rules to beneficiaries?	3
When should providers obtain ABNs?	4
Determining whether a service is medically necessary	5
ABN decision tree	6
What services are excluded from Medicare coverage?	7
How to obtain and deliver ABNs	8
Using the standardized ABN format	8
How to fill out an ABN	9
Guidelines for delivering ABNs to patients	10
Medical emergency, duress, and EMTALA	12
What to do when patients won't sign the ABN	13
Prohibited ABN use	14
Case study 1	15
Risks of not providing ABNs	15
How to bill for suspected medical-necessity denials	17
How to fill out the UB-92	17
Guidelines for completing the CMS-1500	19
Case study 2	21
Collecting from patients	22
Final exam	24
Answer key	26
Certificate of completion	28

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Stacie L. Buck, RHIA, LHRM, is president and founder of Health Information Management Associates, Inc. She has served in several different roles during her 12-year career in the health information management profession, including medical-records coordinator, medical coder, revenue analyst, internal auditor, and corporate compliance officer.

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ABN Training Handbook for Hospital Staff and Physicians

Introduction

An advance beneficiary notice (ABN) is a written form that you or a supplier gives to a Medicare beneficiary. ABNs inform Medicare beneficiaries that the program may not pay for an item or service used during their visit to a provider. The form allows beneficiaries to decide whether they still want to receive the item or service, even if they have to pay for it out of pocket or through other insurance.

New rules for obtaining ABNs took effect in August 2002. The new rules effect the Medicare carrier, intermediary, hospital, and hospice manuals. However, the statutory requirements for providing ABNs have not changed. In fact, little has changed in terms of how and when to obtain ABNs.

What is medical necessity?

Medicare covers only those services that are reasonable and necessary

for diagnosis or treatment. Medicare uses this medical-necessity clause to control costs in outpatient fee-for-service settings. It empowers Medicare contractors to make medical-necessity rules to determine when they will pay for individual services under Medicare.

Beneficiary Notices Initiative

In late 2001, the Centers for Medicare & Medicaid Services (CMS) launched the Beneficiary Notices Initiative (BNI), a Web page dedicated to helping you and beneficiaries understand Medicare coverage rules.

Officially, the BNI provides a means to “wed consumer rights and protections with effective beneficiary communication, so that beneficiaries [have] the opportunity to timely exercise their rights and protections in a well-informed manner.” The BNI also tells beneficiaries when they need to pay for a procedure and allows them to decide whether to receive the items or services “for which [they] may have to pay out of pocket or through other insurance.”

Go to www.cms.hhs.gov/medicare/bni/default.asp to read draft ABNs and instructions.

Why can't providers bill denied medical-necessity charges?

You cannot bill Medicare beneficiaries for charges that Medicare denies without obtaining a signed ABN in most cases. Two types of financial-liability provisions protect Medicare beneficiaries:

- 1. Medicare's Refund Requirement (RR)**—affects medical equipment claims and nonassigned Part B claims. Non-assigned claims come from providers who have not signed a Medicare agreement. In such a case, they bill the patient directly, and the patient submits the claim to the Medicare program to receive payment.
- 2. Limitations on Liability (LOL)**—affects Part A and assigned Part B claims. Physician providers who participate in the Medicare program submit assigned claims. They accept Medicare reimbursement as full payment for care provided to Medicare beneficiaries.

Who explains coverage rules to beneficiaries?

Under the LOL provision, Medicare pays claims for services when neither you nor the beneficiary could have known that Medicare would not cover the service. To make sure you know when Medicare does not consider services medically necessary and to prevent payments for these services, CMS publishes national coverage determinations (NCD), and Medicare contractors publish local medical review policies (LMRP). In addition, remittance advice, sent from fiscal intermediaries and carriers to providers, will explain the reason for any denials and notify you that Medicare does not pay for services when medical-necessity criteria are not met.

CMS and program administrators consider their obligation to notify providers of medical-necessity rules met when they publish NCDs and LMRPs. However, providers—not beneficiaries—

receive NCDs and LMRPs, so beneficiaries don't know that Medicare will not pay for a service due to lack of medical necessity.

Medicare makes providers, not contractors, responsible for explaining medical-necessity coverage rules to beneficiaries. The LOL and RR clauses require beneficiaries to know that Medicare may deny a service because it does not meet the medical necessity rules. That's why Medicare requires providers to give beneficiaries ABNs when the chance of a denial arises.

When should providers obtain ABNs?

Always present beneficiaries with an ABN in the following situations:

1. Medical-necessity denials are determined by NCDs and LMRPs (SSA 1862(a)(1)(A))
2. Statutory screening exams are of limited frequency (e.g., mammograms or prostate-specific antigen testing, colorectal cancer screening) (SSA 1862 (a)(1)(F-H))
3. Prohibition on unsolicited telephone sales calls to beneficiaries from durable medical equipment (DME) providers has been violated (by directly contacting beneficiaries, DME providers forfeit the ability to receive Medicare reimbursement)
4. Medical-equipment supplier number requirements are not met

5. Medicare denies medical equipment and supplies in advance (no certificate of medical necessity)
6. A provider delivers home care to a patient who is not homebound and does not need intermittent nursing care
7. A hospice provides care to a nonterminal patient

Determining whether a service is medically necessary

Facilities must be able to screen for the medical necessity of a service before rendering it to Medicare patients. Staff registering patients must have access to NCDs and LMRPs. A computerized method may be the best solution. Many software vendors have automated this process.

Use the following process to determine the medical necessity of services:

1. Verify whether the test or service has an LMRP or NCD
2. If the test or service to be performed does not have limited coverage under an NCD or LMRP, proceed and perform the test or service ordered
3. If the test or service to be performed does have limited coverage under an NCD or LMRP, review the signs, symptoms, or diagnoses provided by the physician and determine whether the test is considered medically necessary based on the physician's documentation

ABN decision tree

Whether an ABN should be given depends on the physician or supplier's expectation of Medicare payment or denial. Use these guidelines for determining when to obtain an ABN:

DO NOT obtain an ABN

1. if the physician or supplier expects Medicare to pay (e.g., if the test or service to be provided meets medical necessity requirements of NCDs or LMRPs)
2. if the physician or supplier claims to never know whether Medicare will pay for a test or service
3. if the item or service is not a Medicare benefit (e.g., routine physical, tests in the absence of signs and symptoms, routine foot care, dental care)
4. If Medicare is expected to deny payment for an item or service that is a Medicare benefit because it does not meet a technical benefit requirement (e.g., diabetic care shoes not prescribed by a podiatrist or other qualified physician)

Note: Form CMS-20007 Notices of Exclusions from Medicare Benefits (NEMBs) may be used with items and services that are excluded from Medicare benefits. NEMBs alert Medicare

beneficiaries in advance that Medicare does not cover certain items and services because they do not meet the definition of a Medicare benefit or because they are specifically excluded by law; that is, when the use of an ABN is not appropriate.

DO obtain an ABN

1. if you expect Medicare to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary based on an NCD or LMRP (this applies to all assigned Part B items and services and to unassigned physicians' services and medical equipment and supplies)
2. certain screening tests (e.g., mammography, pap smear, pelvic exam, glaucoma, prostate cancer, colorectal cancer) work within frequency limits; obtain an ABN when you expect Medicare to deny payment for frequency of the test
3. if you expect Medicare to deny payment for medical equipment and supplies because it violates the prohibition on unsolicited telephone contacts or supplier number requirements

What services are excluded from Medicare coverage?

You can bill beneficiaries without giving them an ABN after receiving a Medicare denial for statutorily excluded services. These services include, but are not limited to, the following:

- Appearance-enhancing surgeries

- Screening tests other than those added to Medicare by law
- Dental care and dentures (in most cases)
- Investigative drugs and treatments
- Personal comfort items

Note: This is only a general summary of items and services excluded from Medicare benefits.

How to obtain and deliver ABNs

Using the standardized ABN format

CMS has published two official ABNs, one for general use and one for laboratory use. Follow these guidelines to determine which standard format to use:

- **CMS-R-131-G**—use this for any services, including lab services. This form can be customized in the “Items or Services” and “Because” boxes and in the header.
- **CMS-R-131-L**—use this only for lab services, usually at a freestanding diagnostic laboratory. This form can be customized in the header and in the “Reasons and Tests” three-column box area.

To meet program requirements, providers must use the standardized format, which clearly identifies the item or service and states why the provider or supplier believes Medicare will deny payment for that service. The form can be no more than one page long.

List the reason for denial

ABNs do not include sample reasons for denial. However, medical-necessity rules and screening-test frequency limitations are the two most commonly denied items/procedures and therefore require ABNs. Use the following wording for these denials:

- According to local/national coverage guidelines, Medicare does not pay for this item or service for your given condition(s).
- Medicare does not pay for this item or service more often than ____ (frequency limit for service).

Preprint ABNs with this language to help you complete the forms more quickly.

How to fill out an ABN

Follow these rules for filling out the ABN:

1. Complete ABN forms with the patient's name and Medicare health-insurance number.
2. Include the service that Medicare will likely deny in the appropriate box.
3. Include the reason you anticipate the denial in the appropriate box.
4. The provider may estimate the cost for the service. If a

patient requests an estimate, providers should complete the form to the best of their ability. However, not including a price does not automatically invalidate an ABN.

5. Beneficiaries must select one of the following options on the form:
 - Receive the services affected by coverage limitations
 - Decline the services
6. Date the form and have beneficiaries (or their representatives) sign it.

Guidelines for delivering ABNs to patients

1. **Deliver ABNs to Medicare beneficiaries by hand** before performing any service. Prior ABNs do not apply to future services unless a patient receives the same service periodically. These ABNs must clearly state which services are standing orders, and you must renew the ABN annually.
2. **You can notify beneficiaries by telephone** that Medicare may not pay for the items or services they need, as long as you mail patients a copy of an ABN to sign or present at a later visit. If you take this step, the time of the telephone call can count as the time of ABN delivery. (**TIP:** *Do not submit a claim with the required modifier indicating that a signed ABN is on file until the patient returns a signed ABN.*)
3. **You cannot perform “last moment delivery,”** in which

patients feel the service has already begun and they have no choice but to sign the ABN to continue the service. Essentially, you may not present the ABN to the patient after substantially prepping him or her for a test.

- 4. Duplicate all ABNs.** One copy goes to the beneficiary at the time of signing, and at least one copy goes in the medical record/billing record.
- 5. Diagnostic and treatment service providers may also prepare ABNs.** Although the patient's physician is the best individual to prepare an ABN, most physicians do not prepare ABNs when referring the patient to another facility for services. Testing facilities can request that patients complete an ABN before providing a test/service. Additionally, if a lab only receives a specimen (i.e., no patient contact), it may request that the patient complete an ABN before the lab performs the test. However, don't delay the test if the specimen's integrity is at risk.
- 6. Beneficiaries must be able to comprehend ABN instructions,** or Medicare could consider a signed ABN to be "defective." Do not administer an ABN when the beneficiary is legally incompetent, confused, comatose, or unable to comprehend the instructions. Use the following guidelines for obtaining ABNs:
 - If a beneficiary has trouble comprehending the form due to disease or disability, document how you overcame these barriers

- Beneficiaries who do not understand English should receive the notice in their language through a translator (Forms CMS-R-131-G [General Use] and CMS-R-131-L [Laboratory Tests] can be found on the CMS Web site in Spanish)
- If the beneficiary cannot understand or sign an ABN, an authorized representative may sign

TIP: *An authorized representative is an individual permitted under state law to make healthcare decisions (e.g., a legally appointed representative or guardian, or an individual exercising explicit legal authority on the beneficiary's behalf [durable medical power of attorney]).*

7. **You can only obtain an ABN when your facility meets the technical requirements for a given service.** For example, you can use an ABN to prescribe diabetic shoes only if you are a podiatrist or an otherwise qualified physician.

Medical emergency, duress, and EMTALA

A hospital must meet all requirements under the Emergency Medical Treatment and Labor Act (EMTALA) before administering ABNs to patients who present with medical emergencies. EMTALA requirements include performing a medical screening examination to determine whether the patient has an emergency medical condition and performing stabilization services if you find one.

Wait to explain the Medicare coverage rules for any tests or services they may receive until after qualified staff screen and stabilize the patient. Even after a patient has received a medical screening examination and is stabilized, do not give the patient an ABN unless you have a genuine reason to expect Medicare to deny payment for the service.

What to do when patients won't sign the ABN

Under LOL, you can bill beneficiaries who refuse to sign the ABN but demand the service as long as you properly conduct and document the benefits-determination process and provide the patient with an ABN. This means that providers who inform beneficiaries of the likelihood of a Medicare denial can bill patients, even without their signature.

To document such a situation, you and a second witness should sign and annotate the unsigned space on the ABN to state that the patient refused to sign the document.

However, Medicare's RR clause still protects patients who refuse to sign the ABN. Medical suppliers and physicians who do not participate in Medicare must obtain the patient's signature or Medicare will not pay for the services or items they provide.

TIP: *Providers can deny a service to a beneficiary who has refused to sign an ABN unless the consequences (e.g., health and safety of the patient or civil liability in the case of harm) rule out this option. Contact the ordering physician to determine whether the patient's care would be compromised by not performing the test.*

PROHIBITED ABN USE

Providers cannot obtain routine ABNs from Medicare beneficiaries. Routine ABNs include the following:

- Generic or blanket ABNs—routine provisions of ABNs stating that denial by Medicare may be possible, but give no reason
- Signed blank ABNs—a signature is obtained from a patient without explaining which services may be denied. An ABN must be completed in its entirety prior to being presented to the patient for signature.

Exceptions to routine ABN prohibition include cases in which

- services are always denied for medical necessity
- items and services are experimental
- Medicare will cover items and services only a limited number of times over a given period
- medical equipment and supplies are denied because the supplier had no supplier number or made an unsolicited telephone call

Case study 1

Maura works in the admitting department of a hospital. She is responsible for greeting and registering all patients.

Andrew, the admitting manager, asks Maura to have all patients sign an ABN when they register. “Medicare has been denying payment for many of our services. We can only bill Medicare patients if they sign an ABN, but the referring physicians never ask patients to sign one, and it takes too long to determine whether Medicare will pay for a service.”

Andrew says he wants every patient to sign an ABN so the billing department can charge the patient for any services that Medicare denies. Maura thinks this is a good idea, so she agrees to it.



What would you do?



Providers cannot obtain routine ABNs from Medicare beneficiaries. Providers must tell beneficiaries the specific services that may be denied and give the reason for the potential denial. *Note:* For exclusions to the prohibition on routine ABNs, see the section “Prohibited ABN use.”

Risks of not providing ABNs

Given the complexity of obtaining ABNs from beneficiaries, you may desire to just avoid the whole process and adjust your Medicare receivables. But don't do it. Providers who routinely fail to obtain ABNs from their patients face the following risks:

- **Fraud and abuse charges**—If you bill Medicare without checking for medical-necessity rules or other reasons for Medicare denials, the OIG may charge you with offering patients inappropriate incentives by providing “free” care. Because you cannot bill a patient without an ABN, not obtaining one may look like you used improper inducements to obtain referrals and, thus, violated the anti-kick-back statute.
- **Cost-report violations**—Never perform medical-necessity checks on the back end and then omit those charges on the claim. Medicare cost-reporting rules do not treat medical-necessity denials as bad debt when providers decide not to obtain ABNs and omit charges.
- **Sanctions**—If a patient receives services or items that are not medically necessary, you must still submit a claim to Medicare. If you do not submit a timely claim, you have violated the mandatory claims-submission provision, which could result in sanctions. For exclusions and technical denials, you only need to submit a claim if the patient requests it. **TIP:** *Appropriate use of designated modifiers and condition codes for services that are non-covered or not medically necessary is critical to ensure compliance with Medicare billing requirements.*
- **Loss of revenue**—There is no reason not to bill for all services provided to a Medicare beneficiary, even if you

believe Medicare may not pay for them. This is especially important for hospital providers, who are reimbursed under the outpatient prospective payment system, which uses grouped ambulatory payment classifications. Medicare no longer pays many per-item ancillary services. If a claim does not have a service that corresponds to an ambulatory payment classification, Medicare may not reimburse the service.

How to bill for suspected medical-necessity denials

Two sets of requirements exist for facilities to bill services that do not meet medical-necessity rules, one for the UB-92 (CMS-1450) form for hospital and facility billing and one for the CMS-1500 form used for billing professional services.

How to fill out the UB-92

Condition codes and occurrence codes are used on the UB-92 to designate noncovered services or services that do not meet medical-necessity guidelines. Use the following codes on the UB-92:

- 1. Condition code 20**—Facilities bill claims with condition code 20 at a beneficiary's request, when the provider has already advised the beneficiary that Medicare is not likely to cover the service(s) in question. Facilities may submit this claim with both covered and noncovered charges. This condition code may be used when a Home Health ABN Form

R-296 is signed and payment will be made under the home-health prospective payment system, or when a hospital or skilled nursing facility notice of noncoverage has been provided to the patient. **TIP:** *Don't use this condition code if the patient has signed an ABN Form R-131.*

2. **Condition code 21**—Use condition code 21 when submitting Medicare claims to receive a formal denial for supplemental insurance billing purposes. It designates that all services on the claim are noncovered services and that a claim is being filed in order to obtain a denial from Medicare so a secondary payer can be billed. **TIP:** *Don't use this code if the patient has signed an ABN.*
3. **Occurrence code 32**—This signifies that an ABN was given to a beneficiary on a specific date. Use this code if you have obtained an ABN form. Only list services for which an ABN was given on a claim with condition code 32. Also, only include covered charges on the claim form when using this code. **TIP:** *Don't use condition codes 20 and 21 with occurrence code 32.*

Give separate ABNs to patients for procedures performed on different dates, and bill separately for each date involved.

If a provider renders a service not pertaining to the ABN at the same time as services requiring an ABN, submit the services on separate claims. If the time periods cannot be separated (e.g., a service requiring an ABN is given on the same day as a service

not requiring an ABN), submit a single claim for the overlapping period using occurrence code 32, show all services as covered, and place modifier GA on the procedure code to identify the service line for which the ABN was obtained. Only use the GA modifier when it is impossible to separate billing periods.

Guidelines for completing the CMS-1500

The CMS-1500 uses modifiers to designate noncovered services or services that do not meet medical-necessity guidelines. Providers can bill covered and noncovered services on the same claim. Use the following three modifiers to designate services for which Medicare will not pay:

- **GA**—Append this modifier to the procedure code for which the facility has obtained a signed ABN. Also use this modifier if the patient did not sign the ABN but was informed of likely noncoverage and chose to receive the service anyway. Two witnesses should sign the ABN form in this case. **TIP:** *Append this modifier to each procedure listed on the ABN; otherwise, your facility will be held liable and won't be able to bill the patient.*

According to CMS, if the GA modifier is not used, “the question of an abusive billing pattern could arise.” Carriers do not use this modifier to determine medical necessity.

- **GY**—Append this *optional* modifier to a service when an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. This optional

modifier may speed rejection of the claim so the provider can bill a secondary payer or the patient. No ABNs are required in this case; however, Form CMS-20007, Notices of Exclusions from Medicare Benefits may be used. The most common examples are routine physicals and laboratory or radiology tests ordered in the absence of signs/symptoms.

- **GZ**—This *optional* modifier is used for
 1. claims in which an ABN was not presented or signed, and for which the provider believes the service will be denied
 2. physician and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); unassigned claims; and assigned DMEPOS claims when a technical denial is expected
 3. unassigned claims when the patient refuses to sign the ABN and services were provided

Consider these examples of appropriate uses of modifier GZ:

- Example 1: You realize after providing a service that Medicare may not pay for the service and the facility should have obtained an ABN
- Example 2: A specimen was sent to a provider for testing,

and the patient could not be reached to sign an ABN prior to testing

- Example 3: The facility did not provide an ABN because of emergency-care circumstances governed by EMTALA

TIP: *The provider will probably be held liable for the service(s) submitted with this modifier, but CMS instructions state that using this optional modifier "greatly reduce(s) the risk of a mistaken allegation of fraud or abuse."*

Case study 2

Dana works for a radiologist. She is in the process of billing Medicare for a chest x-ray performed on Mrs. Q who was referred by her primary care physician, Dr. P. As Dana is reviewing the medical record, she finds no evidence that the service met Medicare's medical-necessity requirements. She also found no record that Mrs. Q. signed an ABN prior to receiving the test.

Dana contacts Dr. P to obtain additional information about Mrs. Q's condition. She informs him that the test was not medically necessary. Dr. P states, "I ordered the test, so it must be medically necessary. I don't appreciate you questioning my medical judgment. Please just bill Medicare for the services and don't ask me any more questions."

Dana apologizes to Dr. P. and submits the claim to Medicare. She does not include the appropriate modifier on the claim.



What would you do?



Although her instinct was correct, Dana dropped the ball on this one. This service did not meet Medicare's criteria for medical necessity. Billing for this service without using a modifier or condition code may put the provider at risk for fraud and abuse allegations.

Because the provider missed its chance to present the patient with an ABN, it must bill the service using the GZ modifier, which tells Medicare that the provider did not present an ABN but that it believes the service may be denied. Using this code can greatly reduce the risk of fraud and abuse allegations.

Collecting from patients

Unlike other demand-bill situations, you do not have the option to collect from the beneficiary at the time of the service when the beneficiary signs an ABN. However, you do not have to follow Medicare charge limits when subsequently billing under a signed ABN, so you may bill the beneficiary for the full charge of the service.

TIP: *According to the Medicare Provider Reimbursement Manual, providers can bill a Medicare beneficiary for the applicable deductibles and coinsurance even when a claim is denied due to medical necessity. This is not correct. The reimbursement manual has not yet been updated to reflect changes created by the BNI.*

Final exam

1. Who is responsible for explaining medical-necessity coverage rules to beneficiaries?

- a. CMS
- b. Medicare contractors
- c. Providers
- d. All of the above

2. In which of the following instances should you obtain an ABN from a Medicare beneficiary?

- a. If the physician or supplier expects Medicare to pay
- b. If the physician “never knows whether Medicare will pay”
- c. If the item or service is not a Medicare benefit
- d. If you expect Medicare to deny payment for an item or service because it is not reasonable and necessary under Medicare program standards

3. When should you obtain an ABN for a patient who presents to the emergency room (ER) under medical duress?

- a. Before screening the patient
- b. Before stabilizing the patient
- c. After screening and stabilizing the patient
- d. You cannot obtain ABNs in the ER

4. Which of these items or services are statutorily excluded by Medicare?

- a. Appearance-enhancing surgeries
- b. Dental care
- c. Routine foot care
- d. All of the above

5. Which modifier should you use on CMS-1500 to bill for services when you have obtained an ABN?
 - a. GA
 - b. GX
 - c. GY
 - d. GZ

6. Which of the following is a potential consequence of not obtaining an ABN from beneficiaries?
 - a. Fraud and abuse charges
 - b. Cost-report violations
 - c. Loss of revenue
 - d. All of the above

7. True or false: Medicare prohibits the use of generic or blanket ABNs.

8. True or false: You cannot collect payments from the beneficiary at the time of the service when the beneficiary signs an ABN.

9. True or false: You must obtain ABNs for all statutorily excluded services.

10. True or false: You cannot notify beneficiaries by phone that Medicare may not pay for an item or service.

Answer key

1. C
2. D
3. C
4. D
5. A
6. D
7. True
8. True
9. False
10. False

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This is to certify that

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ABN Training Handbook for Hospital Staff and Physicians

Suzanne Perney

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Vice President/Publisher