Affiliated Laboratory, Inc.
Compliance Program

Title: Administration of Advance Beneficiary Notices (ABNs) Notice of Noncoverage

Purpose: To provide instruction for accurate and appropriate Advance Beneficiary Notice (ABN) administration to Medicare patients.

Policy: If a patient has Medicare and their doctor, other health care provider, or supplier thinks Medicare probably (or certainly) won't pay for items or services, a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) should be provided. However, an ABN isn't required for items or services that Medicare never covers.

An ABN should be administered to all Medicare outpatients when either **a)** the test(s) ordered has medical-necessity coverage criteria and the diagnosis(es), sign(s), or symptom(s) that satisfies the test's coverage criteria is not provided, or **b)** the test has frequency limits for coverage, as in screening tests. Medicare **ABNs are administered to traditional Medicare Part B beneficiaries only; they are not for use for beneficiaries covered by Medicare Advantage plans.**

I) ABN form completion

An ABN should be obtained when one or more of the following circumstances exist:

- you have genuine reason to believe the diagnosis provided does not satisfy the NCD or LCD medical necessity requirements of the test(s)
- a test with medical necessity coverage criteria is ordered with a diagnosis indicating a routine exam ("i.e., "physical" or "screening") or the narrative diagnosis is not code-able, as in "rule out ("r/o") …."
- A covered Medicare screening test is ordered

Because administration of the ABN is intended to enable the patient to make an informed decision regarding healthcare services, the ABN must be presented and explained to the patient by ALI staff in a way that:

- clearly informs the patient why the ABN is being administered and that by signing the patient agrees to be financially responsible for the test(s)
- does not place the patient in a position where the patient feels that he/she is being pressured or coerced to sign the ABN

For this reason, the ABN must be administered PRIOR to the patient sitting in a phlebotomy chair and/or otherwise being prepared for specimen collection.

Depending on the patient's registration status and where the patient presents for specimen collection, a particular ABN form must be used. **A separate ABN is used for**:

- ALI-registered patients
- EMMC-registered patients

A) Preparing the ABN form

1. Choose an ABN with the name and logo of the organization (ALI or EMMC) under which the patient's encounter is registered.

2. Complete the ABN form for the following required information:

   a. Patient name and Patient Identifier (medical record, account, or Medicare number, etc.) under the ABN header.
   b. Name of the test(s) Medicare may deny payment for, under the header "Laboratory test(s)"
   c. Indication of the reason why Medicare may deny coverage of the test(s) under the header "Reason Medicare May Not Pay" write/indicate either:

      i. **Medicare does not pay for this testing for your condition(s)**; this is used when diagnostic tests are not covered, ***OR***
      ii. **Medicare pays for this screening test once every 12 months; if testing is covered you won't be billed.;** this is used for screening PSAs, occult blood ('MS'), HIV, STD, etc. testing.

   d. Cost of testing. ALI must make a good faith effort to insert a reasonable estimate of what the testing will cost. Please reference the most recent test price list. When the testing exceeds $150, indicate cost *estimates*, for example:

      - Any dollar estimate equal to or greater than $150
      - "Between $150-300"
      - "No more than $500"

      For testing that costs $500 or more:

      - Any dollar estimate equal to or greater than $375
      - "Between $400-600"
      - "No more than $700"
      - "$1000.00 or more"

NOTE: absence of elements b, c or d listed above will invalidate the ABN and will render the form useless for billing purposes!

B) ABNs & Medicare covered screening tests

The Medicare program covers the following screening laboratory tests:

- PSA
- Fecal occult blood
- HIV-1 and/or HIV-2 antibodies
- STD panel (or chlamydia/gonorrhea testing separately)
- RPR, VDRL, or Treponemal antibody
- Hepatitis B surface antigen
- LIPIDS (or serum cholesterol, HDL or triglycerides separately)
- Serum glucose or 1 or 2 hr. glucose challenge test

The Medicare program will usually pay for one specific screening test per 12-month period. A challenge that these screening tests pose is that we don't know if a screening test has been performed in the past twelve months at another lab or not. **For this reason please administer an ABN every time a Medicare covered screening test is ordered, explaining to the Medicare patient that if Medicare pays for the testing, the patient will not be billed**.

II) Delivery of ABN to the patient

1. Examine the reason for non-coverage check-off and explain to the patient (in words to the effect of):

   - **"Since this screening test is covered only once per 12-month period**, **Medicare may deny coverage. For this reason we ask that you sign the ABN because we do not know if Medicare has already paid for this in the last 12 months. If Medicare has not already paid for this screening test, you will not be billed"** *for screening tests*

   or,

   - "**Medicare is likely to deny payment because your test is not covered for the diagnosis or symptoms indicated by your doctor"** *for diagnostic tests*

2. Ask the patient to acknowledge his/her decision by checking off the box corresponding to one of the three following form options:

   a. ☑ **OPTION 1.** I want the test(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment…..

   b. ☑ **OPTION 2.** I want the test(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment……

   c. ☑ **OPTION 3.** I don't want the test(s) listed above….

NOTE: ALI is not required to, and does not accept immediate payment for testing.

3. Request that the patient sign & date the ABN and inform the patient that by signing he/she accepts financial responsibility for the testing.

   NOTE: an ABN unsigned by the patient is not valid and cannot be used for billing.

   The patient must sign an ABN even if secondary insurance is likely to pay for the test. Explain to the patient that in these cases we must submit the claim to Medicare first so we can get a denial statement in order to bill their secondary insurance carrier.

   In instances where the patient is unable to sign or comprehend the ABN, the patient's representative may sign on the patient's behalf. The representative may be the patient's spouse, relative, guardian, friend, or other person who is not an employee of any EMHS entity. The attending person must indicate on the ABN that they are signing on the patient's behalf (example: "Jane Smith (for Robert Smith)").

4. If the patient refuses to sign an ABN but wants the testing done, document the patient's refusal to sign in the **Additional Information section by writing** "patient refused to choose an option" in the space provided.

III) When ABN administration is complete

1. **Provide the patient with a copy of the ABN.** This is required by law. DO NOT give the original, signed form to the patient.

2. Manage all documentation as follows:

   a. ALI Union St. drawing station
      - attach the original ABN to the requisition

   b. ALI Webber drawing station
      - forward original ABNs to the Chief Compliance Officer

   c. ALI Portland & ALI Vermont
      - attach the original ABN to the requisition