When should a patient sign an ABN?

If the answer to all three questions below is TRUE, a signed ABN is required:
1. The patient is a Medicare Part B beneficiary.
2. One or more of the tests being ordered for the patient appears in this book.
3. The National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) indicate the test(s) ordered does not have a diagnosis code that meets medical necessity and/or has a frequency limitation.

What if the patient is unwilling to sign the ABN?

1. Review and provide all applicable ICD-9 codes.
2. Discuss the medical need for the test and potential payment responsibility with the patient.
3. If patient chooses Option 3, order the lab test(s) and add the following comment:
   “Patient refused testing and signed ABN on file. Test(s) not performed. Diagnosis provided does not support medical necessity per Medicare guidelines.”
4. Cancel the test(s).

Ordering Procedure for Medicare Patients

1. Determine the tests to be ordered and indicate all medically appropriate ICD-9 codes that accurately reflect the patient’s condition or symptoms, and therefore, the diagnostic purpose for ordering the test(s).
2. Check to see if the test(s) or any test in a panel/profile ordered appear in this NCD/LCD book
   - If yes, proceed to Number 3.
   - If no, proceed with normal lab specimen submission procedures.
3. Determine if the ICD-9 codes you have listed are included on the Medicare carrier’s list of the covered ICD-9 codes for that test.
   - If yes, proceed with normal lab specimen submission procedures.
   - If no, proceed to Number 4.

Completing the ABN

4. All of the following sections of the ABN must be completed:
   A) Patient’s first and last name.
   B) Check off or write in the test(s) that Medicare may not cover.
   C) Write in the estimated cost for the test(s) from the Table of Contents.
   D) Have the patient personally selection Option 1, Option 2 or Option 3.
   E) Present the entire ABN form to your patient and be sure he/she reads it in its entirety and understand it. Explain why you think the test(s) is medically appropriate.
   F) Once the Option is selected, the patient must sign the ABN.
   G) The patient must also date the ABN.

Provide the patient with a signed copy of the ABN

Submit the completed ABN with the test requisition
### ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

**NOTE:** If Medicare doesn’t pay for the laboratory test(s) below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the laboratory test(s) below.

<table>
<thead>
<tr>
<th>(B) Medicare does not pay for these tests for your condition</th>
<th>(B) Medicare has frequency limitations for:</th>
<th>(C) Estimated Cost:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ CBC</td>
<td>□ HIV</td>
<td>□ Occult Blood</td>
</tr>
<tr>
<td>□ CEA</td>
<td>□ Lipid</td>
<td>□ Pap Smear</td>
</tr>
<tr>
<td>□ Digoxin</td>
<td>□ Iron Studies</td>
<td>□ Pap Smear/Thin</td>
</tr>
<tr>
<td>□ Ferritin</td>
<td>□ T3, Uptake</td>
<td>(once every 2 years)</td>
</tr>
<tr>
<td>□ GGT</td>
<td>□ Prot time w/INR</td>
<td>□ PSA, Diagnostic</td>
</tr>
<tr>
<td>□ Glucose</td>
<td>□ T4, Total</td>
<td>□ TIBC</td>
</tr>
<tr>
<td>□ Glycohemoglobin</td>
<td>□ PTT</td>
<td>□ PSA Screen</td>
</tr>
<tr>
<td>□ HCG</td>
<td>□ Tumor Antigen</td>
<td>(once every 12 months)</td>
</tr>
<tr>
<td>□ Other: _______________________________________________</td>
<td>□ RPR</td>
<td></td>
</tr>
<tr>
<td>□ Other: _______________________________________________</td>
<td>□Culture, Urine</td>
<td></td>
</tr>
<tr>
<td>□ Other: _______________________________________________</td>
<td>□ PSA Screen</td>
<td></td>
</tr>
<tr>
<td>□ Other: _______________________________________________</td>
<td>□ TIBC</td>
<td></td>
</tr>
</tbody>
</table>

### WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the laboratory tests listed above.

**Note:** If you choose Option 1 or 2, we may help you use any other insurance that you might have, but Medicare cannot require us to do this.

### (D) OPTIONS:  **Check only one box. We cannot choose a box for you.**

- **OPTION 1.** I want the laboratory test(s) listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- **OPTION 2.** I want the laboratory test(s) listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- **OPTION 3.** I don’t want the laboratory test(s) listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

### (E) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

**Signature:**

**Date:**