

 HAWAII HEALTH SYSTEMS C O R P O R A T I O N <i>"Touching Lives Everyday"</i> Policies and Procedures	<i>Quality Through Compliance</i>	Policy No.: FIN 0506
		Revision No.: N/A
Subject: <i>Advance Beneficiary Notice</i>	Issued by: Corporate Compliance Committee	Effective Date: September 15, 2000
	Approved by: Thomas M. Driskill, Jr. President & CEO	Supersedes Policy: N/A Page: 1 of 4

- I. **PURPOSE:** To obtain an Advance Beneficiary Notice (ABN) from Medicare beneficiaries when laboratory tests are not covered according to Local Medical Review Policy (LMRP).
- II. **POLICY:** Medicare will only pay for services which it determines to be reasonable and necessary. An Advance Beneficiary Notice must be obtained when ordered laboratory tests do not meet this requirement.
- III. **PROCEDURE:** It is the responsibility of the Chief Financial Office at each facility to guarantee adherence to this procedure.
 - A. **Guidelines:** The guidelines listed below must be followed to obtain an Advance Beneficiary Notice in accordance with Medicare requirements.
 1. An Advance Beneficiary Notice must be obtained when one or more of the following circumstances exist:
 - The test is for a routine exam or screening.
 - The test is for investigative or research use only.
 - The diagnosis provided may or does not meet medical necessity requirements.
 - No diagnosis provided.
 - The test may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
 - The test has not been approved by the Food and Drug Administration.
 2. For those services which Medicare excludes from coverage under Part A or Part B (e.g., tests associated with routine checkups, glasses, hearing aids, routine foot care, dental work, cosmetic surgery, immunization, custodial care, personal comfort items, etc.) an ABN must be obtained noting the appropriate reason of non-coverage.
 3. An ABN must be in writing and clearly identify the following:
 - Description of service(s) that may be denied, including procedure name and CPT/HCPC code
 - Reason the service may be denied

- Patient's name
 - Patient's Medicare number
 - Patient or guarantor's signature and date
 - Witness signature and date
4. The patient has two choices:
 - a. Obtain the service(s) and agree to be responsible for payment should Medicare deny payment; or
 - b. Refuse responsibility for payment and not obtain the service(s).
 5. In the case in which the beneficiary demands the service(s) and refuses to pay or sign the ABN form, then a second employee should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case, the services may be provided and if Medicare payment is denied, the beneficiary will be responsible for payment.
 6. Routine use of the Advance Beneficiary Notice is prohibited. There must be a specific reason to believe Medicare will determine that the test ordered may not be considered reasonable and necessary.
 7. The physician's office initiating the ABN should keep a copy of the ABN and a copy must be given to the beneficiary.
 8. Facilities must maintain the copies of the ABN with the patient's financial records according to financial record retention guidelines.
 9. An Advance Beneficiary Notice must be obtained for initial standing orders (for extended course of treatment) which contain tests that may not be covered. However, it is not necessary to obtain a new ABN each time the test is performed in accordance with the standing order.

B. Implementation:

1. Laboratory and business office personnel must obtain the Local Medical Review Policies as issued by the Part B Carrier or Fiscal Intermediary and organize the material so that it is readily available for registration staff. Please refer to Medical Necessity Policy.
2. All staff /physicians responsible for referring, registering, performing and billing laboratory services will be educated on the contents of this policy.

C. Daily:

1. Individuals ordering tests and performing registration must review diagnosis for Local Medical Review Policies when processing every outpatient Medicare order.
2. If the patient presents a completed Advance Beneficiary Notice from the physician's office, proceed with performing the ordered tests. Follow step 6 of the Daily process.

3. If the patient presents with no Advance Beneficiary Notice and the diagnosis provided does not meet medical necessity guidelines for the tests being ordered, registration staff must complete an Advance Beneficiary Notice.
4. Instruct the patient on the purpose of the form and ask patient or guardian to sign one of the two options:
 - a. Agree to pay for service(s) which may be denied and therefore obtain the service(s); or
 - b. Deny responsibility and do not obtain the service(s).
5. In the case in which the beneficiary demands the service(s) and refuses to pay or sign the ABN form, then a second employee witness should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case the services may be provided, and if it is denied, the beneficiary will be responsible for payment.
6. If a specimen is received and the test(s) ordered do not meet medical necessity guidelines for the diagnosis provided, and an ABN is not present, laboratory or hospital personnel must contact the ordering physician to determine if an ABN was obtained.

If there is no ABN present, laboratory/hospital personnel must inform the physician that medical necessity requirements were not present for the test(s) being ordered. The physician must verify that the test order and diagnosis provided is correct.

If the physician verifies that the test order is correct, laboratory personnel may perform the test(s) as ordered and instruct business office personnel to remove services from the bill which do not meet the medical necessity criteria.

These services may not be included as Medicare bad debt expenses.

7. If the services are considered excluded from Medicare coverage (e.g., tests associated with routine checkups, glasses, hearing aids, routine foot care, dental work, cosmetic surgery, immunization, custodial care, personal comfort items, etc.) but the patient requests that the bill be submitted to the payor, a condition code 20 must be entered on the UB-92 to indicate the provider realizes the services are non-covered or excluded but the patient requests a determination by the payor.
8. The signed ABN form should be distributed as follows:
 - a. Give the back copy to the patient;
 - b. Retain the middle copy at physician's office or registration office; and
 - c. File the original copy in the business office.
9. If the patient denies payment responsibilities and declines the test(s), then perform only those tests that meet the medical necessity guidelines, and inform ordering

physician that services were not performed. If the patient agrees to pay for the service(s), then perform all tests ordered.

10. If a claim is denied by Medicare, business office personnel must review patient financial records to determine:

- If an ABN is present (either patient agreed to pay or refused to sign with noted witnesses), then the denied services may be billed to the patient (beneficiary).
- If an ABN is not present, the services must be written off as a non-allowable/non-billable service. This write-off may not be claimed as a bad debt.