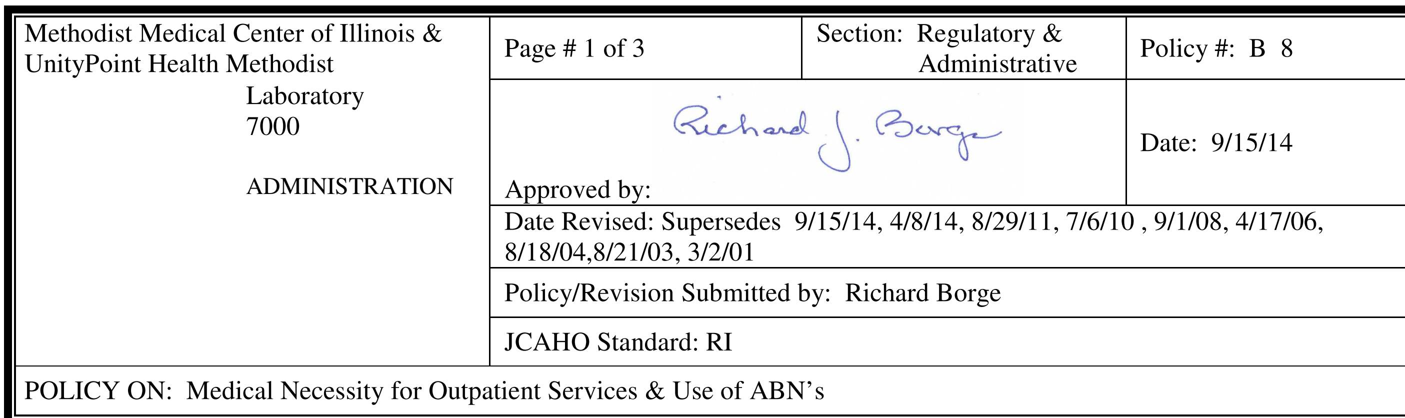

Methodist Medical Center of Illinois & UnityPoint Health Methodist Laboratory 7000 ADMINISTRATION	Page # 1 of 3	Section: Regulatory & Administrative	Policy #: B 8
	Approved by:		Date: 9/15/14
	Date Revised: Supersedes 9/15/14, 4/8/14, 8/29/11, 7/6/10 , 9/1/08, 4/17/06, 8/18/04,8/21/03, 3/2/01		
	Policy/Revision Submitted by: Richard Borge		
	JCAHO Standard: RI		
POLICY ON: Medical Necessity for Outpatient Services & Use of ABN's			

I. POLICY:
UnityPoint Health System will comply with regulations governing the medical necessity of outpatient services.

II. PURPOSE:
- A. To ensure that all outpatient testing and services are accurately coded and provided as specified by the ordering physician.
- B. To ensure that accurate diagnostic information and signed authorization are obtained from the ordering physician.
- C. To ensure that advanced beneficiary notices are properly administered.

III. POLICY SCOPE:
The scope of this policy applies to any staff registering or drawing outpatients.

III. GENERAL INFORMATION:
- A. An ABN is a written document used to notify a Medicare patient of the possibility that Medicare will deny payment for the ordered test(s) and to indicate the patient's agreement to accept responsibility for payment in the event Medicare does, in fact, deny payment.
- B. Outpatients are classified as those patients who obtain services through all hospital outpatient service areas, physician offices, emergency department or ambulatory surgery.
- C. A signed physician's order and complete diagnostic information is required for all outpatient services. A facsimile signature from the physician is acceptable.
- D. A physician order and patient diagnosis are requested prior to testing.
- E. Advanced Beneficiary Notices (ABN) are standardized throughout UnityPoint Health Peoria.
- F. An ABN may be used to bill Medicare patients for test only if it is properly signed in accordance with all Medicare requirements.
- G. Presenting the ABN to the patient is the responsibility of the provider or designee which may include phlebotomists, laboratorians, nurses, physician office personnel, and other caregivers who have contact with the patient.
- H. Methodist personnel are prohibited from independently selecting an ICD-9 diagnosis code or attempting to encourage or influence use of a particular code.
- I. Diagnostic standing orders for individual outpatients must be renewed every twelve months. Medical necessity documentation must be updated by obtaining a renewed signed order and diagnosis. (e.g. standing order for weekly protime)
- J. There is a copy of the ABN form that UnityPoint Health Methodist uses attached to this policy. Whenever we refere to "the ABN" in this policy, we are referencing the attached form.

IV. PROCEDURE:
- A. Scheduling Function
  1. A signed and dated physician's order with complete diagnostic information supporting medical necessity must be requested at the time outpatient tests/services are scheduled.
     a. Exceptions: All self referred tests approved by Federal or State regulatory agencies. (e.g. screening mammogram)
  2. Verbal and telephone orders can be accepted by appropriate staff as designated in the Medical Staff Rules and Regulations.
  3. The following diagnoses according to CMS do not meet medical necessity guidelines and therefore Medicare patients will be asked to sign an ABN.

     a. Rule out

   b. Screening
   c. Questionable
   d. Medication therapy
   e. Possible/probable
   f. Suspected
   g. Routine
   h. Status Post
   i. Differential
4. Medical necessity of the diagnostic information on the order will be verified through the compliance advisor by the employee scheduling the patient.
5. If the diagnosis provided by the physician fails the compliance checker, the physician or office will be contacted to clarify or request additional diagnostic information.
6. If the physician provides a diagnosis that does not meet medical necessity guidelines or is a Medicare non-covered service, an ABN will be generated.
7. Patient registration will print, scan and issue the ABN when the patient presents. The patient will receive the printed ABN and proceed to the department performing the test/procedure. The scanned ABN will become part of the patient file.
8. A copy of the ABN will be sent to Patient Accounts to ensure proper billing procedure; this will be done via account notes.

B. Registration

1. Walk-Ins with order (not scheduled)
   a. If patient has an order and diagnosis, the diagnostic information and signature will be verified by the compliance advisor. If the diagnosis provided by the physician fails the compliance advisor, the physician or office will be contacted to clarify or request additional diagnostic information.
   b. If the physician provides a diagnosis that does not meet medical necessity guidelines or is a Medicare non-covered service, an ABN will be generated and the patient will be asked to sign. (See Section C below.)
   c. The ABN is attached to the order and sent with the patient to the department performing the test/procedure. The ABN and order are filed together in the department.
   d. Patient Accounts will be notified that an ABN is on file, this will be done via account notes.

2. Walk-Ins with no orders (not scheduled)
   a. If there is no order and/or diagnosis, the patient is asked to wait while this information is obtained from the physician's office.
   b. If the diagnosis provided by the physician fails the compliance advisor, the physician or office will be contacted to clarify or request additional diagnostic information.
   c. If the physician diagnosis provides a diagnosis that does not meet medical necessity guidelines or is a Medicare non-covered service, an ABN will be generated and the patient will be asked to sign. (See Section C below.)
   d. The ABN is attached to the order and sent with the patient to the department performing the test/procedure. The ABN and order are filed together in the department.
   e. A copy of the ABN will be sent to Patient Accounts to ensure proper billing procedure
   f. If after reasonable effort fails to obtain order, the patient will be advised the test/service cannot be performed. This will be communicated to the physician as soon as possible.
      1) After reasonable attempt we are unable to obtain a diagnosis, the Medicare patient or legal representative will be asked to sign an Advanced Beneficiary Notice (ABN).
      2) If a proper diagnosis can be obtained prior to billing, the ABN will be discarded.

C. Obtaining the Advance Beneficiary Notice (ABN

1. Present ABN only if you doubt payment.
   a. Do not routinely ask *all* Medicare patients to sign ABNs.
   b. Use the ABN only when you believe Medicare will deny payment for an ordered test(s) for one or more of the reasons listed in the ABN (as set forth in paragraph 3 below).
2. Present ABN before drawing specimen.
   a. If you determine that it is appropriate to present the ABN to a patient, you must do so *before* you draw a specimen or provide any other service.
   b. If you wait until after you draw the specimen, it will be too late and the ABN will be invalid.
3. Fill in ABN before presenting it to patient.
   a. There is certain information that you must fill in *before* you present the ABN to the patient for signing.

b. You cannot have a patient sign a blank form and then fill in the information later.
c. First, fill in the patient's name, and date of service, at the top of the ABN.
d. Then, list the tests or procedures you believe Medicare is likely to deny payment for and their CPT/HCPCS code, if known.
e. Next, indicate the appropriate reason why you think payment will be denied. Some reasons are:
- Medicare does not pay for these because they are defined by Medicare as medically unnecessary.
- Medicare does not pay for routine exams and tests for screening purposes;
- Medicare does not pay for tests that are for "investigative or research use only";
- Medicare does not pay for tests ordered for the patient for this diagnosis (or without a diagnosis);
- Medicare pays for the tests for a limited number of times within a specified time period and the patient is over the limit or there is no way for the laboratory to determine whether other institutions have previously billed Medicare for tests to the patient; and/or
- Medicare does not pay for laboratory tests that have not been approved by the Food and Drug Administration.

f. Finally, an estimated price needs to be added. See list on last page of this document of the top tests that usually lack medical necessity & their approximate gross charge.

4. Ask Patient to sign the ABN.
a. Once you take all the steps set forth in paragraphs 1 through 3 above, you are ready to present the ABN to the patient for signing.
b. Ask the patient or representative of the patient to check option 1 indicating that the patient wants the tests done but also wants Medicare billed or option 2 indicating that he/she wants the test(s) performed and accepts responsibility for payment or option 3 on the form indicating that he/she does not want the test(s) performed since he/she is not willing to accept personal responsibility for payment in the event Medicare does not pay for the ordered test(s).

5. [*Optional]* If patient refuses to sign ABN but still want test(s).
a. A patient may want the ordered test(s) performed but refuse to sign the ABN.
b. In such instances, you should ask a fellow staff member to witness that the patient has been notified of the specific information provided in the ABN, namely, that Medicare is likely to deny payment for the specific test(s) ordered, the reason(s) for doubting payment, that the patient could be personally responsible for payment in that instance, and that the patient had the right to refuse the test(s) but chose to have the test(s) performed.
c. UnityPoint Health Methodist staff will sign and date the ABN and state patient's refusal.

6. When an ABN is received in the laboratory (yellow copy), it is sent to the Business Office after it is scanned into the computer, the white original is sent to Patient Accounts, and one copy is filed.

V. MAINTENANCE AND STORAGE

A. All policies and procedures are reviewed every two years, (except for Safety procedures which are yearly) by Laboratory Administration and or the Medical Director of the Laboratory or designee when there are changes in practice standards, or requirements.
B. All policies and procedures are reviewed every two years (except for Safety procedures which are yearly) by staff or at the time new or revised ones are put in effect.
C. All policies are retained 8 years after being discontinued or revised.
D. All procedures are retained 2 years after being discontinued or revised

REVISION HISTORY (began tracking 2012)			
Rev	**Description of Change**	**Author**	**Effective Date**
1	Combined two policies into one inclusive policy (Medical Necessity for Outpatient Services and Advance Beneficiary Notices	R. Borge	4/8/14
2	Changed responsibility of obtaining signature for ABN and the scanning process into system	R. Borge	9/15/14

Reviewed by

Lead	Date	Coordinator/ Manager	Date	Director	Date
				Richard J. Borge	4/8/14
				Richard J. Borge	9/15/14

UnityPoint Health
Methodist

221 N.E. Glen Oak Ave., Peoria, IL 61636 • 672-5522

Date of Service: **Patient Name:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***Tests, Service, or Items*** 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 **Test, Service, or Item** below.

Test(s), service, item, procedure:	Reason Medicare May Not Pay:	Estimated Cost:
	____Medicare does not pay for these because they are defined by Medicare as medically unnecessary ____Medicare does not pay for these tests this often ____Medicare does not pay for some screening tests ____Medicare does not pay for tests without a diagnosis ____Other :	

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 ***Test(s), Service, Item*** listed above.

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

OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the ***Test(s), Services, Item*** 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 ***Test(s), Services, Item*** 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 ***Test(s), Item*** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

Additional Information: If select option 3, you should notify your doctor

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:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

White copy – Business office
Pink copy – patient
Yellow copy - file

Advance Beneficiary Notice (ABN)

Chart Forms 0938-0566 5/2013 *1ABN*

The Top Tests That Usually Lack Medical Necessity & Their Approximate Gross Charge

Test	Charge
Vitamin D	$214.00
APTT	$ 93.00
Protime	$ 69.00
Urine Culture	$144.00
Lipid II	$201.00
BNP	$174.00
Glycohgb	$142.00
TSH	$164.00
General Health Panel	$285.00
PSA	$142.00
Iron	$ 84.00
Free T4	$163.00
Ferritin	$160.00
Gonor	$145.00
Chlam	$145.00
CBC	$ 96.00
Drug Screen	$ 21.00
Point of Care Glucose	$ 39.00
TIBC%SAT	$ 84.00
Hep B Ag	$144.00