I. Purpose Statement

This policy sets forth the process that a physician and healthcare provider (Provider) will use to obtain an Advance Beneficiary Notice (ABN), when required, pursuant to the Centers for Medicare and Medicaid Services (CMS) guidelines.

II. Policy Statement

Providers are required to provide ABNs to patients before they provide services, procedures or order laboratory tests (services) that they know or believe Medicare does not consider reasonable or necessary. Patients who are not notified before they receive services are not responsible for payment, unless the services are never covered by Medicare.¹

A properly executed ABN acknowledges that coverage is uncertain, yet to be determined, or never provided by Medicare for the services listed. It also stipulates that the patient may be held financially responsible if Medicare does not provide payment for the services.

The ABN must be clearly explained to the patient. It serves as a notice to the patient of the reason(s) why the provider believes that Medicare may deny the payment. The ABN should be provided in a manner to allow sufficient time for the patient to consider available options. The objective is to provide the patient sufficient information to allow an informed choice about receiving and paying for the services.

III. Procedures

A. When a Provider orders a laboratory test or procedure for a Medicare patient, the Provider should take the following steps to help ensure compliance with the ABN requirements for diagnostic tests or services:

1. Determine which tests are not covered under national coverage rules;
2. Determine which tests are not covered under local coverage rules;
3. Determine which tests are only covered for certain diagnoses; and
4. Determine which tests are subject to frequency limitations.
### Brody School of Medicine at East Carolina University

**ECU Physicians**

| Title: Medical Necessity – Advance Beneficiary Notice for Laboratory Tests and Procedures |
|----------------------------------------|---------------------------------|
| Section No. 2 | C32 | Section Name: Clinical |

<table>
<thead>
<tr>
<th>Approval Date:</th>
<th>Approval:</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/15/03; 03/28/13; 06/12/15</td>
<td>Paul R.G. Cunningham, MD, FACS</td>
</tr>
</tbody>
</table>

**B.** When a Provider orders a laboratory test or procedure for a Medicare patient that Medicare may not cover because it is not medically reasonable and necessary, the patient must be given this information in writing on the approved ABN. Accordingly, each ABN should include:

1. Section A - Notifier(s): List the name, address, and telephone number of the notifier;
2. Section B - Patient Name: List the patient first and last name, and middle initial if it appears on the patient’s Medicare card;
3. Section C - Identification Number: List the medical record number, date of birth, or ECU account number. Do not list Social Security, Medicare or Health Insurance numbers;
4. Section D: Identify the specific service that may be denied (procedure name and CPT/HCPC code is recommended);
5. Section E - Reason Medicare May Not Pay: State the specific reason why the Provider believes the service may be denied;
6. Section F - Estimated Cost: Provide a reasonable estimate for the cost of the service per current guidelines;
7. Section G - Options: Have the patient select one of the three options:
   i. Patient accepts financial responsibility but requests that Medicare is billed for an official decision on payment that the patient can appeal;
   ii. Patient accepts financial responsibility and Medicare is not billed; or
   iii. Patient refuses to accept financial responsibility and refuses the recommended services, test or study (see Section III.C.);
8. Section H - Additional Information: If applicable, provide any additional clarification or information that may be useful to the patient
9. Sections I and J – Signature and Date: Be signed and dated by the patient acknowledging that the ABN was provided and that the patient understands its contents.

**C.** If the patient refuses to accept financial responsibility for the recommended service, test or study by refusing to sign the ABN, the Provider will:

<table>
<thead>
<tr>
<th>Recommending Body: ECU Physicians Board of Directors</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Person/Reference Source: Chief Institutional Integrity Officer</td>
<td>Extension: 744-5200</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effective Date:</th>
<th>Contact Person/Reference Source: Chief Institutional Integrity Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/13; 07/01/15</td>
<td>Extension: 744-5200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revision/Review Date:</th>
<th>Revision/Review Person/Source: Chief Institutional Integrity Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/02/12; 06/12/15</td>
<td>Extension: 744-5200</td>
</tr>
</tbody>
</table>

Page 2 of 3
Title: Medical Necessity – Advance Beneficiary Notice for Laboratory Tests and Procedures

Section No. 2  C32  Section Name: Clinical

Approval Date: 09/15/03; 03/28/13; 06/12/15  Approval: Paul R.G. Cunningham, MD, FACS

1. Discuss with the patient or patient’s representative the benefits, risks, and alternatives of the recommended service, test or study to include refusal of said service, test or study. This discussion should be documented in the patient’s medical record.

2. If the patient agrees to the service, test or study but refuses to accept financial responsibility, it is appropriate to refer the patient to a financial counselor to arrange a payment plan.

3. The Provider is not prohibited by CMS guidelines from ordering a service, test or study that he/she knows or believes CMS does not consider reasonable or necessary. Therefore, in some circumstances, the Provider may order a service, test or study if, in the Provider’s medical opinion, not doing so could potentially adversely affect the patient health. However, ECU Physicians cannot bill for the service, test or study.

D. The original ABN signed by the patient accepting responsibility for payment will be sent with the laboratory or procedure request or requisition. The patient will be given a copy of the ABN.

E. A copy of the ABN will be scanned into the patient’s medical record.

F. If a patient refuses to choose an option and/or refuses to sign a properly issued ABN, the Provider will document the patient’s refusal to choose and/or sign on the original ABN in the patient’s medical record and on the ABN.

---

1 Medicare does not require an ABN for 1) statutorily excluded care; or 2) services Medicare never covers. However, Providers may issue an ABN voluntary in these situations. For more information please refer to the “When May I Issue an ABN” section in the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Advance Beneficiary Notice of Noncoverage (ABN) Part A and Part B, 3rd ed. ICN 006266 May 2012.