

Medicare

When ordering laboratory tests that are billed to Medicare, the following requirements apply.

1. Identify limited coverage tests by the color red on the FPL requisition (or refer to LMRP reference books.
2. If there is reason to believe that Medicare will not pay for a test, the patient should be informed. The patient should then sign an Advanced Beneficiary Notice (ABN) to indicate that he or she is responsible for the cost of the test if Medicare denies payment.
3. Only tests that are medically necessary for the diagnosis or treatment of the patient should be ordered. Medicare does not pay for screening tests except for certain specifically approved procedures and may not pay for non-FDA approved tests or those tests considered experimental.
4. The ordering physician must provide an ICD-9 diagnosis code for each test ordered.
5. Panels can be billed only when every component of the panel is medically necessary.
6. Medicare National Limitation Amounts for CPT codes are available through the Centers for Medicare & Medicaid Services (CMS) or its intermediaries. Medicaid reimbursement will be equal or less than the amount of Medicare reimbursement.



ADVANCE BENEFICIARY NOTICE (ABN)

PATIENT NAME	MEDICARE #	DATE OF SERVICE
--------------	------------	-----------------

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

In your case, Medicare is likely to deny payment for the following reasons:

Denial Code
 DIAG
 ROUT
 FREQ
 OTHR

Reasons for Denial

Medicare will deny payment for this service for the provided diagnosis.
 Medicare will not pay for screening or routine test(s).
 Medicare will not pay for this service due to the frequency of testing
 Other: _____

	TEST NAME	ICD-9 CODE	DENIAL CODE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Beneficiary acknowledgment and agreement to pay

I have been notified by my physician/provider that, in my case, Medicare is likely to deny payment for the services identified above for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ Patient Signature	_____ Witness	_____ Date
_____ Spouse, Next of Kin, Parent, Legal Guardian or Other Authorized Representative	_____ Witness	_____ Date
<input type="checkbox"/> Patient refused service identified above.	_____ Caregiver Signature	_____ Date

Effective Date: 9/00

601 EAST ROLLINS STREET • ORLANDO, FLORIDA 32803 • TEL. (407) 303-8557 • FAX (407) 303-8570

