# Billing resource guide

## Contact us

Phone/fax/email

**Phone:** (612) 863-0400
**Fax:** (612) 863-0460
**Email:** labbilling@allina.com

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Mailing address

Allina Health Laboratory Billing
Mail Route 20201
PO Box 342
Minneapolis, MN 55440-0342

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# Contents

# CPT Coding

It is your responsibility to determine the correct CPT codes to use for billing. CPT codes provided by Allina Health Laboratory are for informational purposes only. This coding is based on the Current Procedural Terminology (CPT) guideline manual published by the American Medical Association and the local and third party payer requirements. Any questions regarding the use of a code should be referred to your local Medicare carrier or the payer being billed.

Allina Health Laboratory assumes no responsibility for reimbursement you may or may not receive based upon the procedure codes listed.

# Billing options

You may choose one of the following options for the billing services performed by our laboratory.

- Client Billing – Bill to the physician, provider, clinic or facility
- Patient (self pay)/Insurance billing – Bill to patient or other responsible party or to 3rd party payers

You *must* check which billing option you prefer on the test requisition. If you do not check a box to indicate how the work is to be billed, or if it is marked inappropriately, it can result in incorrect bills to you or your patients.

If no billing preference is indicated on the request along with your sample, charges will be billed to the entity ordering the laboratory service. If your patient presents at one of our patient service centers and no billing option is marked, Allina Health Laboratory will default the billing to the patient's insurance/self pay option.

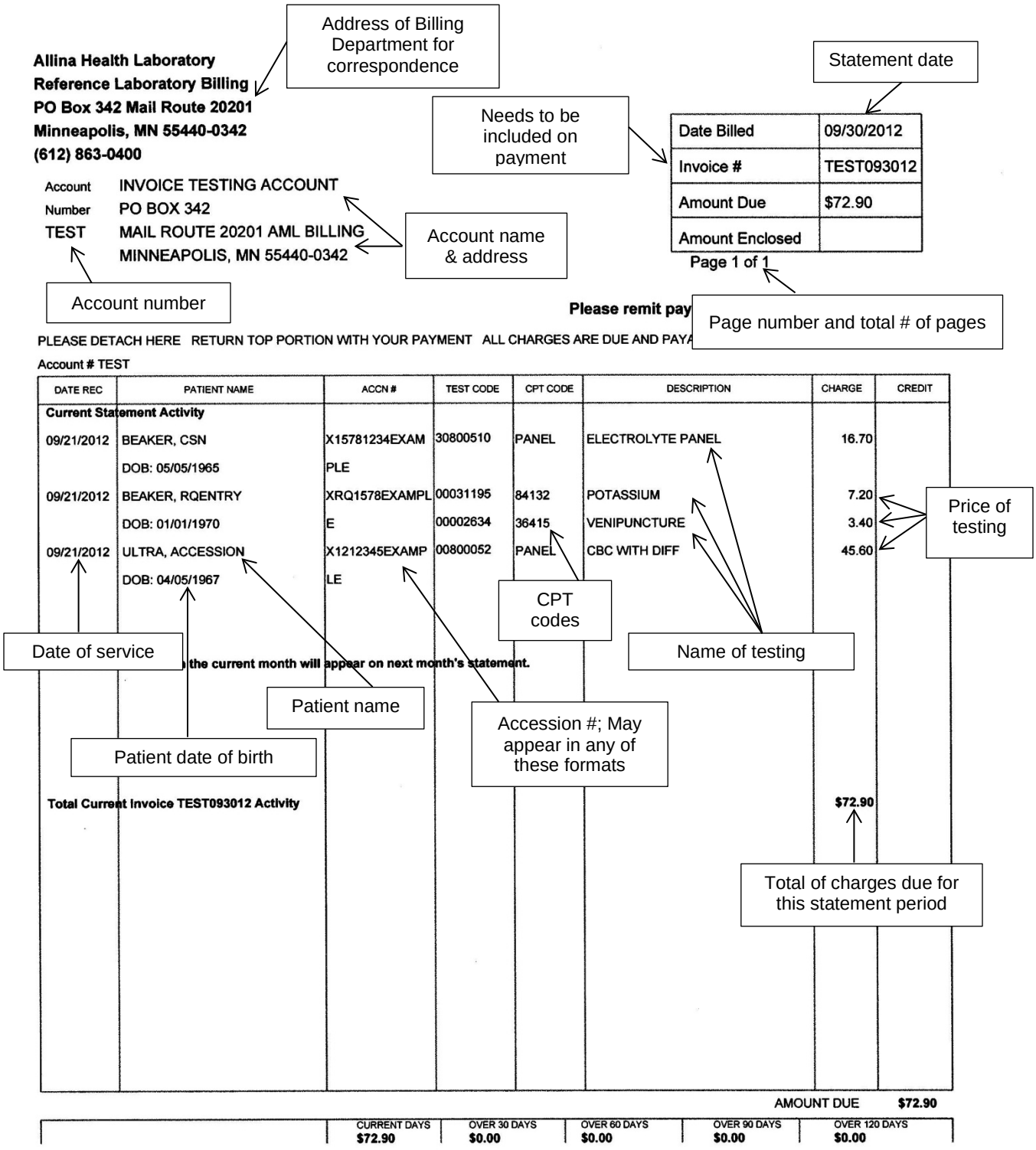
The ability to customize your site's requisitions allows for you to pre-set your bill type. For example, if your site always has Allina Health Laboratory bill the patient's insurance then the phrase "Always Bill Patient's Insurance" can be printed directly onto your hand written requests. Please talk to your Allina Health Laboratory Account Representative to get more specific information on this preprint option.

## Client Billing

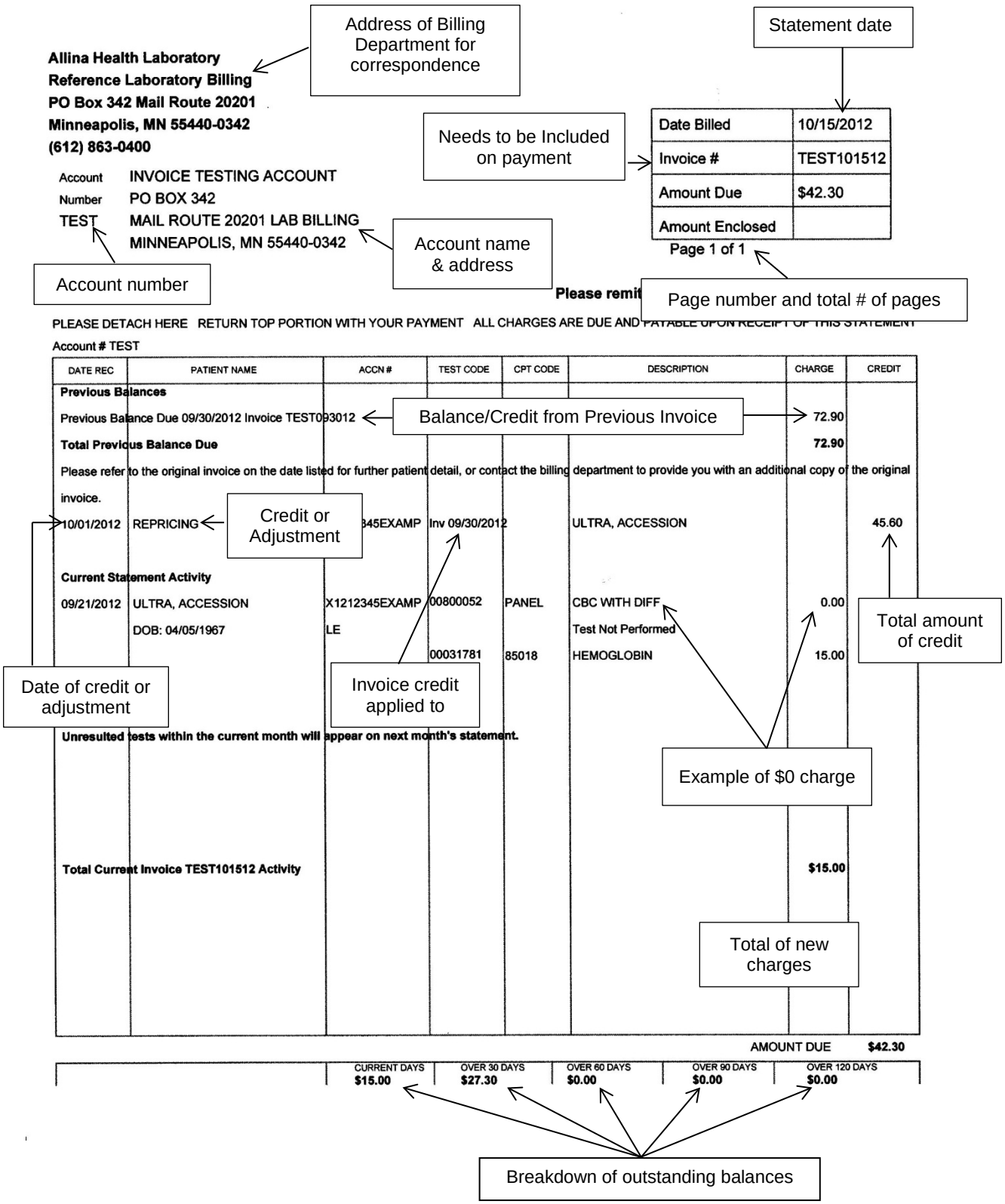
If you select this option, an itemized billing statement will be sent to you on a monthly basis.

The invoice will indicate the date of service, patient name, CPT code, test name, and test charge. Payment of the statement is due upon receipt. ***Should you feel any portion of the statement is in error, please notify us within 60 days***. We will make appropriate adjustments to the bill during this time period. Claims that have exceeded timely filing payer requirements cannot be adjusted. Review your bill carefully when you receive it. Please note that in order to complete the reversal from your client billing to bill the patient's insurance we require a Reversal/Credit form to be filled out completely. These charges cannot be reversed without the required information and within 30 days of the timely filing limit of the specific insurance carrier. Requests to change the bill type from bill client after bill insurance has been submitted is dependent upon whether or not the claim has been submitted and is handled on a case by case basis.

## Invoice example – New charges



## Invoice example – Credits and adjustments



# Billing Correction/Insurance Adjustment Form

## Purpose

When making billing corrections it is important that Allina Health Laboratory Billing staff understands exactly how you would like us to bill each patient's labs. When a billing correction is requested we need the most accurate and up to date information in the clearest format as possible. The insurance adjustment form lists all the information needed in a clear and organized format. This makes it easy for our billing staff to determine which patient you want us to change the billing for, which tests, what DOS, and which insurance if any should be billed. Hopefully, the following instructions & tips will increase our billing accuracy.

## How do I fill it out?

The form can be filled out by hand, as long as the handwriting is clear, or if you have a copy of the interactive form on your computer you can simply type the information directly onto the form. All fields on the insurance adjustment form are required to be filled out. You can open a copy of the form here:

http://www.allina.com/ahs/allinalabs.nsf/page/billingform

## Overview of the form

Below is a list of fields on the form and in depth explanations of each.

Patient Name: The place where the patient's name is listed. Can be listed first name last, last name first or vice versa as long as it is clear which one is first name and which is the last.

Date of Service: This is generally the date the specimen was collected.

Date of Birth: This is the field where the patient's date of birth should be listed. Do not list the responsible party's DOB here.

Medicare/Medicaid/Insurance Co Name: The full name of the insurance to be billed.

Medicare/Medicaid/Insurance Co #: List the ID # first and Group # second (separated by a slash). This makes it easier to identify the numbers for uncommon payers.

Test Name or Test #: This is a very important field to fill in; it tells us which test you would like us to make the billing corrections on. You can list each test separately or if you want us to bill for all tests on this accession just enter "All Tests". CPT codes are not always helpful because several tests (with different names) can use the same CPT for billing. The name of the test is the preferred format.

Face Sheet Enclosed: This tells us whether or not you sent information for the patient that should be attached. This ensures that we received everything you sent us, and if we didn't, it gives us a way of knowing that we are missing something.

Physician: We need to have the first and last name of the ordering physician. The last name alone is not enough to properly ID the correct Physician.

Diagnosis ICD Code: All of the ICD codes that should be billed for this accession are listed here. Narratives are also acceptable as long as they are legible and have the specificity required to code.

Patient Address: The most recent address on file should be entered here. It is important to remember to include the apt. #, lot #, and street numbers.

Responsible Party: If the patient is responsible enter "self". If the person responsible is someone other than the patient, enter that person's name here.

Accession # (Req ID/CSN/MRN): Accession numbers normally begin with an "X" followed by nine numbers. The accession number is located under the fourth column from the left on your daily billing report. On the daily charge (billing) report, it is listed as "accn #" and does not have an "X" at the beginning. The accession number is also located under the 3rd column from the left on your monthly statements. On the monthly statement the accession number should start with an "X". Listing this also increases the accuracy of our correction and how fast we can get them done.

Client Name: This is where you list the name of your clinic or facility. It is very important that this is included so we know who you are.

Requester's Name: This is the name of the person who filled out the form and submitted it to us. We need this information so that we have a contact if we have questions.

Statement Date: The date of the statement or daily charge (billing) report that lists the charges.

Client Account: This is required to make sure we are issuing credits to the correct account. Account numbers for most clients begin with an "X" and are followed by three letters. The account number is located in the upper left of your monthly statement just to the left of the name and address of your facility. Your account number is also listed near the top and center of your daily billing report just under the word "laboratories".

Phone & Fax Numbers: Required so we can contact you if we need more information or have any questions while making the requested corrections.

## How do I submit the forms to Allina Health Laboratory for processing?

You can send the completed forms to us via USPS, e-mail, or fax. If you filled out the form online be sure to save a copy for your records. You can send us a copy of the saved form as an attachment in e-mail form. This is the quickest and clearest way of submitting adjustment forms. This copy also serves as a reference for you to watch for these credits to appear on your next statement.

## When Allina Health Laboratory receives the adjustment forms

When we receive the forms we inspect each one to make sure all required information is present and that it is clear enough to make an accurate correction. The following are additional policies not already covered above:

- Timely Filing: We will change billing (from your facility to bill insurance) at any time up to 30 business days before our timely filing limits for the given payer. When we notice that you have sent us corrections that are past timely filing a notification will be faxed to you listing those patients.
- Charges originally billed to patient's insurance can be reversed to bill client only if we have not already submitted the bill to the patient's insurance.
- The changes that were requested via the adjustment forms should show up on your next monthly statement if the corrections were submitted five days from the last day of the month or earlier. If the billing information sent was not complete or legible the correction may not show up on your next statement.
- We will contact you via phone or fax to obtain any missing or illegible information. This extra step will sometimes slow down the process and may cause the correction to show up late on your statements.
- Face sheets are accepted as well with some exceptions. Face sheets (print outs from your billing system) are accepted given that they adhere to all of the same requirements as the insurance adjustments forms. We prefer that the patient's name, date of birth, date of service, and the test names are filled in on the adjustment form. Any information not on the face sheets should be written in on the adjustment form. The face sheets should be kept in order corresponding to the order on the adjustment forms.

## Questions or concerns?

If you have any questions or concerns about how to complete the form or about our billing policies you can reach the Allina Health Laboratory Billing Office at (612) 863-0400.

We are more than happy to work with you to make the billing process easier, so if you have any suggestions, please let us know.

## Insurance Adjustment Form

We understand that, on occasion, it may be necessary to make adjustments to your monthly invoice. If you would like Allina Health Laboratory to bill the patient or their insurance, provide the information indicated below, and we will make the adjustment.

Allina Health LABORATORY

Client Name _____ Client Account # _____ Invoice # _____

Requestor's Name _____ Phone # (_____)_____ Fax # (_____)_____

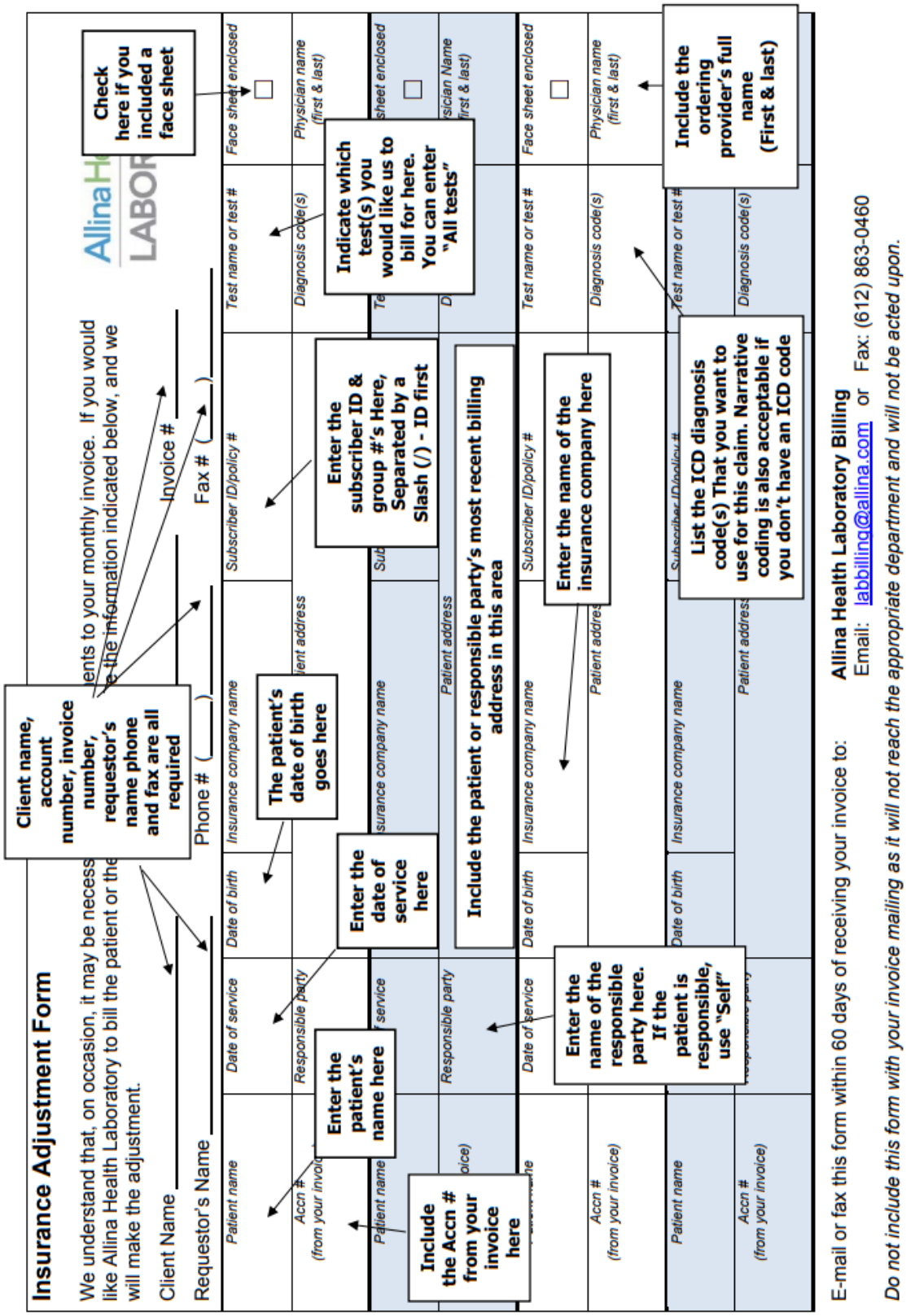
| *Patient name* | *Date of service* | *Date of birth* | *Insurance company name* | *Subscriber ID/policy #* | *Test name or test #* | *Face sheet enclosed* |
|---|---|---|---|---|---|---|
| *Accn # (from your invoice)* | *Responsible party* | *Patient address* | | | *Diagnosis code(s)* | *Physician name (first & last)* |
| *Patient name* | *Date of service* | *Date of birth* | *Insurance company name* | *Subscriber ID/policy #* | *Test name or test #* | *Face sheet enclosed* |
| *Accn # (from your invoice)* | *Responsible party* | *Patient address* | | | *Diagnosis code(s)* | *Physician Name (first & last)* |
| *Patient name* | *Date of service* | *Date of birth* | *Insurance company name* | *Subscriber ID/policy #* | *Test name or test #* | *Face sheet enclosed* |
| *Accn # (from your invoice)* | *Responsible party* | *Patient address* | | | *Diagnosis code(s)* | *Physician name (first & last)* |
| *Patient name* | *Date of service* | *Date of birth* | *Insurance company name* | *Subscriber ID/policy #* | *Test name or test #* | *Face sheet enclosed* |
| *Accn # (from your invoice)* | *Responsible party* | *Patient address* | | | *Diagnosis code(s)* | *Physician name (first & last)* |

E-mail or fax this form within 60 days of receiving your invoice to: **Allina Health Laboratory Billing**
Email: labbilling@allina.com or Fax: (612) 863-0460

*Do not include this form with your invoice mailing as it will not reach the appropriate department and will not be acted upon.*

*October 2016*

## Insurance Adjustment Form example



## Manual request form completion instructions

### Client (vendor) billing

If you wish us **to bill your office or facility**, complete the following sections of the request form:

1. You MUST mark “CLIENT”
3. Date & time collected
4. Gender
5. Birth date
6. Patient’s name (Last, First MI)
7. Chart number (optional)
8. Patient’s address (Street & city)
9. State & Zip
10. Patient’s telephone number
21. Ordering provider

### Insurance billing

If you wish us to bill **Medicare, Medicaid, or other third-party payers,** we must have the following sections of the request form completed:

2. You MUST mark “PATIENT/INSURANCE”
3. Date & time collected
4. Gender
5. Birth date
6. Patient’s name (Last, First, MI)
7. Chart number (optional)
8. Patient’s address (Street & city)
9. State & Zip
10. Patient’s telephone number
11. For Medicare patients only, we request that the appropriate box on the requisition be checked to indicate if Medicare is primary or secondary.
12. Medicare #
13. Medical Assistance # and state in which it was issued
14. Policy holder (if not patient); also used for Guarantor if patient under 18 years of age. If different, please list.
15. Policy holder’s date of birth
16. Member/Policy #
17. Group #
18. Relationship of patient to insured
19. Insurance company name
20. Diagnosis*
21. Ordering provider

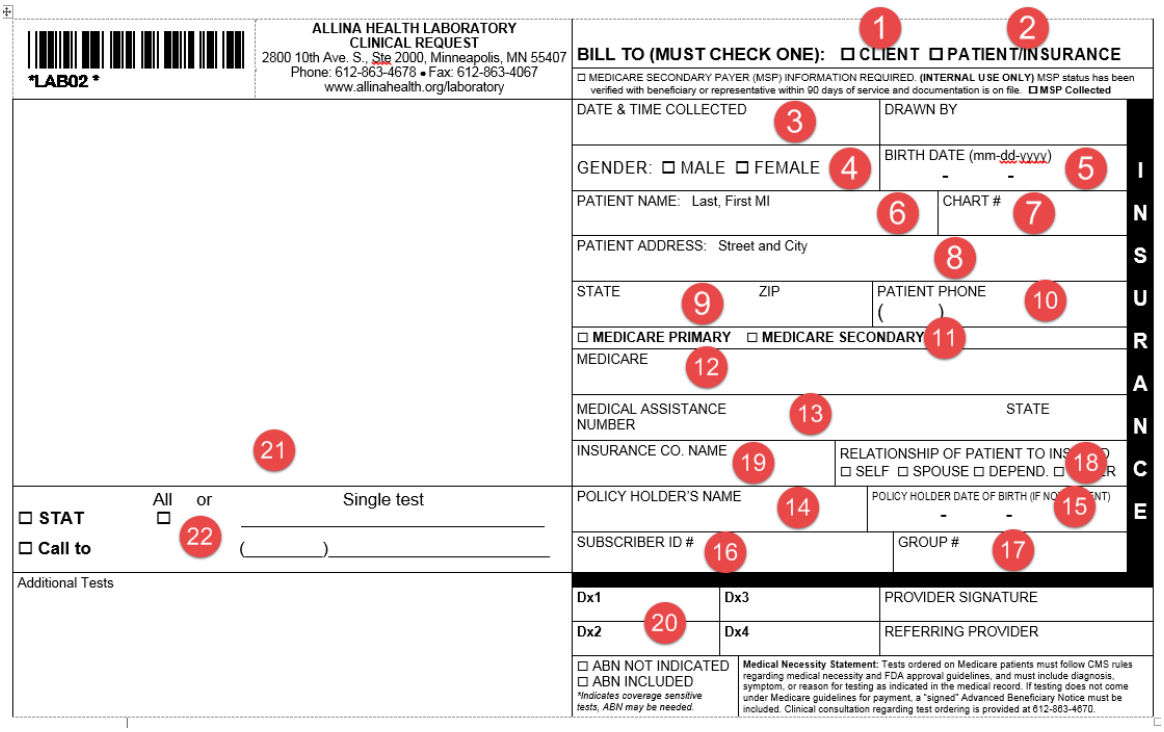
**Patient (self-pay) billing**

If you wish us **to bill the patient directly**, complete the following sections of the request form:

2. You MUST mark “PATIENT/INSURANCE”
3. Date & time collected
4. Gender
5. Birth date
6. Patient’s name (Last, First MI)
7. Chart Number (optional)
8. Patient’s address (Street & City)
9. State & Zip
10. Patient’s telephone number
14. Guarantor listed here if patient under 18 years of age
20. Diagnosis*
21. Ordering provider

* ICD codes or clear diagnostic symptom descriptions are required. Please code to the highest specificity possible.

If you select this option, **please advise your patients that they will receive a bill for laboratory services from Allina Health Laboratory.** This will help the patient understand the billing that they will receive from us. Many patients call our billing office questioning their lab bill since they are not actually seen at Allina Health Laboratory or Abbott Northwestern Hospital which houses the billing department.



**Additional information:**

| ***Item #*** | ***Notes*** |
|---|---|
| 1 & 2 | If the request comes in with a sample to Allina Health Laboratory with no bill type marked, the default is to bill the clinic.<br>If the patient presents at one of our draw sites and no bill type is marked, the default is to bill patient/insurance. |
| 6 | Patient's full legal name, no nicknames, etc. This must match what insurance has on file for the patient or they will reject the claim. |
| 7 | Your chart number is optional. If supplied, it will appear on your patient report. |
| 8 - 10 | Patient's current and complete mailing address and phone number. |
| 11 | One of the two boxes must be marked when Medicare is listed along with another insurance company. |
| 12 | Medicare number and the suffix is required if Allina Health Laboratory is to bill Medicare. Simply using the patient's SSN is not accurate or complete. |
| 14 - 15 | This is the person that holds the insurance policy. For minors this is also the Guarantor, so Allina Health Laboratory can bill out the claim if needed. |
| 16 - 17 | This should be the full complete insurance company identification number.<br>Often the group number is listed separately so that must be included. |
| 18 | Check the relationship between the patient and the policy holder. |
| 19 | List the full name of the insurance company and no abbreviations. If we cannot determine what this is, we will send a letter asking for more information. |
| 20 | Diagnosis is REQUIRED*. ***This cannot be a "rule out" or the word "screen".*** We need the specific information as to why the tests were ordered. Often the codes must have a 4th and even 5th digit in order to bill out for the laboratory services. |
| 21 | The ordering provider must be indicated;<br>1. If preprinted, circle the name and Allina Health Provider ID number on the request form<br>2. If the provider is not preprinted on the request form:<br>a. If you know the ordering providers Allina Health Provider ID number, write the number and full name.<br>b. If you do not know the providers Allina Health Provider ID number, write the providers full name, credentials and National Provider Identifier (NPI) number. |
| 22 | If the testing is STAT, or you need the results called, indicate that here. Results will only be faxed to the requesting location. |

## Patient (self-pay)/Insurance billing

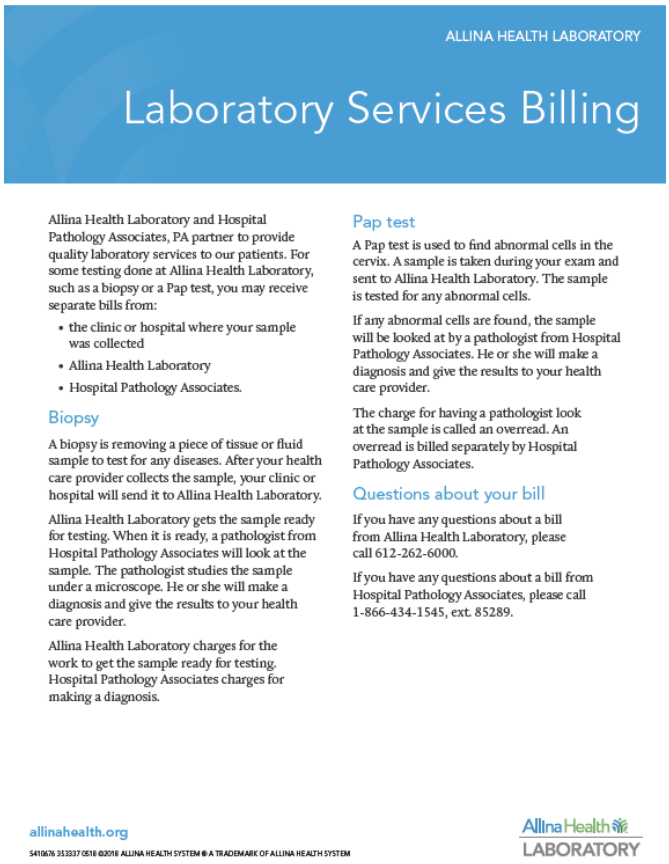
To have testing billed directly to the patient, or other responsible party or to 3rd party payers, refer to the requisition completion instructions on pages 12-14.

## Pathology billing

Allina Health Laboratory contracts with Hospital Pathology Associates (HPA) for pathology services. If your patient is being billed for any type of pathology service, ***they will receive a separate bill from Hospital Pathology Associates***.

Patient information including insurance is needed for ***all*** cases that have pathology involvement even if Allina Health Laboratory is vendor billing. **If we do not receive this information with the specimen, it will necessitate correspondence with your billing department to obtain missing information and may cause delays in patient results.** We will first attempt to gather the information via a fax request, and if no response is received to the fax correspondence, we will follow up with a telephone call.

The image below an example of a document available from Allina Health Laboratory that you can share with your patients to help explain this billing.



ALLINA HEALTH LABORATORY

Laboratory Services Billing

Allina Health Laboratory and Hospital Pathology Associates, PA partner to provide quality laboratory services to our patients. For some testing done at Allina Health Laboratory, such as a biopsy or a Pap test, you may receive separate bills from:

- the clinic or hospital where your sample was collected
- Allina Health Laboratory
- Hospital Pathology Associates.

### Biopsy

A biopsy is removing a piece of tissue or fluid sample to test for any diseases. After your health care provider collects the sample, your clinic or hospital will send it to Allina Health Laboratory.

Allina Health Laboratory gets the sample ready for testing. When it is ready, a pathologist from Hospital Pathology Associates will look at the sample. The pathologist studies the sample under a microscope. He or she will make a diagnosis and give the results to your health care provider.

Allina Health Laboratory charges for the work to get the sample ready for testing. Hospital Pathology Associates charges for making a diagnosis.

### Pap test

A Pap test is used to find abnormal cells in the cervix. A sample is taken during your exam and sent to Allina Health Laboratory. The sample is tested for any abnormal cells.

If any abnormal cells are found, the sample will be looked at by a pathologist from Hospital Pathology Associates. He or she will make a diagnosis and give the results to your health care provider.

The charge for having a pathologist look at the sample is called an overread. An overread is billed separately by Hospital Pathology Associates.

### Questions about your bill

If you have any questions about a bill from Allina Health Laboratory, please call 612-262-6000.

If you have any questions about a bill from Hospital Pathology Associates, please call 1-866-434-1545, ext. 85289.

allinahealth.org



Allina Health LABORATORY

## Billing fax correspondence

Missing information is normally requested by a fax correspondence letter. These letters give patient information including date of service and outline what is missing. Currently we send out letters at the following intervals: 1st letter, 2nd letter (2 weeks after if no response), and a 3rd request is made via phone call one week later.

Types of requests include:

- Unknown provider--missing NPI number or incomplete name.
- Unknown insurance company and/or subscriber ID
- No diagnosis code provided or the narrative requires more information.
- Guarantor information is missing/incomplete
- Lack of Medical Necessity/ABN required

If the timely filing limit for submitting a claim is less than 45 days away, a phone call rather than our correspondence letters will be used to secure the information quickly.

## Correspondence letter example

22-Feb-2013

ALLINA HEALTH LABORATORY
PO BOX 342
MAIL ROUTE 20201
MINNEAPOLIS, MN 55440-0342
(612) 863-0400
Fax: (612) 863-XXXX

Client ID: XDAA
444-444-4444
Fax: 555-555-5555

DRAWN AT ALLINA HEALTH
PO BOX 342, MR 20201
ATTN: LAB BILLING
MINNEAPOLIS, MN 55440

Dear Client:

Our laboratory is unable to bill for services performed on behalf of the patient listed below due to missing data. Please supply the missing information as soon as possible and fax this form back to us at 612-262-0951. Thank you.

**Ordering Physician:**

| | | | |
|---|---|---|---|
| **Patient:** | **LASTNAME, FIRSTNAME** | **Patient ID: XXXXXXX** | **DOB: 01/02/2003** |
| **Accession #:** | **X12121231234** | **Req #: 12-999999999** | **SSN: XXX-XX-XXXX** |
| **DOS:** | **21-Nov-2012** | | |

**Tests Ordered:** 00002634 VENIPUNCTURE
00819714 FACTOR X CHROMOGENIC

Please provide information on whom to bill for these services. If third party, please provide complete insurance billing information and all patient demographics.

| | **Our Records** | **Corrections** |
|---|---|---|
| Payor Name: | NON-SPECIFIED PAYOR | _____ |

Please provide an ICD diagnosis code.

| | **Our Records** | **Corrections** |
|---|---|---|
| Diagnosis Code 1: | | _____ |

Please provide the full name (First, MI, Last) of the ordering physician along with ***NPI Number **, Credentials and Specialty.

| | **Our Records** | **Corrections** |
|---|---|---|
| Ordering Physician: | | _____ |

Sincerely,
ALLINA HEALTH LABORATORY

XDAA

# Medical Necessity

## Advanced beneficiary notice (ABN)

Medicare does not pay for most screening tests or tests deemed experimental or not medically necessary. In order to comply with the Center for Medicare/Medicaid Services (CMS) payer notification guidelines, Allina Health Laboratory must have documentation that the patient was notified that the insurer might not pay, and in that event, is willing to accept responsibility for these charges. A completed CMS approved Advanced Beneficiary Notice (ABN) must be signed by the patient and submitted with the specimen.

A separate more detailed explanation is available; please contact your Allina Health Laboratory Account Representative for a copy.

Allina Health Laboratory will continue to bill Medicare for services performed for its clients. To meet the Centers for Medicare/Medicaid Services (CMS) regulatory requirements mandating acceptable frequency, acceptable ICD codes, and determination of when a patient may have last received testing categorized as a frequency test, Allina Health Laboratory will require an ABN to be completed for a Medicare (and some Medicare Replacement Products) patient presenting to one of the patient care service centers or Metro Hospital Laboratory Reception areas when National Coverage Decision testing is ordered without ICD diagnosis codes justifying medical necessity.

**ABN example**

Allina Health

2925 Chicago Ave.
Minneapolis, MN
612-262-9000 or 1-800-958-5077

**A. Notifier:**

**B. Patient Name:** **C. Identification Number:**

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D.**_____ 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 **D.**_____ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| | | |

**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 **D.**_____ 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.

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

☐ **OPTION 1.** I want the **D.**_____ 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 **D.**_____ 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 **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. 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.

| I. Signature: | J. Date: |
|---|---|
| | |

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**



Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566
4205688 (07/17)

If a patient should request not to have testing performed once the ABN has been presented, Allina Health Laboratory will not notify the provider that the patient decided not to have the testing performed but recommend that the patient themselves call and let the provider know directly. Allina Health Laboratory will document in the patient's medical record that the patient decided not to have the testing performed. * In certain situations the patient may refuse to sign the ABN but still insist on the testing at our Allina Health Laboratory draw centers. In these cases two Allina Health Laboratory employees can sign the form attesting to the understanding of the patient that they are financially responsible for the testing if Medicare denies. If Medicare or a Medicare replacement denies payment based on screening, frequency or medical necessity, the patient is then responsible for these charges. If you are unable to get your patient to sign the ABN, Allina Health Laboratory's bill back policy will be enforced. This policy is explained in more detail on page 32 of this guide.

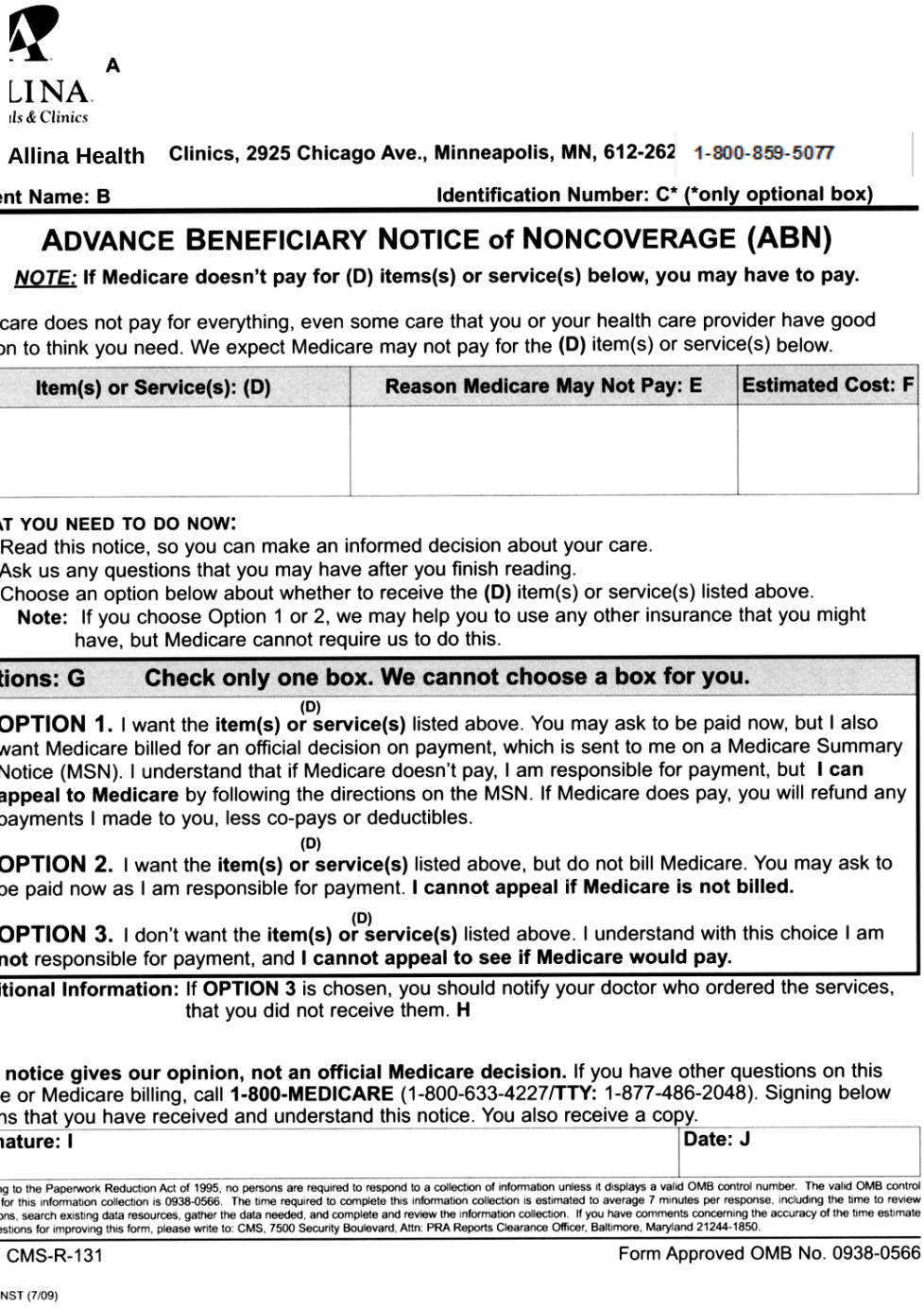
The original copy (white) of the ABN stays in the clinic for clinic documentation. The second copy (yellow) is sent to Allina Health Laboratory attached to the original laboratory requisition. The third copy (pink) is given to the patient. Patients are responsible for yearly deductibles, co-payments, and any balance not covered by the insurance company.

Providing all of the appropriate patient information will avoid follow-up telephone calls from our billing department.

If you have any questions concerning the billing process, contact Allina Health Laboratory Billing at (612) 863-0400.

## Instructions for completing the ABN

The following instructions are supplies by CMS and are available on their website at [www.cms.hhs.gov/bni/](www.cms.hhs.gov/bni/).



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LINA
ıls & Clinics

**Allina Health** **Clinics, 2925 Chicago Ave., Minneapolis, MN, 612-262** 1-800-859-5077

**Patient Name: B** **Identification Number: C* (*only optional box)**

**ADVANCE BENEFICIARY NOTICE of NONCOVERAGE (ABN)**

***NOTE:*** **If Medicare doesn't pay for (D) items(s) or service(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 **(D)** item(s) or service(s) below.

| Item(s) or Service(s): (D) | Reason Medicare May Not Pay: E | Estimated Cost: F |
|---|---|---|
| | | |

**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 **(D)** item(s) or service(s) 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: G** **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **item(s) or service(s)** (D) 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 **item(s) or service(s)** (D) 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 **item(s) or service(s)** (D) 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 **OPTION 3** is chosen, you should notify your doctor who ordered the services, that you did not receive them. **H**

**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: I | Date: J |
|---|---|
| | |

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 Form Approved OMB No. 0938-0566

420568INST (7/09)

**Form Instructions**
**Advance Beneficiary Notice of Noncoverage (ABN)**
**OMB Approval Number: 0938-0566**

## Overview

The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. "Notifiers" include physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories), as well as hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A. They must complete the ABN as described below, and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice. (Note that although Medicare inpatient hospitals and home health agencies (HHAs) use other approved notices for this purpose, skilled nursing facilities (SNFs) must use the revised ABN for Part B items and services.) Beginning March 1, 2009, the ABN-G and ABN-L will no longer be valid; and notifiers must begin using the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131).

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. Employees or subcontractors of the notifier may deliver the ABN. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the notifier must retain the original notice on file.

## ABN Changes

The ABN is a formal information collection subject to approval by the Executive Office of Management and Budget (OMB) under the Paperwork Reduction Act of 1995 (PRA). As part of this process, the notice is subject to public comment and re-approval every 3 years. The revised ABN included in this package incorporates: suggestions for changes made by notifiers over the past 3 years of use, refinements made to similar liability notices in the same period based on consumer testing and other means, as well as related Medicare policy changes and clarifications occurring in the same interval. We have made additional changes based on suggestions received during the recent public comment period.

This version of the ABN continues to combine the general ABN (ABN-G) and the laboratory ABN (ABN-L) into a single notice, with an identical OMB form number. As combined, however, the new notice will capture the overall improvements incorporated into the revised ABN while still permitting pre-printing of the lab-specific key information and denial reasons used in the current ABN-L.

Also, note that while previously the ABN was only required for denial reasons recognized under section 1879 of the Act, the revised version of the ABN may also be used to provide voluntary notification of financial liability. Thus, this version of the ABN should eliminate

any widespread need for the Notice of Exclusion from Medicare Benefits (NEMB) in voluntary notification situations.

Instructions for completion of the form are set forth below. Once the new ABN approval process is completed, CMS will issue detailed instructions on the use of the ABN in its on-line Medicare Claims Processing Manual, Publication 100-04, Chapter 30, §50. Related policy on billing and coding of claims, as well as coverage determinations, is found elsewhere in the CMS manual system or website (www.cms.hhs.gov).

## Completing the Notice

OMB-approved ABNs are placed on the CMS website at: http://www.cms.hhs.gov/BNI. Notices placed on this site can be downloaded and should be used as is, as the ABN is a standardized OMB-approved notice. However, some allowance for customization of format is allowed as mentioned for those choosing to integrate the ABN into other automated business processes. In addition to the generic ABN, CMS will also provide alternate versions, including a version illustrating laboratory-specific use of the notice.

ABNs must be reproduced on a single page. The page may be either letter or legal-size, with additional space allowed for each blank needing completion when a legal-size page is used.

### Sections and Blanks:

There are 10 blanks for completion in this notice, labeled from (A) through (J), with accompanying instructions for each blank below. We recommend that the labels for the blanks be removed before use. Blanks (A)-(F) and blank (H) may be completed prior to delivering the notice, as appropriate. Entries in the blanks may be typed or hand-written, but should be large enough (i.e., approximately 12-point font) to allow ease in reading. (Note that 10 point font can be used in blanks when detailed information must be given and is otherwise difficult to fit in the allowed space.) The Option Box, Blank (G), must be completed by the beneficiary or his/her representative. Blank (I) should be a cursive signature, with printed annotation if needed in order to be understood.

### A. Header

Blanks A-C, the header of the notice, must be completed by the notifier prior to delivering the ABN.

**Blank (A) Notifier(s):** Notifiers must place their name, address, and telephone number (including TTY number when needed) at the top of the notice. This information may be incorporated into a notifier's logo at the top of the notice by typing, hand-writing, pre-printing, using a label or other means.

If the billing and notifying entities are not the same, the name of more than one entity may be given in the Header as long as it is specified in the Additional Information (H) section who should be contacted for questions.

**Blank (B) Patient Name:** Notifiers must enter the first and last name of the beneficiary receiving the notice, and a middle initial should also be used if there is one on the beneficiary's Medicare (HICN) card. The ABN will not be invalidated by a misspelling or missing initial, as long as the beneficiary or representative recognizes the name listed on the notice as that of the beneficiary.

**Blank (C) Identification Number:** Use of this field is optional. Notifiers may enter an identification number for the beneficiary that helps to link the notice with a related claim. The absence of an identification number does not invalidate the ABN. An internal filing number created by the notifier, such as a medical record number, may be used. Medicare numbers (HICNs) or Social Security numbers **must not** appear on the notice.

**B. Body**

**Blank (D)**: The following descriptors may be used in the header of Blank (D):

- Item
- Service
- Laboratory test
- Test
- Procedure
- Care
- Equipment

- The notifier must list the specific items or services believed to be non-covered under the header of Blank (D).
- In the case of partial denials, notifiers must list in Blank (D) the excess component(s) of the item or service for which denial is expected.
- For repetitive or continuous non-covered care, notifiers must specify the frequency and/or duration of the item or service. See § 50.14.3 for additional information.
- General descriptions of specifically grouped supplies are permitted. For example, "wound care supplies" would be a sufficient description of a group of items used to provide this care. An itemized list of each supply is generally not required.
- When a reduction in service occurs**,** notifiers must provide enough additional information so that the beneficiary understands the nature of the reduction. For example, entering "wound care supplies decreased from weekly to monthly" would be appropriate to describe a decrease in frequency for this category of supplies; just writing "wound care supplies decreased" is insufficient.

**Blank (E) Reason Medicare May Not Pay:** In this blank, notifiers must explain, in beneficiary friendly language, why they believe the items or services described in Blank (D) may not be covered by Medicare. Three commonly used reasons for non-coverage are:

- "Medicare does not pay for this test for your condition."
- "Medicare does not pay for this test as often as this (denied as too frequent)."
- "Medicare does not pay for experimental or research use tests."

To be a valid ABN, there must be at least one reason applicable to each item or service listed in Blank (D). The same reason for non-coverage may be applied to multiple items in Blank (D).

**Blank (F) Estimated Cost:** Notifiers must complete Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services.

Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed in Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Thus, examples of acceptable estimates would include, but not be limited to, the following:

<u>For a service that costs $250</u>:

- Any dollar estimate equal to or greater than $150
- "Between $150-300"
- "No more than $500"

<u>For a service that costs $500</u>:

- Any dollar estimate equal to or greater than $375
- "Between $400-600"
- "No more than $700"

Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). Average daily cost estimates are also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations.

CMS will work with its contractors to ensure consistency when evaluating cost estimates and determining validity of the ABN in general. In addition, contractors will provide ongoing education to notifiers as needed to ensure proper notice delivery. Notifiers should contact the appropriate CMS regional office if they believe that a contractor inappropriately invalidated an ABN.

### C. Options

**Blank (G) Options:** Blank (G) contains the following three options:

❑ **OPTION 1.** I want the **(D)**_____ 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.

This option allows the beneficiary to receive the items and/or services at issue and requires the notifier to submit a claim to Medicare. This will result in a payment decision that can be appealed. *See Ch. 30, §50.14.1 of the online Medicare Claims Processing Manual for instructions on the notifier's obligation to bill Medicare.*

**Note:** Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

❑ **OPTION 2.** I want the **(D)**_____ 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**.

This option allows the beneficiary to receive the non-covered items and/or services and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

❑ **OPTION 3.** I don't want the **(D)**_____listed above. I understand with this choice **I am not responsible for payment, and** I cannot appeal to see if Medicare would pay.

This option means the beneficiary does not want the care in question. By checking this box, the beneficiary understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

The beneficiary or his or her representative must choose only one of the three options listed in Blank (G). Under no circumstances can the notifier decide for the beneficiary which of the 3 checkboxes to select. Pre-selection of an option by the notifier invalidates the notice. However, at the beneficiary's request, notifiers may enter the beneficiary's selection if he or she is physically unable to do so. In such cases, notifiers must annotate the notice accordingly.

If there are multiple items or services listed in Blank (D) and the beneficiary wants to receive some, but not all of the items or services, the notifier can accommodate this

request by using more than one ABN. The notifier can furnish an additional ABN listing the items/services the beneficiary wishes to receive with the corresponding option.

If the beneficiary cannot or will not make a choice, the notice should be annotated, for example: “beneficiary refused to choose an option”.

### D. Additional Information

**Blank (H) Additional Information:** Notifiers may use this space to provide additional clarification that they believe will be of use to beneficiaries. For example, notifiers may use this space to include:

- A statement advising the beneficiary to notify his or her provider about certain tests that were ordered, but not received;
- Information on other insurance coverage for beneficiaries, such as a Medigap policy, if applicable
- An additional dated witness signature
- Other necessary annotations.

Annotations will be assumed to have been made on the same date as that appearing in Blank J, accompanying the signature. If annotations are made on different dates, those dates should be part of the annotations.

### E. Signature Box

Once the beneficiary reviews and understands the information contained in the ABN, the Signature Box is to be completed by the beneficiary (or representative). This box cannot be completed in advance of the rest of the notice.

**Blank (I) Signature:** The beneficiary (or representative) must sign the notice to indicate that he or she has received the notice and understands its contents. If a representative signs on behalf of a beneficiary, he or she should write out “representative” in parentheses after his or her signature. The representative’s name should be clearly legible or noted in print.

**Blank (J) Date:** The beneficiary (or representative) must write the date he or she signed the ABN. If the beneficiary has physical difficulty with writing and requests assistance in completing this blank, the date may be inserted by the notifier.

**Disclosure Statement:** The disclosure statement in the footer of the notice is required to be included on the document.

## Non-covered services waiver

Certain Medicare Replacement plans follow the CMS medical necessity policies. These plans will not accept the CMS ABN form. The Non-covered services waiver should be used for these plans.

The form is similar to the CMS ABN. It requires the service to be listed, the estimated price, the reason for the non-coverage and the date of service. This should be filled out prior to presentation to the patient. The patient then has two options:

- Option 1
    - By choosing this option, the patient is stating that they understand and to bill insurance. We will tell the insurance company that the patients signed the form before the claim is submitted.
- Option 2
    - This option is stating that the patient does not want the service and the testing is not able to be billed.

The patient will then need to date and sign the form. The patient's name should be printed as well as the additional field of the patient's date of birth should be completed to ensure that the form can be linked to the correct patient.

## Non-covered services waiver example

### Non Covered Services Waiver

Humana Gold MR, Medica Prime Solutions or
UCARE MR

Allina Health LABORATORY

As a participating provider with your insurance, we are to notify you of services that may not be covered. This notification will allow us to hold you financially liable for the procedure listed below:

| |
|---|
| Service: |
| Estimated Price: $ |
| Reason (specific benefit limitations): |
| Date of service: |

The purpose of this form is to help you make an informed choice about whether or not you want to receive these services, knowing that you may have to pay for them yourself. Before you make a decision about your options, you should ***read this entire notice carefully.*** If you don't understand why you insurance likely won't pay, ask us to explain. Ask us how much these services will cost you.

**PLEASE CHOOSE ONE OPTION; CHECK ONE BOX ONLY.**

| | |
|---|---|
| **Option 1. ☐ YES I want to receive these items or services** | |
| | I understand that my insurance will not decide whether to pay unless I receive these items or services. Please submit my claim to my health insurance. If insurance denies payment, I agree to be personally and fully responsible for payment. This is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal the insurance company's decision. |
| **Option 2. ☐ NO I have decided not to receive these items or services** | |
| | I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that insurance won't pay. |

| Date | Signature of patient or person acting on patient's behalf | Relationship |
|---|---|---|

Patient Name: _____

Patient Allina Health MRN or DOB: _____

***Provide a copy of this completed/signed document to the patient.***

*July 2016*
S415211

Medical necessity test list

| Panel Code | Test | CPT |
|---|---|---|
| 920 | ACETAMINOPHEN | G0480 |
| 696 | ACUTE HEPATITIS PANEL | 80074 |
| 12452 | ADULT FOOD ALLERGY PROFILE | 86003 |
| 60 | AFP MATERNAL INITIAL | 82105 |
| 20 | AFP TUMOR MARKER,SERUM | 82105 |
| Multiple | ALLERGEN IgE TESTS | 86003 |
| 2627 | APOLIPOPROTEIN A-1 | 82172 |
| 2628 | APOLIPOPROTEIN B | 82172 |
| 490 | APTT | 85730 |
| 5531/7095 | BRAIN NATRIURETIC PEPTIDE | 83880 |
| 294 | CA 125 | 86304 |
| 3551 | CA 15-3 | 86300 |
| 259 | CA 19-9 | 86301 |
| 430 | CBC | 85027 |
| 400 | CBC AND DIFFERENTIAL | 85025 |
| 664/7853 | CEA | 82378 |
| 12451 | CHILDHOOD ALLERGY MARCH PROFILE | 86003 |
| 71 | CHOLESTEROL,TOTAL | 82465 |
| 8742 | COMPLIANCE DRUG ANALYSIS | 80307 |
| 8745 | COTININE ORAL, QUALITATIVE | G0480 |
| 431 | DIFFERENTIAL | 85004 |
| 92 | DIGOXIN | 80162 |
| 597 | DRUG SCREEN, IN-HOUSE | 80306 |
| 945 | DRUG SCREEN BLOOD | 80307 |
| 438 | EOSINOPHIL COUNT | 85048 |
| 19/402 | ETHANOL | G0480 |
| 102 | FERRITIN | 82728 |
| 4759 | FRUCTOSAMINE | 82985 |
| 114 | GAMMA GT | 82977 |
| 109/ 7250 | GLUCOSE | 82947 |
| 690 | HCG BETA QUANT, PREGNANCY | 84702 |
| 618 | HCG BETA QUANT,TUMOR | 84702 |
| 3631 | HDL CHOLESTEROL | 83718 |
| 146 | HEAVY METALS SCREEN | 82175 |
| 448 | HEMATOCRIT | 85014 |

| Panel Code | Test | CPT |
|---|---|---|
| 450 | HEMOGLOBIN | 83036 |
| 241/8761 | HEMOGLOBIN A1C | 83036 |
| 7867 | HIV RNA QUANT-TAQMAN | 87536 |
| 741 | HLA B27 | 86812 |
| 8782 | IMMUNE CELL FUNCTION ASSAY | 86352 |
| 1144 | IRON | 83540 |
| 100 | IRON BINDING CAPACITY | 83550 |
| 5665 | LDL CHOLESTEROL, DIRECT | 83721 |
| 160 | LIPID PANEL | 80061 |
| 8161 | LIPID PANEL with REFLEX | 80061 |
| 5751 | LUPUS ANTICOAGULANT (APTT) | 85730 |
| 2920 | N-TELOPEPTIDE (NTX) | 82523 |
| 12480 | NMR LIPOPROTEIN PROFILE 600 | 83704 |
| 12481 | NMR LIPOPROTEIN PROFILE 630 | 83704 |
| 8787 | OCCULT BLOOD STOOL, iFOBT | G0328 |
| 484 | PLATELET COUNT | 85049 |
| 7095 | PRO-BNP | 83880 |
| 487 | PROTIME-INR | 85610 |
| 1102 | PSA SCREEN | G0103 |
| 1097 | PSA TOTAL (DIAGNOSTIC) | 84153 |
| 4765 | PSA, TOTAL AND FREE<br>(List PSA TOTAL on ABN) | 84153 |
| 7189A | RAPID HIV SCREEN | 86703 |
| 12450 | RESPIRATORY ALLERGY PROFILE | 86003 |
| 228 | SALICYLATE | G0480 |
| 847 | T4 (THYROXINE) | 84436 |
| 251 | T4, FREE | 84439 |
| 121 | TRANSFERRIN | 84466 |
| 256 | TRIGLYCERIDES | 84478 |
| 258 | TSH | 84443 |
| 8960 | TSH with REFLEX | 84443 |
| 6564 | URINE CULTURE | 87086 |
| 6680 | URINE CULTURE,  ADDL WORKUP | 87086 |
| 113A | VITAMIN D 25 HYDROXY D2D3 | 82306 |
| 514 | WHITE BLOOD COUNT | 85048 |

For pricing information, contact your Account Representative. For an immediate need during business hours, contact Allina Health Laboratory Billing at (612) 863-0400.

# Miscellaneous billing policies

## Bill back policy

In order to keep rising healthcare costs down, Allina Health Laboratory enforces a bill back policy. This policy allows for Allina Health Laboratory to bill back certain tests that we were unable to bill out due to missing or inaccurate billing information. This includes but is not limited to missing diagnosis codes, unknown provider or lack of covered diagnosis codes or ABN for Medicare policies.

For missing information, lack of supporting diagnosis codes, or lack of ABN two attempts will be made by fax to retrieve this information. If no response this will be followed by one phone call to the clinic. If the information is gathered, billing will occur as usual but if information is unavailable the tests involved will be billed back to your clinic. These tests cannot be reversed back to third party payers if missing information is found unless clinic agrees to pay the $25 service fee for the transaction to be completed in our billing department.

## Professional courtesy policy

Federal Law prohibits offering "professional courtesy testing". Allina Health Laboratory cannot honor requests for this service.

## Courier charges

Certain courier pickups are subject to charges being billed back to your facility. Each charge is dependent on geographical location, scheduled pick up times and other requests. These charges will appear on the monthly statement. Please contact your Account Representative for information.