August 9, 2016

LAURA HANDY-OLDHAM
Executive Director, Revenue Cycle
8911

Subject: ***Advance Beneficiary Notices***
Report 2016-20

The final report for Advance Beneficiary Notices, Report 2016-20, is attached. We would like to thank all members of the department for their cooperation and assistance during the review.

Because we were able to reach agreement regarding management action plans in response to the audit recommendations, a formal response to the report is not requested. The findings included in this report will be added to our follow-up system. We will contact you at the appropriate time to evaluate the status of the management action plans.

UC wide policy requires that all draft reports be destroyed after the final report is issued. We also request that draft reports not be photocopied or otherwise redistributed.

David Meier
Director
Audit & Management Advisory Services

Attachment

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UC San Diego

AUDIT & MANAGEMENT ADVISORY SERVICES

Advance Beneficiary Notices
Report No. 2016-20
August 2016

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I. EXECUTIVE SUMMARY

Audit & Management Advisory Services (AMAS) has completed a review of UC San Diego Health (UCSDH) Advance Beneficiary Notices as part of the approved audit plan for Fiscal Year 2015-16. The objective of our audit was to review practices for issuing ABNs at UCSDH, in the context of Epic system functionality, to evaluate compliance with CMS requirements. Our preliminary review noted that ABN processes were not fully implemented at UCSDH. Therefore, we included in the scope of our review an analysis of Epic ABN and Denial data, which can help management identify services most impacted by the lack of an ABN and facilitate downstream collections.

We concluded that UCSDH was not in strict compliance with CMS requirements to issue ABNs to Medicare beneficiaries for potentially non-covered services. While Epic had the capability to support this process, ABNs were not routinely printed, provided to patients, or retained. This non-compliance was mitigated by the fact that UCSDH did not attempt to recover payment for Medicare-denied services from the Medicare beneficiary. However, as a result, UCSDH was unable to pursue payment for these services. Our analysis of denial data for Medicare "medical-necessity" denials indicated this amount was $1,175,781 for the period of January through April of 2016.

We conducted a review of available Epic data on system ABN triggers, from which we identified the top three ordering departments with ABN triggers: Mammogram, Internal Medicine, and Bone Density. Future rollout of ABN functionality could focus on initial training of clinic staff in these locations, where services triggering an ABN were most common. Our review of Denial data indicated that the top three divisions with the most services denied by Medicare due to lack of medical necessity were Oncology, Emergency Medicine, and Imaging Services.

During our review, an ABN Implementation Team was formed to evaluate Epic ABN functionality and processes to fully implement ABNs at UCSDH. The Team has made a preliminary decision to initiate a project to implement ABNs within the next 12 months. Also, while Epic had some management reports to support oversight for ABN processes, management oversight could be enhanced to reference ABN data to Denials data, for more complete analysis of transactions through the entire process. The Management Action Plan to address our findings is summarized below:

A. **Implementation of ABN Trigger and Report Processes**

The ABN Implementation Team will continue with efforts to fully implement ABNs at UCSDH, to include the following:

- Establishment of clear roles and responsibilities for ABN processes;
- Training and engagement to providers and department staff for ABN policies; and
- Evaluation and implementation of management reports.

Observations and related Management Action Plans are described in greater detail in Section V. of this report.

II. BACKGROUND

Audit & Management Advisory Services (AMAS) has completed a review of UC San Diego Health (UCSDH) Advance Beneficiary Notices as part of the approved audit plan for Fiscal Year 2015-16. This report summarizes the results of our review.

The Center for Medicare & Medicaid Services (CMS) requires providers to inform Medicare beneficiaries when the provider believes Medicare may not pay for an item or service, by issuing an Advance Beneficiary Notice of Noncoverage (ABN). The ABN allows beneficiaries to make informed decisions about planned care and associated costs prior to receiving services, and serves as the institution's documentation of the beneficiary's acceptance of financial responsibility in cases where Medicare does not cover the service. A beneficiary's signature on an ABN means that the beneficiary agrees to pay for expenses out-of-pocket, or through any other insurance they may have. If a provider does not have a beneficiary complete an ABN, and the service is denied by Medicare, the provider may not bill the beneficiary for the denied service.

CMS requires that an ABN be issued under the following circumstances:

- The provider believes Medicare may not pay for an item or service;
- Medicare usually covers the item or services; and
- Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.

In practice, it is expected that Medicare may deny payment for an item or service because it is not considered reasonable and necessary under Medicare Program standards; the care is considered custodial; or outpatient therapy services are in excess of therapy cap amounts and do not qualify for a therapy cap exception. Other circumstances may result in a denials applicable to hospice providers and home health services.

The ABN is used to fulfill both mandatory and voluntary notice functions. Medicare considers issuance of an ABN effective when the notice is:

- Issued to and comprehended by a suitable recipient;
- Completed on the approved, standardized ABN with all required blanks completed;
- Provided far enough in advance of potentially noncovered items or services to allow sufficient time for the beneficiary to consider available options;
- Explained in its entirely with all questions related to the ABN answered; and
- Signed and dated by the beneficiary or his/her representative after his/her selected one option box on the ABN.

Both the provider and Medicare beneficiary should maintain a copy of the signed ABN. An ABN can remain effective for up to one year. The retention period for the ABN is five years from discharge/completion of delivery of care when there are no other applicable requirements under State law. Retention is required in all cases, including those cases in which the beneficiary declined the care, refused to choose an option, or refused to sign the notice. ABNs are also used by home health agencies for Medicare Part A and Part B items and services. ABNs are not required in emergency or urgent care situations. Two standard ABN report formats (***Attachment A and A1***) were published by CMS to serve as examples for issuing providers.

UCSDH implemented the Epic Enterprise System in October 2013, and upgraded to Epic 2015 in June 2016. Epic has functionality that supports the ABN process in the form of medical necessity checks which compare an ordered procedure to the diagnoses associated with the order. If the services would not be covered by Medicare for the associated diagnosis, this "triggers" ABN warnings and generation of an ABN. Epic workflows can facilitate the ABN processes by prompting when an ABN is triggered, generating the form for printing, and retaining the documentation of the patient counseling. Epic also includes an ABN Report and ABN Follow-Up Report to assist with management oversight and reporting.

At UCSDH, ABN processes have not been fully implemented for Medicare patients. While the system was triggering an ABN, processes were not in place for physicians or staff to print the form, counsel patients, and retain the documentation. Because ABNs were not issued and signed, the beneficiary could not be held financially responsible (either directly or through secondary insurance). These Medicare denied charges would ultimately be written off.

During our review, a team was formed by UCSDH leadership to implement Epic ABN functionality to include individual service areas and associated prices for different locations. The team's planned direction is to turn on ABN functionality at order, scheduling, and check-in processes.

To assist prioritize ABN department rollout, denial data can be obtained from the Denial Cube, a self-service reporting mechanism which was developed in early 2016. The Denial Cube was designed to assist Revenue Cycle users in the analysis of denial data and variances reports as needed. From the Denial Cube, a high level summary of total denied transactions for all Medicare patients, inpatient and outpatient, for twelve-month (May 2015 through April 2016) period is summarized below.

May 2015 – April 2016 (12-month period)	Denied Amount Non Duplicate	Number of Denial Count
All Medicare Denied Transactions	$81,158,316	21,461
Outpatient (with Final DRG ID = 9Z)	$28,107,697	20,050
% of Medicare Outpatient Denials to All Medicare Denials	35%	93%

Source: Denial Cube (June 3, 2016)

III. AUDIT OBJECTIVE, SCOPE, AND PROCEDURES

The objective of our audit was to review practices for issuing ABNs at UCSDH, in the context of Epic system functionality, to evaluate compliance with CMS requirements. Our preliminary review noted that ABN processes were not fully implemented at UCSDH. Therefore, we included in the scope of our review an analysis of Epic ABN and Denial data, which can help management identify services most impacted by the lack of an ABN and facilitate downstream collections.

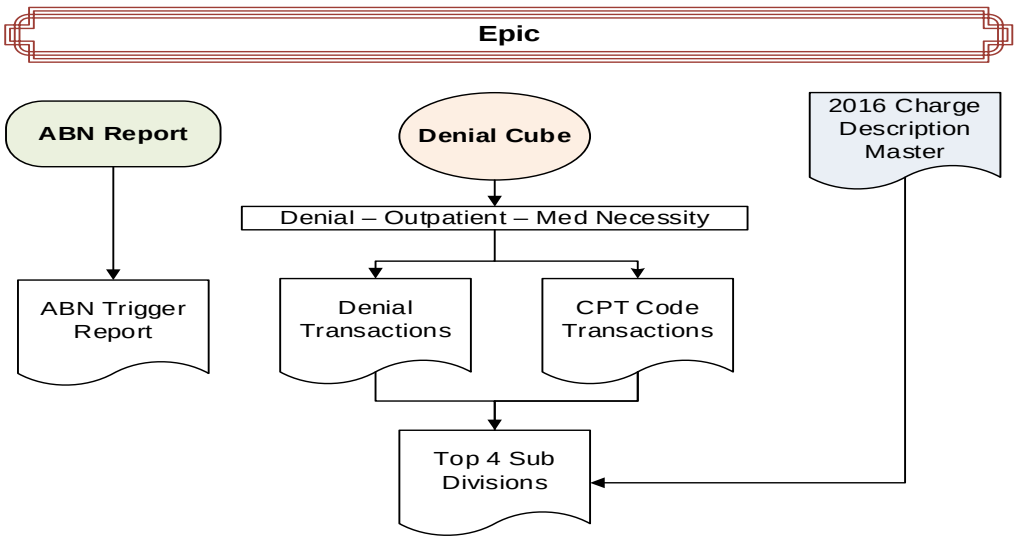
We completed the following audit procedures to achieve our objective:

- Reviewed CMS requirements and related ABN articles and practices;
- Attended Revenue Cycle ABN process presentation and development meetings;
- Reviewed the ABN processes and available reports in the Epic;
- Evaluated available Epic ABN reports;

- Performed data analytics on Epic ABN data and reports, including ABN status, department, and ordering providers;
- Obtained access to the Revenue Cycle Denial Cube and associated training;
- Extracted available Medicare denial data by denied transaction and associated Current Procedural Terminology (CPT) code from the Denial Cube;
- Performed data analytics for downloaded Denial data by department, CPT code, and other key data fields;
- Identified top five areas, departments, service lines, CPT codes with denial encounters; and
- Estimated potential revenue loss due to unable to bill patients after Medicare medical necessity denials for the period of January through April 2016.

Analytic Methodology

Our analytics focused on three data sets: 1) ABN reports for provider ordering and/or patient scheduling procedures; 2) Denial Cube data for Medicare denied outpatient services with denial reason code 50 (Non-covered, Not deemed medical necessity); and 3) the 2016 Charge Description Master (CDM). We focused on the Epic system report functionality and Medicare Denial data for a period of January through April of 2016, since this time period contained more complete Denials Cube and CPT-level data. Because CPT-level detail was not typically retained in the Denials Cube, we obtained this data separately, however some files had limited data fields and these CPT codes were not directly referenced to the associated encounter. In some cases, we noted that duplicate denials could exist for same encounter (HAR), Admit and Discharge Dates, so this data was removed. While we were able to join Denials cube and CPT level detail in most cases, in some cases the lack of same common reference fields prevented us from fully matching the data. A graphical depiction of our analytic approach is provided below:



IV. CONCLUSION

Based on our review, we concluded that UCSDH was not in strict compliance with CMS requirements to issue ABNs to Medicare beneficiaries for potentially non-covered services. While Epic had the capability to support this process, ABNs were not routinely printed, provided to patients, or retained. This non-compliance was mitigated by the fact that UCSDH did not attempt to recover payment for Medicare-denied services from the Medicare beneficiary. However, as a result, UCSDH was unable to pursue payment for these services. Our analysis of denial data for Medicare "medical-necessity" denials[1] indicated this amount was $1,175,781 for the period of January through April of 2016.

We conducted a review of available Epic data on system ABN triggers, from which we identified the top three ordering departments with ABN triggers: Mammogram, Internal Medicine, and Bone Density. Future rollout of ABN functionality could focus on initial training of clinic staff in these locations, where services triggering an ABN were most common.

Our review of Denial data indicated that the top three divisions with the most services denied by Medicare due to lack of medical necessity were Oncology, Emergency Medicine, and Imaging Services. We also found that most of the transactions denied for lack of medical necessity were for services provided at the Moores Cancer Center location.

During our review, an ABN Implementation Team was formed to evaluate Epic ABN functionality and processes to fully implement ABNs at UCSDH. The Team has made a preliminary decision to initiate a project to implement ABNs within the next 12 months. Also, while Epic had some management reports to support oversight for ABN processes, management oversight could be enhanced to reference ABN data to Denials data, for more complete analysis of transactions through the entire process. Additional discussion is provided in the balance of this report.

V. OBSERVATIONS REQUIRING MANAGEMENT ACTION

A.	**Implementation of ABN Trigger and Report Processes**
ABN processes for Medicare beneficiaries were not fully implemented. As a result, UCSDH was unable to pursue payment from beneficiaries for services denied by Medicare.	
Risk Statement/Effect	
Incomplete ABN processes could lead to lost revenue and non-compliance with CMS requirements.	
Management Action Plan	
A.1	The ABN Implementation Team will continue with efforts to fully implement ABNs at UCSDH, to include the following: • Establishment of clear roles and responsibilities for ABN processes; • Training and engagement to providers and department staff for ABN policies; and • Evaluation and implementation of management reports.

[1] CAS Code 50

A. Implementation of ABN Trigger and Report Processes – Detailed Discussion

Epic is currently configured to trigger an ABN at the point when a service is ordered. The ABN trigger for medical necessity is generated within Epic based on logic considering the procedure (CPT code) and the diagnosis (ICD-10 code), and triggering an ABN warning for instances where the service is not routinely covered for the associated diagnosis. Although Epic generated these triggers, these ABN reports were not printed, nor signed by patients, and not maintained in patient's record. We reviewed Epic data for ABN triggers, and summarized ABN triggers by ABN status and payor.

ABN Status / Payor [(a)]	Medicare	Other Payors [(b)]	Total
ABN Void (Order Canceled or Changed, ABN No Longer Applies)	271	9	280
ABN Void (Order Canceled or Changed, ABN No Longer Applies) Notice Printed	1	--	1
ABN Void (Order Canceled or Changed, ABN No Longer Applies) Notice Triggered	57	1	58
Notice Printed	1	--	1
Notice Triggered	3,095	110	3,205
Total Number of ABN Triggers and Reports	**3,425**	**120**	**3,545**

(a) Testing Period: January – April 2016

(b) Beneficiary had another insurance as a primary coverage, and Medicare was the secondary payor.

From this ABN report, we further classified that data by the department to identify the top ten departments with the most ABN notices for patients with Medicare payor. This data essentially shows the departments where services triggering an ABN were most commonly ordered. This information can assist management in the rollout of ABN processes, through prioritization of implementation and training. If needed, this ABN report could also include provider information for each department.

Payor = Medicare Top Ten Departments by Department and ABN Triggers			
Epic Department	**ABN Void [(a)]**	**Notice Triggered**	**Grand Total**
MUC MAMMO	--	659	659
LIM Int Med	35	303	338
LWC MAMMO	--	221	221
MUC BONE	--	205	205
LWC Int Med	27	109	136
MUC Onc	32	67	99
PMC Med Sn	10	76	86
VIS Int Med	6	78	84
LWC Fammed	13	70	83
SRC Fammed	12	71	83
Top 10 Totals	135	1,859	1,994
Total ALL	**330**	**3,095**	**3,425**
Top 10 %	**41%**	**60%**	**58%**

(a) ABN Void includes the following:

ABN Void (Order Canceled or Changed, ABN No Longer Applies),
ABN Void (Order Canceled or Changed, ABN No Longer Applies) Notice Printed,
ABN Void (Order Canceled or Changed, ABN No Longer Applies) Notice Triggered, and
Notice Printed

The Epic ABN reports were created in October 2013, when Epic Enterprise was implemented. Because ABNs were not issued, these reports did not appear to be routinely used or maintained. Review and validation of the report logic and results should be performed before fully relying on these reports, once ABN functionality is implemented.

Medicare Denied Transactions

The future rollout of ABN functionality can also be informed by evaluating data on services denied by Medicare due to lack of medical necessity. This population of denials that could potentially be pursued from the beneficiary, if a valid ABN was in place. We analyzed data from the Denial Cube to identify denials from Medicare, and specifically denials for Medical necessity. For 2016 (January through April) a four-month period, outpatient denials represented 27% of total denied amount and 87% of denied count.

Medicare Denied / Period - 2016	Medicare Denied		Denied Transaction Count	
	All Patient	Outpatient	All Patients	Outpatients
January	$5,795,879	$1,931,719	833	732
February	$6,005,678	$2,613,811	911	798
March	$6,512,358	$1,145,325	681	592
April	$8,517,624	$1,449,495	532	465
Total	**$26,831,539**	**$7,140,350**	**2,957**	**2,587**
		27%		**87%**

Major denial types are Medical Necessity/Level of Care, Non-Covered Charges, Coordination of Benefits, Coding, Additional Documentation Needed, Eligibility/Registration, Past Timely Filing, and Missing claim Information. A detail review on the denial reason code for the period of January through April 2016 revealed the top ten denial reasons for all Medicare patients:

Reason Code	Reason Code Description	Denied Amount	Denied Count	Denied Amount %	Denied Count %
96	NON COVERED CHARGES.	$ 8,954,889	297	33%	10%
50	**NON CVD, NOT DEEMED MED NECESSITY.**	**$ 2,967,357**	**705**	**11%**	**24%**
22	DNIED/RDCD, MAY BE CVD BY OTHR PAYOR.	$ 2,840,149	362	11%	12%
31	DENIED, PAT CANT BE ID AS OUR INSRD.	$ 2,267,064	33	8%	1%
151	PMT ADJ, # OF SVCS NOT SUPPTD.	$ 1,779,499	404	7%	14%
177	DENIED, ELIGIBILITY REQS NOT MET.	$ 1,600,485	19	6%	1%
188	PROD/PX CVD WHN USED PER FDA RECS.	$ 1,232,186	12	5%	0%
119	BENFT MAX 4 TIME PD/OCCURNCE PASSED.	$ 1,141,118	98	4%	3%
B5	PMT ADJ, CVG GUIDELNS NO MET/EXCD.	$ 979,094	275	4%	9%
B22	ADJ, BASED ON DIAGNOSIS.	$ 758,199	189	3%	6%

As noted, denial code 50 – Not Deemed Med Necessity encounter reflects instances where Medicare determined the service was not medically necessary, and an ABN may have been required. A review of denial data for Medicare outpatient with denial code 50 for the period of January through April 2016 is summarized below. Based on this information, $1,175,781 in outpatient services were denied by Medicare due to lack of medical necessity. Had ABNs been issued and signed by patients for these services, payment could be pursued from the beneficiary. Instead, these denials will have to be written off by the institution.

Period: January 2016 – April 2016 (a)	Denied Amount	Denied Code = 50 Denied Amount	Denied Transaction Count	Denied Code = 50 Transaction Count
All Medicare Denied Transactions	$26,831,539	$2,967,357	2,957	705
Medicare Outpatient (with Final DRG id = 9Z)	$7,140,350	$1,175,781	2,587	666
% of Medicare Outpatient	**27%**	**40%**	**87%**	**94%**

(a) Duplicate transactions with same encounter (HAR), admit date, discharge date, and Principal Final Diag were not included in this table.

A focused review of denial data for the outpatient services with denial code 50 (Med Necessity) identified the top five items for major categories, as shown in the table below.

Jan - April 2016 Outpatient, Denial Code = 50	Denied Amount	Denied Count	Denied Amount %	Denied Count %
Total	$ 1,175,781	666	100%	100%
By Patient Class				
Outpatient Infusion - Series	$ 650,539	227	55%	34%
Outpatient Hyperbaric - Series	$ 138,829	9	12%	1%
Hospital Outpatient Procedure	$ 129,058	33	11%	5%
Outpatient Clinic Visit - Encounter	$ 81,582	55	7%	8%
Lab Referred Specimen	$ 79,429	222	7%	33%
By Division				
4 - Oncology	$ 736,192	262	63%	39%
13 - Emergency Medicine	$ 141,671	16	12%	2%
9 - Imaging Services	$ 141,289	52	12%	8%
16 - Other	$ 85,656	208	7%	31%
2 - Medicine	$ 38,649	45	3%	7%
By Sub Division				
25 - Oncology	$ 736,192	262	63%	39%
52 - Emergency Department	$ 141,671	16	12%	2%
20 - Interventional Radiology	$ 92,480	13	8%	2%
51 - Draw Station	$ 86,100	209	7%	31%
57 - Radiology	$ 48,809	39	4%	6%
By Location				
MOORES UCSD CANCER CENTER	$ 600,470	254	51%	38%
HILLCREST HOSPITAL HOD/OP	$ 256,529	58	22%	9%
UCSD ENCINITAS CANCER CENTER	$ 134,399	36	11%	5%
LA JOLLA HOSPITAL HOD/OP	$ 32,297	23	3%	3%
UCSD HYPERBARIC MEDICINE ENCINITAS	$ 21,985	6	2%	1%

CPT Code Analysis

From Denial Cube denied transaction table, an additional extraction was performed to obtain CPT code level data for the denied services. These extracted CPT files contained data fields that include denied month, encounter (HAR), CPT code, standard charges, payment, revenue code, and revenue code description. With the limited CPT data fields, we matched these CPT files with denial files for the same encounter and same month in order to provide more meaningful analytics on specific services at the CPT level which were denied. The following table outlined the monthly summary from the denial file and CPT code file separately.

Period/Denial /CPT	Denial Transactions		CPT Code Transactions	
	Denied Amount	Transaction Count	Standard Charges	Transaction Count
January 2016	$ 471,429	212	$ 990,182	904
February 2016	$ 252,058	136	$ 750,035	811
March 2016	$ 197,798	138	$ 837,451	752
April 2016	$ 254,496	180	$ 1,082,396	1,207
Total	**$ 1,175,781**	**666**	**$ 3,660,064**	**3,674**

Data for the top 50 denied CPT code transactions with CDM description, standard price, and research price[2], sorted by total standard charges and quantity, was provided to management for their review and follow-up. Many of the top denied services related to Pharmacy charges, laboratory services, and oncology services.

We analyzed this data further to identify the top four sub divisions where the denied services were provided. These top four sub-divisions had 96% of the total CPT standard charges and 87% of the total transaction count.

Top 4 Sub Divisions	Standard Charges	Transaction Count
25 - Oncology	$ 2,875,030	1,706
49 - Apheresis	$ 384,731	365
51 - Draw Station	$ 154,235	1,016
57 - Radiology	$ 102,022	100
Top 4 Sub Divisions	**$ 3,516,018**	**3,187**
Total All Divisions	$ 3,660,064	3,674
% of Top 4 Sub Division	96%	87%

Management was provided with a summary of denied CPT codes for the top four areas identified above with total standard charges which exceeded $20,000 for the months of January through April 2016. This data can be used to further identify the most impacted areas and services to focus and prioritize future ABN implementation and training efforts.

[2] Medicare price is adopted as a research price in the UCSDH CDM, therefore this figure is used for comparative purposes.

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:

Notifier(s):
Patient Name: **Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for lab tests checked in box **(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 lab tests checked in box **(D)** below.

(D) **Checked Lab Tests Only:**	□ CA-125: 86304 □ CEA: 82378 □ cholesterol: 82465 □ Ferritin: 82728 □ Fructosamine: 82985 □ glucose: 92847 □ Iron: 83540 □ T3 Uptake 84479 □ other: _____ □ other: _____ □ other: _____	□ cardiovascular disease screen: 80061, 82465, 83718 □ HgbA1C: 83036 □ Pap Screen: G1023, G1024 □ PSA Screen: G0103 □ TSH: 84443 □ other: _____ □ other: _____ □ other: _____	□ AChR Blocking Ab, Ser: 878844 □ Babesia Micro. Ant. Panel: 138315 □ Chromagranin A: 140848 □ Lymphocyte Act. Profile: 505321 □ PTH-Related Peptide: 140194 □ other: _____ □ other: _____ □ other: _____
Reason Medicare May Not Pay:	Medicare does not pay for these tests for your condition.	Medicare does not pay for these tests as often as ordered for you.	Medicare does not pay for experimental or research use tests.
Estimated Cost:			

Sample Lab ABN. Labs and codes are listed as example text only.

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 checked items in **(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.

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

❑ **OPTION 1.** I want the *lab tests* checked 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 *lab tests* checked 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 *lab tests* checked above. I understand with this choice I am **not responsible for payment, and** I cannot appeal to see if Medicare would pay.

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.

Signature:	**Date:**