Under certain circumstances, diagnostic testing such as laboratory, radiology, and cardiovascular tests, that are not covered by Medicare may become your responsibility to pay.

Q. How does the billing of diagnostic services work?

A. When your physician orders testing from a medical facility, such as Lakeland, the facility performing the testing bills Medicare directly. Generally, Medicare pays for 100% of the cost of most laboratory services according to a national fee schedule. For a few tests and other services, Medicare will only pay a portion of the cost after you, the Medicare beneficiary, have met your annual deductible. You may also be responsible for co-pay for certain non-laboratory diagnostic procedures.

Q. Does Medicare pay for all laboratory tests?

A. No. Although Medicare pays for most laboratory tests, there are certain types of tests for which Medicare will not pay. The types of tests that are not covered by Medicare, which may be billed to the patient, include:

- tests ordered for diagnosis or condition that, in Medicare's opinion, are not medically necessary.
- "screening" tests performed as part of a routine exam when the patient shows no evidence of disease.
- tests performed more frequently than recommended by Medicare.
- tests considered experimental or investigational due to lack of Food and Drug Administration (FDA) approval.

Under certain circumstances, as described above, Medicare will not pay any part of the test's cost and you may be asked to pay. In cases where you may be responsible for the cost of your testing, you should be advised of this and asked to sign a form called an **Advanced Beneficiary Notice (ABN)**. This indicates you are aware that Medicare is likely to deny payment for the services and that you understand that you may be responsible for payment.

An exception to this involves a routine or yearly physical exam. During your first 6 months of eligibility for Medicare you are allowed a Physical Exam as a part of the Welcome to Medicare. After that, any Physical Exam given (routine or yearly) with the diagnosis of V70.0 (Routine Medical Exam) is considered Statute and can not be billed to Medicare by our facility. You will not be asked to sign an ABN, since our facility is not able to bill Medicare for the test. You are responsible for the charge. This is described in your Medicare and You handbook in the section "What's Covered".

Q. When will I be asked to sign an ABN?

A. When there is reason to believe that Medicare will not pay for your test, you will be asked to sign an ABN before the service in question is performed.

Q. If Medicare doesn't pay for the test, does that mean I don't need the test?

A. Your physician is the best person to make that decision. He/she knows you and your medical needs best. Physicians order tests to evaluate and monitor health based on a wide range of factors, including age, family and personal medical history, any medication being taken and generally accepted medical practices. Medicare may not consider all of these factors or individual cases when setting its payment policies.

Q. Do I have to sign the ABN every time my physician recommends a laboratory test?

A. No. You will only be asked to sign the ABN when there is reason to believe that Medicare will not pay for the tests. Your physician should be able to determine coverage when he or she order the tests.

Q. What if I can't afford to pay for a laboratory test?

A. Discuss this with your physician at the time the test is ordered. Alternatively, we can develop a payment plan for you. Please contact Lakeland billing department at 1-800-420-1472 to make arrangements.

Q. Who do I call for more information?

A. Lakeland Laboratory Client Services would be happy to answer any questions you may have. We can be reached at (269) 983-8311 or (800) 513-9193. If you have any additional questions, please ask your physician or contact Medicare.

Medicare Patients

Medicare Limited Coverage Policies