The Original Medicare Roadmap

1. The test order — Before the visit

Will Medicare cover it?

What it says

Your doctor's order

The tests, and the diagnosis codes the office chose. Medicare decides coverage from those codes and the records behind them.

What it means

Check the order first

Do the codes match Medicare's coverage rules and frequency limits?[1]

If the codes match, keep a copy of the order.

If they don't, the visit can turn into a denial.

[1] Medterpret checks the codes on your order against Medicare's coverage and frequency rules, from a photo of the order.

What to do next

Codes match: go.

Keep a copy of the order for your file.

Codes don't match:

Ask the ordering office to double-check the chart before you go to the lab.[2]

[2] Never ask anyone to use a code that is not in your chart to get a test covered.

At every step: keep every notice, letter and envelope, log every call, and send anything that matters so you can prove the date it arrived.

Rule on your side, or nothing more to do — Act now

Medterpret can help with this step — You are done

Next: 2. The ABN, page 2

Snap a picture of your order, ABN, denial or bill and see what it says in plain English: medterpret.com

For information and education. It is not medical or financial advice. This is not legal advice and our products are not a substitute for the advice of an attorney. The full notes are on the last page.

2. The ABN — Before the visit

Should I sign?

What it says

A form the lab may ask you to sign before the test

It says the lab believes Medicare may not pay for these items, and it gives an estimated cost. If you sign a valid ABN and have the test, that cost is yours if Medicare does not pay.

What it means

Compare the price

Is the price in line with Medicare's rate and what nearby labs have charged? The ABN's estimate is what you could owe if you have the test and Medicare does not pay.[1]

On a covered test, Medicare pays its rate and you owe nothing.

[1] Precheck shows Medicare's rate for each test ordered and what other labs in the area have charged.

What to do next

If you sign a valid ABN and check the first box, the cost is yours if Medicare denies (Ch. 3).

Questions about the codes or the price:

Double-check the codes with your doctor, or find another lab.

No valid ABN where required: you owe nothing on a denial. This applies to "not reasonable and necessary" denials, not to services Medicare never covers.

☐ Act now Medterpret can help with this step

Next: 3. The denial, page 3

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3. The denial — After the visit

Why was it denied?

What it says

The Medicare Summary Notice (MSN)

Not a bill. It lists what Medicare decided on each claim, the reason codes, what it paid, and your appeal rights with the deadline. The reason is here, not on the bill.

What it means

Read the MSN

The reason codes tell you whether this is a coverage question or a coding error. The reasons are usually in the notes at the bottom of the MSN.[1]

The deadline is printed on the MSN's last page: 120 days from receipt, which Medicare counts as 5 days after the date on it (42 CFR §405.942).

[1] Medterpret reads a photo of your MSN and shows you the reason codes and your deadline.

What to do next

Day one

1. Ask the lab for a copy of any ABN, Doc 13, unless you know you signed a valid one.
2. Ask your doctor for the notes. Doc 5.
3. Start the tracker. Doc 19.
4. Ask the ordering office whether the codes on the claim match your chart, or there was a coding error.

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The denial continues on page 4

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3. The denial (continued)

After the visit

What to do next (continued)

Coding error confirmed in writing:

Ask the lab for a corrected claim. Doc 12. Enclose the correction with your appeal.

Don't hold the appeal past your mail-by date (Ch. 5).

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The lab's corrected claim is paid: you are done.

Otherwise: appeal.

Level 1, addressing each reason code. Doc 1. Mail it 30 days early.

Denied again? Level 2, Doc 2, within 180 days.

Figures for each level: Ch. 6.

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The appeal is granted: you are done.

At every step: keep everything, log every call, prove the date.

Care ending at a skilled nursing facility, home health agency, CORF or hospice: a faster, separate appeal, Doc 30. Hospital discharge: call the number on the hospital's notice.

Rule on your side, or nothing more to do Act now

Medterpret can help with this step You are done

Next: 4. The bill, page 5

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The forms (Doc) and chapters (Ch.) named here are in The Original Medicare Appeal Playbook: medterpret.com/playbooks

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4. The bill

After the visit

Do I owe this?

Ask for the ABN on day one. The final answer comes after the appeal.

What it says

The lab's bill

What the lab wants you to pay, at its own price. A bill rarely says why Medicare denied; it may just say "patient responsibility" or "not covered."

What it means

Check the bill

Each charge next to Medicare's rate for that test. Then the question that decides everything: did the lab give you a valid ABN before the test? (Six rules, Ch. 3.)

No valid ABN where required: you owe nothing on that denial. This applies to "not reasonable and necessary" denials, not to services Medicare never covers.

What to do next

No ABN, or an invalid one:

Doc 23 asks the lab for the write-off (Ch. 4).

Keep your appeal going.

GougeStop, a Medterpret tool. Rule: 42 CFR §§411.400 to 411.406.

Valid ABN, and the appeal lost:

Negotiate from Medicare's rate. Doc 26 and the phone script.

Rule on your side, or nothing more to do

Act now

Medterpret can help with this step

The bill continues on page 6

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4. The bill (continued) After the visit

What to do next (continued)

Sent to collections:

Dispute it in writing within 30 days of getting the collector's notice. Doc 24.

Still billing? Complain. Doc 27.

At every step: keep everything, log every call, prove the date.

Care ending at a skilled nursing facility, home health agency, CORF or hospice: a faster, separate appeal, Doc 30. Hospital discharge: call the number on the hospital's notice.

☐ Act now

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