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Committee on Energy and Commerce
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JOHN D. DINGELL, MICHIGAN
CHAIRMAN

March 8, 2007

To DCM

The Honorable Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Ms. Norwalk:

I am pleased that your agency is reexamining the Advanced Beneficiary Notice (ABN) with the intent to improve the notice for Medicare beneficiaries and providers. As you know, this ABN is used to inform beneficiaries in instances where there is uncertainty surrounding Medicare's coverage of an item or service. I am pleased that the Centers for Medicare and Medicaid Services (CMS) has offered an opportunity for public comment on this newly designed form. Because the form design and content may affect a beneficiary's decision about whether to receive care, it is imperative that the form be clear, concise, and accurate.

I am concerned that, as currently proposed, the revised ABN will be confusing to beneficiaries and may inadvertently discourage beneficiaries from seeking Medicare coverage of a needed service. In addition, the revised ABN does not mention the "limited prior determination process" which beneficiaries can access in certain instances. This information is particularly important as it may encourage beneficiaries to not forgo needed care upon learning initially that a service or treatment may not be covered by Medicare. I worked with former Representative Greg Ganske and the late Representative Charlie Norwood to enact that provision into law.

Attached are more detailed comments on the revised ABN as proposed in the Federal Register Volume 73 Number 36 on February 23, 2007. I appreciate your attention to this matter and ask that this letter and attachment be made part of the record.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

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Attachment to March 8, 2007, letter from Rep. John D. Dingell

1. Typically one Advanced Beneficiary Notice (ABN) is provided *for each service in question.* The proposed revision of the ABN form, however, appears to permit as many as six services to be listed on the notice. Yet the notice does not allow beneficiaries to demonstrate that they want some, but not all, of the services/care or that they want some but not all of the services/care billed to Medicare. The ABN should be revised so that only one service is covered by an individual ABN notice.

2. As mentioned in the cover letter, the ABN does not address the "limited prior determination process." This process would allow beneficiaries to find out in advance whether Medicare would cover a service for which the provider was unsure of Medicare coverage. The ABN should be revised to allow beneficiaries to use the limited prior determination process.

3. The ABN should better emphasize the right to appeal if the Medicare claim is denied. The notice does mention that once, under G.3., however this should also be included earlier on. After the phrase "We must bill Medicare when you ask us to," the CMS should add, "and you can appeal if Medicare declines to pay." The following sentence regarding billing private insurance should go elsewhere, since it is confusing in this location where the subject is Medicare billing.

4. Option 2 under G states that if you choose 2, "you **cannot** appeal to Medicare." This is not completely accurate. Someone can choose 2, and a few months later change her mind, and ask the provider to bill Medicare. The language should be changed to "I understand that if a bill is not submitted to Medicare, I have no appeal rights."

5. Option 3 under G states that the provider can ask for the money upfront even though the person has requested a demand bill. Depending on the setting in which the ABN is used, this may not be right. The ABN should say "Part B ABN" to clarify that this is not to be used in the SNF setting where rules are different.

6. Option 3 under G should be moved up in the order. Since the norm in Medicare is to receive a service and bill Medicare, the process with which patients are most familiar, that should be the first item listed, or at a minimum listed before having the beneficiary pay 100 percent of the cost of the service and not have Medicare billed.

7. CMS must ensure the ABN is printed in other languages. At the very least, it should be printed in Spanish.

8. Too much of the ABN is in bold and underlined, which then loses its effect. CMS should minimize the use of bold and underline in the document.