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CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development – C
Attention: Bonnie Harkless
Room C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

CMS-1321-P-131

April 9, 2007

Re: Public Comment Advance Beneficiary Notification of Non-coverage

Dear Bonnie,

Based upon the wording of the revised ABN, the University of Michigan Hospitals and Health Centers is concerned with the elimination of the use of the Notice of Exclusion from Medicare Benefits (NEMB) and the potential impact for patients and departments within the health system. While the NEMB is not required to be issued for excluded services, its purpose was to protect facilities by informing the patient of excluded benefits and the cost associated. As you are aware the NEMB currently list some excluded services.

According to the Form Instructions OMB Approval Number: 0938-0566; the section which covers when the ABN is delivered states; "This new version of the ABN must also be used in place of the Notice of Exclusion from Medicare Benefits (NEMB) to provide voluntarily notification of financial liability". It is unclear if the intent is to require Providers to issue the new ABN to all patients receiving excluded services.

Since it was not a previous requirement to issue an NEMB for excluded services, change in this Policy will place an undo burden upon Providers rendering excluded services.

Please provide direction and clarity to the intent of replacing the NEMB form with the new combined ABN.

Thank you,

Darryl E. Campbell
Financial Senior Manager

Enclosure (1)

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

Physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B, as well as hospice providers paid exclusively under Part A (hereinafter "the notifier"), must complete the ABN as described below, and deliver the notice to the affected beneficiary or their representative before providing the items or services that are the subject of the notice. The ABN must be verbally reviewed with the beneficiary or their representative and any questions raise during that review must be answered before they sign it. 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. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, the notifier retains the original notice on file, and gives a copy to the beneficiary or representative. (Note that other Medicare institutional providers paid under Part A use other approved notices for this purpose.)

When the ABN is Delivered

This version of the ABN combines the former ABN-G and former ABN-L into a single notice. Previously, the ABN was only required for denial reasons recognized under section 1879 of the Act. This version of the ABN must also be used in place of the Notice of Exclusion from Medicare Benefits (NEMB) to provide voluntarily notification of financial liability Employees or subcontractors of the notifier may deliver the ABN, but the notifier remains responsible for both proper delivery of the notice and retaining the original notice on file.

Completing the Notice

OMB-approved ABNs are placed on the CMS website at: http://www.cms.hhs.gov . Notices placed on this site can be downloaded and must be used as is. Additionally, ABNs must be reproduced as a single page document. 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, subdivided into five parts in the following order on the page, from top to bottom: the header, body, option box, other insurance and signature box. Blanks (A)-(F) may be completed prior to delivering the notice. 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. The Option Box, Blank (G), as well as other insurance, Blank (H), 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.

Header

Blank (A) Supplier /Provider:

Notifiers may elect to place their logo at the top of the notice. At a minimum, the name, address, and telephone number (including TTY) of the notifier must appear, whether incorporated into the logo or not, to ensure the beneficiary's ability to follow-up with additional questions. The title for Blank (A) may be completely removed during reproduction so that the entire top of the notice above Blank (B) is clear to accommodate letterhead type logos that go across the entire page.

Blank (B) Beneficiary Name:

Notifiers must enter the first and last name of the beneficiary receiving the notice, and middle name/initial also if used on the beneficiary's Medicare (HICN) card.

Blank (C) Identification Number:

Notifiers should enter an identification number for the beneficiary that helps to link the notice with a related claim when applicable. When a number such as a Medicare number or HICN is used, the notice must be delivered in a secure manner consistent with federal privacy requirements.

Body

Gridlines appear across all 3 blanks in this section of the notice so that when there are multiple items or services at issue, the name of each item or service, the reason it is not covered by Medicare and the estimated cost are all parallel. This will ensure that the beneficiary or representative understands which reasons and costs match particular items or services. It is permissible for multiple items or services to all be explained by one reason or bundled under one cost, in which case the same information would not have to be entered multiple times. The ABN allows for entry of up to 6 items or services. If more items or services need to be described, another ABN should be used. Notifiers may also place a single entry on multiple lines (e.g., a single item may be described across the first two rows of Blanks (D)-(F)).

Blank (D) Items(s)/Service(s):

Notifiers must enter the name/description of all item(s) and/or service(s) that are the subject of the notice. Whenever possible, language that is easy for beneficiaries to understand should be used. If technical language must be used, it must be explained verbally to the beneficiary or representative. It is never permissible to add items or services to Blank (D) after the beneficiary or representative has signed the notice. The ABN is only effective for items and services clearly described on the notice at the time it is signed by the beneficiary or representative.

Blank (E) Reason:

In this blank, notifiers must explain, in beneficiary-friendly language, why they believe the care that is the subject of the notice is not covered by Medicare. For example, in the previous version of the ABN-L, there were 3 possible reasons for noncoverage pre-printed on the ABN:

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

These reasons are still appropriate for use in Blank (E) of this ABN.

Blank (F) Estimated Cost:

Notifiers must enter a cost estimate in this blank for the items or services described in Blank (D).

Option Box

Blank (G) Options:

These 3 checkboxes represent the beneficiary's possible choices regarding the potentially noncovered care described in the body of the ABN. The beneficiary or representative must select only 1 of the 3 checkboxes. Under no circumstances can the notifier decide for the beneficiary or representative which of the 3 checkboxes to select. If the beneficiary cannot or will not make a choice, the notice should be annotated.

If a beneficiary chooses to receive some, but not all of the items or services that are subject of the notice, the items and services in Blank (D) that they do not wish to receive may be crossed out, if this can be done in a way that also clearly strikes the reason(s) and cost information in Blanks (E) and (F) that correspond to that care. If this cannot be done clearly, a new ABN must be prepared.

Other Insurance

Blank (H) Other Insurance:

Completion of this blank is optional. Beneficiaries or their representatives may write down any insurers or payers, other than Medicare, that may provide payment for the care that is the subject of the notice.

Signature Box

Blank (I) Signature:

The beneficiary or representative must sign the notice, with his or her own name, to indicate that he or she has received the notice and understands its contents.

Blank (J) Date:

The beneficiary or representative must write the date he or she signed the ABN.

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(A) Supplier/Provider:

(B) Beneficiary Name: _____ (C) Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare does not pay for things listed below, you may have to pay.

We think Medicare will not pay for the "**Item(s)/Service(s)**" listed below because of certain rules for coverage described under "**Reason**". You still can receive this care, since you or your health care provider may have good reason to think you need it, but it is likely you or other insurance will have to pay. We have estimated about how much you may have to pay under "**Estimated Cost**" to help you decide whether or not to receive the care listed.

(D) Item(s)/Service(s):	(E) Reason:	(F) Estimated Cost:

- **Medicare wants us to be sure you make an informed choice.** Read this whole notice, which explains our opinion that Medicare won't pay. **This is not an official Medicare decision**. Ask us for more explanation if you need it. For questions on this notice or on Medicare billing, you can also call **1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048)**.
- **You need to make a choice about receiving the care listed above.** You must choose **only one** of the three options below. **We cannot choose for you.**
- **We must bill Medicare when you ask us to.** We may help you with billing other insurance if you choose Option 2 or 3 below, though Medicare cannot require us to do this.

(G) OPTIONS

❑ **1. Do not provide me with anything listed above.** With no care provided, there is no billing. I understand that **I cannot appeal** to Medicare when choosing this option.

❑ **2. Provide me with what is listed above. I do not want Medicare billed. I agree to be responsible for payment.** I understand that **I cannot appeal** to Medicare when choosing this option.

❑ **3. Provide me with what is listed above. I want you to bill Medicare for an official decision on payment. You can ask for payment now that will be refunded if Medicare pays.** I understand that if Medicare does not pay, **I can appeal that decision.**

(H) Other insurance to consider for billing: _____

Your signature below means that you have received this notice and understand it. You will also get a copy.

(I) Signature:	(J) Date:

PRIVAY NOTICE: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OM control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated t average (0 hours)(7 minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review th information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Securit Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB Approval No. 0938-0566 **Form No. CMS-R-131** **(June 2007)**

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Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES.** **I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare'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 Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

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

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these laboratory tests.**
I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision.
If Medicare does pay, you will refund to me any payments I made to you that are due to me.
If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.
I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these laboratory tests.**
I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.
I will notify my doctor who ordered these laboratory tests that I did not receive them.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated Cost: $**_____).

Medicare will not pay for: _____
_____;

☐ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**