American Academy of Family Physicians

(19) 173

April 13, 2007

Center for Medicare & Medicaid Services
Office of Strategic
Operations and Regulatory Affairs
Division of Regulations Development-C
Attention: Bonnie L Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Harkless,

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents nearly 94,000 family physicians and medical students nationwide. Specifically, I am writing to offer our comments in response to the request for information on the Advanced Beneficiary Notice of Noncoverage.

Burden of ABN

We agree that the estimated burden to physicians should be updated in terms of the growth of Medicare and an increased estimate of the time spent in provision and completion of ABN forms. However, the total cost per notifier of $69.39 does not agree with the statistics provided and significantly underestimates the burden. If the 1.3 million notifiers will deliver 40,302,506 or 31.7 ABN's each per year as indicated in number 2 of the supporting statement and the estimated total cost of delivering the ABN's is $326,255,502.00, the burden would be $256.62 per notifier.

Besides not taking into account the cost of printing the ABN forms as noted under number 13 of the supporting statement, this estimate does not include the staff time spent in reviewing local and national coverage determinations to verify the need for an ABN. Resources are also required to scan or file the paper document into the patient record. Accounting for these additional burdens, the estimated burden for 31 forms per year is actually closer to $275.00 based on an additional 3 minutes of staff time per ABN.

We also feel that the estimated 31.7 ABN's per notifier is seriously underestimated for most family physicians. While some of the notifiers included in the 1.3 million may seldom deliver ABN's due to the nature of the services provided, for those who provide services with frequency limitations or other services for which an ABN is routinely necessary, the number of ABN's delivered will be higher by 50x to 150x. As Chapter 30, Section 40.3.6.4C of the Medicare Claims Processing Manual indicates, virtually all beneficiaries receiving frequency limited items and services may be at risk of having their claims denied in those circumstances. We would ask that CMS consider again the calculation of the estimated number of ABN's per notifier based on the consideration of whether certain types of notifiers would be known to have higher utilization.

To aid physicians who continue to provide care to the growing number of Medicare beneficiaries, we urge CMS to seek ways to lessen the administrative burdens associated with

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Medicare wherever possible, including avoiding overuse of local and national coverage decisions. Each local and national coverage decision requires substantial administrative work to review, track and integrate into practice work flow. Local coverage decisions should be discouraged for purposes other than delineation of the evidence-based appropriate use of services which are new or for which frequent utilization outside of appropriate indications or frequencies have been identified.

Use of a Single ABN Form

While we appreciate the efficiencies which may be gained by using one form for both general and laboratory notifications, the current laboratory ABN form directs the patient to inform the ordering physician when they choose not to undergo testing. This instruction is pertinent to maintaining the physician-patient relationship and continuity of care. With Medicare patients often seeing multiple physicians in different practices, it is especially important that the patient contact their primary care physician when faced with a decision to forego recommended testing or pay out-of-pocket. This may become even more critical as Medicare moves toward value-based purchasing of physician services (i.e., pay-for-performance).

Therefore, if the one revised ABN is to be used for all non-coverage notifications, we recommend that Option 1 of Section G be revised as indicated in italic font below:

> **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. *I agree to contact my primary care physician to discuss this decision and potential alternative care plans.*

Use of ABN for Excluded Services

We also note that the instructions provided for the new ABN form state, "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." We feel this is inappropriate for several reasons.

- Neither the current nor draft ABN forms include the specific information regarding services which are excluded under Medicare Part B as listed on the NEMB.

- Where a physician chooses to voluntarily use a written notification to ensure a Medicare beneficiary understands their financial responsibility for services excluded from Part B benefits, it is inappropriate for CMS to mandate the type of notice to be used for this purpose.

- A physician is under no obligation to file a claim for services which are never covered under Part B unless the patient has other insurance coverage which may provide benefits for the service. As the NEMB does not reference submission of a claim for the purpose of getting a Medicare determination, it is more appropriate to voluntary notification of financial liability.

Therefore, we request that this instruction be removed or edited to indicate the ABN may also be used in place of the Notice of Exclusion from Medicare Benefits (NEMB) to provide voluntarily notification of financial liability.

Patient's Right to Medicare Billing

We agree with the addition of the patient's right to have a potentially non-covered service billed to Medicare for determination of benefits. However, the notice as provided on the draft form may cause confusion as it is listed above the three options, only one of which provides for billing to Medicare. Based on this, we would again suggest revision as noted in italic font:

> **We must bill Medicare when you ask us to** *by choosing Option 3 below.* We may help you with billing other insurance if you choose Option 2 or 3 below, though Medicare cannot require us to do this.

Patient Signature

For the sake of clarity, the field for patient signature on the revised ABN form should be further defined to indicate the signature should be that of the patient or the patient's representative. Where the patient is not able to write their name and is not accompanied by a representative, it should be clarified in the instructions that a witness to their mark (X) is satisfactory.

Thank you for the opportunity to comment on the proposed changes to the ABN form. We appreciate the opportunity to provide input on the administration of the Medicare program and look forward to continued communications.

Sincerely,

Larry S. Fields MD

Larry Fields, M.D., FAAFP
Board Chair

Professional Review Network, Inc.

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April 13, 2007

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

Re: Revised ABN, Form No. CMS-R-131 and public comment period-

Dear Ms. Harkless,

With over 25 years of experience with the Long Term Care Industry and working to assure that beneficiaries receive proper and timely notification of Medicare non coverage, we recommend the following:

Delete: "or other insurance" in the opening paragraph ".....but it is likely that you **or other insurance** will have to pay". Delete item (H). See attached highlighted.
The reasons for this recommendation are:

1.) another insurance rarely, if ever, pays for an item or service when not covered under the Medicare program.
2.) The term "or other insurance" is misleading to the beneficiary, implying that there is a significant likelihood that should the beneficiary have another insurance, that insurance may pay.

Thank you for the opportunity to comment on this very important notice and issue.

Respectfully,

Darlene S. Almand, RN, Director of Utilization Management

(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 OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to 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 the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security 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)**

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

April 11, 2007

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

Dear Ms. Harkless

The Centers for Medicare & Medicaid Services (CMS) published a notice in the February 23, 2007 Federal Register on page 8167 indicating CMS is combining CMS-R-131-G with the CMS-R-131-L. These are the Advanced Beneficiary Notice (ABN) forms. Medicare designates form CMS-R-131-G for general use and form CMS-R-131-L is specific to clinical laboratory services. Providers would only use one of these forms if the designated service were an otherwise covered service by Medicare but in this instance, the provider believes the patient's specific situation does not meet Medicare requirements. The ABN allows the patient to make an informed consumer decision whether or not to receive the items or services when notified he or she may be responsible for payment.

In an e-mail notification through a Congressional ListServ, we received a draft of the revised form. CMS indicated they would consider public comments as part of finalizing the revised ABN. I am a Senior Analyst with the Provider Outreach & Education department of Wisconsin Physicians Service (WPS) Medicare. We process claims for Wisconsin, Illinois, Michigan, and Minnesota. I believe the revised version of the form will cause additional confusion within the provider and beneficiary community. Here are my comments:

The CMS Internet Only Manual (IOM) 100-04, Claims Processing, Chapter 30, Financial Liability Protections, Section 20.1 provides detailed information on when it is and is not appropriate to provide this form to the patient. Providing this form to the patient for items or services a provider expects Medicare to deny equates to patient responsibility for the charges. Providers are often confused between the differences in a denial based on medical necessity and a denial for non-coverage.

1. The title of the form indicates "non-coverage." This title is inaccurate. This language is too close to the Notice of Exclusion of Medicare Benefits (NEMB) (CMS-20007). The services described on the ABN are covered services under Medicare. In the patient's specific circumstances, the provider is anticipating denial based on medical necessity, not a statutory or technical coverage issue.

2. There is a statement on the form "We must bill Medicare when you ask us to." Providers are required to submit claims to Medicare for covered services per Sec. 1848 (g) (4) of the Social

Security Act unless Medicare never covers the services based on categorical or technical denials. The wording on the revised form allows providers to request payment from the patient and not submit the claim to Medicare. The non-submission of the claim precludes the patient from receiving a Medicare denial indicating patient responsibility.

An example of a categorical or technical denial not requiring submission would be a podiatrist providing foot care services where the patient does not have either the covered diagnosis or indications needed for payment. The podiatrist may use the NEMB (CMS 20007) and is not required to submit the claim to Medicare. However, a podiatrist is required to submit claims for a patient who meets the categorical and technical requirements, but Medicare will probably deny the service based on frequency. The provider may provide the ABN and must submit the claim. If we deny payment, then the patient is responsible.

3. Section G, Option 2 as listed on the form is the same type of concern as listed in statement #2 above. The provider should bill Medicare for the service and if Medicare denies the service, the patient should have the right to request an appeal. Unscrupulous providers could use this option to require patient payment for items or services that are never the patient's responsibility such as items considered part of a global surgery package, or the Correct Coding Initiative (CCI), among others.

4. Section G, Option 3 is going to cause the providers a problem. Providers choosing to accept Medicare assignment on all claims are Participating (PAR.) A PAR provider collecting an amount from the patient when Medicare subsequently allows the service would violate the PAR agreement. The patient only becomes responsible for payment if Medicare denies the charges under the IOM reference listed above. A provider giving the patient an acceptable ABN would add the GA modifier to the service when submitted. The definition of GA modifier is "Waiver of liability statement on file." Should Medicare allow the service, the ABN and GA modifier are no longer relevant. However, if Medicare denies the service, then the GA modifier to indicate the provider has a valid ABN on file, would cause a denial message providing for patient responsibility. If the GA modifier was not on the line of service, our denial message would indicate the patient is not responsible for payment.

Thank you for the opportunity to provide comments on this proposed revision. Should you have any questions on the items I have listed above, please do not hesitate to contact me.

Sincerely,

Ellen Berra

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CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development - C
Attention: Bonnie L. Harkless
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Baltimore, Maryland 21244-1850

April 11, 2007

To Whom It May Concern:

SUBJECT: CMS-R-131 NEW 07 ABN DRAFT

We have the following comments/questions to the proposed revisions to the General ABN form:

We prefer (C) Identification Number: to remain as it is on the current General ABN form as "Medicare # (HICN)"; reason: this is the terminology that has been ingrained in us to use, switching it will cause confusion and unnecessary re-education.

The current General ABN form allows the reason for non-coverage to be customized. Can section (E) Reason: be customized on the new version?

The current General ABN form directs that we only "must" give a cost estimate if the beneficiary asks for it. The lab that performs a lab test must bill Medicare directly. If the Lab ABN and General ABN are combined and the provider who orders the lab test, obtains the specimen, and presents the ABN to the beneficiary is not the billing entity, will the new version of the ABN be invalid if section (F) Estimated Cost: is not completed?

The center of the new ABN form has three bulleted items. The first bullet tells the patient to "Read this whole notice, which explains our opinion that Medicare won't pay." The only part of the document that explains "our opinion" is the box above this statement. This is confusing. Would you consider moving this to the top of the page? This first bullet also contains Medicare's phone number for questions. This information would be less confusing for the patient if it was at the bottom of the form.

The third bulleted item may pose a problem. We usually cannot get a secondary insurance to process a claim without first getting a denial from Medicare; therefore the statement "We may help you with billing other insurance if you choose Option 2 or 3 below..." is misleading to include Option 2.

The word privacy is misspelled at the bottom of the form it says "Privay Notice".

Thank you for your kind attention to our comments.

Respectfully,

Sheri Vermeulen

Sheri Vermeulen, CPC
OSF Saint Francis, Inc.

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April 11, 2007

CMS, Office of Strategic Operations and Regulatory Affairs,
Division of Regulations Development – C
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After reviewing the proposed changes to the ABN, we have a question as to what the purpose of " (H) Other insurance to consider for billing:" is? Why is this being put on the ABN?

Thank you for your consideration.

Sincerely,

Denise A. Vollbrecht

Denise A. Vollbrecht, CPC, CCP
Coding Compliance Auditor
Waukesha HealthCare