AARP

(23) 1 of 2

April 20, 2007

rec'd 4/23/07

Centers 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

RE: **Advance Beneficiary Notice of Noncoverage (ABN);**
72 Federal Register 8167, February 23, 2007

Ms. Harkless:

Thank you for the opportunity to comment on the proposed revision to the Advance Beneficiary Notice (ABN), which providers ask Medicare beneficiaries to sign when the provider believes that Medicare will not cover a proposed treatment or service.

We appreciate the goal of more user friendly language in the proposed revision, and can see merit in having one ABN form that incorporates physician-ordered laboratory tests into the General Use ABN. We also agree that the 1-800-MEDICARE number, information about the beneficiary's right to demand that Medicare be billed, and providing a space for other insurance information are useful additions to the form.

However, we urge you to provide more clarity and balance in the sentence informing beneficiaries of their payment options when they choose to receive a service listed on an ABN. Rather than state that "You can ask for payment now that will be refunded if Medicare pays," as suggested in the proposed form, it should instead state:

> "I understand that I can either wait to see whether Medicare will cover this service before I make payment, or make payment now that will be refunded if Medicare pays."

Also, in the introductory paragraph, it would be better to state that "we believe, " rather than "it is likely" that your or other insurance will have to pay, since Medicare coverage determinations are not always clear in advance.

Prior Authorization Rights

Finally, we are concerned that this ABN revision does not inform beneficiaries of their rights under Section 938 of the Medicare Modernization Act. This provision allows physicians and beneficiaries to request a prior determination of coverage for certain physician services. The statute specifically requires the Secretary to establish mechanisms for such prior determinations not later than 18 months after the date of enactment. However, it has been more than 3 years since enactment and there is still no final rule, and no proposal to explain this right to beneficiaries when they are asked to sign an ABN.

We urge you to act expeditiously to meet your statutory obligation by issuing a final rule implementing Section 938. The final rule should adopt changes to the proposed rule suggested in public comments filed by the American Academy of Family Physicians. Specifically, the pool of services on which prior authorization can be sought should include any service or situation in which coverage is unclear, as local and national coverage policies are often ambiguous and not generally known by beneficiaries. Also, Medicare contractors should be required to process prior determination requests as quickly as possible, not merely within 45 days.

Provisions of that final rule should then be incorporated into this revised ABN so that beneficiaries are fully and clearly informed about how to exercise this important right to prior determination when they are asked to sign an ABN.

Thank you for considering our comments. If you have any questions please feel free to contact Paul Cotton on our Federal Affairs staff at (202) 434-3778.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Relations and Advocacy

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(24) 1 of 1

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President and Chief Executive Officer
Saint Barnabas Health Care System

LORRAINE SCIARA, CHE
Executive director

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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 Boulevard
Baltimore, Maryland 21244-1850

Re: ABN for hospice patients

Dear Ms. Harkless,

According to the MLN Matters: MM5117, there are three instances when an ABN is appropriate for hospice.

1. Ineligibility because the beneficiary is not "terminally ill"...
2. ... Physicians' services were not reasonable and necessary...
3. The level of hospice care is determined not reasonable or medically necessary...

Per PM Transmittal AB-02-168, issuing an ABN also requires the hospice to submit a claim using occurrence code 32 on the UB 92.

I have difficulty reconciling the direction to issue an ABN and billing Medicare when the hospice team has already determined that a patient no longer meets criteria. In fact in the FAQs the following appears:

Q. "if the medical director does not re-certify the patient for hospice under Medicare (patient has no other insurance) why would we need to issue and ABN?

A. You would not need an ABN.

Therefore, it is unclear why MLN Matters states that (1) ineligibility because the beneficiary is not "terminally ill" requires an ABN. I apply the same logic to (3) above. If the hospice team determines that the level of care is no longer appropriate how can the hospice bill Medicare?

Although the hospice must notify any beneficiary of the potential liability for non-covered services the ABN does not appear to be the appropriate tool since it implies that the hospice will be billing for services it already determined to be inappropriate.

I look forward to your advice.

Sincerely,

Patricia Kelley

Patricia Kelley

Director of Education and Quality

Joint Commission
on Accreditation of Healthcare Organizations

95 OLD SHORT HILLS ROAD ■ WEST ORANGE, NJ 07052 ■ (973) 322-4800 / FAX (973) 322-4795

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CharlotteRadiology

3030 Latrobe Drive
PO Box 30488
Charlotte, NC 28230-0488

704/362-1945
Fax: 704/367-5722

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(25)

April 16, 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: ABN Proposed Changes (CMS-R-131)

To Whom It May Concern:

I appreciate CMS's efforts in simplifying two forms into one. Overall, the proposed ABN is fine. I feel some of the wording is a bit elementary and awkward. Other than the misspelling of "privacy" at the bottom, my only concern would be the possible misconception under option 3 that indicates payment will be refunded if Medicare pays. If there is a deductible applied or co-pay due and the patient does not have a secondary insurance, the patient may not be refunded in full.

Please contact me if you have any questions.

Thank you.

Christine Hussey

Christine Hussey
Government Supervisor
704-367-7884 phone
704-367-5722 fax

MAYO CLINIC

(26) 1 of 2

200 First Street SW
Rochester, Minnesota 55905
507-284-2511

April 18, 2007

Centers for Medicare and 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:

We appreciate the opportunity to comment on the proposed Advanced Beneficiary Notice of Noncoverage (ABN) that was referenced in February 23, 2007 Federal Register. We offer the following comments for your consideration.

VERBIAGE

We feel that some modifications to the proposed verbiage should be made. Please refer to the following:

- The NOTE section could be changed to state "NOTE: *You need to make a choice about receiving this procedure(s) or test(s)"* We believe this sounds more patient-friendly.

- The third sentence under the "NOTE" section should be changed to state "You can still receive this care, since you or your health care provider *have established that there is a medical reason for ordering this test"*

- In the bulleted section in the middle of the form we are requesting that the information following the section for "Items/Services" be simplified to state "For questions call 1-800-MEDICARE" and located at the end of the form.

- The statement in the first bullet should be changed to state "*This is an official Medicare document"* vs. "This is not an official Medicare decision" This would assist the patient in understanding that this an official document from CMS and not a provider designed document.

- The second bullet should be simplified to give the patient instruction on choosing ONE option and signing and dating the form.

- In the patient option section, the second sentence of the third option currently states "You can ask for payment now" we request that this is changed to *"Provider/Supplier can ask for payment now"*, to avoid confusion.

- Patient option # 2 conflicts with Medicare Claims Processing Manual Chapter 1, 60.4.1 which states "Must submit all ABN-related services as covered charges" and should be removed as an option.

CLARIFICATION

We respectfully request clarification of the following:

- Medicare Claims Processing Manual, Chapter 30, 40.3.1.1 states that at least a 12 point font should be used; given the additional information and the items/services that may be listed on the form, this may not be feasible. Would a provider be allowed to change the font size in less significant areas of the form?

- The header section is significantly smaller; can pre-printed labels be utilized in this section?

- In the "Reason" section, it does not specify if the reason should state non coverage due to the diagnosis or the actual test/procedure. Can there be section or checkbox on the form that allows the provider to specify?

We are also seeking guidance when multiple tests/procedures are needed and the patient would like to have one test performed but not the others.

REMARKS

We believe that if the patient option area remains as drafted this would create operational issues for front desk personnel. It would require cash flow in clinical designated areas where the ABN is most likely obtained.

If this ABN truly requires 7 minutes on average to complete, we feel this will cause significant time delays for the check-in process. Previous measurements show that this process currently takes less than 3 minutes.

Thank you for the opportunity to comment on the proposed Advanced Beneficiary Notice of Noncoverage. Please feel free to contact either Desiree Ramirez (904) 953-0579 or me at (507) 284-4627, if you have any questions.

Very truly yours,

Ronald W. Grousky
Director, Medicare Strategy Unit
Mayo Clinic

RWG/dkr