ACP
AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

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March 29, 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 Blvd.
Baltimore, Maryland 21244-1850

Dear Ms. Harkless:

The American College of Physicians, representing more than 120,000 physicians specializing in internal medicine and medical students, is pleased to offer comments on the proposed change to the Advanced Beneficiary Notice of Noncoverage (Form No. CMS-R-131), commonly referred to as the ABN. The ABN is a form frequently used by the members of ACP because internists see many patients in the Medicare program, and unfortunately not all of their necessary medical services are covered.

ACP supports the proposed transition from two ABN forms to one. Since the two existing forms have nearly identical content and similar purposes, consolidating the two will reduce the burden for practices that are currently stocking two forms.

ACP feels that the new form is easier to understand for both physicians and patients. The inclusion of additional instructional language for patients to truly understand their rights and responsibilities is a step in the right direction. Patients should understand their financial obligations in their interaction with the healthcare system.

ACP supports the inclusion of the new options (G) listed on the form. In addition to the existing options for a patient to refuse the service or accept responsibility in the case in which the claim is denied, this new form adds an option for the patient to pay without the practice submitting a bill to Medicare. There are many services which are never paid by Medicare and this new option avoids the administrative inefficiency of submitting a claim for a service which a practice knows will be rejected. Patients always have the option of having Medicare billed if they so desire, so this will not cause any problems of patients paying out-of-pocket for Medicare-covered services.

ACP does note that the old form included a definitive statement about the Medicare program not covering all healthcare costs. It is less clear on this form that the Medicare program may not cover all costs. ACP recommends that a statement similar to that of the original form: "Medicare does not pay for all of your health care costs. Medicare only

pays for items and services when Medicare rules are met" be placed on the new form to make it transparent to patients that the lack of coverage is not due to a decision made by the physician but by the government.

ACP appreciates the opportunity to review this form and offer comments. If you have any questions about this letter, please contact Brian Whitman at (202) 261-4544 or bwhitman@acponline.org

Sincerely,

Joseph W. Stubbs

Joseph W. Stubbs, MD, FACP
Chairman, Medical Service Committee

(9)

C. Thomas Crooks, III, O.D.
President

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ATTENTION: Bonnie L. Harkless
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Harkless:

On behalf of its nearly 36,000 members, the American Optometric Association (AOA) is pleased to submit comments related to the February 23, 2007 *Federal Register* publication regarding the Revised Advance Beneficiary Notice (ABN).

With respect to the form, the second line that begins with NOTE: If Medicare does not pay for ***things*** listed below. We would suggest that the term "things" be replaced with **Item(s)/Service(s)** so it would be consistent with the next paragraph.

With respect to the third bullet: **We must bill Medicare when you ask us to.** We may help you..... This implies that the Doctor will bill for the services or at the very least makes the provider look bad if they do not. We feel that this is another burden on the provider especially when many covered individuals have no knowledge of who their secondary carrier is or what the coverage is.

In the boxed bullets, #3 also increases the burden even though the provider knows the item will be denied. Again, this puts the provider in an uncomfortable position. Most patients will choose this while the provider waits for a decision and payment is delayed.

Thank you for your consideration of these suggestions. If you have any questions, please contact Kelly Hipp, Director, Professional Relations at 703 837-1346 or KHipp@aoa.org.

Sincerely,

C. Thomas Crooks, III, OD

Holland Hospital

602 Michigan Avenue Holland, Michigan 49423-4999 (616) 392-5141 hollandhospital.org

To Whom It May Concern:

I am writing with comments related to ABN Revision CMS-R-131.

Thank you for the opportunity to comment on this proposed change. Below are my comments-

1. It appears the signed ABN must be received in person or via hardcopy mail. Why is it not acceptable to receive a signed, faxed copy or a signed scanned copy via email? Patients would benefit from the speed at which ABN's can be transmitted electronically in a standard format such as .pdf, .tif, etc.

2. Regarding the section entitled "frequent collection": Are we still able to issue one ABN to cover a period of time for repeated services, i.e. Laboratory Standing Orders?

3. We believe that an average of 7 minutes per response it too low. We estimate that we average 10-15 minutes to issue each ABN. Staff time includes patient discussion, ABN creation either via use of triplicate form or software application, ABN routing to PFS and HIM and ABN scanning into repository system. This does not include the time involved should a patient seek further clarification from a physician or ask to speak with a financial counselor.

4. We may not be able to gather, at times, middle initial to match Medicare records. Will this produce a problem upon audit?

5. Does Blank C need to contain the HIC# or can it contain the provider-generated account number or medical record number for the beneficiary? The previous form stated HIC on the form. The proposed form just states Identification Number.

6. The previous form asked for "Patient Name". The proposed form asks for "Beneficiary Name." While providers understand the term beneficiary, will all patients? This does not seem to follow the CMS goal of putting all verbiage on the ABN in user-friendly language.

7. Blank H is not a useful field. It may confuse the patient if they enter the name of a secondary carrier and are stilled billed for the service.

8. A place for the Total Estimated Cost of all services listed is useful to the patient.

Sincerely,

Tracy J. Paquin

Tracy J. Paquin
Patient Registration Manager

(11)

Chambersburg Hospital
an affiliate of Summit Health

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Assistant Director of Pathology Fax (717) 267-7127
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February 26, 2007 CMS-1321-P

Dear Ms. Harkless,

I'm not sure why CMS found it necessary to mess with the ABN, the one we have is working quite nicely. I have only one good comment about this proposed ABN and several negative comments.

POSITIVE

1) The Medicare phone number on the form is a good addition.

NEGATIVE

1) Under the NOTE the word "things" should be consistent with the entire document i.e. "Item(s)/Service(s)"
2) The language should not be definitive, we don't know until the bill is processed and denied. The language should reflect that Medicare "may not pay".
3) Leave the current two options! Do not go to 3 options! The patient always wants us to bill Medicare. They will NEVER pick option 2. Also, many systems may not be able to accommodate this request. This population doesn't understand this form to start with, the simple Yes I want the services and understand that I may be billed or No I don't want the services because I don't want to be liable is all the choices the patient needs. Also, don't change the order many of our patients are use to the format, if you change the order this may confuse them.
4) Don't add the Other insurance to consider for billing – most institutions capture this information at the point of registration and the patients are good about giving us their supplemental insurance information.
5) The current PRIVAY NOTICE is good as it stands. The patient doesn't need this extra wording and the patient doesn't care about the time it takes to fill the form, they don't care about the form. They care about getting the tests paid for.
6) We would like to see added a place to document that the patient refused to sign the ABN, but still wanted the services performed.
7) We also would like the signature to read Signature of patient or person acting on patient's behalf.
8) Not all systems can format the ABN into neat little columns. As long as the ABN clearly shows the "Item(s)/Service(s)", the Reason, and the Estimated Costs that should meet the requirements.
9) There are move than 3 reasons why medicare does not pay, you forgot "Medicare does not pay for routine screening work" and "Medicare considers this test an excess component".

Respectfully submitted,

Robin Barrows, MBA, MT(ASCP)
Assistant Administrative Director