

## Medicare Changes and Confusion Require Providers' Close Attention

The federal Medicare program is in a state of both change and disarray as the Centers for Medicare and Medicaid Services (CMS) consider a new Advance Beneficiary Notice (ABN) form, prepare for the May 23<sup>rd</sup> NIP deadline and grapple with the massive distribution of incorrect editions of Form 1500.

### New ABN Form to be required starting in July

On February 19, 2007, CMS published a notice on a proposed new ABN form and request for public comments in the *Federal Register*, allowing a 60-day comment period. The proposed new form will feature expanded information about the right of a Medicare beneficiary to require the provider to bill Medicare for a service before paying out-of-pocket, marking a major shift for the procedures previously followed by "non-participating providers." The new form will also offer beneficiaries a new third option, instead of the previous two. The new form will allow the patient to decide to have the provider:

1. Not provide the service
2. Provide the service, and pay out-of-pocket
3. Provide the service and bill Medicare first.

According to the CMS announcement, the impetus behind the ABN campaign is the protection of both provider and patient rights. "Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers."

By way of further explanation for the new form, CMS asserted that beneficiaries have always had the right to

insist that the provider bill Medicare and receive a denial before collecting the out-of-pocket payment from the beneficiary, but the old form did not make this clear. Thus, according to CMS, the patient has more authority over their administration and payment for their own care with the new ABN.

The instructions for the new ABN Form that has been proposed and is scheduled to become effective in July, 2007 will now include the following language:

*"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."*

This will provide an easier way to allow patients to choose to accept only some of the services, without having to re-generate multiple forms after they have reviewed the information and stated their preferences. This also provides official CMS guidance that the form remains valid if patients designate their wishes in this way.

For practices using paper ABN forms, the patient may mark such notations directly on the printed ABN form. For facilities using the e-signature module, the system already provides an option for allowing patients to choose to accept or refuse each procedure/test while they are signing the signature pad.

In response to the call for comments, ICA expressed concern about the apparent lack of flexibility and the need to execute a new form with every amendment to a care plan that would require

more or additional services that were outlined in the original form. As well, ICA is concerned that initial estimates of the cost of care, understanding the rapidly changing needs of senior citizens, may be used in some kind of new wave of review and enforcement efforts, using differences in estimates and the ultimate actual charges to seek penalties or refunds.

### CMS Form 1500 errors force implementation delay

On March 9, 2007, CMS announced that certain print vendors, specifically the Government Printing Office (GPO), are selling incorrectly formatted versions of the revised form. The National Uniform Claim Committee (NUCC) revised the CMS-1500 (12-90) last July to accommodate the NPI. Medicare announced in September 2006 that beginning April 1, 2007, it would accept only the new form, CMS-1500 (08-05). If a provider has obtained updated CMS-1500 forms from the GPO or other vendors offering a similar form to accommodate the National Provider Identifier (NPI), the forms may not be valid.

According to the official CMS press release, "After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. This resulted in the sale of both printed forms and negatives which do not comply with the form specifications."

In recognition of this massive potential snag, CMS has announced that they will extend the CMS-1500 (12-90) version acceptance period beyond the original April 1, 2007, deadline while the situation is resolved. "Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease," CMS said, estimating a target date of June 1, 2007.

CMS is directing contractors to return any CMS-1500 (08-05) forms they receive that are not printed to specification. For more information

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## CALIFORNIA BOARD

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rivals of the Governor have not been able to resist the temptation to try and make political hay for themselves out of this situation.

As part of this partisan response, the Democratically controlled legislature held a Joint Hearing of the Senate Business, Professions and Economic Development and the Assembly Business and Professions Committees at the State Capitol in Sacramento on March 28<sup>th</sup> to review the recent actions of the California Board of Chiropractic Examiners. At that three-hour hearing, a few political opponents of the Governor sought to place the Board's actions in some sort of questionable light, but objective observers were clear that the Board was working to fully comply with all rules and regulations and to act within its authority, and in the best interests of the public and the profession.

At that hearing, Board Chair Tyler told legislators:

*"The Board values open dialogue, supports full disclosure, and transparency in government. It is the mission of this Board to protect consumers. Under my leadership, the Board will fulfill its mission and exemplify these values through our actions... We on the Chiropractic Board are, like you, common citizens drawn into public service by the desire to serve the people of this great state. We seek the cooperation and guidance of our elected officials that these stated goals may be satisfied."*

With this hearing behind it, the Board will now proceed to address the wide range of challenges and needs, including pressing personnel issues and the complete elimination of any possible conflict of interest where consultants to the Board are also working as consultants for insurance companies. On March 23<sup>rd</sup>, the Board issued a press release reporting that Mr. Brian Stiger, a distinguished public employee made available on loan to the Board from the California Department of Consumer Affairs (DCA), had been appointed as Acting Executive Director, and that an effort would be undertaken immediately to begin the search for a new permanent Executive Director.

"The International Chiropractors Association is united in the hope that the California Chiropractic Board will not let up in its efforts to restore credibility and the complete appearance of fairness, objectivity and the responsible enforcement of the statutes and regulations governing chiropractic in California," said Dr. Maltby. "This is all any good citizen can ask, and once again, we thank Governor Schwarzenegger for his leadership on this vital issue."

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