

MAR 29 2005

116 Lexington Avenue
Elmira,
New York 14905-1907
March 18, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4064-IFC
P.O. Box 8011
Baltimore, MD 21244-8011

Re: CMS-4064-IFC

Dear Sirs:

Thank you for the opportunity to comment on the above item.

I. Background

We agree with moving the appeals process from the Social Security Administration to the Department of Health and Human Services.

II. "Appeal Rights - Basis and Scope, etc."

We agree with allowing Medicare providers to appeal under Part A and Part B.

Medicaid State Agencies

No comments

Appointed Representatives

No comments

Assignment of Appeal Rights

405-912 You note that a beneficiaries may assign their right to appeal an individual item or service to a provider but that the provider must list all items or services provided on the date of service. We feel that the provider should have to list only assigned items.

"Initial Determinations"

Sec. 405.910 - A beneficiary should be allowed to designate that their appointed representative or assignee should receive the MSN.

We agree with your additions to the list of what is not an initial determination.

"Redeterminations"

"Redetermination, Notification and Subsequent Limitations on Evidence"

No Comments

Reconsideration

No Comments

"Conduct of Reconsideration"

No comments

"Reopenings of Initial Determinations"

Reconsiderations, Hearings and Reviews”

No comments

Expedited Access to Judicial Review”

No comments

“ALJ Hearings”

We agree that the 180 day deadline is reasonable.

In the case of escalation, it is a good idea to give the QTC, ALT, MAC 5 more days to see if they can complete their work.

“ALJ Consolidation of Hearing”

No comments

“When an ALJ can dismiss a request for a Hearing”

No comment

“Content of ALJ’s Decision”

No comment

“Appeals Involving Overpayments”

No comment

“Review by the MAC and Judicial Review”

No comments

Thank you for the opportunity to comment.

Sincerely,



David Eichenauer

DE/se



Suite 418, The Public Ledger Building
Philadelphia, PA 19106-3499
Direct dial: (215) 861-4455
FAX: (215) 861-4462
Email: michael.leonard@hhs.gov

March 14, 2005

Re: Comments on Interim Final Rule on
Medicare Part A and Part B Appeals, 70
Fed. Reg. 11,420 (Mar. 8, 2005)

NOTE TO MICHELE D. EDMONDSON-PARROTT:

Below are some "in-house" comments for your consideration on the interim final rule on Medicare appeals published in 70 Fed. Reg. 11,420 on March 8, 2005. Please feel free to call me at 215 861 4455 if you wish to discuss.

1. No Specific Date Given To Start Period In Which Party Must File Appeal.

ALJ Hearings
Review By The MAC

In two situations it is unclear when the period in which to file an appeal begins. Specifically, to obtain a hearing, a party must file an appeal within 60 days "after receipt of the notice of a QIC's reconsideration" (§ 405.1002(a)(1)) or "within 60 days from the date the party received notice of the OIC's reconsideration" (§ 405.1014(b)(1)).

Similarly, to obtain MAC review of a hearing decision, a party must file an appeal within 60 days "after receipt of the ALJ's decision or dismissal" (§ 405.1102(a)).

In these two situations, the regulations deviate from parallel provisions for appeals of initial determinations (§ 405.942), redeterminations (§ 405.962), and MAC decisions (§ 405.1136(c)(2)), all of which provide that the date of receipt of notice of the decision being appealed is presumed to be 5 days (or 5 "calendar" days for MAC decisions) from the date of the notice, unless there is evidence to the contrary.

It would avoid problems to conform all of the dates of receipt to the same standard, presumptively 5 "calendar" days from the date of the decision. This revision should be added to §§ 405.1014(b)(1) and 405.1102(a). And the 5-day period specified in §§ 405.942 and 405.962 should be revised to 5 "calendar" days.

We assume that CMS will assure (by manual or instructions) that the date of transmittal is in the file. Otherwise a party can always assert that it did not receive the notice, or receive it within the presumptive 5 day period. Contractors should routinely:

- Mail the notice on the date of the notice (which in our experience has not always been the case);
- In the case of mailed notices, document the file that the notice was mailed (possibly checking off a box on a form in the file);
- retain copies of FAX transmittal receipts showing that FAXes were received; and
- retain file copies showing the date an email or electronic notice was sent.

CMS should also give examples (in manuals or instructions) of acceptable evidence that the notice of a decision was not received or received within the presumptive 5-day period.

For example:

- If the contractor has proof that the letter was put into the mail, there should be a presumption that it was delivered. Thus, mere assertions that a mailed notice was not received should be insufficient absent some other affirmative evidence. On the other hand, if the contractor has no proof of mailing, these assertions would suffice.
- Evidence that a beneficiary was unexpectedly absent from his or her regular address for a protracted period (perhaps due to illness) and therefore not able to receive the notice.

2. No Documentation Of Dates On Which Decision Makers Receive A Request For Review

Redeterminations

Reconsideration

ALJ Hearings

Review By The MAC

A related problem in the current draft of the regulations is on what date does the decision making period begin to run. The current draft provides that the period begins to run on receipt:

- of a clean claim for initial determinations (§ 405.922),
- of “a timely filed request for redetermination” (§ 405.950(a)),
- of a “timely filed request for reconsideration” (§ 405.970(a) & (c)),
- of a request for a hearing by the entity specified in the OIC’s notice of reconsideration (§ 405.1016(a); and
- of the appellant’s request for MAC review (§ 405.1100(c)) or of a request for expedited judicial review (§ 405.990(d) & (f)(2)).

Do these request have to be received by any particular person/unit to start the period running? If so, should that be specified in the regulations?

How will CMS document the file showing the date of receipt that starts the period running? Will the decision makers time stamp the documents on receipt?

3. Unclear Requirement For QIC On New Issues

Reconsideration

Section 405.968((b)(5) permits a QIC to raise and develop new issues relevant to the claims in a particular case as long as the claims have been subject to a redetermination. This requirement is unclear because under § 405.960 a party must obtain a redetermination decision before appealing to a QIC.

Is this merely redundant or is there some intent to subject “new” issues to a redetermination?

4. Should the CMS Administrator or the DAB Have Authority To Review Challenges To CMS Interpretive Guidance

The regulations give decision makers at the QIC, Administrative Law Judge and MAC levels authority to determine whether policies in LCDs, LMRPs, Program Instructions, or CMS Manuals apply in a particular case, and to disregard them if inapplicable as long as the decision maker explains why the policy is inapplicable; their decision is limited to the specific claim under review. §§ 405.966(b); 405.1062.

However, § 405.1062 leaves open the question whether CMS’ Program Instructions or Manual provisions can be reviewed on their merits in appeals to ALJs or the MAC. Although these bodies must give the Program Instructions and Manual provisions “substantial deference” when they are applicable, the decision maker may find that a provision is inapplicable because it is arbitrary, or insufficiently supported or unpersuasive, leading to the question of whether these reviewing bodies should be able to substitute their judgment on these provisions for that of CMS. Even though the regulation limits the impact of a decision to the particular claims at issue, once an ALJ or MAC decision has concluded that a particular policy is inapplicable because it is unpersuasive, for example, the same rationale could apply in other appeals. The regulation thus does not preclude review of the merits of CMS’ interpretive guidance.

CMS may wish to confer authority on the Administrator to make a final ruling in cases involving an Administrative Law Judge decision invalidating CMS interpretive guidance in a particular case. A similar procedure has been adopted for review of PRRB decisions, which the Administrator may review or not, and the Administrator’s decision is the final appealable decision for purposes of judicial review.

Alternatively, the regulation could impose an additional or alternate route for questions about the validity of a CMS Manual provision or Program Instruction, requiring that they be referred to the DAB (or a DAB “review entity” as defined in § 405.990 for purposes of certifying expedited judicial review).

On the other hand, the ALJs and MAC members will presumably be so specialized in the Medicare area that they would not lightly set aside a CMS policy.

5. Inconsistent Provisions For Statistical Sample Cases

Appeals Involving Statistical Sampling

Section 405.1064 imposes the obligation on an ALJ reviewing an overpayment appeal to base the decision on a “review of the entire statistical sample used by the QIC.” The preamble explains that “A decision that is based on only a portion of a statistical sample does not accurately reflect the entire record.” 70 Fed. Reg. 11,466 (middle column).

This requirement for review of the entire sampled cases appears to be onerous and unnecessary to the extent that:

- an appellant may dispute only some of the claims in the sample; in fact, only some of the sampled claims may be revised in whole or in part;¹
- these cases can involve large quantities of materials (i.e., the “big box” cases) and be time consuming,
- As recognized in the preamble, QICs may be unable to complete review of cases involving statistical sampling during a 60-day review period. 70 Fed. Reg. 11,420, 11449 (first column). Thus, the hearing request may arise without a QIC reconsideration decision.
- if the sampling methodology is in dispute, a sampling error would affect the entire sample or strata. But even in this event, review of all sampled claims would be unnecessary.

The ALJ should therefore only have to consider disputed claims in the sample.

6. Contractor Reopening Of Initial Determinations Or Redeterminations In the Case of Statistical Sampling

As discussed in the preamble, CMS has decided to eliminate a proposal to permit reopening within

¹ Under § 405.1014(a)(5) & (6), a hearing request must state the reasons for disagreeing with the determination being appealed, and identify the specific services and items in dispute (as discussed below). Under § 405.1032, the ALJ decides issues previously not decided entirely in a party’s favor. The requirement to consider all of the sampled cases thus appears inconsistent with these provisions.

5 years to collect an overpayment based on a statistical sample. 70 Fed. Reg. at 11,452 (second column). Under the regulation, the contractor may reopen within four years for "good cause" or at any time for "fraud or similar fault." § 405.980(b).

Currently, the Medicare Claims Processing Manual, ch.29, § 60.27.6, provides for a "good cause" reopening when a statistically valid random sample (SVRS) is undertaken. If the SVRS is undertaken during the four-year reopening period, the study effects a reopening of all determinations in the population from which the sample is drawn, as long as the SVRS decision is documented and was clearly intended to question the correctness of all such determinations. The contractor must send a notice to the supplier as soon as possible explaining the reason for the study, the period to be reviewed, and the sampling procedure. If the study is being done because fraud is suspected, no notice is sent. *Id.*

This provision appears to be consistent with the definition of "good cause" in § 405.986(a) as new and material evidence that was not available or known at the time of the earlier decision. CMS may wish to consider whether this SVRS reopening procedure should be in the regulation.

7. No Reopening QIC, ALJ or MAC Decisions After 6 Months

Section 405.980(d) departs from long-standing practice by precluding ALJs and the MAC (and also QICs) from reopening their decisions on their own motion for good cause after 6 months from their decisions (except in the case of fraud or similar fault). Given that adverse decisions by the QICs, ALJs, and MAC must be appealed before the 6 month period elapses, and that no reopening is permitted during the pendency of any appeal (§ 405.980(a)(4)), CMS has virtually extinguished the ability of these entities to reopen their decisions for good cause.

Exiting regulations have never limited ALJs or the MAC in this way. (42 C.F.R. §§ 405.750; .855, .856). The preamble gives no rationale for treating these entities differently than contractors reopening initial determinations and redeterminations.

CMS should not limit the reopening powers of the QICs, ALJs or the MAC and enable them to reopen their decisions on the same basis as contractors at the initial determination and redetermination stages.

8. Possible Drafting Errors

A. Regarding Expedited Access to Judicial Review

Section 405.990 provides for expedited access to judicial review and states that a party may obtain such review "in place of an ALJ hearing or MAC review if among other things the party has requested a hearing and "a final decision of the ALJ has been issued." § 405.990(b)(i)(A). It appears that there would be no need to seek expedited review in place of a hearing if the hearing decision has already been issued.

Note to Michele D. Edmondson-Parrott - Page 6

Perhaps this paragraph should read "and no final decision of the ALJ has been issued."

B. Regarding Content of Request for Hearing

Section 405.1014(a)(5) requires parties to identify only "the dates of service" in a hearing request.

This seems incomplete given the more explicit provision in other sections that require parties to identify "specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service" [§ 405.964(b)(3)], or "the specific service(s) or item(s) for which the review is requested; [and] the specific date(s) of service" [§ 405.1112(a)].

We recommend that CMS make the content of hearing requests conform on this point to that required for requests for QIC reconsideration and MAC review by stating that a hearing request must identify the specific service(s) or item(s) for which the review is requested; [and] the specific date(s) of service."

C. Discovery Time Limits

Section 405.1037(c)(1) states that a discovery request is timely if received by the date specified by "the ALJ hearing." This appears incorrect, and should be revised to ~~delete~~ "hearing."

James C. Newman
Chief Counsel, Region III

By: _____
Michael Leonard
Assistant Regional Counsel

cc:

Amy Kiesel, OGC
Victoria Corke, OGC



MAY - 9 2005

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Regional Emergency Medical Services Authority

May 5, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4064-IFC
P.O. Box 8011
Baltimore, MD 21244-8011

Re: Comments on CMS-4064-IFC—Medicare Claims Appeal Procedures

Dear Sir or Madam:

As the major ambulance company serving Northern Nevada, REMSA appreciates the opportunity to comment on the proposed regulation that would implement statutory changes to the Medicare claims appeal procedures. The Medicare claims appeals process has been a concern of ours for a number of years and we welcome the changes that are designed to expedite the handling of appeals and provide additional assurances of fairness and independence in the process. We appreciate the time and effort that CMS has spent in developing the regulations to implement these important changes.

REMSA is a member of the American Ambulance Association, which represents ambulance services across the United States that participate in serving more than 75% of the U.S. population with emergency and non-emergency care and medical transportation services. REMSA views prehospital care not only as a public service, but also as an essential part of the total public health care system.

We also have concerns that ambulance services receive appropriate reimbursement for services provided to Medicare and Medicaid patients and that disputes over that reimbursement are resolved in a timely fashion through a fair and impartial process. We believe the interim final rule could help to achieve these objectives. However, a number of changes to the interim final rule are necessary to level the playing field and to assure that providers and suppliers have a fair opportunity to present their appeals and receive a fully considered and impartial decision. The necessary changes are outlined below.

Reconsiderations. Section 405.966(a)(2) of the rule, implementing section 1869(b)(3) of the statute, provides that if evidence is not submitted by a provider or supplier at the qualified independent contractor ("QIC") level, it cannot be submitted during a subsequent appeal without a finding of good cause. Ambulance suppliers, through no fault of their own, are often unable to obtain a record or other documentation that may be necessary to prove their case at the reconsideration level. Lack of cooperation by a facility treating the patient or refusal of a physician to supply a letter documenting the order for an ambulance to be called are examples of such inability to produce needed evidence. The regulation must make clear that such occurrences, totally outside the supplier's control, would constitute good cause for such documentation to be considered at a subsequent appeal level.

ALJ Hearings. Section 405.1010(d) provides that if CMS or a contractor participates in an ALJ hearing, they cannot be called as a witness. We do not understand the purpose of this provision or how it can lead to a more complete examination of all the issues, which we understand to be CMS's objective in allowing CMS or a contractor to participate in a hearing in the first place. It is frequently necessary for a supplier to call a contractor representative, or even CMS, as a witness in order to establish the grounds on which they based their action on a claim or determination. The fact that CMS or the contractor has been made party to the hearing is irrelevant to the usefulness of such testimony. CMS or its contractors should not be able to immunize themselves against being called as a witness simply by deciding to participate as a party to the hearing. We believe you should delete this provision of the rule.

Section 405.1036(f) allows subpoenas to be requested for an ALJ hearing, but states that they must be requested within 10 days of the notice of the hearing. Furthermore, a subpoena may be requested only after discovery is sought, a motion to compel is filed and granted, and the subpoenaed party does not supply the requested records. In light of the requirement that a party must exhaust these other efforts to obtain the records before seeking a subpoena, it is unreasonable to require that the request for a subpoena be filed within 10 days of the notice of hearing. The provision should be amended to require only that a subpoena request be filed before the decision of the ALJ. Alternatively, a party requesting a subpoena should be allowed a reasonable amount of time, after he has exhausted all other required efforts to obtain the records, to file the request for a subpoena.

Conclusion. The above comments all reflect our overriding concern that the rules governing these appeals not erect unnecessary and unfair barriers to the presentation of a provider or supplier's case at the various hearing levels. The primary purpose of the rules should be to assure that a complete picture of the facts and circumstances is presented to the hearing officer and that the government or its agent should be required to the fullest extent to ensure that the record is complete. Unfortunately, as explained above, the rules set forth in the interim final regulation too often inject adversarial procedures that may stand in the way of developing a full and accurate record upon which a decision can be based. I urge you to examine these issues with a view toward what should be our common goal—adjudicating claims on the basis of a true and accurate set of facts.

I appreciate the opportunity to submit these comments. Please let me know if I can provide any additional information or assistance.

Very truly yours,



Patrick Smith
President/CEO

MAY 10 2005

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May 6, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-4064-IFC
P.O. Box 8011
Baltimore, MD 21244-8011

Dear Administrator McClellan:

Thank you for the opportunity to comment on the Changes to the Medicare Claims Appeal Procedures published by the Center for Medicare and Medicaid Services (CMS) in the Federal Register on March 8, 2005. The purpose of this document is to submit comments on behalf of the American Physical Therapy Association (APTA) in response to the Interim Final Rule. The APTA is a national organization representing over 67,000 physical therapists, physical therapist assistants, and students of physical therapy. We commend CMS on implementing these changes which will significantly improve the appeals process for providers and beneficiaries. We have three areas of concern based on our review of the Interim Final Rule. First, we question the qualifications of the QIC panel members as it relates to physical therapy claims. Second, we are concerned that contractors may be able to reopen claims to retroactively implement changes in local or national coverage decisions. Third, APTA questions the requirement that providers and suppliers submit all evidence at or before the reconsideration level, while beneficiaries are permitted to submit evidence at the ALJ level. We hope these comments and concerns are useful to CMS as the Agency moves forward with the new Medicare appeals process.

1. Conduct of a Reconsideration

Under §405.968(c) of new appeals rule, the qualified independent contractors (QICs) must have "sufficient medical, legal and other expertise, including knowledge of the Medicare program. When a redetermination is made with respect to whether an item or service is reasonable and necessary, the QIC designates a panel of physicians or other appropriate health care professionals to consider the facts and circumstances of the redetermination." APTA supports this provision of the new appeals process, but believes that in cases where physical therapy claims are reviewed by a QIC panel, physical

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Association

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therapists should be the “appropriate health care professionals” reviewing the case. APTA suggests rewording §405.968(c)(2) to include specific language designating that a QIC panel of appropriate health care professionals be in the same field as the claim under review.

Section 405.968(c)(3) provides a precedent for this reasoning, as physicians have a specific carve out: in cases where a claim pertains to the furnishing of treatment by a physician, or the provision of items or services by a physician, the reviewing professional must be a physician. However, physicians should not be the only profession entitled to peer review under the QIC reconsideration process. APTA believes that claims for physical therapy services provided by physical therapists should be reviewed by a licensed physical therapist during this part of the appeals process. Physical therapists are the most qualified professionals to conduct medical review of physical therapy claims and make appropriate Medicare coverage determinations since they have unique experience, skills and training in this field.

In the past, a number of government agencies, including the OIG and CMS, have recognized the value of having physical therapists conduct reviews of physical therapy claims. For example, the OIG issued a report in August 2001 titled “Physical, Occupational and Speech Therapy for Medicare Nursing Home Patients, Medical Necessity, Cost, and Documentation under the \$1,500 Caps.” The OIG conducted on-site medical and financial reviews using teams of physical therapists, occupational therapists and speech-language pathologists to review medical records and assess the medical necessity, overutilization, and quality of care provided. Because of the training and education of physical therapists, they were able to clearly identify physical therapy services that were overutilized and not medically necessary. For the same reasons, they are the best professionals to interpret documents and supporting evidence in QIC reconsiderations involving physical therapy claims, as physical therapists are specifically trained in the nuances of the profession.

CMS also has recognized the importance of having physical therapists review physical therapy claims. In Chapter 6 of the Intermediary Medical Review Guidelines in the Medicare Program Integrity Manual, CMS specified criteria for medical review of outpatient physical therapy services. Section 5.2 of this Chapter relates to the Level II review process. According to this provision, “If a bill is selected for medical review, intermediaries refer it to the Level II health professional MR staff. If possible, they have physical therapists review outpatient physical therapy bills.” APTA recommends a similar provision to the “Qualifications of the QIC’s panel members” section of the new appeals procedures. APTA would be pleased to work with CMS to facilitate the process of selecting qualified physical therapist reviewers for this stage of the appeals procedures.

2. Reopenings of Initial Determinations, Reconsiderations, Hearings, and Reviews

Under §405.986(b) of the appeals procedures, contractors are not precluded from reopening a case to effectuate a local or national coverage decisions issued under the authority of the Act. APTA suggests clarification of the language of this provision. Currently, the provision could be interpreted to allow contractors to reopen a case based on a local coverage decision taking effect within one year from the initial determination or redetermination. APTA is concerned

this could lead to contractors reopening decisions when coverage is no longer extended to a certain treatment. Providers could then be forced to repay contractors for payments made while the treatment was part of the local or national coverage decision. We strongly believe that CMS should not permit contractors to apply local or national coverage decisions retroactively to providers and this should be made clear in the rule. If this is not the intent of CMS, APTA recommends rewording §405.986(b) to reflect this change by specifying that coverage decisions cannot be applied retroactively under this provision, or by removing the sentence entirely.

3. Evidence Rules for Providers

Under §405.966 and §405.1028 of the rule, suppliers and providers must submit all evidence at the redetermination or reconsideration level. Absent good cause, providers and suppliers will not be able to submit new evidence at the ALJ or MAC levels. This limitation applies to providers and suppliers and not to beneficiaries – who will be permitted to submit new evidence at the ALJ and MAC levels. The limitation on the presentation of new evidence will also apply to beneficiaries represented by providers or suppliers to ensure that providers or suppliers do not circumvent this rule by offering to represent beneficiaries. While these provisions are codified under section 933(a) of the MMA, APTA disagrees with this limitation on the introduction of evidence.

CMS justifies the evidence limitation on providers and suppliers by presuming that providers and suppliers have a better understanding of the appeals process and should know what materials to submit as evidence in an appeal. APTA questions this logic, as many providers do not seem well-informed about the Medicare appeals process. As the new regulations are supposed to afford providers and suppliers with similar appeals rights to beneficiaries, limiting when providers and suppliers may introduce new evidence may put these entities at a significant disadvantage when navigating their way through the new appeals rules. To minimize confusion, APTA recommends that CMS specify the types of evidence providers and beneficiaries should present at the redetermination and reconsideration levels. Moreover, CMS should consider including additional examples in §405.1028, or issuing a separate guidance document, for providers and suppliers as to the kinds of evidence that meets (and fails to meet) the good cause standard.

Conclusion

APTA welcomes the implementation of a streamlined appeals process and one that includes increased rights for providers and suppliers. We appreciate the opportunity to comment on the Interim Final Rule, and have relatively few concerns with the new appeals procedures. In summary our three areas of issue in the Interim Final Rule are:

- Amending §405.968 to add physical therapists to physicians as professions that will have their reconsideration cases reviewed by other physical therapists during the QIC panel review.

- Clarifying §406.968(b) to ensure contractors cannot use this provision to reopen cases to retroactively implement local or national coverage determinations on providers.
- Addressing the limitation on the introduction of evidence for providers and suppliers to the redetermination and reconsideration level except with good cause, as many providers have little understanding of the appeals process.

The American Physical Therapy Association looks forward to the next steps implementation of the new Medicare appeals procedures and would be pleased to work with CMS concerning any questions or additional information APTA can provide on the appeals issue. Please contact Jonathan Morse at JonathanMorse@apta.org or at (703) 706-8547 if you have further questions.

Sincerely,

A handwritten signature in black ink, appearing to read "G. David Mason". The signature is fluid and cursive, with a prominent initial "G" and "M".

G. David Mason
Vice President, Government Affairs



MAY 16 2005

Protecting, Maintaining and Improving the Health of Minnesotans

May 12, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3145-IFC
P.O. Box 8018
Baltimore, Maryland 21244-8018

Dear Sirs:

The purpose of this letter is to provide comments regarding file code CMS-3145-IFC, "LOCATION". Specifically, the Department is providing comments regarding the requirement that long-term care facilities install battery-operated smoke detectors in resident sleeping rooms and public areas, unless they have a hardwired smoke detector system in resident rooms and public areas or a sprinkler system throughout the facility.

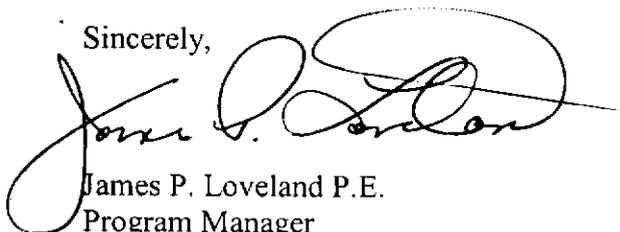
If CMS is willing to exempt a building that is protected throughout by an approved automatic sprinkler system, it seems to make sense to also exempt smoke compartments that are protected throughout by an approved automatic sprinkler system. Many of the long-term care facilities in Minnesota consist of an original building and one or more additions that have been constructed over the years. Depending on construction type and year constructed, many of the additions are fully sprinkled. The result is that the long-term care facility, as a whole, is viewed as only partially sprinkled. A partially sprinkled facility is required to install additional smoke detectors throughout, including those sections of the facility that are sprinkled (assuming the facility does not have the required hardwired smoke detector system in the bedrooms and public areas). Many smoke compartments of these facilities will then have both a sprinkler system and smoke detectors in resident bedrooms and public areas.

By requiring additional smoke detectors in only those smoke compartments not protected by an approved sprinkler system; the facility can reduce the total cost of compliance. In some cases, this cost savings can be significant. The lack of smoke detectors in resident bedrooms and public areas within smoke compartments already protected by an approved automatic sprinkler system will not negatively impact the safety of residents living in those smoke compartments.

Centers for Medicare & Medicaid Services
Comments Regarding CMS-3145-IFC
Page 2

Thank you for your consideration. If you have any questions concerning this matter, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "James P. Loveland". The signature is written in a cursive style with a large initial "J" and a long horizontal flourish extending to the right.

James P. Loveland P.E.
Program Manager
Engineering Services Section
Division of Compliance Monitoring
Telephone: (651) 215-8738 Fax: (651) 215-8710