Submitter : Cindy White **Date:** 04/30/2007

Organization : Highmark Medicare Services

Category : Health Plan or Association

Issue Areas/Comments

GENERAL

GENERAL

Sec 405.874(h)(1), 405.874(h)(2) and 405.874(h)(3) (pages 9488 & 9489)

Currently, as outlined in Pub 100-8; Chapter 10, contractor timeliness standards are tiered:
' Initial applications (including revalidations)
o 80% within 60 calendar days of receipt
o 90% within 120 calendar days of receipt
o 99% within 180 calendar days of receipt.'

' Changes of information (including reassignments not submitted in conjunction with an initial enrollment application)
o 80% within 45 calendar days of receipt
o 90% within 60 calendar days of receipt
o 99% within 90 calendar days of receipt.'

The proposed rule indicates initial enrollments and revalidations must be processed within 180 days of receipt, and changes of information must be processed within 90 days of receipt. Will CMS be changing the processing standards to non-tiered, or will the tiered standards remain in place?

Submitter : **Ms. Mari Johnson** **Date: 04/30/2007**

Organization : **American Medical Association**

Category : **Physician**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6003-P2-2-Attach-1.PDF

AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

May 1, 2007

Ms. Leslie Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Dear Ms. Norwalk:

On behalf of the physician and medical student members of the American Medical Association (AMA), I respectfully submit the following comments in response to the proposed rule *Medicare Program; Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges* that the Centers for Medicare & Medicaid Services (CMS) issued on March 2, 2007. As noted in the preamble, CMS's use of the term "supplier" for the purposes of this rule includes physicians.

Physicians who bill Medicare have long been concerned about the overall enrollment process. However, of particular ongoing concern has been the time associated with establishing Medicare billing privileges as well as the paperwork requirements associated with the application. While we are pleased with the additional rights afforded physicians pursuant to section 936 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) concerning enrollment denials and non-renewal, we have significant concerns with many of the provisions CMS has proposed in this rule. Our specific concerns are outlined below.

Section 405.874 Appeals of carrier determinations that a supplier fails to meet the requirements for Medicare billing privileges

The policy CMS has proposed in section **405.874(b)(3)** is confusing and we are requesting that CMS provide clarification. The proposed rule would prohibit payment for items or services unless a physician has a valid Medicare billing number. Furthermore, this section would provide carriers with the discretion to reject claims if a physician doesn't have a valid billing number. The foregoing carrier action would not be subject to an appeal. We have four concerns which are detailed below.

American Medical Association 515 North State Street Chicago Illinois 60610
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First, we are concerned about retaining a physician's ability to bill retroactively. As written, this section is sufficiently unclear with respect to whether or not physicians will be allowed to continue billing retroactively. Presently, physicians treating Medicare patients with pending enrollment applications hold their Medicare claims until they are granted billing privileges. While CMS states in the preamble that a supplier may resubmit claims once their enrollment application is approved, the plain meaning of the proposed regulation creates ambiguity as to whether CMS will allow the current practice to continue. We strongly urge CMS to clarify that claims submitted by physicians during the enrollment approval process are held rather than rejected. **In addition, we strongly urge CMS to clarify that physicians may continue billing retroactively upon receiving billing privileges.**

Second, the terminology used in this subsection is inconsistent. In section **405.874(b)(3)(i)** the term "billing privileges" is used, while section **405.874(3)(b)(iii)** the term "active Medicare billing number" is used. Earlier in the proposed rule, on page 9483, CMS states that the term "Medicare billing privileges" will replace the term "Medicare billing number." The terminology should be conformed throughout.

Third, the AMA submitted comments to CMS on the earlier, proposed carrier determination rule published on October 25, 1999, *Medicare Program; Appeals of Carrier Determinations That a Supplier Fails to Meet the Requirements for Medicare Billing Privileges,* in which we noted that claim reimbursement rejections should only occur when a physician's enrollment has been revoked (denied), not when the carrier has yet to process a physician's enrollment application. The preamble section of the current, proposed rule provides that:

> [c]laims are rejected when the supplier does not have valid billing privileges at the time that claims were submitted. When a supplier's application is approved and it is assigned a billing number, these claims may be resubmitted and paid retroactively, except for DMEPOS suppliers, who do not have retroactive billing privileges.

Slow carrier reviews of physicians' enrollment applications have forced some physicians to wait over six months to become enrolled and establish Medicare billing privileges. The proposed rule coupled with the slow processing time of enrollment applications will create significant financial hardship to new physicians. To some this will prove to be an absolute barrier to participation in the program. **We therefore strongly oppose this proposed language and recommend claim reimbursement rejections should only occur when a physician's enrollment has been revoked.**

Fourth, under section **405.874(b)(3)(iii)** CMS proposes that, "[r]ejections of claims because a supplier does not have a valid billing number may not be appealed by the supplier." As stated in our earlier comments, we strongly oppose the application of this proposed rule to claims that are submitted by a physician and which are solely rejected because no billing number has, yet, to be assigned. Again, this language is confusing given CMS' decision to use the term "Medicare billing privileges" instead of "Medicare billing number." The proposal that these rejections would be non-appealable would further exacerbate the hardship created by the application of this provision to a physician who is attempting to enroll in the Medicare program for the first time. **We urge CMS to allow physicians who have submitted claims prior to receiving Medicare billing privileges to be afforded the opportunity to appeal a reimbursement decision once their enrollment has been approved.**

Under proposed section **405.874(c)(2)** we are pleased that CMS agrees that the carrier must notify the physician of the reasons relied upon by the carrier to deny or revoke the physician's enrollment. However, CMS states that a "provider or supplier's Medicare billing privileges *may be* handled by a carrier hearing officer not involved in the initial determination." (Emphasis added). The foregoing language is permissive and does not confer physicians with the right to review by an objective hearing officer. Language in the preamble appears to afford physicians an unambiguous right to appeal. **We urge CMS to clarify that this will in fact occur should the physician request it, rather than leaving it within the discretion of the carrier, which as currently written is how it could be interpreted.**

CMS proposes under section **405.874(c)(5)** to bar the introduction of new evidence by physicians at higher levels of appeals. It is possible that new evidence could become available only after the initial appeal request has been filed and heard. Therefore, a physician should be allowed to present new information at a later stage in the appeals process. Further, it is unclear how this section relates to section **498.56** on "Hearing New Issues," since under the latter section it provides that "[a]n ALJ finds good cause, for example, when the new evidence is material to an issue addressed in the reconsideration and that issue was not identified as a material issue before the reconsideration." **We urge CMS to permit physicians to introduce additional, new information that was not available at earlier stages of an appeal, during later stages in the appeals process.**

Under proposed section **405.874(d)(3)** CMS provides for reinstatement of a physician's billing privileges back to the date that the revocation became effective once a physician has successfully appealed revocation. However, under section **405(d)(4)** CMS proposes that where the denial of a physician's billing privileges is reversed, billing privileges should be established back to the date of the appeal decision. **We urge CMS to allow the billing privileges to be established no later than 60 days following the carrier's receipt of the physician's enrollment application.**

CMS proposes under section **405.875(h)(1)** that contractors have 180 days to process new enrollment applications. The AMA strongly opposes the length of time afforded contractors to process the applications. Six months is far too long for physicians to wait to enroll in Medicare. Many commercial payers enroll physicians in less than half that time. Furthermore, since Medicare prohibits physicians from submitting claims to Medicare until they have an active billing number, this presents a significant financial hardship for many physicians since they would be unable to bill for their work.

Additionally, although application processing timeframes are proposed in this regulation, they were already relaxed last year. Prior to publication of this proposed rule, CMS published Medicare Transmittal #134 on March 1, 2006, which extended the amount of time and percentage of applications which must be processed within specified timeframes. Prior to this time, CMS required carriers to process 90 percent of applications within 60 days and 99 percent within 90 days compared to the newly adopted standards which require them to process 80 percent within 60 days and 99 percent within 180 days. Given the transition to the Medicare Administrative Contractors (MACs), which are performance driven contracts, the standards by which they are measured should not be lower than what is currently required of the carriers. **The AMA urges CMS to return the application processing timeframes to those in effect prior to March 1, 2006.**

Section 424.510 – Requirements for enrolling in the Medicare program

The AMA understands CMS has chosen to interpret U.S. Treasury Department requirements as the basis for requiring physicians to receive reimbursement through Electronic Funds Transfer (EFT). According to these rules, the U.S. Treasury Department has adopted use of the Automated Clearing House (ACH) as the primary system for use by federal agencies conducting EFT.

As more physicians are required by Medicare to use EFT, we have heard increasing concerns about the parameters under which a Medicare contractor may recoup monies through EFT from a physician's bank account. While it is our understanding such situations are rather limited in scope the ACH rules are highly complex banking rules which are not clearly articulated under Medicare policy. For example, the agency's policy is not sufficiently clear regarding Medicare's treatment of situations involving "reversing entries" whereby a physician's bank account is debited in the case of an erroneous duplicate payment. **We have learned of situations where such recoupments have occurred with no notice, causing significant cash flow problems for physicians. We are encouraged that CMS has expressed a willingness to work with Medicine to address these concerns and we look forward to seeing this reversed entries policy narrowly defined in Medicare manuals.**

Section 424.525 Rejection of a provider or supplier's enrollment applications for Medicare enrollment

CMS has proposed to shorten from 60 days to 30 days the amount of time a physician has to furnish missing enrollment application information. The current 60 day requirements was part of the final regulation published last year in the *Medicare Program; Requirements for Providers and Suppliers To Establish and Maintain Medicare Enrollment; Final Rule.* CMS also acknowledged in the enrollment final rule that, "[c]ontractors may extend the 60-day period if the contractor determines that the provider or supplier is actively working with CMS to resolve any outstanding issues." Thirty days is an especially short timeframe given that it could often take more than this amount of time to obtain additional documentation requested by the carrier which is outside the control of the physician. The foregoing is particularly true for government and banking documents. We have similar concerns with CMS's proposal to reduce the length of time physicians would have to supply carriers with additional documentation from 60 days to 30 days.

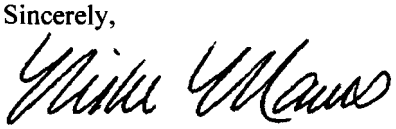
Finally, we are troubled by CMS's assertions that "approximately 70 percent of the submitted applications are incomplete or lack the supporting documents for enrollment," because it does not recognize a number of confounding factors that have contributed to this result that are outside the control of physicians such as backlogs created by a large number of CMS initiated changes to the enrollment process in 2006. Other delays are due to carriers losing documents and the inability of physicians to reach the carrier to obtain clarification on enrollment requirements. In an era when CMS has pledged to remove bureaucratic hassles associated with the enrollment process, these types of assertions are puzzling. **Furthermore, we urge CMS to retain the 60 day timeframe for allowing physicians to submit missing and additional enrollment information to the carriers as 30 days is inadequate.**

Section 424.535 Revocation of enrollment and billing privileges from the Medicare program

CMS proposes in **section 424.535(c)** that after a "provider, supplier, delegated official or authorizing official" has had their billing privileged revoked, they must wait three years before they can reapply for Medicare enrollment and billing privileges. The majority of reasons concern fraudulent and criminal wrongdoing, however, among the reasons a physician's billing privileges can currently be revoked is for "[i]nadequate reverification information" (section 424.535(a)(6)). We strongly oppose the application of this three year bar to a physician who has not submitted updated enrollment information within the current 60 day timeframe reestablishing Medicare billing privileges. Further, it is unclear whether CMS's proposed change under section 424.525 which calls for shortening the length of time to supply information, also applies to situations when a carrier is seeking "reverification information." If so, the AMA strenuously disagrees that 30 days is an adequate amount of time for a physician to compile the necessary documentation required for a reverifying enrollment information. Finally, while it appears CMS does not intend this provision apply to overturned revocations, it is unclear as written whether revocations which have been successfully overturned are included. **We urge CMS to: work with Medicine to establish an appropriate response time for physicians to supply a carrier with reverification information; exclude from the three year reapplication following revocation rule those physicians who were revoked as a result of "inadequate reverification information;" and specifically exclude revocations which have been successfully overturned, from this provision.**

The enrollment process remains a significant concern for physicians. The volume and degree of changes to the enrollment process over the past twelve months remain a significant challenge for practicing physicians due to the constantly changing rules and policies associated with it. The AMA appreciates the opportunity to share our comments and concerns with CMS. Should you have any questions please contact Mari Johnson at mari.johnson@ama-assn.org or (202) 789-7414.

Sincerely,



Michael D. Maves, MD, MBA

Submitter : Ms. Allison Glenn **Date:** 05/01/2007

Organization : Spruce Pine Community Hospital

Category : Hospital

Issue Areas/Comments

General

General

As a Hospital we are in favor of the new rule allowing for an appeal of a denied provider application. We have experienced several problems with provider applications as well as status inquires. A set time frame for deciding appeals is a welcome improvement as well. Our organization has had to wait over a year for a provider number in the past as a result of refilling the provider applications. I believe the ability to appeal denied applications will prevent this problem in the future. Providers in search of an update on the status of a provider number or application should not be directed to a web site that does not help in any way.

Submitter : **Ms. Denise Bonn** **Date: 05/01/2007**

Organization : **National Association for Home Care & Hospice**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-6003-P2-4-Attach-1.DOC

May 1, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6025-P
P.O. Box 8017
Baltimore, MD 21244-8014

Via: Electronic submission

Re: Medicare Program; Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges

72 Fed. Reg. 9479 (March 2, 2007)

File Code CMS-6003-P2

To whom it may concern:

Thank you for the opportunity to provide comments on the above-referenced Proposed Rule. The National Association for Home Care and Hospice, Inc. ("NAHC") is the largest trade association in the country representing the interests of home care and hospice providers and their patients. As a central part of its membership, NAHC represents over 6,000 Medicare participating Home Health Agencies ("HHA"), hospices and providers of Durable Medical Equipment ("DME"). Accordingly, the Proposed Rule is of great interest to NAHC and its members.

General Comments Regarding the Preamble

We would like to begin our comments by expressing our concern about the lack of clarity on the application of these rules. At the beginning of the Preamble, the Centers for Medicare and Medicaid Services ("CMS") cites the definition of "provider" for purposes of Part 498 of the Medicare regulations, which includes a home health agency or hospice, 72 Fed. Reg. 9479, 9480. No further definition of "provider" is furnished in the Preamble or the proposed rules.

After the definition of "provider," CMS refers to regulation section 405.874 governing the appeals process for Durable Medical Equipment, Prosthetics and Orthotics and Supplies ("DMEPOS"), and CMS Ruling 98-1 governing physician and other practitioners. CMS concludes this section by advising that:

> This proposed rule is different from the clarification of appeals procedures found in CMS Ruling 98-1, because it adds provisions in order to comply with the MMA. Whereas the ruling followed the procedures in §405.874, this proposed rule would grant suppliers the right, after denial or revocation of a supplier's billing privileges, to a hearing by an ALJ....

This conclusion implies that the proposed rules will not affect home health agencies or hospices, which are not suppliers.

The initial discussion in the Preamble, pages 9480 through 9483, is in regard to comments and responses to a Proposed Rule CMS issued on October 25, 1999 regarding supplier appeals of revocation of billing privileges. The term "supplier" does not include a home health agency or hospice, so we do not interpret this part of the Preamble to address changes which apply to a home health agency or hospice.

Part IV of the Preamble on page 9483 is entitled, "Provisions of the Proposed Rule." CMS states, "We propose to maintain §405.874, which specifies provisions that would apply to certain suppliers as defined in §405.802." CMS then discusses proposed changes to section 405.874(a), (b), (c), (d), (f) and (g). This discussion references suppliers and carriers, but is also interspersed with references to "a provider or supplier." Although CMS uses the term "provider," the discussion does not appear to apply to a home health agency or hospice. Regulation section 405.874 is entitled, "Appeals of carrier determinations that a supplier fails to meet the requirements for Medicare billing privileges." Intermediaries and contractors, but not carriers, make decisions regarding Medicare enrollment for a home health agency and hospice. Based upon the cited language in the Preamble and the title of the proposed regulation, NAHC assumes that the proposed changes to section 405.874 do not apply to a home health agency or hospice. The discussion of proposed rule 405.874 goes through page 9484.

In the middle of page 9484, with no heading signaling a change in application from suppliers, to suppliers and Part A providers, CMS proposes changes to regulation section 424.510(d)(2), which in its current form does apply to providers, such as home health agencies and hospices, as well as to suppliers. This is followed by proposed changes to regulation section 424.545(a), which in its current form applies to home health agencies and hospices as well as to suppliers, and then is directly followed by proposed changes to section 405.874(h). This discussion is all on page 9484 of the Preamble. We assume that proposed subsection 405.874(h), like the other subsections of proposed 405.874, does not apply to home health agencies and hospices. This is not clear, however, since the proposed rule refers to "contractors" and "provider enrollment," whereas the Preamble refers to "carriers." The discussion on the next page proposes changes to regulation section 424.525(a) and regulation section 424.535, which in its current form do apply to providers, such as home health agencies and hospices. This is followed by proposed changes to Part 498, which in its current form has provisions which apply to providers, such as home health agencies and hospices.

In short, the Preamble is not clear as to which provisions CMS intends to apply to providers such as a home health agency or hospice, and which provisions CMs intends to apply to suppliers, making meaningful comment mere guesswork. To the extent that the

following guesses do not reflect CMS' proposed rules for home health agencies and hospices, NAHC maintains that the Proposed Rule is legally insufficient for a meaningful opportunity to comment. Before imposing any provisions upon home health agencies or hospices for which NAHC has not had an opportunity to submit meaningful comments, CMS must propose in clear fashion such provisions prior to implementation, and furnish an opportunity for interested parties to comment.

Comments Addressing Specific Provisions

Comments Addressing Enrollment

CMS is proposing to reduce the time that a provider must submit complete information requested by a contractor from 60 to 30 days from the date of the request, and to reduce the time a provider must submit all supporting documentation from 60 to 30 days from the date of submission of the enrollment application. NAHC opposes both reductions of time in proposed section 424.525(a)(1) and (a)(2). CMS states that it is proposing this change because "approximately 70 percent of the submitted applications are incomplete or lack the supporting documents for enrollment." While we appreciate CMS' concern with "reduc[ing] the administrative burden associated with processing these applications, CMS has wrongly attributed the cause to providers.

In 2006 alone, CMS issued new provider enrollment regulations on April 21, 2006, a new provider enrollment form on May 1, MLN Matters Nos.SE0632 and SE0634, and further changes to provider enrollment through significant revisions to Chapter 10 of the Program Integrity Manual on June 30 and November 13, 2006. Although providers were not required to have National Provider Identifiers (NPI's) for Medicare billing until May 23, 2007, CMS required providers to include an NPI on their enrollment forms as early as the release of the new enrollment forms more than a year earlier per MLN Matters Nos.SE0632 and SE0634. Even someone trying to keep up with all of the changes to provider enrollment was unlikely to comply with all of the requirements CMS and the intermediaries demanded on the initial filing.

This problem was compounded by additional information the intermediaries required to be included on the 855A which was not required by the form. This was not only in violation of the Paperwork Reduction Act, 44 U.S.C. §3501 *et seq*, but caused the need to submit revised 855A pages in response to a request for information, and unnecessarily delayed processing. For example, intermediaries were requiring home health agencies to write in on the form on Section 4, page 17 "Main Site" after checking the box marked "Other hospital practice location." It is not surprising that a home health agency did not know to check this hospital box and include this information. On the Section 6, home health agencies were also directed to write-in "Administrator/DON" for the individual who held this position, although this information is not requested on the form. There was also much confusion regarding the application of Section 12, although this section, in its entirety, does not apply to a sale of stock, or to a change of ownership where the buyer accepts assignment of the provider agreement. However, some intermediaries required stock purchasers to complete Section 12 and satisfy the

capitalization requirements, and other intermediaries required buyers who accepted assignment of the provider agreement to complete some of the information in this section. In those situations in which section 12 does apply, some intermediaries required the submission of supporting documentation in addition to that specified on the form and held home health agencies to capitalization requirements not required by 42 C.F.R. §489.28.

In regard to a change of ownership, current policy permits the submission of the 855A 90 days before the anticipated closing of the sale of assets, or other proposed ownership change, Program Integrity Manual, Chapter 10, §5.5. The proposed change from 60 to 30 days for responding to requests for additional information and the reduction from 60 to 30 days from the date of the application for receiving supporting documentation will result in these applications being rejected unnecessarily. It may also have the effect of deterring submission of the application prior to closing. The early submission permitted by the Manual enables intermediaries to start processing these enrollments, many of which involve complex transactions. If providers only have thirty days to respond to requests for additional information, and only thirty days from the date of the application to receive supporting documentation, many of these 855A's will be rejected by the intermediaries for failure to submit the requested information or documentation. Since the final sales document and/or bill of sale must be submitted, the proposed regulation would reduce the time before the anticipated closing when providers could submit 855A's from 90 to 30 days. This will result in more of the intermediary processing time after the closing date. It must be remembered that the intermediary is not the end of the line of this processing. The intermediary merely makes a recommendation to the State Agency, which then forwards the information and its recommendation on to the CMS Regional Office, which makes the final determination regarding approval or denial. The result of the proposed regulation will be a significant increase in the time after closing until a change of ownership is approved.

Current policy only imposes deadlines upon contractors for the processing of provider enrollments, Program Integrity Manual (CMS Pub. 100-08) Chapter 10, §2.1 and 2.2. CMS should impose deadlines on the State Agency and the CMS Regional Office for the processing of these enrollments as well.

We note also that the OIG recently released a report which found that significant administrative delays in processing enrollment forms were caused by delays contractors incurred in accessing PECOS, the Provider Enrollment, Chain and Ownership System, *Provider Enrollment, Chain and Ownership System: Early Implementation Challenges (OEI-07-05-00100, April 2007), at ii.* The OIG also concluded that, "Because of misinterpretation of CMS guidance, the majority of Part A applications contractors reported as exceeding timeframes as of July 31, 2005, had not actually exceeded timeframes." *Id.*

As detailed above, NAHC concludes that contractors' misinterpretation of CMS guidance has also caused providers' enrollment forms to be submitted presumably without all necessary information or supporting documentation, when the reality is that

the contractors were requiring the submission of information and documentation not required by the forms or regulations. NAHC urges CMS to conduct further training of the contractors and to direct them not to require information and documentation not required by the forms or the regulations.

We propose two procedural changes which could reduce some of the contractor's administrative burden in processing enrollment forms. First, we propose the addition of regulatory language permitting a provider to withdraw an enrollment form. Due to the complexity of this process, some providers discover after they have filed, and have been contacted by the intermediary or received an information request or request for supporting documentation, that they have misunderstood the requirements and cannot comply within the remaining timeframe. Rather than keeping the timeframe open, causing additional work for the intermediaries, providers should be able to withdraw their applications. Second, CMS should permit contractors and/ Regional Offices to reopen their enrollment decision. NAHC has discovered situations which were not processed properly by the intermediaries and the Regional Office, but the provider had no choice but to start all over again. There is confusion on the part of intermediaries and Regional Offices regarding rejection under 42 C.F.R. §424.525 for failure to submit all requested supporting documentation, and denial under 42 C.F.R. §424.530 for not meeting the capitalization requirements because all requested supporting documentation wasn't furnished. Letters have been issued by both the intermediary and Regional Office which do not contain appeal rights, but the provider has been prevented from re-submitting an enrollment application until a 60 day period has expired, which is not tied to an appeal period. Such action seems to be neither a rejection nor a denial. A reopening would provide a process to efficiently clarify what action has been taken and to correct the erroneous decision.

Comments Addressing Revocation

CMS is proposing to add a new subsection 424.535(a)(8) to permit revocation of a provider's or supplier's billing privileges when "the provider or supplier submits a claim or claim for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred." We do not believe that CMS intended to apply this to home health agencies and hospices which bill in compliance with Medicare requirements. We furnish billing examples below which could be swept into the broad language of the proposed rule. NAHC seeks clarification that the following and similarly compliant billing would not be subject to this provision. A home health agency bills a sixty-day episode of care. When a beneficiary dies during the episode, a home health agency may bill for the episode, with the "through" date on the bill being the date of death. Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 10, §10.1.16. While a beneficiary must be "under the care of a physician who establishes the plan of care," the physician need not be in the State or country on the particular day when the home health agency furnishes services to the beneficiary. In fact, even the certification

"may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence," Medicare General Information, Eligibility and Entitlement Manual (CMS Pub.100- 01), Ch. 4,§30.1. Similarly, a hospice is paid through the date of death of the beneficiary receiving services under the Medicare Hospice Benefit, *see, e.g.,* Medicare Claims Processing Manual (CMS Pub. 100-04), Ch. 11, §30.1, and the physician who certifies that the beneficiary is terminally ill need not be in the State or country when services are furnished.

We note also that billing errors by other providers may lead to incorrect conclusions by contractors. For example, a hospital may fail to record a patient's leave of absence on its claim form, although a patient might legitimately receive home health services during such a leave of absence.

Although CMS states that providers may appeal a contractor revocation pursuant to this proposed ground, this is no cure for this overly broad provision. Payment is not made during an appeal, 42 C.F.R. §424.545 (a), and no provider should be required to undergo the expense and delay of an appeal to correct language that will cause inappropriate revocations. CMS has also proposed that "providers or suppliers that expressly flag claims that they believe might be perceived by us as being in this category [subject to this revocation provision] would not face prosecution under the False Claims Act." Preamble at 9485. Providers should not have to flag claims properly billed under Medicare requirements to avoid being caught in the overly broad language of this proposed provision. Often they have no way of knowing that another provider's error might cause their claims to be perceived as false claims.

Nor should providers have to wait three years after revocation to reapply to Medicare as proposed in new subsection 424.535(c). It is particularly important that CMS clarify that if a home health agency's or hospice's provider agreement is terminated pursuant to 42 C.F.R. §489.53, which also results in the revocation of the provider's billing privileges, that any time period adopted in this proposed provision does not govern when the provider may reapply to Medicare. Under current policy, a provider may reapply for certification at any time, State Operations Provider Certification Manual (Pub. 100-07) (hereafter "SOP"), Ch. 2, §2016C, and must operate without the deficiencies which caused the termination before reinstatement into the Medicare Program, 42 C.F.R. §489.57, SOP, Ch. 10, §2016B. Such "reasonable assurance periods" are generally 30-120 days, *id.* at §2016B, and CMS has introduced no evidence that this period is inadequate to protect the Medicare program.

We also urge CMS to send a provider a pre-revocation notice and adopt a process for the provider to respond to the notice prior to revocation. This procedure will furnish providers with the opportunity to respond to the allegations and may avoid an inappropriate revocation.

Comments Addressing Appeals

CMS has proposed clarifying section 424.545(a), which permits a provider to appeal the revocation of billing privileges when this also results in the termination of the provider agreement according to Part 498. One decision which addresses the billing privileges and provider agreement will be issued. CMS is now proposing to revise section 424.545(a) to clarify that a provider use a single appeals process for both issues and follow the appeal procedures for revocation of Medicare billing privileges if the provider wants to appeal both issues. CMS is also proposing changes to Part 498 which change the appeal process for home health agencies and hospices. Currently, if an existing home health agency's or hospice's billing privileges are revoked, it may appeal this provision through the procedures in Part 498, which provide for an appeal to an ALJ, 42 C.F.R. §§ 424.545(a) and 498.5(b). As proposed in section 424.545(a)(1)(ii) and section 498.5(l)(1), a home health agency or hospice would not be able to appeal the revocation of its billing privileges directly to an ALJ, but would have to seek reconsideration in accordance with proposed section 498.22(a). Proposed regulation section 498.22(a) permits the reconsideration to be performed by a contractor or CMS. Current regulation section 424.545(a), as well as proposed section 424.545(a)(2), provides that payment will not be made during the appeal process. Although CMS has maintained the existing policy regarding non-payment on appeal, no explanation is furnished regarding the significant changes to the appeal procedure for providers such as home health agencies and hospices.

NAHC respectfully disagrees with an appeal process for existing providers which removes the ability to have an immediate appeal to an ALJ for revocation of billing privileges and a resulting termination of the provider agreement. Reconsideration before the contractor or CMS is just an unnecessary delay in the appeal process, and a potential delay in the resumption of payment. The proposed rule is also a significant departure from existing procedure which treats existing providers differently from prospective providers. Whereas the former currently may appeal directly to an ALJ, the latter must first seek reconsideration before CMS. The current procedure has different appeal routes to address these very different situations. CMS has furnished no basis for this change in procedure.

CMS is also proposing in section 498.22(a) that a contractor or CMS may perform a reconsideration. Under the current regulation, a prospective provider that does not pass its survey, *i.e.*, "that it does not qualify as a provider" per section 498.5(a), would have reconsideration solely before CMS. The proposed change to section 498.22(a) would permit a contractor to hear both a reconsideration of a denial of enrollment, as well as the reconsideration of the initial determination that a prospective provider does not satisfy the Conditions of Participation ("COP's") to be a home health agency or hospice. NAHC respectfully disagrees with this proposal, and instead recommends that the reconsideration of either or both issues be performed by CMS, and be performed by an appeals group at CMS not involved in the initial determination of denial of enrollment or of denial of compliance with the COP's. There will likely be cases which involve both a denial of enrollment and a denial of compliance with the COP's. Having two

reconsiderations, one by the contractor and one by CMS would not be an efficient use of resources. Contractors do not make decisions regarding compliance with the COP's, and therefore should not be the entity making this decision. Similarly, contractors make a recommendation regarding approval or denial of enrollment, but the decision is actually made by CMS. CMS is the entity which should perform the reconsideration.[1]

Under current rules 498.5 and 498.22(a), CMS issues the reconsideration decision regarding a proposed provider, and does not have a right to seek a hearing before an Administrative Law Judge ("ALJ"). As proposed, CMS or one of its contractors may issue a reconsideration decision regarding an initial determination that affects a prospective provider or an existing provider, and both CMS and its contractor have a right to seek a hearing before the ALJ if dissatisfied with a reconsideration decision pursuant to Proposed Rules 498.2, 498.5(l)(2), 498.22(a) and 498.40(a)(1). CMS furnishes no explanation for this proposed rule change. Having chosen in this proposed rule to delegate its authority to issue reconsideration decisions, CMS should not then accord itself the right to second-guess its delegate, and seek an appeal of the reconsideration decision. Nor should a contractor have a right to seek a hearing regarding the decision of CMS. And, neither CMS nor its contractor should have the right to seek an appeal of its own reconsideration decision.

NAHC also respectfully disagrees with CMS' proposal to limit the introduction of evidence and issues for enrollment appeals at the ALJ and DAB appeal levels unless a "good cause" exception is satisfied pursuant to Proposed Rules 489.56(e) and 489.86(a). Many of the issues to be addressed in a denial or revocation of enrollment are complex legal issues. First, the provider or prospective provider may not know to raise these issues and to submit the evidence relevant to them. Second, even if the provider or prospective provider had counsel and did raise these issues and submit the relevant evidence, the contractor does not have counsel available to consult with to address these issues. It is only at the ALJ level and above that an attorney makes or is available to furnish advice regarding the decision. Restricting the submission of evidence before a provider or prospective provider reaches the level of a decision maker able to address the relevant issue or evidence arbitrarily restricts the right of appeal.

CMS is proposing to eliminate the requirement in current rule section 498.78(a) that a provider or prospective provider must agree to a request by CMS to remand the case to an ALJ. Since a provider or prospective provider is not paid during the appeals process, a remand may unnecessarily delay the decision in the case, which otherwise might have been made by the ALJ. Although a provider who is successful on appeal may resubmit claims for services furnished during the overturned period, proposed rule 424.545(a)(2), many providers will not be able to continue furnishing services to Medicare beneficiaries during the appeals process without payment, and would prefer a quicker reinstatement. NAHC respectfully requests that CMS maintain the current

[1] In the alternative, if CMS proceeds with its proposal to have reconsideration by a contractor, CMS should require that the reconsideration be performed by a separate appeals group within the contractor by personnel not involved with the initial determination.

requirement that a provider or prospective provider must agree to a request by CMS to remand the case to an ALJ.

Comments to Proposed Rule 405.874 on Behalf of Our Members That Furnish DME, Prosthetics and Orthotics

Some NAHC members furnish DME, prosthetics and orthotics, and have Medicare supplier numbers. NAHC submits these comments to proposed rule section 405.874 on behalf of those members. CMS has proposed that a supplier may seek a reconsideration of the denial of supplier enrollment or the revocation of a supplier's billing privileges, Proposed rule section 405.874(c)(1), which will be performed by a carrier hearing officer, *id.* at section 405.874(c)(2). CMS is proposing to require suppliers to submit all evidence to the carrier hearing officer, or be barred from submitting it at higher levels of the appeals process, *id.* at section 405.874(c)(5). NAHC respectfully disagrees with this proposal because it requires the submission of evidence at a point in the appeals process when the supplier is unlikely to be represented by counsel, and is unlikely to be aware of all of the evidence which should be submitted to address all of the issues which may be relevant to the appeal. NAHC incorporates by reference our discussion above regarding proposed rule sections 489.56(e) and 489.86(a).

CMS has also proposed timeframes for contractors to process new enrollment applications and revalidations within 180 days of receipt, and changes of information within 90 days of receipt in proposed regulation section 405.874(h). We note that these are the maximum timeframes contained in Program Integrity Manual (CMS Pub. 100-08), Chapter 10, §§2.1 and 2.2. NAHC urges CMS to reiterate in the Final Rule that contractors are expected to satisfy the timeframes contained in these manual sections: process 80% of new enrollment and revalidation applications within 60 days and 90% within 120 days of receipt, and process 80% of changes of information applications within 45 days and process 90% within 60 days of receipt.

Respectfully Submitted,

Denise Bonn
Deputy Director
Center for Health Care Law
National Association for Home Care
& Hospice
228 Seventh St., S.E.
Washington, D.C. 20003
(202) 547-5262

Submitter : Ms. Linda Leone **Date:** 05/01/2007

Organization : Illinois HomeCare Council

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6003-P2-5-Attach-1.DOC

ILLINOIS HOMECARE COUNCIL
NATION'S FIRST HOMECARE ASSOCIATION

May 1, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6003-P2
P.O. Box 8017
Baltimore, MD, 21244-1850

Dear Sir or Madame:

Thank you for this opportunity to comment on proposed revisions to 41 CFR Parts 405, 424 and 498 published in the Federal Register on March 2, 2007 (Vol. 72, No. 41) pages 9479-9491. The filing is referenced as CMS-6003-P2.

The Illinois HomeCare Council (IHCC) is a trade association representing more than 200 home care providers and suppliers in Illinois. Included among our members are home health agencies, hospices, home infusion companies and durable medical equipment suppliers. These comments were developed by IHCC's Regulatory and Reimbursement Committee.

Section 405.874 Appeals of carrier determinations that a supplier fails to meet the requirements for Medicare billing privileges.

Comment: IHCC members find the language in this section, particularly in Section 405.874(c) Appeal rights, to be very confusing. Both the Section, and Subpart H in which the Section appears, clearly reference Medicare Part B and suppliers who participate in Medicare under Part B. However Section 405.874(c) references both suppliers and providers. Providers generally participate in Medicare under Part A and suppliers under Part B.

Recommendation: Revise this Section so that it applies only to suppliers and insure that similar appeal rights are included in the appropriate sections of CMS' regulations for providers.

Comment: IHCC members have grave concerns about all of the time frames included in Section 405.874(h) for CMS contractors to process provider and supplier enrollment applications.

A 180 day time frame for processing initial enrollment applications is quite excessive. Individuals and organizations that are initially applying for enrollment as either a Medicare supplier or provider have made a significant commitment of time and resources to prepare themselves in order to be eligible for Medicare enrollment. Often they have formed corporations, hired staff, and secured state licensure. Having to wait for up to 6 months to find out whether they are considered even eligible to enroll in the Medicare program is excessive, particularly for home health agencies and hospices which still must undergo an initial survey to determine compliance with the Medicare Conditions of Participation prior to being able to complete the enrollment process.

In addition, CMS has instructed state survey agencies that initial surveys of home health agencies and hospices should be their lowest priority for these programs. Since most other third party payers require Medicare certification, the combination of the 180 days allowed for processing the application and the low priority for survey means that many home health and hospice organizations may have to maintain their business for over one year before being able to generate any revenue. This presents a significant barrier to entry.

Is CMS proposing these excessive time frames to act as a deterrent to new providers or suppliers seeking Medicare participation? Rather than authorizing such excessive time frames, CMS should consider publicly instituting moratoria on new enrollments in categories where they believe no additional providers or suppliers are required. Frankly, this would be a more direct and fair approach to limiting the number of suppliers and providers.

A 180 day time frame for processing revalidation applications is, perhaps, even more problematic. A 6 month time frame for review places providers and suppliers at significant financial risk if CMS' contractor ultimately decides that the entity is not eligible for continued participation in Medicare based on a revalidation application. Even though appeal rights may be available, very few home care organizations are in a position to survive financially if CMS suddenly stops payments and initates an effort to recoup up to 6 months of payments already received.

IHCC members also have similar concerns about the 90 day time frames allowed for review of change-of-information filings and reassignment of payment requests. Though the vast majority of these filings are likely to be routinely approved, a 90 day period after which CMS may disallow the reported change is unrealistic and potentially very disruptive to agency functioning. How is a home health agency supposed to explain to a potential investor or new administrator or clinical manager that CMS' contractor may ultimately disallow their ownership or management position after three months have passed? If CMS wishes its contractors to be involved in reviewing routine changes such as these they must be in a position to inform providers and suppliers promptly if a problem is identified.

Recommendation: Limit all time frames for CMS contractor review of initial enrollment applications, revalidation applications, change-of-information filings and reassignment of payment requests to 60 days.

Section 424.535 Revocation of enrollment and billing privileges from the Medicare program.

Comments: Proposed Section 424.535(a)(8) has also raised strenuous objections from IHCC members. IHCC is wholly opposed to CMS' proposal to allow for the revocation of the billing privileges of providers or suppliers if implemented in this way. The criteria for imposition of this penalty are impossibly broad and there is no standard for scope or severity of the billing issues that might be invoked in the process.

First, it appears from the language that a single problem claim could result in a revocation of billing privileges. IHCC believes strongly that a remedy as drastic as revocation of billing privileges should be reserved for situations in which a pattern of fraudulent billing is identified.

Second, many of the examples listed in the proposed regulation are inappropriate when applied to home health and hospice services. It is not impossible or even inappropriate for a physician who signs a home health plan of care or who certifies a patient as appropriate for hospice care to take these actions and then be out of the state or country during a portion of the time during which services are furnished. Providers always insure that another physician is available for consultation should the need arise during one of these absences. Similarly, hospices can bill for services delivered on the date of the patient's death. And, home health agencies and hospices must both cover certain services that cannot be provided in the patient's home during the service delivery period using funds paid to them for the patient's care by the Medicare program.

Another concern raised by the proposed language is the three year period during which the provider or supplier which has had its billing privileges revoked must wait to re-apply (see Section 424.535(c)). Again, if implemented as written this penalty is too broadly written to be acceptable to IHCC members.

IHCC members strongly support decisive measures to address Medicare fraud and abuse. Our organization has recently adopted an updated Code of Ethics that endorses ethical and compliant operations, service delivery, and billing practices. IHCC agrees that significant penalties should be applied to providers and suppliers who are defrauding the Medicare program.

However, IHCC also strongly supports due process procedures that insure that decisive actions are taken only when fraud is proven, that the willful acts of individuals do not necessarily disqualify entire organizations, and that errors are

identified as such and addressed accordingly. It appears to IHCC members that the proposed regulation would allow CMS to prevent a home health agency or hospice from taking action to restore billing privileges as a result of minor errors or infractions committed by a single agency employee. IHCC members do not believe that such an outcome would be fair or appropriate.

Contrary to CMS' contention on page 9485 of the preamble IHCC believes that mechanisms are in place to allow CMS to take appropriate action against agencies that are defrauding Medicare, as well as to work with agencies that are billing in error. These mechanisms include fraud investigations conducted by the Office of Inspector General, reviews undertaken by the Program Safeguard Contractors, and probe reviews and other medical review activities undertaken by intermediaries and carriers. IHCC opposes providing CMS with the ability to revoke billing privileges for ill-defined and overly broad reasons, and keep organizations out of the Medicare program, particularly in sectors that are primarily reimbursed by Medicare such as home health and hospice.

Recommendations: IHCC believes that CMS should delete proposed Sections 424.535(a)(8) and 424.535(c).

Sincerely,

Linda Leone
President

Submitter : Ms. Leslie Lloyd **Date:** 05/01/2007

Organization : The American Occupational Therapy Association

Category : Occupational Therapist

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6003-P2-6-Attach-1.DOC

CMS-6003-P2-6-Attach-2.DOC

AOTA The American Occupational Therapy Association, Inc.

Occupational Therapy: Skills for the Job of Living

Via email to http://www.cms.hhs.gov/erulemaking

May 1, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-6003-P3
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-7850

Re: Medicare Program; Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges; Proposed Rule

Dear Ms. Norwalk:

The American Occupational Therapy Association (AOTA) represents more than 35,000 occupational therapy professionals, many of whom provide outpatient services to Medicare beneficiaries. We appreciate the opportunity to comment on the regulations proscribing the appeals process for providers and suppliers whose applications for enrollment or renewal of enrollment were denied. This proposed rule was published in the *Federal Register* on March 2, 2007 (72 Fed. Reg. 9479).

AOTA respectfully requests that the Centers for Medicare and Medicaid Services (CMS) revise the definition of supplier in 42 C.F.R. §§ 405.802 and 498.2 to specifically include occupational therapists in private practice. The proposed rule contemplates revising this definition in these two sections of the regulations in the process of codifying the statutory requirements of section 936(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which provides an ALJ hearing and judicial review for any provider or supplier whose application for enrollment or reenrollment in Medicare has been denied. Currently, occupational therapists in private practice enroll in the Medicare program as suppliers, so this request simply is an editorial change.

The Social Security Act and current regulations support the inclusion of occupational therapists in private practice among the practitioner types designated as "suppliers" in 42 CFR §§ 405.802 and 498.2. To provide some historical background, the definition of "outpatient occupational therapy services" was added as subsection 1861(g) of the Social Security Act in 1986, and states:

> The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational" shall be substituted for "physical" each place it appears therein.

Omnibus Budget Reconciliation Act of 1986, P.L. 99-509, Sec. 9337 (codified at 42 U.S.C. § 1395x(g)) (hereinafter "OBRA"). In addition to adding the definition for "outpatient occupational therapy services," the bill included provisions to amend other portions of the Social Security Act relating to Medicare including the

scope of benefits, limitations on payments, certification, and provider enrollment. The language at 42 U.S.C. § 1395k(a)(2)(C) was added stating that a Medicare beneficiary would be entitled to payment for "(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and *outpatient occupational therapy services* (other than services to which such sentence applies through the operation of section 1861(g))." (emphasis added).

The statutory authority for occupational therapists in private practice to enroll as Medicare Part B suppliers is found by reading section 1861(g) of the Social Security Act along with section 1861(p), which states, "The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations..." In 1998, the Health Care Financing Administration (HCFA)(CMS' predecessor agency) codified the requirements for occupational therapists in private practice by establishing the regulations at 42 C.F.R. §410.59, in a manner that "parallels the §410.60 requirements for outpatient physical therapy." See 63 Fed. Reg. 58813 at 58869 (November 2, 1998). In doing so, HCFA explicitly stated that it would "use the same enrollment and billing process as is currently used for individual physicians and physician group practices." Id. Consequently, there is clear evidence that this agency does apply the same enrollment processes to occupational therapists in private practice as it does to physical therapists in private practice and to physicians. It is logical then to conclude that the same appeal rights should be afforded occupational therapists in private practice as is to physical therapists in private practice and to physicians.

The current regulations relating to the enrollment of suppliers do not adequately reflect both the statutory and regulatory intent described above. AOTA is concerned that the failure to make this editorial change could result in the unintended consequence of occupational therapists in private practice enrolled in the Medicare program as suppliers lacking the clear authority to participate in the appeals process if their applications for enrollment or renewal of enrollment are denied. *Therefore, AOTA strongly urges CMS to modify the language in 42 C.F.R. §§ 405.802 and 498.2 to specifically include occupational therapists in private practice in the definitions of supplier.*

The AOTA requests that due consideration be given to these comments. Thank you, again, for the opportunity to comment on this proposed rule. We look forward to a continuing dialogue with CMS on these issues as they apply to occupational therapy.

Sincerely,

Leslie Stein Lloyd, Esq.
Senior Regulatory Counsel

Submitter : **Mrs. Rachel Hammon** **Date: 05/01/2007**

Organization : **Texas Association for Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

GENERAL

GENERAL

TAHC comments are attached. See Attachment

General

General

The Texas Association for Home Care (TAHC) represents over 900 Home Care agencies many of which provide Medicare home health, hospice and Durable Medical Equipment (DME) services, to beneficiaries across the state. We appreciate the opportunity to provide comments on the aforementioned rule published in the Federal Register March 2, 2007.

CMS-6003-P2-7-Attach-1.DOC

May 1, 2007

Centers for Medicare and Medicaid Services
Department of Health and Hyman Services
Attention: CMS – 6025 –P
P.O. Box 8017
Baltimore, MD 2144-8014

Via: Electronic Submission

Re: Medicare Program; Appeals of CMS or Contractor Determinations when a provider or supplier fails to meet the requirements for Medicare billing privileges

72 Federal Register 9479 (March 2, 2007)

File Code CMS – 6003 – P2

From: The Texas Association for Home Care

To whom it may concern:

The Texas Association for Home Care (TAHC) represents over 900 Home Care agencies many of which provide Medicare home health, hospice and Durable Medical Equipment (DME) services, to beneficiaries across the state. We appreciate the opportunity to provide comments on the aforementioned rule published in the Federal Register March 2, 2007. Below are our comments to the proposed rule.

Comments regarding section IV. Provisions of this Proposed Rule

TAHC would like to express concern regarding the lack of clarity of this section. In section I. Background, CMS refers to part 498 for the definition of providers to include home health (HH) and hospice agencies. Yet in section 405.802 providers are not defined, leading one to believe that this section does not apply to HH or hospice agencies. In addition, throughout this section CMS discusses various parts of the proposed rules such as 405.874(a), (b)(1), (b)(2), (b)(3), and (c)(1) where only "suppliers" and not "providers" are mentioned. Again, it is not clear as to whether these sections apply to HH or hospice agencies.

When CMS goes on to discuss 405.874(d) related to reversal of carrier determination on claims processing both providers and suppliers are mentioned. Intermediaries and contractors make determinations related to home health and hospice agencies not carriers. In fact, then entire section related to 405.874 is titled "Appeals of carrier determinations that a supplier fails to meet the requirements for Medicare billing privileges" and would lead a "provider" including a home health or hospice agency to believe that the entire section does not apply.

Bottom line, it is not clear which provisions CMS intends to apply to providers such as home health agencies and hospice, which provisions apply to suppliers and which provisions apply to both.

Section 424.510. Requirements for enrolling in the Medicare program

The proposed rules state "At the time of enrollment, an enrollment change request or revalidation, providers and suppliers must agree to receive Medicare payments via EFT." This is already required by CMS per the Program Integrity Manual (PIM) chapter 10. If a provider was submitting a simple change request or revalidating the application and was already receiving Medicare payments via EFT, then why would they have to re-agree and fill out and send another CMS – 588 if the change was unrelated to the banking information or if they were simply revalidating existing information? If it is required that a provider resubmit a CMS – 588 when there are no changes to the bank information this could potentially cause unnecessary payment issues if payments are held for the 15 day pre-certification period or if the form is returned because the provider has no applicable box to fill in related to the reason for the submission of the CMS-588.

Section 424.525. Rejection of a provider or supplier's enrollment application for Medicare enrollment

In this section CMS proposes to reduce the time that a provider must submit complete information requested by a contractor from 60 days to 30 days. Although CMS states "approximately 70 percent of the enrollment applications are incomplete or lack the supporting documents for enrollment" TAHC does not believe this issue falls entirely on the provider. For example, several changes have occurred related to provider enrollment over the past year starting in April 2006. A new provider enrollment form was available May 1, 2006 that included the NPI number. Providers were not expected to have the NPI number until May 23, 2007. Many unsuspecting providers filled out the form without the NPI not realizing this was required as part of a complete form. In addition, significant revisions occurred to the PIM Chapter 10 that affected enrollment in June 2006 and November 2006 that were not well publicized.

The reduced timeframes will also have a negative impact on change of ownerships (CHOW). The current policy located in the PIM, chapter 10, section 5.5 permits the submission of the 855A 90 days before the anticipated closing date. The reduced timeframes could result in unnecessary application rejections and deter submission of the application prior to closing, thus delaying the approval of the CHOW. The CHOW not only requires the processing of the enrollment application, but includes processes for approval by the CMS RO and the state agency that would be delayed further by an enrollment delay.

Section 424.535. Revocation of enrollment and billing privileges from the Medicare program

TAHC opposes the broad language included in this section and recommends that language be added to clarify that HH and hospice agencies will not experience a revocation if they comply with Medicare billing requirements. The broad language as it is currently written will have unintended consequences that lead to unnecessary revocations of HH and hospice agency billing privileges secondary to unique situations that could be construed as abusive billing practices as detailed by the examples given in the proposed rules. For instance, HH agencies bill sixty day episodes of care. When a beneficiary dies during the episode, a home health agency may bill for the episode, with the "through" date on the bill being the date of death according to the Medicare Claims Processing Manual Ch. 10, section 10.1.16.

When receiving HH services, a beneficiary is "under the care of a physician who establishes the plan of care". The physician does not need to be in the state or country on the particular day the agency provides the services that are ordered as part of the plan of care. In addition, the POC and other orders may be

"signed by another physician who is authorized by the attending physician to care for his/her patient in his/her absence". This policy seems to conflict with the examples given in the broad language proposed in the rules.

This would also be problematic for hospices, since they are paid through the date of death of the beneficiary receiving services under the Medicare Hospice benefit and the physician who certifies that the beneficiary is terminally ill need not be in the country when services are furnished.

Lastly, a client may leave a hospital stay for a "leave of absence" and receive home care services during that period. If the hospital bills the date of the "leave of absence" incorrectly, this could lead to an assumption of inappropriate HH billing and cause an unnecessary revocation.

Unnecessary revocations related to the overly broad language of this proposed rule will be financially over burdensome for HH and hospice providers. Why should providers be subject to undergo the expense and delay of an appeal (during which time they are not receiving Medicare payments) because the language promotes inappropriate revocations? In addition, CMS states that providers can "flag claims" they believe will be perceived as abusive according to this rule. Providers should not have to identify claims that were billed correctly according the Medicare guidelines just so they are not indiscriminately sanctioned secondary to the overly broad language. Furthermore, providers cannot be expected to know every instance that may be perceived as abusive billing related to this rule.

Part 498. Appeals procedures for determination that affect participation in the Medicare program and for determination that affect the participation of ICFs/MR and certain NFs in the Medicaid program.

The proposed language in this section significantly changes the appeals process for HH and hospice providers. TAHC opposes many of these changes. Currently the HH or hospice provider may appeal directly to the ALJ if their billing privileges are revoked. The proposed language at 424.545(a)(1)(ii) and section 498.5(1), would not allow a direct appeal, but would mandate reconsideration in accordance with 498.22(a). Reconsideration before the contractor or CMS is an unnecessary delay in the appeals process that could result in an unnecessary delay in payment.

The language at 498.22(a) as written could result in procedures that are beyond the scope of a contractor. For instance, if a prospective HH or hospice provider does not pass their initial state survey, they would not "qualify as a provider" under section 498.5 (a). In this circumstance providers would have reconsideration solely by CMS since the issue was related to compliance with the CoPs. The proposed rules would allow a contractor to reconsider this issue. It would not be appropriate for contractors that do not make determinations based on compliance with the CoPs to be the entity performing the reconsideration in this instance.

Respectfully submitted,

Rachel Hammon RN

Rachel Hammon BSN, RN
Director of Clinical Practice and Regulatory Affairs
Texas Association for Home Care

Submitter : **Date: 05/01/2007**

Organization : **Medical Group Management Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6003-P2-8-Attach-1.PDF

MGMA

MGMA Center for Research
American College of Medical Practice Executives
Medical Group Management Association

May 1, 2007

Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 314-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges

Dear Ms. Norwalk:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed regulation "Medicare Program; Appeals of CMS or Contractor Determinations When a Provider or Supplier Fails to meet the Requirements for Medicare Billing Privileges" as published in the March 2, 2007 *Federal Register*. MGMA commends the Centers for Medicare & Medicaid Services' (CMS) efforts to improve the Medicare provider enrollment process and greatly appreciates the formal and informal consultations that MGMA and its members have exercised throughout this process. However, we have some grave concerns regarding the regulation as proposed.

MGMA, founded in 1926, is the nation's principal voice for medical group practice. MGMA serves 21,000 members who lead and manage more than 12,500 organizations in which almost 270,000 physicians practice. MGMA's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Its diverse membership is comprised of administrators, CEOs, physicians in management, board members, office managers and many other management professionals. They work in medical practices and ambulatory care organizations of all sizes and types, including integrated systems and hospital- and medical school-affiliated practices.

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General comments

For the first 35 years of the Medicare program, physicians were assumed to be eligible to provide services to Medicare beneficiaries and bill the program on their behalf. With the advent of the Medicare provider enrollment application (CMS-855), this assumption no longer applied. Instead, the burden of proof is now on physicians and other Part B suppliers to establish their eligibility.

The amount of time required to complete the CMS-855 applications continues to grow with each revision to the form, not to mention the numerous changes to regulation and guidance. Rather than becoming easier, the process has only grown more cumbersome with each adjustment. The CMS-855I application alone is 28 pages and requires a minimum of five attachments. In fact, as an MGMA member recently stated, "Credentialing for Medicare used to be the easiest [application] to do. Now it's one of the hardest." This new proposal will only serve to further complicate the application process for providers and generate additional work for Medicare carriers.

The proposed rule, as a whole, is vague and detrimental to providers. It penalizes them for failing to fully understand an overly complex and burdensome process that they are forced to use in order to enroll in the Medicare program. MGMA's comments highlight the major flaws, rather than pointing out the numerous individual flawed provisions.

CMS-855 errors

The number of provider errors made during the completion of the CMS-855 forms is often cited by CMS as the primary reason for application processing delays. MGMA acknowledges that providers do make errors when completing the CMS-855, including failing to include all of the required supporting documentation. However, a large number of these errors could be avoided with a simplified and more transparent application process, as well as increased outreach and education to physician practices.

Carrier misinformation

Generally, providers consult with Medicare carrier enrollment staff to determine the particular applications that need to be completed and how those applications need to be completed. MGMA has received numerous reports from members that have followed the instructions of Medicare carrier enrollment staff, only to have their applications returned because incorrect forms were completed or forms were missing. This is particularly troublesome in light of the length of time it takes to complete the applications, as well as the current processing timeframes and backlogs. Other members have reported correcting returned applications based on carrier instructions, only to be told that the applications had been completed correctly in the first instance and would need to be resubmitted. MGMA is concerned that group practices are held to one standard, while carrier enrollment staff is held to another, much lower standard.

One of the most common problems relates to the new requirement that all physicians and other suppliers who enrolled in the Medicare program prior to Nov. 2003 must now, upon making any changes to their enrollment application, complete a new CMS-855I, in addition to the CMS-855R. Many providers are unaware of this requirement and are not informed of it when they call the carrier to inquire as to what forms must be completed for a new provider joining the practice. Medical practices should also be informed that if a CMS-855B is not on file with the carrier, one will have to be completed, along with CMS-855Is and CMS-855Rs for any providers in the group who do not have CMS-855s on file before any other CMS-855 forms can be processed. How can CMS expect providers to complete the provider enrollment applications correctly if carrier enrollment staff is not providing appropriate and accurate information? CMS and the carriers need to conduct additional outreach to educate providers regarding this requirement.

Through this proposed rule, CMS formalizes the presumption that providers are entirely to blame when it comes to problematic enrollment applications and assumes that the carriers and CMS itself are entirely without fault. The inaccurate information distributed by the carriers to providers contributes to the delays in processing enrollment applications and increases costs for both the Medicare program and providers. MGMA urges CMS to simplify the Medicare enrollment process in a fashion that would permit providers to enroll in the Medicare program in a timely fashion. Additionally, MGMA recommends that CMS conduct increased outreach and education efforts for providers and carrier enrollment staff.

The goal should be to facilitate enrollment through timely and accurate technical assistance, not to deny enrollment and force applicants into an expensive and time consuming appeals process.

Frequent guidance changes

Contributing to the number of errors made by applicants and carrier enrollment staff is the frequency with which the Medicare Program Integrity Manual (Pub. 100-08) has been amended during the last year. The chapter was rewritten in its entirety after the release of the Medicare provider enrollment regulation and the new CMS-855 applications. In addition to this full-scale rewrite, the chapter has been amended at least seven times, and it is clear from a recent review of the chapter that additional amendments are planned.

While some physicians practice in organizations large enough to have a separate department focusing entirely on provider credentialing, most do not. Instead, most providers practice in organizations where one or two staff members are responsible for any enrollment activities, in addition to other tasks. It is even more difficult to complete the Medicare enrollment application correctly if the process is changing on a frequent basis, with little or no notice, as has been the case over the last year.

For the most part, practice administrators and practice credentialing staff do not have the time to check the CMS web site on a regular basis for changes that may have occurred while they are preparing an enrollment application for submission. They count on the fact that the process will remain constant unless and until they are notified otherwise in advance of the implementation date. MGMA recommends that CMS notify providers at least 60 days prior to making any changes to the enrollment process. Additionally, MGMA recommends that any applications following the guidance in effect at the time of the postmark date be treated as submitted prior to the implementation date.

Provider enrollment application processing timeframes

Prior to Mar. 1, 2006, Medicare carriers were required to process 90 percent of initial enrollment applications within 60 days of receipt. On Mar. 1, 2006, CMS changed the requirement to allow carriers to process only 80 percent of initial enrollment applications within 60 days of receipt and extended the time carriers had to process virtually all enrollment applications to 180 days. MGMA has previously expressed its concerns regarding the extension of the application processing timeframes and urges CMS to reinstate its previous policy.

Carrier backlogs

Since that time, a number of carriers, including Trailblazers, First Coast and Cigna, have experienced difficulties meeting even the relaxed deadlines. Enrollment staff at Trailblazers has publicly stated that it is behind in its processing of initial enrollment applications and does not expect to be caught up with the backlog until the end of May. These delays are causing extreme hardships for practitioners new to the Medicare program and raise concerns regarding the ability of the carriers to conduct revalidation activities, in addition to their current new provider enrollment responsibilities.

Effect on private payer claims

Frequently, providers are unable to obtain private payer and Medicaid numbers until they have a Medicare billing number. Unlike Medicare, providers are unable to retroactively bill private payers for patients seen before they are credentialed with those plans. The lack of cash flow is forcing some providers to borrow money merely to keep the doors to their practices open to patients.

MGMA remains concerned that Medicare carriers are currently allowed up to 180 days to process provider enrollment applications. While, Medicare allows claims to be filed for up to a year following the Dec. 31 after a service has been rendered (with some exceptions), there are states where claims must be filed in less than the 180 days Medicare carriers have to process provider enrollment applications. If a provider's Medicare enrollment application is not processed for six months, those with claims affected by secondary payer rules will not be able to collect those outstanding funds that they are entitled to collect from private payers.

Do Not Forward initiative

In 2002, CMS instituted the "Do Not Forward" (DNF) initiative. Under this initiative, when any provider mail is returned to a Medicare carrier, whether it is a check or other mailing, all payment for Medicare claims is stopped. The Medicare provider enrollment regulation published in the *Federal Register* on April 21, 2006 requires practices to notify their Medicare carrier within 90 days of any change to Medicare enrollment information, including mailing address. This proposal gives carriers an additional 90 days to process enrollment applications filed for the purpose of changing information. This means that it may take six months from the date of a mailing address change for that change to actually be entered into the enrollment database. Given the lengthy delay in processing CMS-855 applications, the potential for triggering the DNF initiative is great and could cause significant problems for medical practices. MGMA members have reported that it can take upwards of six weeks to resolve a situation where the DNF initiative has been invoked. MGMA opposes these lengthy enrollment application processing timeframes and recommends that the DNF initiative be revised.

Academic medical centers

Unlike independent ambulatory facilities, academic medical centers generally contract with physicians on a regular cycle, typically corresponding with the academic calendar. For the most part, academic medical centers know six months to one year in advance that a provider will be practicing in the facility. However, the Medicare Program Integrity Manual, Chap. 10, Sec. 3.2 restricts the centers from submitting applications until 30 days in advance of the practitioner's start date, despite the amount of notice the facilities have and the length of time it takes carriers to process the applications. This means that reimbursement for these providers will be delayed longer than necessary. MGMA encourages CMS to allow academic medical centers to submit CMS-855 applications at least six months in advance of a provider's start date, with the understanding that billing privileges will not be effective until the provider's start date, as contained within the CMS-855I.

Retroactive billing

Under current CMS policy, providers are allowed to retroactively bill for services provided within a reasonable period of time prior to formal enrollment in the Medicare program. The language used in the proposed rule would seem to indicate that a change in this policy is being considered. Proposed Sec. 405.874(b)(3)(i) states, "Medicare does not pay for any items or services furnished by a supplier during a period in which a supplier does not have billing privileges." The proposed rule also provides in Sec. 405.874(b)(3)(iv), "Medicare does not pay for items and supplies unless the supplier has a valid, active Medicare billing number." Since a provider does not technically have billing privileges until after his enrollment application has been approved, the ability of providers to retroactively bill for services provided while their enrollment applications are being processed would be curtailed. MGMA understands the inability to pay for services rendered by

providers who have not taken steps to become enrolled in the Medicare program, as well as those whose billing privileges have been revoked and those who have been legitimately denied the ability to bill the Medicare program. However, MGMA is concerned that providers whose applications have been subjected to the lengthy enrollment process would not be able to receive reimbursement for services rendered while their applications are pending.

This limitation would cause a tremendous hardship for providers. As it is, most private payers do not permit retroactive billing for services rendered while a provider's credentialing application is being processed. Practices must either limit the patients seen by new providers to Medicare patients, the uninsured and those with insurance where the providers can be treated as out-of-network. If Medicare will no longer permit retroactive billing, this will further restrict the patients that new providers can see and make it even more difficult for practices during the initial months of a new provider's employment. In CMS' response to similar comments on the proposed provider enrollment regulation, the agency clarified that it had no intention of changing the policy; however, the language used in this proposed rule indicates otherwise. MGMA urges CMS to reconsider this change in policy and to make clear its intentions to retain the current policy of permitting retroactive billing by providers.

Appeal of rejected claims

In May 2006, CMS began requiring that providers have their National Provider Identifier (NPI) prior to submitting their Medicare enrollment application in preparation for the NPI compliance date of May 23, 2007. On this date, CMS will cease the issuance of unique provider identification numbers (UPINs). Some confusion may result as to when providers can begin submitting claims to the Medicare program, since up until this compliance date, the triggering event was the receipt of their billing number. Since the billing number will be replaced by the NPI, providers will essentially have their billing numbers prior to enrollment in the Medicare program. Providers who enroll in the Medicare program after this compliance date may not understand that they will still have to complete the CMS-855 application and may begin submitting claims to their carriers for payment upon receipt of their NPI. MGMA recommends that, rather than rejecting claims submitted by these providers, these claims be denied and the denials be appealable to the carriers upon receipt of their billing privileges or that providers be able to re-file these claims once their billing privileges are granted.

Provider response timeframes

The proposed rule would limit the amount of time providers have to respond to a request for additional information to 30 days. Guidance currently allows providers to take up to 60 days to respond to such a request. This additional 30 days can be critical in a situation where a document must be requested, such as a copy of a medical license or professional degree, especially in a situation where the documentation must be sent from a foreign country and then translated into English.

Limiting the response time to 30 days will also create problems for larger medical practices and academic medical centers where mail or facsimiles may not be immediately directed to the appropriate person. Instead, mail or facsimiles in larger institutions may have to wind its way through distribution channels until the appropriate person is located. This distribution process may reduce precious available response time. Additionally, the limitations on the amount of time a medical practice has to respond to a request do not take into account potential vacation or leave by a provider or critical staff member.

Frequently, providers do not receive the requests for additional information sent by the carriers. It is not that they intentionally fail to respond to the requests; instead, the person responsible for responding may not be aware that the request even exists. In other cases, providers respond to requests for additional information, and the information is lost before it can be documented by the carrier. Retaining the 60-day policy makes it more likely that the medical practice will be made aware that a problem exists because the practice will likely contact the Medicare carrier during that time period to conduct a status check. This is less likely to happen if only 30 days have passed. MGMA recommends that CMS continue to allow providers 60 days to respond to request for additional information.

Abuse of billing privileges

Current regulations permit CMS to revoke enrollment and billing privileges from providers for a number of reasons, including noncompliance with the terms and conditions set forth in the Medicare enrollment application. Sec. 14 of the CMS-855 forms lays out the penalties for deliberately falsifying information. Included in this list is reference to 18 U.S.C. 1347, which prohibits individuals from knowingly and willfully defrauding any health care benefit program. Clearly, providers who knowingly and willfully file claims for services that could not have been furnished to a specific individual on the date of service would be guilty of fraud and would be subject to the penalties of 18 U.S.C. 1347, which are more severe than a revocation of Medicare billing privileges. A conviction for such activities would render the provider eligible for prosecution under the False Claims Act and Civil Monetary Penalties provisions of the Social Security Act., as well as exclusion from the Medicare program, both of which are also more severe than revocation of Medicare billing privileges. MGMA believes that the addition of language permitting the revocation of enrollment and billing privileges for abuse of billing privileges is redundant and unnecessary and urges CMS to reconsider its inclusion in a final rule.

In the event that CMS does not reconsider the inclusion of this section, MGMA urges CMS to clarify the language so as to indicate that the agency intends to only revoke enrollment and billing privileges for individuals who knowingly and willfully submit a claim or claims for services that could not have been furnished to a specific individual on the date of service. Without this clarification, the provision could permit the revocation of enrollment and billing privileges for providers who accidentally misdate a claim for services provided or whose practice management system erroneously labels a claim with one beneficiary's information when it should have been another. In a system as complicated as Medicare's, even the best managed practices will commit innocent errors and should not be penalized as though there was intent to defraud the government. While the preamble indicates this is not the agency's intention, a strict reading of the proposed regulation indicates otherwise. Thus, MGMA urges CMS to reconsider the language in this provision.

Provider enrollment appeal determination timeframes

As discussed above, the length of time it takes to process a CMS-855 has increased dramatically, causing increased problems for providers. This proposed rule would further extend the time it could take until a final determination regarding enrollment has been made by providing lengthy adjudication timeframes. Taken together, it could take more than two years until the matter reaches a federal district court. This could translate to practitioners being prohibited from participating in the Medicare program, making it financially difficult, if not impossible, for a medical practice to survive and/or to wait out the appeals process. Practices have a financial incentive to file appeals as quickly as possible, while there is no such incentive for the adjudicating body to do respond in a timely fashion. When coupled with the length of time it

takes carriers to make the initial determinations, it is difficult to believe that carrier personnel will be able to adjudicate appeals in a more timely fashion. MGMA recommends that the adjudication timeframes be reduced to permit a final determination to be arrived at in a judicious fashion.

Electronic funds transfers

MGMA supports CMS' administrative simplification efforts and is pleased that CMS has given group practices the ability to receive reimbursement via electronic funds transfer (EFT);. However, MGMA urges caution in mandating the use of EFT for all providers, as some providers have encountered significant problems with this mode of payment. The current EFT guidance does not adequately address the concerns of physician practices. MGMA recommends CMS postpone mandating EFT until the following issues have been resolved.

Federal law

The Debt Collection Improvement Act of 1996 (31 USC § 3332) requires that all federal payments be made via EFT, except where the Secretary of the Treasury permits another method to be used. According to regulations promulgated under this Act by the Secretary of the Treasury in the *Federal Register* dated Sept. 28, 1998 and effective Jan. 2, 1999, only limited exceptions to this mandate are permitted. Specifically, the term "federal payment" has been interpreted broadly to include payments made directly by the federal government and indirectly through an intermediary. However, the preamble to the regulation specifically states, "in light of specific statutory provisions governing the issuance of Medicare payments, as well as the overall structure of the program, the issuance of paper Medicare payments by intermediaries and carriers would be in compliance with this part." Thus, the regulation explicitly uses the Medicare program as an example of a situation where payments may be made via paper checks when an intermediary is involved. MGMA urges CMS to continue to allow providers the option to receive payments via paper check, as permitted in the Treasury Department regulation.

Access to technology

At this time, the full impact of transitioning all Medicare providers to EFT is not known. Some practice administrators have reported difficulty in arranging these transactions with some financial institutions, especially those practice administrators in rural areas. Others have reported a lack of EFT availability at their financial institution. Group practices typically have long-standing relationships with financial institutions. Moving a group practice's accounts to another financial institution would be costly and time consuming and could impact their ability to avail themselves of loans and other banking products. MGMA urges CMS to work with affected parties, including providers and financial institutions, to ensure that all affected entities are able to achieve the necessary compliance without experiencing undue burdens. MGMA welcomes the opportunity to work with CMS on this issue.

Another challenge facing physician practices forced to adopt EFT is the lack of access to high-speed Internet. This most likely will negatively impact the practice's ability to access financial information electronically. Additionally, there are frequently costs associated with online banking for businesses. MGMA urges CMS to continue to allow providers to adopt the payment methodology of their choosing.

Costs

MGMA is concerned physician practices will incur fees for transactions performed electronically, including EFT transactions. Currently, practices are reporting EFT transaction costs of $.30 per transaction or more, with payments made by the carrier multiple times during the course of the day. The cumulative financial impact of these charges is a significant operating expense for a practice.

Medicare Administrative Contractor (MAC) implementation process

According to the "MAC Workload Implementation Handbook – Appendix D," CMS will require providers in the regions transitioning to a MAC who currently accept EFT to complete a new Electronic Funds Authorization Agreement (CMS-588). This seems contrary to the stated reasons for the new policy requiring providers to accept EFT, that is, to reduce paperwork and the associated administrative costs. The CMS-588 requires additional provider time to complete and will also take the MAC time to verify and re-enter the information, further increasing costs. MGMA urges CMS to reconsider the unnecessary and burdensome requirement of completing a new CMS-588. In the alternative, MGMA recommends that adequate notification and education be provided to all who have chosen or are required to accept funds via EFT. MGMA would welcome the opportunity to work with CMS to educate providers regarding this requirement.

Pre-certification

CMS-588 provides a 15-day pre-certification period when information provided on the CMS-588 is verified. It is unclear as to whether a new CMS-588 resulting from the MAC transition process will subject providers to an additional 15-day pre-certification period. MGMA requests that CMS clarify that providers already receiving funds via EFT will not be subject to a second pre-certification period.

MGMA also requests that CMS clarify the enrollment application processing timeline guidance to reflect whether or not the 15-day EFT pre-certification period must be completed within that timeline. While this proposal addresses CMS-855 processing timeframes, the effect of the EFT pre-certification period is not clearly defined or addressed herein. MGMA urges that the issue of the pre-certification period and its effect on those processing timelines be considered and clarified in the final rule. Where the EFT pre-certification and setup period would extend the amount of time carriers have to process the CMS-855, this time should be considered outside of the prescribed application processing timeline. Billing privileges should be granted to providers upon the processing of enrollment information, regardless of whether the EFT pre-certification has been completed. MGMA recommends that paper checks be issued where claims are submitted and payable prior to the completion of EFT pre-certification.

It is unclear whether the information for those providers who are currently receiving Medicare payments via EFT will be submitted for an additional pre-certification period when they file new CMS-588 forms with the new MAC as discussed above. MGMA requests that CMS clarify the policy affecting EFT pre-certification where the practice submits a new CMS-588 solely because of the transition to a MAC.

Notice of EFT processing

Group practices currently accepting Medicare payments electronically have reported that no notice is provided upon completion of the EFT setup. Instead, funds simply begin appearing in

the practices' accounts, and the administrators must then determine the identity of the depositor. Given the frequency of identity theft and financial theft, the sudden appearance of additional funds may give rise to concerns that account and/or personal information has been stolen, which would create additional difficulties for the medical practice. MGMA recommends that notice of pre-certification completion be provided to group practices prior to the payment of funds via EFT.

Payment delays and stoppages

One of the motives for accepting funds electronically has been the assumption that payments would be made in a more rapid fashion than is currently done. While carriers have 14 days to process a claim submitted electronically, there would seem to be no reason to delay payment of clean claims. MGMA encourages CMS to mirror the standard practice adopted by health plans in the private sector and pay providers upon adjudication of the claim, as opposed to immediately prior to the 14-day period permitted.

Group practices that have agreed to accept EFT will not be free from the difficulties caused by the DNF initiative. As long as any piece of mail is returned to the carrier for an address problem, payment is stopped, regardless of whether payment is made via EFT or paper check. Rather than abruptly stopping payment of claims, Medicare carriers should be required to contact providers by telephone or facsimile prior to stopping claims payment. This communication between carrier and practice will save both parties a great deal of time and money, given the effort that goes into restarting payments stopped as a result of the DNF initiative. MGMA urges CMS to reconsider the DNF initiative.

Reassignment exception

The CMS-855I application currently exempts individuals reassigning their benefits to a group practice from the EFT requirement, unless changes must be made to the group practice's enrollment application. This provision is highlighted in the "Tips to Facilitate the Medicare Enrollment Process." However, it is not contained within the Medicare Program Integrity Manual, nor does this proposal provide for such an exception. MGMA urges CMS to clarify this provision to reflect the current policy of permitting individuals reassigning their benefits to remain exempt from this requirement.

Hospital-based faculty practices

Post September 11, 2001, without the legal structure of a group, hospital-based faculty practices are unable to open their own bank accounts because they lack the ability to obtain an Employer Identification Number (EIN). In order to do so, the practice must have the ability to persuade the hospital to open a separate account for the practice's funds to prevent the funds from being commingled with those of the hospital. The only alternative is for the practice to open individual accounts for each provider, thereby increasing the costs and burdens on practices. MGMA urges CMS to consult with hospital-based faculty practices to determine the best way to implement EFT in this particular setting. MGMA would welcome the opportunity to work with CMS on this issue.

EFT authorization agreement

Despite the brevity of the CMS-588, the instructions still leave room for confusion. One MGMA member reports that she has had the form returned to her three times for failure to complete it

properly without any explanation as to what errors are being made. Another member recounts how a Medicare enrollment application was returned to the practice because the instructions to the CMS-588 were not included. Requiring EFT and the completion of the CMS-588 form simply adds another layer of complexity to an overly burdensome and cumbersome process.

Reversing entries

Under 31 CFR Part 210, the federal government's EFT transactions are governed by the NACHA ACH Operating Rules except where noted in federal regulation. 31 CFR 210.6(f) specifically permits the federal government to initiate reversing entries where duplicate or erroneous payments are made. MGMA has concerns regarding the ability of CMS and/or Medicare carriers, acting as agents of CMS, to reach into providers' bank accounts and rescind payments made to those providers.

It is not uncommon for Medicare carriers to make errors in payments they initiate. In fact, reversing entries are fairly common in the banking industry. At times, group practices accepting funds electronically may receive payment for the same service multiple times or be paid incorrectly for a service because of a typing error. The above-referenced Treasury Department regulation permits the carrier to reverse these duplicate or erroneous payments when made if the carrier discovers the error within five banking days of settlement.

Unfortunately, information regarding such an error may not be readily available to a practice. Until the practice receives the explanation of benefits, it has no way of knowing that a duplicate or erroneous payment has been made. Instead, confusion may result from the discrepancies in the accounting that are discovered when funds are reconciled if the remittance advice has not yet been received. If the error is not discovered until after the five days have passed, the carrier must notify the practice of the error and attempt to recover the monies following overpayment regulations and guidance. Where a business' ledgers, in this case, a medical practice's accounts, are not reconciled regularly, it is easier, and therefore, more likely for fraud to be committed. Thus, it is in the best interests of the Medicare program to reduce the number of errors committed by the carriers necessitating a reversing entry and to provide clear instructions to the carriers and providers on this issue.

The Medicare Program Integrity Manual contains no guidance to carriers, nor has any been transmitted to the carriers of which MGMA is aware, that would impose these limitations on carriers when initiating reversing entries. In fact, the Medicare Internet-Only Manuals contain no references at all to reversing entries. Additionally, while the form does incorporate the Treasury regulation by reference, there is no language on the CMS-588 explaining to providers the meaning of this provision. MGMA urges CMS to rectify this situation by issuing guidance to Medicare carriers explaining the limitations on the use of this type of transaction and by educating providers as to the ability of the Medicare carriers to initiate such transactions, as well as the limitations on this ability.

MGMA also recommends that Medicare carriers be required to provide notice prior to the initiation of a reversing entry. Some providers deposit their funds into "sweep accounts," where funds are moved, or "swept," into interest-bearing accounts on periodic basis. In practices with sweep accounts, the funds may not be available when a reversing entry is initiated. Other practices may not have enough funds in their accounts because they have paid other expenses. In either situation, the funds may not be available to cover a reversing entry. This could create additional problems and confusion for both the medical practice and the Medicare carrier. An appropriate notice requirement would alert the medical practice to the error and allow sufficient

time to ensure that the funds are available for the carrier to remove and, if necessary, a dispute process to be initiated.

835 transaction standard

MGMA has concerns that the current iteration of the ANSI X12 4010A1 835 is not providing the expected administrative simplification. EFT should be developed to work in concert with the 835. In many practices, EFT does not work well because the financial posting does not match what the provider receives in the 835.In other practices, the two transactions are sent so far apart that it makes reconciliation very difficult. Additionally, some practices report that the 835 shows one amount, but the EFT payments come in small, separated amounts, again making reconciliation difficult.

MGMA recommends facilitating the automation of the linking of the two streams of data: EFT and 835. This permits the accurate posting of payments, regardless of how many EFT/835 files a practice receives. Practices can then research to find missing payment information or funds for those that do not clearly connect. Without automation, practices have to manually review EFT data from the bank - and make educated guesses as to who/what is being paid. For larger organizations, with potentially thousands of providers, this reconciliation of cash and payment data is extremely difficult and costly.

In addition to these proposal specific concerns, MGMA has a number of concerns regarding the enrollment process generally. MGMA continues to believe that the Medicare enrollment process is overly burdensome. The new provider enrollment forms, while consisting of fewer pages than the previous burden, continue to be lengthy and time-consuming to complete. Encouraging provider participation in the Medicare program benefits both providers and beneficiaries. Having a complex and cumbersome credentialing process discourages provider participation and may ultimately lead to a decrease in provider participation in the Medicare program, which will cause access problems for Medicare beneficiaries. MGMA would welcome the opportunity to work with OMB and CMS on a broader review of the enrollment process, the CMS-855 forms and other enrollment forms. If you should have any questions, please contact Lisa P. Goldstein in the Government Affairs Department at (202) 293-3450.

Sincerely,

William F. Jessee, MD, FACMPE
President and Chief Executive Officer

Submitter : **Date: 05/01/2007**

Organization : **American Association for Homecare**

Category : **Other Health Care Provider**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6003-P2-9-Attach-1.PDF

Via Electronic Transmission
http://www.cms.hhs.gov/erulemaking

May 1, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: **Medicare Program; Appeals of a Contractor Determinations When a Provider Fails to Meet the Requirements for Medicare Billing Privileges [CMS 6003 –P2] RIN 0938 – A149**

Dear Ms. Norwalk:

The American Association for Homecare (AAHomecare) submits the following comments on the Centers for Medicare and Medicaid Services' (CMS') notice of proposed rule making (NPRM) on the above captioned regulation. AAHomecare is the only national association representing every line of service within the homecare community. AAHomecare members include suppliers, state associations, and manufacturers of DME, prosthetics, orthotics, and supplies (collectively "DMEPOS"), rehab and assistive technologies, and pharmacies that provide infusion and inhalation drug therapies to patients in their homes. Our membership reflects a cross-section of the homecare community, including national, regional, and local providers and suppliers. With approximately 500 member companies at 3,000 locations nationwide, AAHomecare and its members are committed to advancing the value and practice of quality health care services at home.

I. Background

The NPRM clarifies a DMEPOS supplier's right to appeal decisions denying or revoking Medicare billing privileges. Consistent with current rules, the proposed rule would prohibit suppliers whose privileges have been revoked from receiving payment from Medicare. Claims submitted to a contractor during a period of revocation will not be denied, however. These claims will be rejected and can be resubmitted if the supplier's billing privileges are reinstated on

appeal. The rule specifies that suppliers will have one year from the date of reinstatement to submit claims held during the appeals process.

The proposed rule also specifies the timeframes for the appeals process and clarifies that a contractor's rejection of a corrective action plan is not an initial determination subject to appeal. Importantly, the proposed rule would expand the timeframe in which a contractor may process supplier applications and render an initial determination. Generally, the contractor will have 180 days from the date the application is completed to process an enrollment or reenrollment. Finally, the proposed rule contains new authority that would allow CMS or a contractor to revoke the billing privileges of a supplier upon a determination that the supplier has engaged in abusive billing practices. While the rule states that this finding would not constitute a finding of fraud, suppliers whose billing privileges are not reinstated on appeal may not reapply for billing privileges for three (3) years.

AAHomecare appreciates CMS's efforts to standardize and streamline the appeals process when a supplier's billing privileges have been denied or revoked. While we believe that many of the provisions of the proposed rule provide important and necessary clarifications to the current process, we have concerns about CMS' proposal to extend the timeframe in which a contractor must make a determination on an application for Medicare billing privileges. Similarly, although AAHomecare strongly supports CMS' efforts to revoke the Medicare billing privileges of suppliers who engage in abusive billing practices, we are concerned that the proposed rule is too broad and would apply to mere billing errors as well as to intentionally abusive billing patterns. We address each of these issues in more detail below.

II. Comments

A. Revocation of Medicare Billing Privileges Based on Abusive Billing Patterns

As we stated above, AAHomecare strongly supports CMS' efforts to revoke the Medicare billing privileges of suppliers that engage in abusive billing practices. We agree that the Medicare program should not be required to continue to do business with suppliers that abuse their billing privileges. We are concerned however because the proposed rule is so broad that it would include inadvertent billing errors within its scope. The examples cited in the preamble include billing for medical equipment when the beneficiary is an inpatient in a facility or billing for items and services after the date of death. These examples are more likely to be the result of a billing error than intentional abuse.

Importantly, DMEPOS suppliers lack real time data about the beneficiary's Medicare benefits. Consequently, suppliers may only learn about an inpatient hospital stay, or the beneficiary's death after billing has been submitted. AAHomecare members report that, when these billing errors are identified, suppliers reconcile their billing by refunding the Medicare program's money. Finally, the preamble states that suppliers who notify the carrier in advance that a claim (or claims) could fall within the scope of the proposed rule would not be subject to liability for submitting false claims. The language of the proposed rule, however, does not define how the supplier would accomplish such notice.

We suggest that CMS further define what constitutes an abuse of Medicare billing privileges so as to distinguish abusive billing patterns from what are otherwise inadvertent, routine billing errors. The regulation should define how CMS or a contractor will make a determination that a supplier has engaged in an abusive billing pattern. Will the decision be based on the supplier's claims volume? Will the carrier notify the supplier and provide it with an opportunity to rectify billing errors before revoking its billing privileges? Unless CMS addresses these issues, the regulation is too broad and would apply to billing errors that are not intentionally abusive.

III. Application and Appeals Process Timing and Procedural Issues

CMS has greatly expanded the time that contractors have to process enrollment or reenrollment applications. At the same time, the proposed rule decreases the time that suppliers have to submit additional information requested by a contractor. The expanded timeframe for processing applications adversely impacts supplier operations especially when the enrollment follows an acquisition. If the supplier can not submit claims for the new location pending the approval of its application, its ability to serve Medicare beneficiaries could be compromised. We understand the need to perform a comprehensive evaluation of a new supplier entering the program for the first time. However, for acquisitions and new locations of suppliers that are currently in good standing with the Medicare program, the processing time should not exceed 60 days inasmuch as CMS and the contractors already have experience with the supplier.

We also suggest that CMS allow suppliers more time to submit additional information requested by contractors during the enrollment process, especially in the context of acquisitions. Although the enrollment of a new location following an acquisition can be routine, there may be delays on the part of State regulatory authorities that are beyond the supplier's control. Requiring the supplier to begin the application process again in this situation would not be efficient for the contractor or the supplier. We suggest that CMS allow the carrier more flexibility for accepting additional documentation when a supplier is enrolling a new location.

Finally, we suggest that CMS clarify that a supplier who attempts to use a corrective action plan is not precluded from also appealing the carrier's decision, although a denial of the corrective action plan is not itself subject to appeal. We also request that CMS clarify that the denial of a supplier's enrollment or reenrollment application (as opposed to a revocation for abusive billing patterns) does not limit the supplier's ability to reapply to the program at a future date.

IV. Conclusion

To summarize, we request that CMS modify the proposed rule to define how CMS will determine that a supplier has engaged in an abusive billing pattern and the process that will apply to the determination. We also request that CMS shorten the timeframe in which a contractor must process an application for enrollment, at least in the case of suppliers reenrolling or enrolling a new location. Similarly, CMS should provide more time for suppliers to submit additional information when enrolling new locations. CMS should clarify that suppliers that pursues a corrective action plan are not also precluded from filing an appeal. Finally, we request that CMS clarify that the denial of an application for enrollment or reenrollment does not limit the supplier's ability to apply to the program in the future.

AAHomecare appreciates the opportunity to submit these comments. Please feel free to contact me if you have any questions, or we can be of further assistance.

Sincerely,

Tyler Wilson
President
American Association for Homecare

Submitter : Ms. Hema Anwar **Date:** 05/01/2007

Organization : Kaiser Foundation Hospitals and Health Plan

Category : Health Plan or Association

Issue Areas/Comments

General

General

See attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.