Submitter : Dr. Bruce Quinn **Date:** 03/02/2007

Organization : NHIC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I support the overall approach, improvements, and clarifications. I am concerned the preamble is unclear, in stating (p 9485) "We do not believe the determination made by CMS FFS contractors constitutes a determination of fraud" and defines the topic as 535(a)(8) as "abuse of billing privileges." In light of the 3 year re-enrollment penalty, the conditions and discretion for revocation must be made more clear. 535(a)(*) pivots the decision on "a claim or claims for services that could not have been furnished." CMS contractors do find providers with an anomalously high proportion of claims for dead beneficiaries, which may turn out to represent phantom offices, lead to criminal prosecution, etc. However, screening all CMS claims with "a" dead beneficiary denial code pulls up a wide scattering of individual, rare events from a sea of providers. The regulation provides no guidance in how to filter out appropriate candidates for revocation and contractors may be either reluctant to implement it or feel compelled to implement it widely. If it is, in fact, implemented to cause revocation only on a tiny percent of all incoming claims with "a" dead bene, then the appropriate and fair filtering mechanism should be laid out. For example, CMS could find out how many of its million-odd suppliers would be affected, in having submitted one claim in the past two years with a dead bene denial code. I am not at all sure that a simple numeric line is the answer, like "1 dead bene claim in 3 years" or "2 dead bene claims in 1 month", etc., and I do not offer a specific solution. Because of well-known due process and regulatory clarity concerns, CMS must address this issue appropriately either during rulemaking or in later litigation.

Submitter : Ms. PAULA GOLSON **Date:** 03/05/2007

Organization : ALL CHILDRENS HOSPITAL

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Congress PLEASE DO NOT allow these CMS funding cuts to proceed. The proposed funding reductions would be devastating to the health care of Florida's children

Submitter : Ms. Connie Joy **Date:** 03/05/2007

Organization : Ms. Connie Joy

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Please do not cut payments from CMS for uninsured children. Look at this bill carefully. It DOES NOT represent what Florida wants for their children.

Thank you,
Connie Joy

Submitter : **Dr. shuan wang** **Date: 03/05/2007**

Organization : **ValleyCare**

Category : **Pharmacist**

Issue Areas/Comments

GENERAL

GENERAL

Being LA county health center pharmacies (non-Medicare Part D participant) manager, I am instructed by local administrators, if we send MediCal seniors out to fill prescriptions, we're jeopardizing CBRC (group MediCal billing), so we should continue filling all MediCal (California Medieaid) 65 and older, MediCal 65 and older should be Medi/Medi ??? I worry that we're not in compliance with CMS Medicare Part D regualations.

Submitter : Mrs. Pamela Gehrich **Date:** 03/08/2007

Organization : All Children's Hospital

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

This proposed docket will adversely impact our hospital and the care we provide our patients.

Submitter : Ms. Patricia Thomas **Date:** 03/08/2007

Organization : HealthNow New York Medicare Part B

Category : Federal Government

Issue Areas/Comments

GENERAL

GENERAL

Federal Register Volume 72, No. 41 - Friday, March 2, 2007 Proposed Rules -
42 CFR Parts 405, 424 and 498 - IV. Provisions of This Proposed Rule - Under Medicare provider enrollment determination there are two paragraphs that seem to contradict eachother. The first paragraph states that CMS is proposing that contractors reduce the number of days from 60 to 30 for providers to furnish requested documentation on enrollment applications. The next paragraph states that CMS is proposing that contractors be allowed to reject (within 30 days) an enrollment application that is submitted incomplete or fails to include all required supporting documentation. Does CMS mean that if the contractor chooses to develop for information, then the 30 day waiting period applies?

Submitter : Mrs. Katherine Anderson **Date:** 03/27/2007

Organization : Professional Home Nursing

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

A billing error can be made by honest providers, so basing severe consequences (3 year ban from billing Medicare) could negatively impact them. A three year ban from Medicare billing is "death" to an agency. A penalty that severe should be limited to fraudulent behavior, not an agencies honest mistake.

Submitter : Mr. Bob Wardwell **Date:** 03/29/2007

Organization : Visitng Nurse Associations of America

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-6003-P-8-Attach-1.DOC

VNAA Visiting Nurse Associations of America®

I am writing on behalf of the Visiting Nurse Associations of America, representing over 400 non-profit, community-based home health agencies and hospices in the United States. We appreciate the opportunity to comment on CMS-6003-P2, Medicare Program Appeals of CMD or Contractor Determinations When a Provider or Supplier Fails to Meet the Requirements for Medicare Billing Privileges.

We are concerned about the addition of section 424.535 (a) (8). While we understand and fully support the intent of this provision we believe that it may leave too much discretion to Medicare administrative contractors. We support the revocation of enrollment for providers who continually, systematically or purposefully bill for services that could not have been furnished. However since the complexity of our health care system and billing systems generate an unfortunate but inevitable level of honest errors, we believe this provision should be modified to rule out revocation of enrollment in the case of such errors. In the case of home health agencies, whose patient population is largely Medicare, revocation of Medicare billing is the end of the home health agency. Thus we believe that agencies are not put out of business for honest and inevitable errors, but only when the errors clearly reflect abusive conduct. We urge CMS to revisit the language of this provision to clarify that revocation would only be justified in cases of continuous, systematic or intentionally abusive situations and not for lapses understandable as errors.

Thank you for your consideration of this comment. You may direct any questions to me at 202-549-5932.

Sincerely,

Bob Wardwell
VP, Regulatory and Public Affairs.