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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.

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