June 26, 2013

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS – 6045-P: Medicare Program Requirements for the Incentive Reward Program and Provider Enrollment

Dear Administrator Tavenner:

On behalf of the Healthcare Billing and Management Association (HBMA), I want to thank you for the opportunity to comment on the Medicare Program Requirements for the above referenced proposed rule.

HBMA is the primary trade association for third-party medical billing companies. HBMA member companies provide a range of services for their clients including claims preparation and submission, enrollment and overall practice management.

HBMA has more than 700 member companies and its members are responsible for submitting and/or processing nearly 30% of all physician insurance claims in the United States.

HBMA provides a substantial amount of education and information on proper Medicare billing and compliance with Medicare policies in general. HBMA has been and continues to be supportive of CMS efforts to prevent unethical providers from participating in the Medicare program.

That having been said, we are deeply concerned that several of these new standards, while well intentioned, could result in ethical providers being denied Medicare billing privileges or enrollment opportunities due to errors on the part of the Medicare contractors.

The proposed rule if adopted as written would place unprecedented discretion to revoke billing privileges in the hands of CMS contractors. Given our extensive interaction with the Medicare contractors, we do not feel this level of discretion is warranted. Furthermore, it does not appear that there is an adequate appeal process for providers wrongly terminated or denied enrollment in the Medicare program.

Permitting CMS contractors the authority to revoke billing privileges with limited provider appeal rights raises many questions, not the least of which is the possible arbitrary and inconsistent application of the new authority. The Proposed Rule suggests CMS contractors would not use billing revocation for isolated, sporadic, or innocent billing errors, but rather would reserve its use for situations that pose a risk to the Medicare Trust Fund. Unfortunately, the proposed rule provides no guidance on how the new authority will be applied by the contractors. Instead, it appears that CMS is saying to the provider community, "trust us."

Recommendation

CMS must clearly articulate the appeals rights providers have when the provider believes he or she has been inappropriately denied enrollment in Medicare or whose billing privileges have been revoked.

Provider Enrollment Provisions

In general, HBMA does not oppose the efforts by CMS to deny enrollment for individuals who have committed fraud or truly abused their billing privileges. HBMA would not be able to support the current proposed provision if adopted because of the concern that erratic enforcement without appropriate precautions could be devastating to providers and ultimately Medicare beneficiaries.

While for the most part, Medicare contractors do a good job of processing Medicare claims accurately and in a timely fashion, the fact is that contractors do make mistakes. HBMA members frequently are the ones to notify the contractor of errors. We have, over the years, brought numerous examples of contractor errors to CMS' attention and to its credit, CMS has been quick to intervene and get the problems resolved.

Now, with this new authority, Medicare contractor errors will be even more harmful to the provider as it could result in either termination or the inability to add a new practice site until an overpayment gets resolved.

We are particularly concerned about how this new authority will work in conjunction with the recently announced overpayment threshold of $1,500.00 announced via Transmittal 469. The Transmittal sets the aggregate overpayment threshold at $1,500 yet the rule does not set any minimum threshold?

Recommendation

CMS should reconsider its policy on denial of enrollment when there is an overpayment. The current threshold ($1,500.00) is too low and the definition of what constitutes an overpayment is not clearly defined. Questions include but are not limited to: are pending normal course of business recoupments included; are contested or appealed findings of error included; are contractor processing errors that created overpayments included if the provider is unaware of the overpayment?

We believe that providers should be permitted to enroll additional practice sites as long as the provider is actively participating in a plan with the contractor to recover any overpayments due the Medicare program and/or any overpayment allegations are under appeal.

Ambulance Services

The NPRM proposes to limit the ability of ambulance companies to "back bill" for services furnished prior to enrollment.

Currently physicians, non-physician practitioners, and physician and non-physician practitioner organizations cannot bill for services furnished prior to the later of the date the provider filed an enrollment application that was subsequently approved or the date the provider began furnishing services at a practice location. Independent diagnostic testing facilities (IDTFs) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) have similar restrictions.

For Provider Enrollment, Chain and Ownership System (PECOS) applications, the date is the date that the contractor received an electronic version of the enrollment application and a signed certification statement submitted via paper or electronically.

While HBMA supports efforts to prevent inappropriate billing by ANY provider, placing restrictions on the ability of ambulance providers to bill for services delivered before enrollment in the Medicare program may cause problems.

Ambulance services are often operated by municipalities who, for various reasons may find it necessary to temporarily curtail this governmentally provided service. In these situations, a municipality may seek to contract with a private ambulance service or other municipality ambulance services on an emergency, short-term basis. It may not be possible in these emergency situations to secure all of the necessary paperwork in the requisite amount of time to permit Medicare billing for transport services. Ambulance services in these situations should not be held financially responsible for providing appropriate transport services to Medicare patients when confronted with these emergency situations.

Recommendation:

CMS should treat ambulance services in a manner consistent with physicians and non-physician when it comes to enrollment and the filing of Medicare claims. HBMA recommends that Ambulance services already enrolled in Medicare, be permitted to bill Medicare based upon the later of the date the ambulance supplier files its enrollment application with the Medicare contractor or the date it first began furnishing services to Medicare patients at a new location.

HBMA also recommends that CMS establish a process to permit retroactive billing for ambulance services similar to the 30 day retroactive billing authority that exists for physicians and non-physicians. An Ambulance service could seek a longer retroactive

billing period when the supplier can demonstrate that exigent circumstances led to a situation that forced the service to provide transport services prior to the normal billing requirements.

Abuse of Billing Privileges

Section 424.535(a)(8) states that a provider or supplier's Medicare billing privileges may be revoked if the provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. Examples include situations where the beneficiary is deceased or the physician or beneficiary is not in the state or country when services were furnished.

CMS proposes to expand this revocation authority by adding a new paragraph. The new paragraph would permit revocation if CMS determines that the provider or supplier has a "pattern or practice of billing for services that do not meet Medicare requirements" such as the requirement that the service be reasonable and necessary.

We oppose this expansion at this time.

As noted earlier, we believe this authority is not well defined and affords too much discretion to the contractor due to the ill-defined nature of this authority. We recognize the intent behind the authority CMS seeks but we do not believe CMS has developed this language in such a way to provide comfort to the provider community that this will not be abused by the contractor.

While we appreciate the fact that CMS is seeking industry feedback on this new requirement, we do not believe that engaging in this type of review and analysis during a 60 day public comment period is appropriate. We believe this is a dialogue that requires greater discussion and collaboration with the stakeholder community to try to achieve a consensus.

CMS poses several questions and seeks industry feedback on how best to operationalize this new authority. In explaining the purpose behind this new initiative, CMS provided some examples (noted above) of what would constitute claims for services that could not have occurred, such as services provided to a deceased patient.

While services provided to a deceased patient would seem like a perfectly logical example of an abusive billing practice, the fact is that in the case of diagnostic testing, this is not a particularly uncommon situation. It is not unusual, for example, for a radiologist, cardiologist or pathologist to submit a claim for the professional interpretation of a diagnostic test for a patient who expired between the time the technical component was performed or obtained and the professional interpretation was provided. This is particularly true in the case of hospitals that are not required to have 24 hour ancillary professional services available.

Claims for services provided to deceased patients should not be paid by Medicare but there are circumstances where a provider unknowingly submits a claim for a service provided to a deceased patient due to circumstances such as those described above.

In situations where there is a face-to-face encounter between the patient and the provider, it is clear that the provider knew (or should have known) that the patient was deceased and therefore the submission of a claim was inappropriate. This could reasonably be interpreted as abusive billing behavior.

However, in the case of a service provided in which the provider did not have a face-to-face encounter with the patient but instead, was providing only a professional interpretation of a diagnostic test, this should not be interpreted as prima fascia evidence of abusive billing behavior. Payment for the interpretation of a diagnostic test provided for a patient who passed away prior to the interpretation of that test should be denied, but the occurrence of such events should not trigger an investigation or allegation of abusive billing.

Use of repeated "Medical Necessity" based denials as a marker for potential pattern of billing abuse.

First, we agree that a provider should be responsible for submitting valid claims at all times and failure to do so puts the Medicare Trust Fund at risk. However, using the type of statistical analysis CMS appears to want to pursue as a means of determining patterns, is fraught with problems.

For example, denial reason "not medically necessary" (CO50) is a high volume, routine, normal course of business explanation on the preponderance of denials. It encompasses a wide variety of reasons that are not related to malicious intent.

Examples of this issue include but are not limited to cases where it is known Medicare will deny the claim but the beneficiary needs a Medicare denial to file secondary insurance or beneficiaries who have exceeded a benefit category unbeknownst to the provider, i.e. screening mammograms. In addition, primary commercial insurances often cover services Medicare does not but the "not medically necessary" designation will appear on the Medicare adjudication of legitimate cross-over claims from the primary insurance.

We fear that using the type of statistical analysis you suggest would likely trigger an investigation into the billing practices of many physicians who are appropriately submitting claims for legitimate reasons and with no intent to receive any improper payment. We do not believe CMS has any capability to distinguish between patterns indicative of abuse and normal course of business claims since this adjudication explanation is widely used for all denial types.

Finally, we are concerned about the lack of definition of "directing physician." In the proposed rule, CMS includes the presumption that an abuse of billing privileges includes, "…the directing physician or beneficiary is not in the state or country when services were furnished…" While we fully understand the country concern, depending on the definitions CMS will use, the beneficiary and provider may very well be in different states. As discussed in our other comments, the professional component of diagnostic testing services is often not performed in the same physical location or contractor jurisdiction as the technical component. More importantly, the date of service may also be different if the interpretation is provided on

a date different than the technical component. We are fearful that normal, compliant practices could be misinterpreted based on the nebulous descriptions in the proposed rule.

Recommendation

In providing examples of what may constitute a pattern of abusive billing behavior, CMS must be more sensitive to certain specialty specific situations that can occur due to the nature of the provider-patient encounter. Diagnostic services, for example, should not be subject to the same standard as other providers due to the remote nature of the physician-patient relationship.

Recommendation

CMS should be very cautious about using statistically based programs as a means of detecting suspected inappropriate billing. As noted in our comments, while certain activities may be examples of abusive behavior, they can also be perfectly appropriate. Statistical programs are not very effective at making that distinction. It is not a matter of percentages or numbers but intent. Whatever process CMS uses to attempt to detect abusive billing practices it must incorporate some mechanism for assessing the intent of the provider; otherwise you will falsely accuse and/or investigate many providers for actions that are perfectly appropriate.

Recommendation

CMS should withdraw this proposal and form an industry stakeholder group with broad representation to develop consensus standards for what would constitute "patterns of practice." HBMA continues to support CMS in your ongoing efforts to deter fraud and abuse in the Medicare Program.

Incentive Reward Program

The Proposed Rule would revise the Medicare Program's Incentive Reward Program (the "IRP") as authorized by HIPAA and as set forth in 42 C.F.R. § 420.405, by increasing the potential reward amount for information leading to a recovery of Medicare funds from 10 percent of the overpayments recovered or $1,000, whichever is less, to 15 percent of the final amount collected applied to the first $66 million. We are concerned about the significant increase in the reward amount, especially without clarification regarding what actions may constitute "sanctionable conduct" and how CMS will conduct education of the public in this area.

CMS notes that the IRP as currently structured has failed to produce many reports of fraudulent conduct and recoveries have been modest. If modified as proposed, HBMA is concerned that it could result in too many reports of irrelevant information. A consequence of the increased allegations would be to place a heavy burden on providers who would be forced to fight unwarranted complaints. In addition, we believe this would also result in increased tension between providers and patients. Moreover, a situation of "report first, ask questions

later" could result if CMS adopts its proposal to limit the eligibility for the reward to the *first* reporter of such information.

CMS has requested comments on its proposed approach of requiring an attestation from the reporter which would address, among other things, the accuracy and truthfulness of the information being furnished. HBMA supports the use of such an attestation form if CMS goes forward with the proposed changes to the IRP. HBMA urges CMS to submit a proposed attestation form for public comment. HBMA also urges CMS to consider other mechanisms to discourage the provision of frivolous or irrelevant information, as directed by HIPAA.

CMS notes in the Proposed Rule that it will seek to enhance its educational efforts of Medicare beneficiaries regarding the reward program.

Recommendation

As with other proposals put forward in the NPRM, HBMA respectfully requests CMS work with an appropriate mix of stakeholders to develop the substance of the educational materials used in any such efforts.

Conclusion

Despite our concerns about several of the proposed changes, HBMA continues to be supportive of CMS efforts to eliminate unnecessary, wasteful or inappropriate payments from the Medicare program. We believe that engaging groups such as HBMA and its members in this endeavor will lead to more productive solutions – and solutions that achieve an appropriate balance.

During a recent meeting with HBMA leaders a senior CMS official made the following observation with regard to program integrity, "We want to stay out of the way of the good providers and get in the way of the bad ones." We fully concur with this sentiment.

It has been our experience that most providers are honest, law abiding individuals who simply want to be paid appropriately and in a timely fashion for the medically necessary services they provide to their patients. We are concerned that several of the proposed changes will result in many of these law abiding providers being accused of behavior that will result in their termination from the Medicare program or their inability to add additional sites from which they can provide high quality, cost-effective healthcare.

If this proposed rule is adopted as drafted, we fear that in your legitimate desire to get in the way of the "bad ones" you will end up getting in the way of far more "good ones."

Your consideration of these comments is greatly appreciated. If you have any questions, please do not hesitate to contact HBMA's Director of Government Affairs, Bill Finerfrock (bf@hbma.org).