



**American Hospital
Association**

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July 6, 2010

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-6010-IFC, Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements; Interim Final Rule with Comment Period (Vol. 75, No. 86), May 5, 2010.

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) interim final rule (IFR) on the changes to the provider and supplier enrollment process, ordering and referring providers and documentation requirements. Our comments focus on the new requirements for payment of claims for ordered or referred Part B items and services, and the proposed provider and supplier documentation requirements for enrolling and maintaining active enrollment status in the Medicare program.

EFFECTIVE DATE

The AHA appreciates CMS' recent decision to delay enforcement of one of the provisions in the IFR that would have automatically rejected provider claims based on orders, certifications, and referrals made by physicians and other eligible professionals who did not have an approved enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) by July 6, 2010. CMS' decision will help to ensure uninterrupted beneficiary access to essential Medicare Part A and B home health services and other Part B services – including durable medical equipment (DME) and the services of laboratories, imaging suppliers and specialists. This delay in enforcement also will prevent the serious negative financial implications for hospitals that furnish these services.



We also strongly support CMS' commitment to work with the provider community to provide guidance on enrollment and to update and streamline the enrollment process so that all applications can be dealt with expeditiously. The AHA will continue to work with CMS to improve the enrollment process and educate hospitals and their staffs about the need to have updated enrollment records in PECOS.

There is clearly a great deal of work that still is needed to improve the functioning of the PECOS system, and to educate providers and suppliers about Medicare requirements for enrollment. There is evidence of growing delays and backlogs in Medicare contractor processing of paper-based and on-line enrollment applications as more physicians and other eligible professionals respond to calls from CMS and their national associations to establish an enrollment record.

Further, despite efforts by AHA and other national associations to encourage physicians and hospitals to enroll or update their enrollment records in Medicare through PECOS, many have not yet done so. These likely include physicians who do not usually treat Medicare beneficiaries and, therefore, have never felt it necessary to enroll in the Medicare program, such as physicians in the military, Public Health Service, dentists and pediatricians. However, these physicians may, on occasion, order or refer Medicare beneficiaries for Medicare Part A or B services. Additionally, there are many physicians who are enrolled under Medicare, but have not updated their enrollment information within the last six years and, therefore, would not have an approved PECOS record. In particular, we have heard from our members and other national associations that many physicians who certify home health services or order DME do not yet have approved enrollment records in PECOS.

The enforcement delay provided by CMS presents an opportunity for all stakeholders to help address these issues in coordination with the agency. We encourage CMS to increase its educational efforts directed at physicians who order and refer services, and also to partner with the AHA and other national associations to clarify the nature and extent of problems with PECOS and to find ways to expedite solutions. The enforcement delay should not be revoked until these issues have been resolved.

NEW PAYMENT REQUIREMENTS

The AHA believes that CMS should clarify whether ordered or referred Part B services *furnished by hospitals* are included in the new claims payments rules at 424.507(a) and (b). Specifically, we request that CMS clarify whether ordered or referred Medicare Part B services furnished directly by a hospital and billed using the Uniform Bill (UB-04) format are subject to the claims payment requirements of the IFR, which state that claims must identify the ordering or referring physicians, and that the ordering or referring physician must have an approved enrollment record in PECOS. There is confusion about this issue, with some individuals asserting that the rule will apply only to ordered or referred services that are billed using the CMS 1500 format¹ and that CMS would have no way to edit these hospital claims billed on the UB-04 for compliance.

¹ Hospitals also submit claims for ordered/referred services via the CMS 1500 when they bill for the services of employed physicians or other eligible professionals who have reassigned their billing privileges to the hospital. Since nearly 70 percent of hospitals employ physicians, this is a common scenario.

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Hospitals furnish many Medicare Part B services that are ordered or referred by physicians or other eligible professionals. This includes clinical laboratory tests, imaging studies and other therapeutic and diagnostic services. Hospitals submit these claims using the UB-04, not the CMS 1500. For instance, a community physician may refer an individual to a hospital outpatient department for an imaging study or a clinical laboratory test. In this case, the hospital would bill the Medicare program under the outpatient prospective payment system or the clinical laboratory fee schedule, respectively, for its Part B facility services using the UB-04. In these examples, Medicare also would receive a bill from a physician for the professional service furnished, i.e., the interpretation of the imaging study or the laboratory test.

While it seems clear to the AHA that the IFR at 424.507(a)(1) includes claims submitted by both suppliers and providers, the confusion around this question requires a more precise answer.

DOCUMENTATION REQUIREMENTS

The AHA asks that CMS specify the type and format of documentation that it is requiring providers and suppliers to maintain.

The IFR at 42 CFR 424.516 requires that providers and suppliers who furnish ordered or referred home health, laboratory, imaging or specialist services maintain documentation for seven years from the date of service and, upon request, provide CMS with access to that documentation. Similarly, the rule also requires physicians or eligible professionals who order or refer these services to maintain documentation for seven years and make it available to CMS upon request.

There is very little other information provided in the IFR regulatory language or in the preamble section of the rule regarding exactly what CMS considers adequate documentation and in what format the information should be kept. Because failure to properly document information could result in the revocation of enrollment and billing privileges for one year for each act of noncompliance, it is imperative that providers and suppliers clearly understand what is expected of them. We seek additional specifics from CMS regarding the information required and the preferred format of the information that must be maintained.

If you have any questions, please contact me or Roslyne Schulman, senior associate director for policy, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

Rick Pollack
Executive Vice President