



National Home Infusion Association
Providing solutions for the infusion therapy community

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Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 1503-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011, Proposed Rule (CMS – 1503 – P)

The National Home Infusion Association (NHIA), a national membership association for clinicians, managers and organizations providing infusion therapy services for patients in home care and outpatient settings, offers these comments in response to the proposed rule (Rule) published in the Federal Register on July 13, 2010 entitled, “Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011.”

Our comments address the time limits established for filing Medicare claims as well as the grandfathering provisions related to the competitive bidding program for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). We recommend that CMS:

- Apply the general exception to the timely filing requirement for beneficiaries retroactively entitled to Medicare to dual-eligible individuals who become retroactively entitled to Medicare;
- Change the deadline for filing claims for beneficiaries retroactively entitled to Medicare;
- Create an exception to the timely filing requirement for cases where Medicare is a secondary or tertiary payer; and
- Extend the grandfathering option of the DMEPOS competitive bidding program to suppliers of all DMEPOS product categories.

The general exception to the timely filing requirement for beneficiaries retroactively entitled to Medicare should be made applicable to dual-eligible individuals.

The Patient Protection and Affordable Care Act (PPACA) amended the time frame for filing Medicare claims; claims for services furnished on or after January 1, 2010 must be filed within one calendar year of the date of service (“timely filing requirement”). CMS has the discretion to create exceptions to the timely filing requirement. The Rule

proposes two exceptions in addition to the existing exception for errors or misrepresentations made by CMS, its contractors or agents, including:

- (1) An exception for when a beneficiary was not entitled to Medicare when the service was furnished, but then becomes retroactively entitled to Medicare benefits, and
- (2) An exception for when a dually-eligible beneficiary was not entitled to Medicare when the service was furnished, but then becomes retroactively entitled to Medicare benefits, and a State Medicaid agency recovers the Medicaid payment for the furnished service from the provider or supplier 11 months or more after the service was furnished.

With our suggestions set out below, NHIA supports CMS' creation of exceptions to the timely filing requirement. We also support the broad applicability of the exceptions to the timely filing requirement to all categories of Medicare providers and suppliers. In addition, NHIA supports CMS' proposed exception to the general filing deadline for instances where beneficiaries become retroactively entitled to Medicare benefits.

The exception for retroactive Medicare entitlement should be sufficient to cover dual-eligible individuals who become retroactively entitled to Medicare. NHIA believes that it is unnecessary to impose an additional restriction to the exception for claims filed for services provided to dual-eligible individuals. The proposed limited applicability of the exception for dual-eligible individuals who become retroactively entitled to Medicare to instances where a State Medicaid agency recovers the Medicaid payment 11 months or more after the date of service is too restrictive.

The time limit for filing claims for beneficiaries who become retroactively entitled to Medicare should be extended.

For the general exception to the timely filing requirement applicable to claims for services furnished to beneficiaries who become retroactively entitled to Medicare, the Rule extends the filing deadline through the last day of the 6th calendar month following the month in which the beneficiary received notification of retroactive Medicare entitlement. For the exception applicable to claims for services furnished to dual-eligible beneficiaries who became retroactively entitled to Medicare, the Rule extends the filing deadline through the last day of the 6th calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

We believe that the timeframe for filing claims applicable to services provided to beneficiaries who become retroactively entitled to Medicare (regardless of whether they are dual-eligible beneficiaries) should be extended to the later of: (1) the date that is 12 months after the date that the beneficiary is notified of retroactive Medicare entitlement, or (2) the date that is 12 months after the provider or supplier becomes aware of retroactive Medicare entitlement.

Before individuals are granted retroactive Medicare entitlement, they are frequently covered by other payers, such as commercial insurance plans, military insurance (TRICARE) and Medicaid. Suppliers and providers often become aware of an individual's retroactive Medicare entitlement when the other payer recovers its payment. With respect to dual-eligible individuals who become retroactively entitled to Medicare, it can easily exceed one month's time for recovery notices to be mailed by the State Medicaid agency, received at a provider or supplier's remittance address, routed to the provider or supplier's reimbursement office, and addressed by the provider or supplier's responsible billing clerk.

Thus, basing the timeframe for submitting Medicare claims exclusively on the date the beneficiary is notified of his or her retroactive Medicare entitlement may not afford suppliers or providers with sufficient notice to file their Medicare claims in a timely manner. We believe the filing deadline should be based on the latter of the date that the beneficiary is notified of retroactive entitlement or the date that a supplier or provider is made aware of the beneficiary's retroactive entitlement. Such knowledge may be supported with documentation, such as a remittance advice statement verifying that a beneficiary's alternative health plan recovered its payment.

Due to the limited home infusion benefit under Medicare Part B, home infusion suppliers often bill Medicare for the purpose of obtaining Medicare denial billing remittance advices, which are required by other payers. It would be unreasonably costly and confusing for home infusion suppliers to receive timely filing limit denials for services provided to individuals for whom the supplier is unaware of retroactive Medicare entitlement during the allowable filing period. We urge CMS to ensure that infusion suppliers do not have to face this situation.

An exception to the timely filing requirement should be created for instances where Medicare is not the primary payer.

We recommend that CMS create an exception to the timely filing requirement for claims for services for which Medicare is not the primary payer. Before a claim balance is submitted to Medicare, the provider or supplier is required to submit and receive successful adjudication from the beneficiary's primary payer(s). Even if a claim is submitted to the primary payer(s) in a timely manner, the primary payer(s) may have problems adjudicating the claim. Similarly, the correct adjudication by the primary payer(s) may take a considerable length of time. Delays caused by a beneficiary's primary payer(s) postpone the submission of the claim to Medicare.

NHIA suggests that in cases where Medicare is not the primary payer, the filing deadline be extended to 12 months from the date the payment is made for the products or services by the payer immediately primary to Medicare (i.e. the primary payer when Medicare is the secondary payer, and the secondary payer when Medicare is tertiary).

All DMEPOS suppliers should have the option to be grandfathered into the competitive bidding program.

We recommend that CMS provide suppliers of all DMEPOS product categories subject to the competitive bidding program with the option to be grandfathered into the program. The current rules only extend the grandfathering option to suppliers of certain categories of DMEPOS. As a result, any beneficiary who receives non-grandfathered products from a non-winning supplier must find a new supplier.

The brief operational period of the competitive bidding program in July 2008 demonstrates the importance of the grandfathering option for suppliers and Medicare beneficiaries. Beneficiaries requiring durable medical equipment and oxygen were afforded the opportunity to continue receiving items and services from the supplier with which they had an established relationship even if the supplier was not selected as a winning bidder. However, many beneficiaries requiring enteral nutrition, which is not a grandfathered product category, experienced disruptions in care.

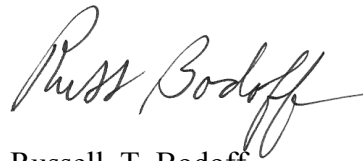
Some Medicare beneficiaries had difficulty finding enteral nutrition suppliers that won the competitive bidding contracts in their geographic area. Other beneficiaries encountered inexperienced suppliers when searching for new suppliers; some “winning” suppliers did not have previous experience with the enteral nutrition product category they were selected to furnish or in the area they were selected to serve. In other cases, suppliers’ personnel were not informed that they were responsible for providing certain items and services. Congress ultimately intervened and delayed the implementation of the competitive bidding program, which likely prevented additional harm from occurring.

Extending the grandfathering option to all DMEPOS suppliers will ensure that beneficiaries continue to have access to high quality DMEPOS. Medicare payment levels will not increase if all DMEPOS suppliers are provided with a grandfathering option because grandfathered suppliers are required to accept the single payment amounts in their areas. However, beneficiaries will be permitted to continue receiving items and services from suppliers with which they have established relationships.

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We appreciate the opportunity to comment on the proposed rule. If you have any questions or need additional information, please contact me at 703-838-2678. Russell.Bodoff@nhia.org.

Sincerely,



Russell. T. Bodoff

President & Chief Executive Officer