CMS-1304-P-1 **Home Health Prospective Payment System Rate Update for Calendar Year 2007 and Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment**

Submitter : Mr. william Adam **Date & Time:** 08/07/2006

Organization : WA HealthCare consultants

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

you are absolutely correct in cutting the reimbursement of 02 coverage to home care patients. But, you are missing the boat with allowing portable O2 coverage being increased to $55.00 since the cost of a small portable aluminum cylinder with 02 contents is less than $200.00 to purchase and own. the reimbursment of such a small piece of equipment should be capped as well at under $25.00 per month since the ROI on such a piece of equiment is less than one year which is reasonable in anyone's standard. After one year a 85% profit is realized by the home care provider of such equipment. I am sure all of the DME / 02 supply companies are very worried about losing their most lucrative piece of business , which is home portable and stationary 02 supplies.

The facts are clear, most of the portable 02 systems placed in COPD patients homes are never used anyway and the Gov't (us) continue to pay for these systems as long as the patient is alive and has the disease.

As a concerned citizen and experienced home care provider I know what this waste is costing us taxpayers.

thank you .

Submitter : Mr. DAVID MCCALL **Date: 08/10/2006**

Organization : Mr. DAVID MCCALL

Category : Health Care Professional or Association

Issue Areas/Comments

Background

Background

While it is true that, 'Some manufacturers of commonly used oxygen equipment offer full warranties that cover parts for up to five years.', the same can not be said about most capped rental items. Case in point, most nebulizers, CPAPs, and BiPAPs on the market today only have a one or two year manufacturer's warranty. Additionally, the cost of repairing these items will almost always exceed 60 percent of the replacement cost for the item and would therefore mean that the supplier would be responsible for replacing the item at their own expense as many as 3 to 5 times during the course of the five year period. With that in mind, why would any supplier continue to supply these capped rental items when there is a very high probability that they will be expending 2-3 times the amount of the reimbursable for the items. What works for oxygen equipment can not be said for capped rental items. There is a very real chance that this provision will effectively eliminate supplier bids for these types of capped rental items. It is not reasonable to expect a supplier to furnish the same piece of equipment to the same patient multiple times without additional compensation.

Submitter : Mr. Glen Langlinais **Date:** 09/14/2006

Organization : Langlinais & Broussard, CPA's

Category : Other

Issue Areas/Comments

GENERAL

GENERAL

The Wage Index for CBSA No. 12940 (East Baton Rouge,Ascension, Livingston, West Baton Rouge, Louisiana), reflects a substantial decrease from the CY 2006 CBSA Wage Index. The wage index reflects a decrease from .8593 in CY 2006 to .8099 in CY 2007, a decrease of nearly 6%. It appears that this must likely be the result of an error. We ask that the wage index for CBSA 12940 be reviewed for accuracy.

Submitter : **Ms. Elinor Frampton** **Date: 09/16/2006**

Organization : **Ms. Elinor Frampton**

Category : **Individual**

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

I have been on oxygen for 6 years. I can't afford to take care of the equipment after I have (Medicare) has paid for them. Every so many hours on my consentrater, they (Apria) replaces it with another one. Sometimes they have had to replace it sooner because of a malfunction. My portable has had to be replace at least a couple times a year, because it quits working, or it doesn't work right. I would just have to give up using a portable or my concentrater, because they do malfunction every so often I couldn't afford to take care of them.Please reconsider. Elinor Frampton

Submitter : **Ms. Ronile Valenza** **Date: 09/16/2006**

Organization : **Ms. Ronile Valenza**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

I urge you not to implement this change. The impact on oxygen users will be devastating, increasing their cost of life giving oxygen care and reducing independence. An all around bad idea!

Submitter : **Mrs. Donna Bruffey** **Date: 09/16/2006**

Organization : **EFFORTS**

Category : **Individual**

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

In reading the following (after my signature), I must make my thoughts known. I have been on continous oxygen (24x7) for over five years. My first concentrator died about a month ago. That means that if this bill were passed, a NEW Oxygen concentrator would need to be purchased, and the three year limit begin again. When they burn out, there is no "fixing" them.

As regarding to the increases proposed, those of us on Oxygen can honestly tell you that we cannot afford an extra penny to stay alive. Perhaps you all do not realize that it's not only Oxygen that we need, it's also SEVERAL prescription medications that we require daily which are very costly, and which insurance does not cover totally. There are times when we must make the choice of medications or food.

Please tell the bill makers to make their cuts elsewhere. I have a few suggestions for that also. Cut the governmental salaries. There is not ONE person on this earth who requires more than a $100,000 salary! If one think they do, that person(s) needs to learn how to cut back on their spending, just like those of us requiring Oxygen have learned to do.

More info follows my signature...

Sincerely,
Donna Bruffey
3993 Saddlewood Drive
Charlottesville VA 22902
mailto:donnawb@earthlink.net

"Regarding the new oxygen classification system puts stationary and
portable oxygen contents into two separate payment classes, and a third payment class for new technologies, such as portable concentrators and home transfilling systems, is also proposed.

Monthly payment for portable oxygen systems would increase to $55 compared to the current average payment of $21, and the monthly payment for stationary oxygen equipment and contents would drop to $177 compared to the current average of $199.

Monthly payment for oxygen contents only (after transfer of equipment
ownership) would be $101 for stationary systems, and $55 for portable systems.

Many other oxygen supply details are also included in the proposed Rule."

Submitter : Ms. Linda Torr **Date: 09/18/2006**

Organization : Detroit Oxygen & Medical Equipment Co.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

Based on Detroit Oxygen's review of the Deficit Reduction Act of 2005, comments of the proposed rule are listed on the attached document.

CMS-1304-P-7-Attach-1.DOC

Attachment to #7

Detroit Oxygen's Comments For Deficit Reduction Act of 2005 Changes for Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment Proposed Rule

Based on Detroit Oxygen's review of the Deficit Reduction Act of 2005 Changes for Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical Equipment Proposed Rule, we are proposing the following:

Page 15:

The proposed rule states that "payment for reasonable and necessary maintenance and servicing of beneficiary owned oxygen equipment will be made for parts and labor not covered by a supplier's or manufacturer's warranty".

The proposed rule does not address nor suggest reimbursement for the significant labor costs associated with providing 24 hour, 7 days per week service to beneficiaries after the rental payments cease.

Page 62:

The proposed rule states "We believe that it is reasonable for the beneficiary to have an expectation that he or she will not be forced to change equipment or suppliers during the period of medical need unless he or she wants to".

It is unreasonable to mandate a provider to continue to service a beneficiary if a beneficiary is non-compliant with the provider's instruction on the safe and appropriate use of the medical equipment. In addition, providers should not be expected to continue servicing a beneficiary who is abusive to the provider's staff members.

Page 63:

With regard to exception number 2, "cases where a beneficiary relocates on either a temporary or permanent basis to an area that is outside the normal service area of the initial supplier".

The proposed rule does not address how the second supplier will be reimbursed and for how many rental months once the patient transitions to the new provider.

Page 69:

The proposed rule states "we propose that suppliers must transfer title of all equipment . . ., including those oxygen cylinders or vessels . . .".

- To segregate beneficiary-owned oxygen cylinders during the refilling, testing and storage process is not operationally possible.
- Transferring ownership of full and empty oxygen cylinders requires a provider to significantly increase their inventory.
- A beneficiary's portability needs change throughout the period of medical necessity. Therefore, the number of oxygen cylinders delivered to the beneficiary fluctuates. The proposed rule does not address this issue.

Page 76

The proposed rule states, "In addition, portable oxygen concentrators are now available that meet both the beneficiary's stationary and portable oxygen needs".

Portable oxygen concentrators are not capable of delivering high and/or continuous flow of oxygen. Therefore, this modality cannot be used on beneficiaries who require high or continuous flow of oxygen.

Page 79

The proposal states "We would propose to achieve budget neutrality by reducing the current monthly payment amounts (the stationary payment) for stationary oxygen equipment and oxygen contents (for stationary or portable equipment) made during the rental period".

Why is it necessary to implement the proposed oxygen reimbursement reductions effective January 1, 2007 when implementation of competitive bidding will reduce oxygen payments across the country?

Page 97

The proposed rule states that the supplier must still replace beneficiary owned oxygen equipment or beneficiary owned capped rental equipment at no cost to the beneficiary or to the Medicare program, if the total accumulated repair costs exceed 60% of the replacement cost and the item has been in continuous use for less than its reasonable useful lifetime.

It is unreasonable to expect a provider to replace equipment, free of charge in these situations. A new rental period must begin.

General:

With regard to the proposed rule which mandates that title for oxygen equipment transfers to the beneficiary after 36 months, CMS does not address what a beneficiary/caregiver does with the equipment after the oxygen is no longer needed. A beneficiary/caregiver could give the oxygen to another individual to use without a physician ordering or monitoring its use. Also, who would ensure the proper disposal of the oxygen equipment? There are strict regulations concerning the storage, transportation and disposal of oxygen.

Page 15: The proposed rule states that 'payment for reasonable and necessary maintenance and servicing of beneficiary-owned oxygen equipment will be made for parts and labor not covered by a supplier's or manufacturer's warranty'. The proposed rule does not address nor suggest reimbursement for the significant labor costs associated with providing 24 hour, 7 days per week service to beneficiaries after the rental payments cease. Page 62: The proposed rule states 'We believe that it is reasonable for the beneficiary to have an expectation that he or she will not be forced to change equipment or suppliers during the period of medical need unless he or she wants to'. It is unreasonable to mandate a provider to continue to service a beneficiary if a beneficiary is non-compliant with the provider's instruction on the safe and appropriate use of the medical equipment. In addition, providers should not be expected to continue servicing a beneficiary who is abusive to the provider's staff members. Page 63: With regard to exception number 2, 'cases where a beneficiary relocates on either a temporary or permanent basis to an area that is outside the normal service area of the initial supplier'. The proposed rule does not address how the second supplier will be reimbursed and for how many rental months once the patient transitions to the new provider. Page 69: The proposed rule states 'we propose that suppliers must transfer title of all equipment . . ., including those oxygen cylinders or vessels . . .'. *To segregate beneficiary-owned oxygen cylinders during the refilling, testing and storage process is not operationally possible. *Transferring ownership of full and empty oxygen cylinders requires a provider to significantly increase their inventory. *A beneficiary's portability needs change throughout the period of medical necessity. Therefore, the number of oxygen cylinders delivered to the beneficiary fluctuates. The proposed rule does not address this issue. Page 76 The proposed rule states, 'In addition, portable oxygen concentrators are now available that meet both the beneficiary's stationary and portable oxygen needs'. Portable oxygen concentrators are not capable of delivering high and/or continuous flow of oxygen. Therefore, this modality cannot be used on beneficiaries who require high or continuous flow of oxygen. Page 79 The proposal states 'We would propose to achieve budget neutrality by reducing the current monthly payment amounts (the stationary payment) for stationary oxygen equipment and oxygen contents (for stationary or portable equipment) made during the rental period'. Why is it necessary to implement the proposed oxygen reimbursement reductions effective January 1, 2007 when implementation of competitive bidding will reduce oxygen payments across the country? Page 97 The proposed rule states that the supplier must still replace beneficiary owned oxygen equipment or beneficiary owned capped rental equipment at no cost to the beneficiary or to the Medicare program, if the total accumulated repair costs exceed 60% of the replacement cost and the item has been in continuous use for less than its reasonable useful lifetime. It is unreasonable to expect a provider to replace equipment, free of charge in these situations. A new rental period must begin. GENERAL: With regard to the proposed rule which mandates that title for oxygen equipment transfers to the beneficiary after 36 months, CMS does not address what a beneficiary/caregiver does with the equipment after the oxygen is no longer needed. A benficiary/caregiver could give the oxygen to another individual to use without a physician ordering or monitoring its use. also, who would ensure the proper disposal of oxygen equipment? There are strict regulations concerning the storage, transportation and disposal of oxygen.

Submitter : Christy Williams **Date:** 09/19/2006

Organization : Misys Healthcare Systems - Homecare Business Unit

Category : Health Care Industry

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

Paragraph that begins "We propose to use&." seems to indicate that although CMS wants the entire OASIS assessment submitted, they will be satisfied with the OASIS items related to the 10 Measures. Is this the intent?

Submitter : Deborah Albaugh **Date:** 09/20/2006

Organization : Deborah Albaugh

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

Revision of the OASIS requirements for Home Health is needed to clarify questions that are vague or do not demonstrate improvement for the patient when completed. Some examples are:

1. M0 520- The incontinence questions does not allow for improvement. Responses should include slight or moderate improvement to show clear clinical picture.
2. All questions should include, can the activity be performed safely by the patient?
3. MO 670 - The bathing questions needs to have the response 2(a) transfer in and out of tub removed. The questions really deals only with the bathing itself. Transfer confuses the issue and encourages a wrong answer.
4. Medicare Managed care patients should not be included in an agency's outcomes. Agencies have no control of the number, frequency, or duration of the visits, therefore agencies should not be held responsible for the outcome.
5. MO 700 Ambulation - Consideration for improvement when progressing from a walker to a cane should be included in this question. Many patients following orthopedic joint procedures progress from a walker to a cane but remain on the cane at the time of discharge until cleared for independent ambulation by the physician. The way the question is currently worded does not take into consideration that the patient has indeed improved in their ability to ambulate.

Thank you for your consideration of my comments.

Submitter : **Mrs. Lisanne Bright** **Date: 09/20/2006**

Organization : **Home Preferred Home Health**

Category : **Home Health Facility**

Issue Areas/Comments

Background

Background

In regard to OASIS: MO 280 Life Expectancy- I would like to see this item removed. It is never answered 6 months or less because the clinicians do not feel that it is in their scope of practice to be making a prognosis. MO 520/530 Urinary incontinence/When does this occur: If a patient has stress incontinence due to coughing or sneezing, the patient is incontinent all of the time because they can't control what time of the day or night that they cough or sneeze. MO 700- Can't see a patient's progress in the outcomes when a patient improves from a walker to a cane. This should be separated out. Thank you for this opportunity. Lisanne Bright, RN, BSN, MA

Submitter : **Mrs. Susan Staley** **Date: 09/20/2006**

Organization : **Samaritan Home Care**

Category : **Home Health Facility**

Issue Areas/Comments

Background

Background

MO420 This question should be as simple as does patient have pain, Yes or No, then a pain scale (1-10). We do not show improvement on the oasis, because patients on admission may have pain daily but not constantly at a level 8, but pain daily but not constantly at a level of 2 on discharge, improvement definety, but improvement does not show on OASIS. The same is true of MO 700, I believe the assistive devices needs to be broken down more, I think progressing from a walker to a cane or stand by assist in an improvement. The answers do not let that be reflected. Thanks

GENERAL

GENERAL

See above

Submitter :

Date: 09/20/2006

Organization :

Category : Private Industry

Issue Areas/Comments

Background

Background

Here are the major problems I see with the proposal:
1. Warranty for this type of equipment is void if title is transferred
2. Providers can not affort to supply addition equipment in the event it needs to be replaced after the title is transferred
3. The disease state of Oxygen patients progresses with age. The sickest patients will be responsible for the routine maintenance of the equipment. They will not be able to perform routine maintenance and their care will suffer with ER visits and death to some a result.
4. Many patients use humidifier bottles which they will not be able to easily change. If not put on correctly the patient doesn't get the oxygen. The patient hears the machine on, thus thinking they are getting oxygen, yet the are not...these patients may also die, especially if they live alone.
5.There will be no 24 hour service for down time due to power outage, there is no backup reimbursement (not medically necessary), these people will also end up in ERs and some will die.
6. How will the handling/disposal of oxygen cylinders occur....garage sales, ebay, and landfills.
7. There are very few providers that bill for service, the bottom line is no provider is going to rush out to provide service on this patient owned equipment, why would they, they can't afford to...Sorry grandma call the ER or your on your own...I can't get out there right away.
8. Nobody will take care of patients that the get no revenue from....they will find a way to get rid of the patient or shut down their operation....who will handle all those patients from all the companies that shut down as a result of not being able to sustain a business that has expenses (continueing to care for patient) with almost no reimbursement.
9. Why would someone want to take these dumped patients, they would get the on going service/replacement of equipment having never received the funds necesssary to pay for any of the costs.
10. Companies would go out of business and who would handle those patients....what choices would the patient have....every provider would refuse service because there is limited revenue after the 36 monthly payments have been used up.
11. This system actually encourages companies to go out of business and dump the patients....just open up a new company.
12. If it was in a competetive bid area, then the lucky winning bid would inherit all these dumped patients...It is likely that these providers will not build this into their bid....guess what we have then is a bid that was too low....now all of your competitive bidders that got the contract can't sustain....guess what more er visits....and a lot more dead people....there are so many holes and problems in this proposed regulation the result will surely be ER visits and a lot of dead bodies with cannulas attached to equipment that was managed by a 80 year old COPD patient....I think we are setting up a system that is government murder...I would sure like to know who is responsible for this irresponsible proposed regulation and change them with criminal charges...please take this very seriously as 1 death as a result of bad regulations is too many...I would expect many dead bodies, suffering a horrible death of gasping for oxygen and not getting it because that same sick COPD patient did a poor job of managing the maintenance fo their equipment..can you picture your mother/gradmother who dead on the floor with the cannula in their nose?????? Do something right.....I wholeheartedly pray to GOD that you take these and other comments very seriously as you will surely be murderers in just a few years if this type of regulation gets implemented....Hopefully you have a conscience!!!!

Submitter : Mr. Peter Cobb **Date:** 09/21/2006

Organization : Vermont Assembly of Home Care Agencies

Category : Health Care Professional or Association

Issue Areas/Comments

GENERAL

GENERAL

September 21, 2006

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1304-P

RE: Wage Index Applied to Home Health Prospective Payment System (PPS)

The Vermont Assembly of Home Health Agencies submits the following comments on the proposed rules relative to Home Health Prospective Payment System Rate Update for Calendar Year 2007, published in the Federal Register on August 3, 2006.

Starting January 2006, the new wage index for home care agencies moved from the application of metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs) in calculating the prospective payment rates (PPS). This system presents significant problems here in Vermont as it has produced a wage index for our most urban county that is much lower than that for the rural counties of our state.

Hospitals that experience a decrease in the wage index can ameliorate the impact on their reimbursement by seeking reclassification into a neighboring region with a higher index or by taking advantage of the rural floor when that is higher than their CBSA index. Unfortunately, under current PPS rules, these options are not available to home health agencies. In the interest of fairness and equity, we ask that CMS incorporate language into the proposed home health rate regulation for 2007 that would apply the rural floor to home health and hospice services.

This is a reasonable strategy to address what is an inequitable application of the wage index resulting in unintended consequences harmful to many home health care agencies and their patients and employees in Vermont and elsewhere. Further, this solution has the advantage of being simple to administer, requiring no individual provider evaluation beyond whether the urban index is lower than the rural index, and it would be budget neutral.

CMS has the authority to make such a policy change. Section 1895 [42 U.S.C. 1395fff] (b)(4)(C) reads as follows:

"Establishment of Area Wage Adjustment Factors - The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E)."

Nothing in this section precludes CMS from utilizing any of the policies it has already applied to hospitals under the applicable sections of the law.

Thank you for your consideration.
Peter Cobb

VAHHA Executive Director

Submitter : Mrs. Lisa Kuric **Date: 09/21/2006**

Organization : Elkhart General Home Medical Equipment

Category : Health Care Provider/Association

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

Section K. "Payment for Replacement of Beneficiary-Owned Oxygen Equipment, Capped Rental Items, and Associated Supplies and Accesories".
You state that "Medicare has traditionally paid for replacement items used in conjunction with beneficiary-owned DME" and then you go on to list examples. However, you give no guidelines or timetable as to how often Medicare will pay to replace the disposable supplies associated with home oxygen therapy. Many other disposable Respiratory items have specific replacement guidelines set forth by CMS, such as CPAP and BIPAP supplies. How often will CMS pay to replace disposable home oxygen supplies, such as; cannulas, oxygen tubing, humidification bottles, adaptors, and filters?

Submitter : **Priscill Mills**

Organization : **Medstar VNA Homecare**

Category : **Home Health Facility**

Date: **09/22/2006**

Issue Areas/Comments

GENERAL

GENERAL

Consolidated Billing PPS

Priscilla Mills, RNCMS
Medstar VNA Homecare
9601 Pulaski Park Dr.
Baltimore, MD 21220

September 12, 2006

To whom it may concern:

We need to look at other options for providing urological supplies to patients while under home care, especially patients on sterile intermittent catheters. These patients have chronic health issues which require the lifetime use of these catheters and usually have homecare for unrelated problems such as the need for physical therapy. We should not be providing supplies for chronic problems unrelated to our plan of care.

These supplies are very expensive and we are not reimbursed enough to provide sterile intermittent catheters, making it difficult to even serve these patients. These urological products are very specialized and our formulary may not carry the specific products that work for each patient, forcing them to change to a different product or pay for the supplies out of pocket. If we cannot provide a sterile routine for the patient, he is at risk for infections. This creates either a financial burden for the patient or puts him at risk for problems that would then increase the cost to the Medicare system to treat.

I hope that CMS will address this issue and ask that you forward this communication to them.

Thank You,

Priscilla Mills RNCMS
Sr Operations Director
Medstar VNA Homecare

Submitter : Calvin Herron

Organization : Calvin Herron

Category : Individual

Date: 09/22/2006

Issue Areas/Comments

GENERAL

GENERAL

Consolidated Billing PPS
September 13, 2006

To Whom It May Concern:

My husband, Calvin Herron, is a paraplegic as a result of aortic aneurysm surgery in 2001. He has been using a closed-system sterile intermittent catheter for his catheterization needs.

Calvin was on home health care following hospitalization, and we did not let our supplier know as it did not occur to us that home care would interfere with his catheters when they were seeing him for something unrelated. Once we became aware of Medicare s policy, I asked the home health agency to provide his catheters and was told they did not have to provide anything not included in their treatment. Ultimately, the agency did not provide any catheter supplies, and Calvin was only able to continue using sterile catheterization technique because of samples provided by our supplier and some extra he had from being in the hospital.

It has been very frustrating dealing with the home health agency to get his catheter supplies and has been frightening thinking that he would be unable to get them at all.

I do hope CMS can assist in this and ask that you copy my letter to them.

Sincerely,

Frances Lucille Herron

Submitter : Mrs. Jean Sullivan **Date:** 09/22/2006

Organization : Community Health Professionals

Category : Home Health Facility

Issue Areas/Comments

GENERAL

GENERAL

I just want to express my comments/concern with an agency's outcome data being affected when the patient has an HMO plan. If visits are limited by managed care this can affect the patient outcomes and there is nothing the agency can do to combat this.

I think outcomes of these patients should be charged to the HMO and Medicare should look at their performance and determine if the cost saving is worth the outcomes of the care.

Here are a few OASIS changes I would like to see

One area that I feel needs revision is Urinary Incontinence. The question does not allow an agency to show mild, moderate, controlled, or any type of improvement. The client is either incontinent or not. Many times improvement is made, but the patient still has to be classed as incontinent due to the wording of the question. Also the occurence of incontinence should include during the day also....not just day and night...or night only.

Another question is the bathing, if the question is to only pertain to the act of bathing and not the transfer then 2b should be removed as an option and # 3 should include the work continuous.

Also if the questions are to be answered using the determination of what the patient can do safely...the word safely should be included in all questions. We have many clients who do things independently, but are not safe doing them.

Submitter : Jim Weatherford **Date:** 09/22/2006

Organization : UroMed, Inc.

Category : Health Care Industry

Issue Areas/Comments

GENERAL

GENERAL

Consolidated Billing PPS - See Attachment

CMS-1304-P-23-Attach-1.PDF

#23

September 22, 2006

Herb B. Kuhn,
Director of Management and Policy
Centers for Medicare & Medicaid Services
MS C5-01-14
7500 Security Boulevard
Baltimore, MD 21244-1849

Re: Home Health Agency (HHA) Consolidated Billing for Urological Supplies

Dear Mr. Kuhn:

We are writing to request consideration of a new provision for the Medicare home health consolidated billing provisions for urological supply,A-4353, furnished under certain specific conditions, as described below. UroMed, Inc. is one of the few Medicare-participating direct-to-consumer that carries extensive spinal cord injury specialty urological supplies.

The primary purpose of the Medicare consolidated billing rules is to assure that all ancillary services, reasonably expected to be provided as part of a home health plan of care, are provided by the HHA and reimbursed solely under the Medicare home health benefit. For the most part, these rules are accomplishing their intended purpose. However, one of the most vulnerable beneficiary groups, individuals with spinal cord injuries (SCI), have been and continue to be negatively impacted by these consolidated billing rules. Persons with SCI typically practice self-care related to certain of their specific needs and conditions, including the chronic use of specialty urological supply, A-4353.

Although these individuals are generally self-sufficient in their use of urological supply, from time-to-time they often suffer from other temporary medical conditions, separate and apart from their bladder care, that require the assistance of outside medical nursing help under a home health plan of care. In these situations, under the current Medicare "consolidated billing" guidelines, the HHA that provides the plan of care service generally is required to provide all other medical supplies to the patient, irrespective of whether the need relates to the home health plan of care. These situations often negatively impact both the patient and the HHA when the patient has been otherwise self-managing conditions that are not a part of the home health plan of care.

Most HHA's are ill prepared to provide the specific urology products that an SCI beneficiary may need. Many times the nurse,physical therapist, or speech pathologist, is not even aware of the additional product needs as the plan of care visit is for an unrelated need. Even if they are aware of the additional product needs, most nursing agencies do not carry specialty urological supplies, specifically code A-4353. From the constantly changing contact individuals with whom we speak, we realize staff turnover is also a constant problem within HHA's. New personnel are often not knowledgeable of the agencies' obligations under consolidated billing. Additionally, the nursing agencies are under financial constraints with their plans of care to provide the supplies that are routine and non-routine; however, this specialty product, the A-4353, will place an excessive financial burden to meet the patient's ongoing urological needs. Hence, patients usually suffer as agencies provide quantities only sufficient to meet a non-sterile routine and products that may not be usable by the patient in question.

Therefore, despite a physician's prescription, a qualifying diagnosis and documentation, the patient gets denied the supplies for which they qualify once they need home health agency services. We understand, they are not supposed to do that. But, unfortunately, from a financial survival standpoint, the HHA may have to make an impossible choice: to ignore the home health presenting complaint and drop the patient or give them an inadequate type or quantity of their chronic bladder routine management products.

Bladder and bowel issues are quite sensitive for most people, and can directly impact a Medicare beneficiary's quality of life. Accordingly, SCI users of urology products often try many different products before they find what will work well for them. Once they find the products that work and get comfortable (both medically and psychologically) with those products, they are understandably reluctant to change the specific supplies. As noted above, many times, nursing agencies are unprepared and unwilling to provide the specific urological products that a user may need. This can actually result in a medically compromising situation for the beneficiary.

Unfortunately, once a beneficiary learns that he or she cannot rely on the HHA to provide the specific products that he or she requires, the beneficiary becomes desperate to find a way to maintain his/her customary supplies. Accordingly, in most cases, the beneficiary will not inform UroMed that he or she is under a home health plan of care, even when specifically queried. They do so, understandably, in order to have the supplier continue to send their specific supplies, proven to prevent their urinary tract infections and subsequent complications. When the supplier receives a payment denial due to the home he alth c onsolidated b illing rules as c urrently im plemented a nd de fined a nd the supplier calls the beneficiary to clarify, they express their fear of losing their supplies as the cause. This happens to UroMed on a regular basis requiring write-offs. UroMed suffers large financial losses every month because of these rules. As a Medicare supplier, UroMed and the beneficiaries we serve have been subject to the Medicare consolidated billing rules since their enactment in October of 2000.

UroMed
We Know.

In spite of our financial losses, it is really the beneficiaries who end up being hurt the most. In these cases, the home health consolidated billing provisions have served to take away a valuable and longstanding benefit of the beneficiary, and likely compromise his/her health and well being because of it. Such situations are clearly not consistent with the purpose of the consolidated billing rules, and unfair to both the suppliers, the HHA's and, most importantly, to the beneficiaries.

Accordingly, we respectfully request that consideration be given to creating an exception to the consolidated billing rules permitting urological supply, A-4353, to continue to be provided and billed away from the HHA plan of care. For patients with spinal cord injuries who have been receiving these products prior to the start of their home health care and who will continue to need these products after completion of the home health plan of care. We believe that such an exception would have only a limited impact on reimbursements made by CMS, but would have a very significant impact on the lives of SCI beneficiaries and the suppliers who serve them diligently.

We would be glad to meet with you and your medical advisors to further explain the needs of this special group of patients and to answer any questions that you may have. You may contact me at 800-841-1233.

Respectfully submitted,

Jim Weatherford
President
UroMed

Submitter : Ms. Lori Corey

Organization : Oxygen One, Inc.

Category : Other Health Care Provider

Date: 09/22/2006

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1304-P-27-Attach-1.PDF

Submitter : Susan Young

Date: 09/22/2006

Organization : Home Care Association of New Hampshire

Category : Home Health Facility

Issue Areas/Comments

Provisions of the Proposed Regulations

Provisions of the Proposed Regulations

The Home Care Association of New Hampshire submits the following comments on the proposed rules relative to Home Health Prospective Payment System Rate Update for Calendar Year 2007, published in the Federal Register on August 3, 2006.

The wage index moved from the application of metropolitan statistical areas (MSAs) to core based statistical areas (CBSAs) in calculating the prospective payment rates (PPS) for home health agencies in January 2006. As we had anticipated in our comments on the 2006 PPS rules, this change has had a significant negative impact on home health agencies serving residents in the four southern New Hampshire counties that were formerly classified in the Boston MSA. Not only have these agencies suffered a net decrease in their Medicare reimbursement rates, but they have also fallen further behind hospitals in their ability to compete in the healthcare labor market.

Hospitals that experience a decrease in the wage index can ameliorate the impact on their reimbursement by seeking reclassification into a neighboring region with a higher index or by taking advantage of the rural floor when that is higher than their CBSA index. In fact, in New Hampshire, ALL hospitals (except Community Access Hospitals) are now governed by the rural floor, which is significantly higher than the indices applicable to the state s non-rural counties. Unfortunately, under current PPS rules, this option is not presently available to home health agencies.

In the interest of fairness and equity, we ask that CMS incorporate language into the proposed home health rate regulation for 2007 that would apply the rural floor to home health and hospice services.

We believe this is a reasonable strategy to address what is an inequitable application of the wage index resulting in unintended consequences harmful to many home health care agencies and their patients and employees in New Hampshire and elsewhere. Further, this solution has the advantage of being simple to administer, requiring no individual provider evaluation beyond whether the urban index is lower than the rural index. Finally, it will be budget neutral if incorporated in the PPS rule CMS.

In the responses to comments on the proposed 2006 PPS rates, CMS asserted that reclassification for home health agencies is not authorized in statute and is inconsistent with the payment system for home health services which is based on where the patient resides, not where the agency is located. Our recommendation does not involve reclassification, but simply assigns a wage index rural or urban to the CBSA where the beneficiary lives.

Finally, we believe CMS does have the authority to make such a policy change. Section 1895 [42 U.S.C. 1395fff] (b)(4)(C) reads as follows:

Establishment of Area Wage Adjustment Factors. The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

Nothing in this section precludes CMS from utilizing any of the policies it has already applied to hospitals under the applicable sections of the law.

Submitter : **Karen Bischoff** **Date: 09/22/2006**

Organization : **UroMed, Inc.**

Category : **Health Care Industry**

Issue Areas/Comments

GENERAL

GENERAL

Consolidated Billing PPS
CMS

September 22, 2006

To whom it may concern:

I am writing to comment on the problems with A4353 being included in the Consolidated Billing PPS policy. Under the current Medicare consolidated billing guidelines, the home health agency that provides the plan of care service is required to provide these sterile intermittent catheters, regardless if these catheters are related to the plan of care or not. These situations often negatively impact the patient when he/she has been otherwise self-managing conditions that are not a part of the home health plan of care.

Most home health agencies are ill prepared to provide this specific urology product and many times the agency is not even aware of the additional product needs if the plan of care visit is for an unrelated need. Additionally, under the current rules, agencies have a financial incentive to provide the minimum possible alternative for medical needs not related to the condition generating the home health plan of care.

Unfortunately, once a beneficiary learns that he or she cannot rely on the home health agency to provide the sterile intermittent catheter, the beneficiary becomes desperate to find a way to maintain his/her needed sterile routine. In most cases, the beneficiary will not inform UroMed that he or she is under a home health plan of care, even when specifically asked by UroMed. They do this, understandably, in order to have the supplier continue to send them the specific supplies which are necessary for them to maintain their sterile catheterization technique.

This situation has proven difficult for all parties involved but most of all for the beneficiary. Removing this code from the Consolidated Billing policy would insure continued provision of sterile intermittent catheters necessary for these beneficiaries to maintain their health.

Thank you,
Karen Bischoff
Account Review Manager

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

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Please direct your questions or comments to 1 800 743-3951.