NACDEP

National Coalition for Dually Eligible People

3315 Tulane Avenue
New Orleans, Louisiana 70119

July 21, 2003

Manager, Professional Services
Louisiana Medicare Operations
8687 United Plaza Blvd
Suite 200
Baton Rouge, LA 70809

Re: Response to your suggestions regarding the overly-restrictive Medicare Part B Privacy Policy complaint: Your suggestions will not work.

Dear Professional Services Manager:

Thank you for your e-mail correspondence addressed to the Orleans Parish Medical Society dated June 7, 2003, which responds to my April 27, 2003 letter of complaint regarding the overly-restrictive Medicare Part B Privacy Policy, which was sent to Walter Stone at the Centers for Medicare & Medicaid Services. My letter of complaint stated that the Medicare Part B Privacy Policy decreases access to community health care for our most disabled Medicare beneficiaries. By refusing to verify Medicare eligibility, this excessively stringent policy increases medical costs and disparities in health care for these vulnerable people. In my April letter, I described five Medicare beneficiaries who had significant problems obtaining medical access to my office because of this restrictive Medicare Part B privacy policy.

Your suggestions will not work.

You stated in your email that I have "a valid concern" and suggested three options to obtain the required Medicare beneficiary information. Unfortunately, as we discussed on the telephone, none of these three suggestions would fix the problem, which is the need for *immediate, real-time access* to Medicare Part B eligibility information, similar to the accessibility for Medicare Part A.

Your First Suggestion: You suggest that I use the "HIPAA electronic transaction 270/271," which will allow providers to access information electronically.

As we discussed on the telephone, the HIPAA 270/271 is *not a working system*. There is not a single Medicare provider in our entire multi-state area using this system. Thus, your first suggestion does not work.

Your Second Suggestion: You suggest that I use the PEA or Provider Eligibility Access, which is an electronic file processed in the "batch mode."

In order to access the Provider Eligibility Access, a provider sends you an electronic request for Medicare information and then you return an electronic reply. However, the turnaround time for transmitting this information is *24 hours*. This long delay requires the patient to return to my office the next day or the next week to be treated. Such a delay is not acceptable. Therefore, your second suggestion does not work.

Your Third Suggestion: You suggest I have the Medicare beneficiary or their legal authorized representative sign an authorization form and fax or mail the form to Medicare. This would allow your organization to include a notation in the Medicare beneficiary's computer record stating that the patient has given you permission to release the information to the provider. You state this would also address my concerns when the legal authorized representative does not accompany the patient to the office.

According to our telephone conversation it may take up to *45 days* to update a Medicare beneficiary's computer record to allow a provider to access the required information. If 24 hours is too long to wait for eligibility information, then certainly waiting 45 days is an impossible situation. Therefore, your third suggestion does not work.

None of your suggestions would have helped any of the five disabled Medicare beneficiaries I described in my April 27, 2003 letter. None of your three suggestions would have allowed my staff to verify their Medicare Part B eligibility information.

Your current telephone policy is not adequate and is not acceptable.

Currently a provider may access Medicare Part B eligibility information by calling a Medicare representative on the telephone, and either the patient or their legal authorized representative may give verbal permission to release the information. Your telephone hours, however, are limited to Monday through Friday, 8:00 am to 4:30 pm.

In order to make their medical practices accessible to a wide variety of patients, physicians often have office hours in the evening or on weekends. Even if a patient is able to answer a Medicare representative's questions on the telephone, please tell me how a physician can verify a Medicare beneficiary's Part B eligibility on Thursday at seven o'clock in the evening, or Saturday at 11 o'clock in the morning. On occasion I have made a home visit to a disabled Medicare patient at 7:00 am before coming to my office. How can I verify a patient's Medicare information at 7:00 am while I am at the patient's home? The practice of medicine can be a 24-hour-a-day, seven-day-a-week profession.

Limiting your telephone availability to a maximum of 42 ½ hours per week cannot serve our diverse Medicare population.

Your legal authorized representative requirement is a burden.

Your requirement that a patient who cannot communicate on the telephone must have their authorized representative speak for them is not acceptable. I have many disabled Medicare beneficiaries in my practice who are being well cared for by family or community friends, who are not their legal representatives. Few people in my patient community have a legal representative prior to becoming ill. Many people who suddenly become ill never regain the intellectual capacity to fill out the required forms after they become disabled. Few of these severely disabled people or their families have the financial resources or ability to get legal help to complete this process once they become disabled by a stroke, Alzheimer's disease, etc. Medicare Part A has adjusted to this reality, just as Medicare Part B must adjust its regulations, too. Examine the next two situations involving actual patients of mine:

Patient H.S. is a severely disabled 55-year-old African-American male with mental retardation, a speech impediment, psychosis, and a seizure disorder, whom I have been treating for 17 years. He lives in a boarding home and is well cared for by the owner of the boarding home. He has no legal representative. Recently H.S. had a seizure, fell down and fractured his wrist. He had a cast applied in a local emergency room, and several days later he was admitted to a hospital for elective surgery to repair his wrist fracture. I asked the caretaker how she was able to monitor and control his care in the emergency room and hospital without being the patient's legal representative. She told me that whenever H.S. needs hospital or emergency room services she "just tells the doctors that I'm his cousin, and they all accept this." Nobody questions this arrangement, and no one asks to see her legal paperwork.

Patient M.R. is a severely disabled 75-year-old African-American woman with advanced Alzheimer's disease whom I have been treating for 10 years. When she was no longer able to live by herself, she moved in with a distant family member who now oversees her financial and medical affairs. Recently M.R. required admission to a geriatric psychiatric hospital because of her increasing agitation and worsening psychotic behavior. The caretaker is actually M.R.'s daughter-in-law through a common-law marriage. I asked the caretaker how she was able to direct the patient's medical care while in the hospital, and she told me that she "just tells everyone that I'm her niece." No one questions her further.

These Medicare Part A facilities were quickly able to verify the patient's eligibility by using the telephone. They were not interested in making it more difficult to treat these two patients by insisting the caretakers produce technical documentation before they would treat these severely disabled patients. In these Medicare Part A facilities the caretaker authorizations were done with a "wink-and-a-nod" because everyone involved understood that the most important thing was to treat these patients

and it would be wrong to allow bureaucratic formalities to stand in the way of what is obviously in the best interest of these patients.

I do not object to these and similar living arrangements because I understand that these informal arrangements are common practice in my patient community. According to the AARP, "Most minority older persons remain in the community and are cared for by family, friends and relatives. But as the number of frail older persons continues to grow, so does the burden placed on those who care for them."[1]

Whenever I see patient H.S. or M.R in my office they are well groomed, calm, and pleased to be with their caretakers. These caretakers have shouldered the responsibility of caring for these disabled Medicare beneficiaries because they love these people and have made them part of their household. It would be difficult, however, to accept these patients into my Medicare Part B outpatient practice using the current Medicare Part B authorization forms. According to the form, "Permission to Release Facts About Medicare Record," which the authorized representative must sign and mail or fax to Medicare to allow the provider to verify the billing information, the caretaker must sign a statement that asserts: "I understand that any false representation . . . is punishable by a fine of not more than $5,000 or one year in prison." Informal caretakers are rightly reluctant to sign such a form — even though they are providing the very best care these patients will find in the community. Thus, the "wink-and-a-nod" authorization that goes on in Medicare Part A cannot be used in Medicare Part B, to the detriment of the patient. Even if a patient has a true legal representative, the requirement that the representative be present in the emergency room or physician's office only adds another administrative impediment to the already stressful job of caring for a severely disabled person.

Finally, last week a 70-year-old man was referred to me from a psychiatric daycare facility for a medical examination. He recently moved to New Orleans from California and lives in a boarding home. Although he was able to speak with the Medicare representative on the telephone and correctly stated his social security number and his date of birth, he could not correctly recall the mailing address, which was listed on his Medicare computer record. The man, who is mentally impaired, simply could not remember his previous mailing address in California, which is an understandable lapse for someone with his disability. Nonetheless the Medicare representative would not release his Medicare billing and eligibility information. This makes no sense at all.

The solution is simple.

What is good enough for Medicare Part A must be good enough for Medicare Part B. If a simple telephone call is good enough for Medicare Part A, then this must be good enough for Medicare Part B. Allowing easy access to expensive Medicare Part A facilities, while making it difficult to access information for inexpensive Medicare Part B

[1] Bacon, Carrie, project manager. Portrait of Older Minorities. AARP Minority Affairs. [Washington]: Nov. 1995. 18 Feb. 2001 <http://research.aarp.org/general/portmino.html>.

outpatient services is not in the best interests of our disabled patients and costs more money for our Medicare system.

Medicare Part A facility numbers are not password-protected numbers. Every physician who bills Medicare for home health services must store the facility number of several home health agencies in his or her computer in order to complete the Medicare claim forms. The facility number is also plainly visible on many of the home health documents that are sent back and forth for the physician to review.

Give me a Medicare Part B telephone number to call at any time of the day or night and allow me to input my Medicare UPIN number or other password-protected number to obtain the necessary eligibility and billing information. If you allow a clerk in a Medicare Part A facility to obtain this information, then certainly a physician who has sworn an oath and has a medical license, business, and reputation to protect should be trusted to use the information wisely and in the best interests of our Medicare patients. Give me *immediate, real-time access* to Medicare Part B eligibility and billing information, in the same manner as Medicare Part A.

Thank you.

Sincerely yours,

Sheldon Hersh, MD

CC: Orleans Parish Medical Society
Louisiana State Medical Society
American Medical Association
Walter Stone, CMS
And others