

**Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction
Summary of Provisions that Affect AAO-HNS in Proposed Rule**

CMS proposed a rule on October 18th designed to address unnecessary, obsolete, or excessively burdensome Medicare and Medicaid Regulations. CMS estimates that the proposed rule would create overall cost savings to regulated entities and to patients that may approach \$200 million in the first year.

Below is a summary of a few of the provisions that would affect Otolaryngology- Head and Neck Surgery.

1. Revocation of Enrollment and Billing Privileges in the Medicare Program (§424.535)

This provision eliminates the one to three year barring of re-enrollment in Medicare when providers or suppliers have not responded in timely manner for requests for revalidation of enrollment.

2. Deactivation of Medicare Billing Privileges (§424.540)

This provision changes the deactivation of billing privileges when claims have not been submitted for 12 consecutive months. In the change, deactivation would occur for providers and suppliers that do not submit form CMS-855I. The regulation would also deactivate, rather than revoke, billing privileges for providers or suppliers that do not provide correct information within 90 days of receiving notification from CMS. Once deactivated, providers or suppliers would have to submit a complete enrollment application again.

3. Removal of Obsolete Provisions Related to Initial Determinations, Appeals, and Reopenings of Part A and Part B Claims and Entitlement Determinations (§405.701 through §405.877)

This provision removes a separate pre-Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) appeals process for all Part A and Part B claims. The tables below show how a pre-BIPA appeal related to Part A or Part B claim at one level of review would be handled.

Table 1 – Pre-BIPA Part A Appeals	
Pending Pre-BIPA Level of Appeal in part 405 subpart G	Appeal resumes at the following level in part 405 subpart I
Reconsideration (§405.710)	Redetermination (§405.940)
ALJ Hearing (§405.720)	QIC Reconsideration (§405.960)
Departmental Appeals Board Review (§405.724)	Medicare Appeals Council Review (§405.1100)

Table 2 – Pre-BIPA Part B Appeals	
Pending Pre-BIPA Level of Appeal in part 405 subpart G	Appeal resumes at the following level in part 405 subpart I
Review of Initial Determination (§405.807)	Redetermination (§405.940)
Carrier Hearing (§405.821)	QIC Reconsideration (§405.960)
ALJ Hearing (§405.855)	QIC Reconsideration (§405.960)
Departmental Appeals Board Review (§405.856)	Medicare Appeals Council Review (§405.1100)

4. E-prescribing (§423.160)

This provision revises e-prescribing standards under Medicare Part D to make them consistent with HIPAA regulations effective January 1 2012.

CMS is also finalizing a separate rule that is anticipated to reduce costs in Ambulatory Surgical Centers

1. Ambulatory Surgical Centers (§416.50)

In a separate proposed and final rule, CMS revised the Ambulatory Surgical Center (ASC) patient rights proposed rule at 42 CFR § 416.50(a) to allow ASCs to continue providing services based on the criteria determined by applicable ASC patient scheduling standards and policies that were in effect prior to implementing the patient rights final rule published on November 18, 2008. In addition, the final rule revises conditions for coverage to allow patient rights information to be provided to the patient, the patient's representative, or the patient's surrogate prior to the start of a surgical procedure.

CMS estimates that there were roughly 7 million ASC admissions in 2009. Of this amount, they predict that approximately one in five (which would ordinarily require two medical visits, one on each of two separate days) would be reduced by one visit allowing ASCs to perform surgical procedures on the same day a patient is referred to an ASC. CMS calculates that the final rule is proposed to help patients avoid roughly 1,400,000 visits or \$35 million per year. Notably, CMS also projects that this will result in \$17.5 million a year in provider cost savings.