

**HOW MEDICARE SUPPLIERS AND BENEFICIARIES
CAN COMPLAIN ABOUT DURABLE MEDICAL EQUIPMENT,
PROSTHETICS, ORTHOTICS, AND SUPPLIES
("DMEPOS") CONCERNS**

Overview, Instructions and Forms

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The Competitive Bidding Interactive Public Docket
<http://www.thecre.com/blog/>

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PREFACE

The Center for Regulatory Effectiveness (“CRE”), through its Competitive Bidding Interactive Public Docket (“IPD”) <http://www.thecre.com/blog/> has been a major interventionist in the CMS’s DMEPOS competitive bidding program.

CRE understands the need to reform a program which includes elements that have oft time has been criticized for abuse and fraud. However, when reforming the program, special care needs to be given to ensuring that Medicare beneficiaries are not harmed in the process. Thus, CRE recommends that CMS modify its DMEPOS competitive bidding program to allow any qualified small business that meets the US Small Business Administration’s definition of a small business to participate in the program if they are willing to accept the competitively determined “single payment amount.”

CRE’s recommendation is at found on the IPD at, <http://www.thecre.com/blog/2009/06/cms-competitive-bidding-adopt-the-cre-small-business-enhancement-option-2/>

As currently constituted, CMS’s competitive bidding program will severely reduce the number of DME suppliers. CRE, and the beneficiaries themselves, believe that decreasing the number of suppliers will harm the health and well being of the nation’s elderly. For more information on the views of Medicare beneficiaries, and to hear their views, please see <http://www.thecre.com/blog/2009/10/cre-dme-hotline-inaugural-post/>

What follows in this handbook are descriptions and filing instructions for three complaint processes. We encourage all suppliers and beneficiaries to use these complaint forms as appropriate. When filing the form(s), we encourage the petitioners to provide a copy of their complaint to CRE along with permission to use it in our discussions with CMS.

CREs ultimate objective is to use the weight of the petitions as a basis for seeking substantive changes in the CMS competitive bidding process before CMS commences the next round.

CRE wishes to notify all suppliers and beneficiaries that although we do not have the resources to answer to each email cmscomments@thecre.com, comment received on the Discussion Form, <http://www.thecre.com/Forum/> or on the Beneficiaries Hotline 1-800-613-7678, we do read/listen to all of them.

MANUAL OVERVIEW

There are three different ways that Medicare durable medical equipment suppliers and beneficiaries can complain about DMEPOS issues. All three of the complaint processes may be used by beneficiaries and one of the complaint processes may also be used by suppliers.

This manual provides instructions and forms for all three complaint processes.

Suppliers and beneficiaries should understand that they do not have to limit themselves to only one avenue of complaint. The same concern can be pursued using more than one type of complaint process.

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Complaint by a DMEPOS Supplier or Individuals to the CMS Competitive Acquisition Ombudsman

Instructions

The Medicare Improvements for Patients and Providers Act of 2008 (“MIPPA”), section 154(f), requires the Secretary of Health and Human Services to provide for a “Competitive Acquisition Ombudsman” within CMS. The responsibility of the Ombudsman is “to respond to complaints and inquiries made by suppliers and individuals related to the application of the competitive acquisition program” The Ombudsman must report annually to Congress.

Currently, there is an Acting Competitive Acquisition Ombudsman (“CAO”). CMS is preparing a new CAO website. But it is not necessary to wait for a new website or a permanent CAO in order to submit complaints or inquiries.

The Acting Competitive Acquisition Ombudsman is expected to be particularly interested in the adequacy of rural DMEPOS providers and services.

This form of complaint can be used by both DMEPOS suppliers and by any individual who is complaining about durable medical equipment issues. Under the rules, an “individual” does not have to be a Medicare beneficiary.

If you are a supplier, you could use this complaint process along with the preceding complaint process (complaint to an AO).

A form for filing complaints is attached, or you can send a letter. The complaint or letter should be sent to:

Ms. Tangita Daramola
Acting Competitive Acquisition Ombudsman
Centers for Medicare & Medicaid Services
U.S. Dept. of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

If you choose to supplement the sample form with an attachment to further describe your complaint, please put your name at the top of each extra page and mark them as attachments to the form. Also please date each supplemental page.

If you wish to include any documentation relevant to your complaint, please attach it to the sample form and indicate on the form that you are attaching documentation and provide a brief description of the documentation.

If you do not receive a response from the CAO, or an acknowledgment of receipt, within two weeks, call the above office at **410-786-4050** to confirm that they received your complaint and to inquire as to its status and when you can expect to receive a response.

Please provide a copy of your complaint to CRE along with permission for us to use it in our discussions with CMS. You may send it via email to cmscomments@thecre.com, or via mail to:

The Center for Regulatory Effectiveness
1601 Connecticut Avenue, NW – Suite 500
Washington, DC 20009

**Complaint by a DMEPOS Supplier or an Individual to
the Medicare Competitive Acquisition Ombudsman**

(pursuant to sec. 154(f) of the Medicare Improvements
for Patients and Providers Act of 2008)

Name of Supplier or Individual:	
Address of Supplier or Individual:	
If a Supplier, Supplier Contact Name, Phone, and Email	
If an Individual, Phone Number and Email (if any):	
Describe complaint about CMS of DMEPOS competitive acquisition program (here or in attachment):	
Signature of Contact or Individual:	Date:

Complaint by a Medicare Beneficiary to the Medicare Beneficiary Ombudsman

Instructions

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (otherwise known simply as the Medicare Modernization Act, or “MMA”) established the Office of the Medicare Beneficiary Ombudsman (“OMO”).

The Ombudsman receives and responds to complaints by individuals enrolled in Medicare “with respect to any aspect of the medicare program.” The OMO must submit an annual report to Congress concerning such complaints and include “such recommendations for improvements” in the Medicare program as he determines appropriate.

Thus, Medicare beneficiaries can complain to the Ombudsman concerning any flaw in their ability to receive adequate service in the form of DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies).

The OMO does not have a specific form for filing complaints. Therefore, a sample form for OMO complaints is attached on the next page. Alternatively, an individual can simply send a letter. The complaint form or letter should be sent to --

Mr. Daniel J. Schreiner
Medicare Beneficiary Ombudsman
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

If you choose to supplement the sample form with an attachment to further describe your complaint, please put your name at the top of each extra page and mark them as attachments to the form. Also please date each supplemental page.

If you wish to include any documentation relevant to your complaint, please attach it to the sample form and indicate on the form that you are attaching documentation and provide a brief description of the documentation.

Please provide a copy of your complaint to CRE along with permission for us to use it in our discussions with CMS. You may send it via email to cmscomments@thecre.com, or via mail to:

The Center for Regulatory Effectiveness
1601 Connecticut Avenue, NW – Suite 500
Washington, DC 20009

If you do not receive a response from the OMO, or an acknowledgment of receipt, within two weeks, call the above office at **410-786-0630** to confirm that they received your complaint and to inquire as to its status and when you can expect to receive a response.

**Complaint by a Medicare Beneficiary to the
Medicare Beneficiary Ombudsman**
(pursuant to 42 U.S.C. § 1395b-9(c))

Name:	
Medicare No.	Date of Birth:
Address:	
Phone No. and Email (if any):	
Describe complaint either here or in attachment (indicate attachment):	
Signature:	Date:

Complaint by a Medicare Beneficiary to a Medicare Quality Improvement Organization (“QIO”)

Instructions

Medicare amendments in 1986 required the Centers for Medicare & Medicaid Services (“CMS”) to establish professional standards of care for Medicare beneficiaries. The amendments also required CMS to establish a Quality Improvement Organization (“QIO”) in each State to oversee implementation of the standards of care.

In addition, the amendments established a complaint process which allows Medicare beneficiaries to file complaints with any QIO about the quality of Medicare service they have received (or failed to receive) which doesn’t meet professionally recognized standards of care.

CMS has developed a complaint form and instructions for use by beneficiaries wishing to complain about their Medicare service.

A copy of the form and instructions is attached. (The underlined blanks in the form and instructions can be disregarded.)

A complaint should be filed with the QIO for the State in which you are located. A list of all QIOs and the States they cover can be found at:
<https://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQGeneralPage/GeneralPageTemplate&name=QIO%20Listings>

If it is not clear from the your State’s QIO website where a complaint should be sent to, call the QIO and ask how it should be addressed.

If you do not receive a response from the QIO, or an acknowledgment of receipt, within two weeks, call the QIO to confirm that they received your complaint and to inquire as to its status and when you can expect to receive a response.

If you are dissatisfied with the response of the QIO, you can file a complaint concerning the QIO with the Medicare Beneficiary Ombudsman, as explained in the preceding pages of this manual (p. 9).

Please provide a copy of your complaint to CRE along with permission for us to use it in our discussions with CMS. You may send it via email to cmscomments@thecre.com, or via mail to:

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Medicare QUALITY OF CARE COMPLAINT FORM

Information to Help You Fill Out the “Quality of Care Complaint” Form

The Medicare Program works to ensure that beneficiaries get the best care possible. We take your concerns seriously and would like to get more information to help us review your request. Use of this form will ensure that we process your concerns in an efficient manner. Quality Improvement Organizations (QIOs), under contract with Medicare, are required to conduct reviews of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of health care. You may contact the QIO for assistance in completing this form or for general assistance regarding your complaint.

Please use this step-by-step instruction sheet when completing your “Quality of Care Complaint” Form. Be sure to complete all sections of the form. In addition, if your personal information has been included in the form based on contact you have had with the QIO for your state, please review the information to confirm its accuracy.

1. Print the name of the Medicare beneficiary who has a complaint about the quality of health care he/she received.
 2. Include the Beneficiary’s Medicare (HICN) number if known.
 3. Check the appropriate box designating the sex of the individual listed in number 1. In addition, please indicate the age of the beneficiary in the blank space provided, if known.
 4. Check the appropriate box or boxes indicating the race/ethnicity of the individual listed in number 1. Please note that this information is strictly voluntary and has no impact on the processing of the complaint.
 5. Print the name of the beneficiary’s authorized representative if someone other than the beneficiary will be the contact for the processing of the complaint.
 6. Print the contact information for the beneficiary or for the beneficiary’s authorized representative someone other than the beneficiary will be the contact for the processing of the complaint.
 7. Provide a brief description of the incident or concern. The description should include any information you believe is relevant to the review of your complaint, including:
 - dates and times,
 - physicians and provider staff involved,
 - information from witnesses if available, and
 - a description of what happened.
- If you require more space to describe your complaint, you may attach additional sheets of paper. In addition, you may provide any documents you believe support your complaint.
- Please note:** If you raise concerns that are not quality of care concerns within the scope of the QIO’s authority, your complaint will be referred to the appropriate entity.
8. Check the appropriate box indicating whether you would like the physician or provider who is the subject of your complaint to know that you have filed a complaint with the QIO about the care you received. The QIO will not reveal your identity if you check “No.”
 9. By signing the form, you are authorizing the QIO to review your complaint and render a formal determination. The processing of your complaint may require the requesting of pertinent medical records.
 10. PLEASE keep this page for your information. Only mail the second page (Medicare Quality of Care Complaint Form) to the QIO. The phone number of your QIO is _____. A decision on your complaint will be made within ____ days of receiving the signed complaint form.

Medicare QUALITY OF CARE COMPLAINT FORM

1. Beneficiary Name:		
2. Medicare # (HICN):		
3. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Age: _____		
4. Race/Ethnicity (Completion of this section is voluntary): How would you describe your race? Please mark one or more boxes. <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino		
5. Beneficiary's Authorized Representative's Name (If applicable):		
6. Contact Information:		
Street/Apt.		
City:	State:	Zip:
Phone:	Alternate Phone:	
7. Briefly Describe the incident or your concerns: Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate.		
8. May we reveal your identity during the review of your complaint? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For your information: <ul style="list-style-type: none"> • If you have any questions about your complaint, please call _____. • You will be contacted within ___ days upon the QIO's receipt of the signed complaint form. • The QIO will utilize a physician who practices in the same or similar clinical area as the physician who provided your care in completing its review. • You may provide any information you believe is relevant to your complaint, including copies of documentation, names of witnesses, etc. • A decision will be made on your complaint within ___ days of receiving the signed complaint form. • If your complaint includes concerns not within the scope of the QIO's authority, the concerns will be referred to the appropriate entity. 		
9. By signing this form, I am requesting that the QIO review my complaint.		
Signature of Beneficiary/Representative:		Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is XXXX-XXXX. The time required to complete this information collection is estimated to average __ minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.