Centers for Medicare & Medicaid Services
Special Open Door Forum:

Medicare's Prior Authorization for Power Mobility Devices Demonstration

Friday, July 27, 2012
3:00pm - 4:30pm Eastern Time
Conference Call Only

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for **suppliers and providers** to hear more and ask questions about the Demonstration.

The Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers.

CMS received many comments/suggestions on the Prior Authorization of Power Mobility Devices (PMDs) demonstration. The CMS has considered these comments carefully. In response to comments received from stakeholders, the CMS has made a number of modifications to the Prior Authorization of PMD demonstrations.

To read more about the Demonstration visit: go.cms.gov/PAdemo

Participants may submit questions prior to the Special ODF to pademo@cms.hhs.gov .

We look forward to your participation.

Special Open Door Participation Instructions:

Dial: (866) 501-5502 & Conference ID: 61960446
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.gov/opendoorforums/ .

Future Special Open Door Forums Scheduled for Medicare's Prior Authorization for Power Mobility Devices Demonstration: 8/29/12 at 3PM ET. Call information TBA.

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/072712PMDSODFAudioID61960446.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Melanie Combs-Dyer
July 27, 2012
3:00 p.m. ET

Operator: Good afternoon. My name is (Adam) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare & Medicaid Services Prior Authorization of Power Mobility Devices Demonstration special open-door forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Matthew Brown, you may begin your conference.

Matthew Brown: Thank you very much, (Adam). My name is Matthew Brown and I work in the Office of Public Engagement here at CMS and I'll be your moderator for today's call. The purpose of this call, this special open-door forum is to provide an opportunity for suppliers and physicians to hear a little bit more about the Medicare Prior Authorization for Power Mobility Devices Demonstration and it's an opportunity for you to ask more questions.

On this call, we will make a few announcements and then we'll open the call up to questions. The operator will then instruct you on how to get in line to ask your questions. I'd like to remind you that there will be a transcript for this special open-door forum on the special open-door forum Web site in about a week. And you have that Web link on your announcement.

Now, I'd like to turn the call over to our call leader, Melanie Combs-Dyer who is the Deputy Director of the Provider Compliance Group here at CMS. Melanie?

Melanie Combs-Dyer: Hi. Thank you, everyone, for joining us today. I'd like to start by just refreshing everyone's memory about some general information about our Power Mobility Device prior authorization demonstration. For those of you who have heard this before, I apologize. I'll try to go quickly.

People should keep in mind that this prior authorization demonstration applies to fee-for-service Medicare only. If you are someone who submits claims to Medicare Advantage, you don't need to worry about this. If you're someone who only submits to private payers or to Medicaid, you don't need to worry about it. It only applies to folks who submit claims to the fee-for-service Medicare program.

And it really will – it's really those who submit claims to our Durable Medical Equipment Medicare Administrative Contractors, we call them DME MACs. Those are the folks if you submit claims for PMDs to those four organizations then you may be impacted by this and you should be listening.

Our DME MACs will be reviewing prior authorization requests for scooters and power wheelchairs and collectively we call the scooters and power wheelchairs PMDs. Scooters are those devices that cost around $1,500 and power wheelchairs are the ones that cost upwards of $3,600 over the course of the rental.

Our start date is still listed as summer 2012. And the demonstration is going to be in place in seven high-fraud states. Those states are California, Illinois,

Michigan, New York, North Carolina, Florida and Texas. And it's important to recognize that the demonstration applies to beneficiaries who reside in these states, not necessarily suppliers who are located in or physicians who are located in. It depends on where the beneficiary resides.

And one more quick thing about the start date, I said it started in summer 2012, it's for orders written on a start date that will be announced later. That start date will be in the summer of 2012. So if this is an order that was written back in May and the beneficiary has already received the PMD and they've been getting rentals – you've been submitting rental claim every month since May, you will not be impacted by this. It's only new orders that are written after our start date which is still to be determined but it will be sometime in the summer of 2012.

And last time (inaudible) asked the question why – why are you doing this. We're really doing this because there's a very high error rate, a high incidence of fraud and improper payments. The OIG – the Office of Inspector General for the Department of Health and Human Services recently reported that 80 percent of claims for power wheelchairs did not meet Medicare coverage requirements.

A couple of reminders about some changes to the demonstration, if you were tuned in last fall, you may have heard us talk about the demonstration back then but it has been revised quite a bit since that time.

There were four major changes that we made. The first is that we eliminated phase one. We originally were planning to have a prepayment-only phase for a few months and then go into a prior authorization phase. We've eliminated phase one and we're going to go straight into the prior authorization.

Number two, we originally said that the ordering physician and only the ordering physician could submit the prior authorization request. We've made a change there as well. We are now saying that the physician or the supplier who's acting on behalf of the physician can submit the prior authorization request.

Number three, we originally had planned on staggered start dates for our seven states. Folks said that's awfully confusing and so our revised demonstration has all seven states starting the prior authorization program at the same time.

And finally, there is a concern that we have not given enough notice about the start date. We made our announcement originally in mid-November. We held our first open-door forum call in December and the start date was January 1. Folks said "That's way too soon. You need to give us more information and a longer lead time." So we delayed the demonstration, the start date of the demonstration to summer of 2012.

It's important to keep in mind that the ordering physician or ordering practitioner or the supplier can submit the prior authorization request. And once they do, the DME MAC will have 10 days to make a decision, write out their detailed letter and put it in the mail to the physician practitioner, the beneficiary and the supplier so all three interested parties will be notified about the decision.

Again, that decision on an initial request, the DME MAC will get postmarked within 10 days. If the – if the DME MAC decides to not affirm the request or to deny the request, the letter will be quite detailed explaining what was missing from the documentation or why the denial was being made.

And in those situations the submitter may submit a subsequent request and there's no limit in terms of how many subsequent requests can be sent in. However, we're not waiving any of the normal timeframe. So if there are certain rules that say that the item has to be delivered within a certain number of days of the order, that is still in place.

DME MACs will review all subsequent requests within 20 days. A couple of scenarios that we can walk through here, the four most common scenarios that we are expecting are as follows; number one, if a prior authorization request is submitted and the DME MAC decides to affirm it – they give it a thumbs up, they approve it – then the supplier can deliver the item, can submit the claim and the claim will be paid so long as all the other requirements are met.

Under scenario number two, the submitter submits the prior authorization request – remember the submitter can be either the supplier or the physician treating practitioner. And in scenario number two, the DME MAC reviews the request and makes a non-affirmative decision. They decide not to approve it.

In that situation, the supplier has two choices; they can either submit the claim – deliver the item and submit the claim and the claim will be denied – they might want to do that so that they can go submit it to a secondary payer. The other choice that the supplier has is to fix the prior authorization request and resubmit that prior authorization request and get themselves back into scenario one where there is an affirmative decision where they can deliver the item and submit the claim and the claim will be paid.

Scenario three is where the physician and supplier decide not to submit a prior authorization request. This is not a mandatory program. Physicians and suppliers don't have to do this. We're strongly encouraging them to in these seven states.

But if they choose not to, then obviously the DME MAC will not be sending them a letter affirming or non-affirming the prior authorization request. Instead, the supplier can deliver the item and submit the claim.

And if they are a competitive bid supplier, the DME MAC will stop their claim, send an additional documentation request to the supplier, receive the documentation back – again, it takes 45 days, they wait for that additional documentation request letter to result in documentation coming in from the provider. And then they have 60 days to review the documentation once it comes in. If it is determined to be a payable claim, then they will pay it at the normal rate.

Scenario four is the supplier who chooses not to submit so there is no DME MAC decision. If the supplier chooses not to submit a prior authorization request they get no decisions on that prioritization request from the DME MAC. If they are a non-competitive supplier they can go ahead and deliver the items, submit the claims, the DME MAC will send a letter to the supplier requesting additional documentation, the DME MAC will review the claim

and if it's payable they will pay it at 75 percent of the Medicare payment amount.

Now that's after a couple of months of grace period. For a couple of months they'll pay it at 100 percent but after the demo has been in place for three months there will be a 25 percent payment reduction that will apply.

So in summary this is going to be a demonstration that will be in place for beneficiaries who reside in seven states, California, Illinois, Michigan, New York, North Carolina, Florida and Texas, it will be starting in the summer of 2012 based on the date of the order. The prioritization request can be submitted by the physician, practitioner or the supplier and the demonstration will end in the summer of 2015. That will be three years after the start date.

For more information you can go to our Web site, (go.cms.gov/PADemo), that's (go.cms.gov/PADemo). The P, and A, and the D have to be capitalized to get to the right page. We also encourage you to go to our frequently asked questions, that's (go.cms.gov/PAFAQ2012), that's (go.cms.gov/PAFAQ2012). And if they don't come up right away put in the key word (PMD) and you should be able to find them.

So with that as background I'd like to talk for just a second about our start date. Our start date continues to be the summer of 2012. We are planning to display a Federal Register notice soon that will announce the start date of the demonstration. This notice will display for at least 30 days before the start of the demonstration and the Web site for the Federal Register is www.federalregister.gov , again, www.federalregister.gov .

And once the Federal Register notice has been displayed we will update our Web site to link to it and to also announce the start date. Again, we are anticipating moving forward with that display shortly so for those of you who really care about this you can check back to our Web site. I would suggest maybe a couple of times next week you want to check our Web site and see where things stand.

One final thing before I turn it over to Doris to tell us about the demonstration operations guide, I wanted to talk about the letters. We are planning to send

certified letters to all physicians who have ordered PMDs in these seven states over the last couple of years and all suppliers who have supplied PMD in these seven states over the last couple of years. We are preparing those letters and they will be sent by our DME MAC. They will tell physicians and suppliers more about the demonstration, point them to our Web site and announce the start date, again, they will go out before the demonstration begins.

At this time I would like to turn it over to Doris to talk about – this is Doris Jackson, she is going to be talking about our demonstration, operations guide which you can find on our Web site.

Doris?

Doris Jackson: Good afternoon. The guide has been updated since our last posting probably about a month and a half ago. Actually Melanie touched on some of the changes that are in the manual. One item that we have changed, well, we haven't changed; we actually have a place hold concerning accessories. At this point in time we have not made a decision and we will talk about that later and once we have made a decision we will surely let the industry know what that position is and of course that information will be placed within the manual and also our frequently questioned and Web site also.

Another item that has actually changed, initially when we started the demonstration, for the re-submitted request, it would be a resubmitted decision letter would be within 30 days. That has changed now and we heard your comment and we changed to 20 days, so that letter would be postmarked within 20 days and that information if you're looking at the manual, it's actually on page eight.

Then the third item is claim submission. There is actual language in the manual that describes how you should submit your claims and attach the tracking number and that is on page nine. Bear with me because I am not a systems person so I will read it to you, "Submission of the prior authorization PMD claim is to have the 14 bytes unique tracking number that is located on a decision letter. For submission of a claim the unique tracking number is

submitted in Item 23 of the 1500 claim form. For electronic claims the unique tracking number is submitted at either loop 2300 (REFO-2) or loop 2400 (REFO-2)."

Hopefully everyone knows what that means, if not we will surely help you with that if anyone has questions about that. That is the last update that we have concerning the manual and as we move along through the process of starting the demonstration we will modify the manual to include more guidance as needed.

And at this time I think we have some questions that we received that we would like to go over.

Melanie Combs-Dyer: This is Melanie and I would like to talk about one question that we received last time that we have a partial answer for.

The question had to do with accessories and it was actually a two-part question. The first part of the question is, "In those situations where the power mobility device space is going to be one of the bases that is with power options that requires certain accessories according to the local coverage determination to be reviewed by the DME MAC in order to make a decision on the base. What should the suppliers send in with their prior authorization request? Should they only send in documentation about the base or should they send documentation about the base and the accessory?"

And we have an answer to that question and that is whenever documentation is required before delivery by the LCD to support the base, that's what you need to send in with your prior authorization request. And you can be watching our FAQ site over the next couple of days. We will be issuing that in writing on our FAQ site.

So, again, what you have to send in with the request, do you send in stuff about the accessories or do you send in stuff just about the base? If the LCD says that the base decision requires you to send in accessories documentation then you need to send in the accessory documentation.

The second part of the question is what will the prior authorization decision letter say? Will it just address the base or will it address the base and the accessories? And we are still working on our answer to that and we will be putting out an FAQ probably within the next month and we will be addressing that also at our next Open Door Forum call.

Now I believe that we had a question that came in to our e-mail box about documentation, longitudinal documentation, documentation about the patient's past medical history and whether or not that needed to be submitted. And I believe that we have Dr. Brennan on the phone who can help answer that question.

Dr. Brennan, can you help us answer that question?

Stacey Brennan: Good morning, Melanie and everybody attending. The question was that in the PMD policy or LCD there's a statement and I'm going to read that statement, "Upon request, supplier shall provide notes from prior visits to give a historical perspective of the progression of disease over time and to corroborate the information in the face-to-face exam.

That sentence, I think, is there to illustrate that, once again, we would like the physician who is ordering the power wheelchair to give us the best picture – sorry.

Melanie Combs-Dyer: Dr. Brennan, are you back?

Stacey Brennan: Yes, I'm back, I'm sorry. We'd like them to give us the best picture that they possibly can of the patient and in fact to be able to give any form of progress notes would be excellent.

Now when I have reviewed cases, I have from time to time have seen that the physician does have included from the physician's progress notes, prior times that the patient was in to see the physician about the functional problems that are being discussed in the face-to-face exam and these have been included.

It is not, however, mandatory that such notes be included, but certainly if they are available that would be excellent to include. I think that once again we're

after an opportunity for the nurses to have the best picture of the beneficiary for whom the power wheelchair is requested, (inaudible) and this type of information would be very beneficial.

Is that helpful?

Melanie Combs-Dyer: Yes, thank you very much, Dr. Brennan.

The last thing that I would like to mention before we open it up to questions is to just make sure that everybody on the phone saw the announcement that we made on our Web site a day or two ago and that is that CMS has received our PRA number, our Paperwork Reduction Act number from OMB. And we are planning to, like I said, display a Federal Register notice in the near future that will announce the start of the demonstration. It was really getting that PRA number that allowed us to get to the point that we can move forward with our – the clearance of our Federal Register notice. So we are getting close. And again I encourage everyone to check our Web site often next week to see where we are with that Federal Register notice.

At this time, I would like to turn it back over to our moderator to give the instructions for how folks can get in the queue for asking a question.

Matthew Brown: Thank you, Melanie. And, (Adam), I believe you have a script to help the callers enter the queue to have their question asked.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of Walter Gorski, from American Association. Your line is open.

Walter Gorski: Thank you. This is Walt Gorski, of the American Association for Home Care. Thanks, Melanie, for walking us through this. And you too, Doris.

I have a couple of questions. I hope you can – I've collected a lot from our membership on this issue.

Operator: I'm sorry, sir, to jump in. Can we limit to one question per caller? We want to make sure everyone has an opportunity to ask a question. You can re-enter the queue for any additional questions.

Walter Gorski: Melanie, you mentioned that there would be an update to the PIM on the use of a template. And as a follow-up to that, I noticed that when I go to the doctor, sometimes he or she will pull out a form, use that and then they'll put the form in the record and then note that they'll say, please see the template for additional information.

Could you respond to both those two issues?

Melanie Combs-Dyer: Not at this time. We will be issuing a program integrity manual or PIM change about that shortly and we set up a separate open-door forum call to discuss electronic clinical templates and templates in general.

Walter Gorski: Melanie, this is not an electronic template. This is a paper template to start the program off because as you noted, there's not 80 percent fraud rate but an 80 percent error rate, which error is different than fraud. If we move forward with this, we've done nothing to educate providers or physicians on how this program works. And I know that both (a) home care as well as other organizations that have been working with you have been clamoring for the use, the ability to use a paper template when this program starts.

Melanie Combs-Dyer: Walt, there are no new documentation requirements in this demonstration. And we will certainly put on our agenda for the next time we have this call to talk about paper templates and that PIM change that will be coming out shortly. And don't worry, we've got plenty of time today. We'll be able to come back and take your second and third and fourth question in just a minute.

But let's go ahead and see if there's anybody else in the queue that has a question on another topic.

Operator: Your next question comes from the line of Don Clayback, from NCART. Your line is open.

Don Clayback: Thank you. And thank you, Melanie, for the call today. I had a question on the letter, the certified letter that you had mentioned will be going out to everyone. And I would try and pick up on one of the comments that Walt made, as I still think there's a great deal of concern on the supplier community folks that there's the additional education you know what's being done to really improve the understanding education from the physician's perspective.

And you know again, we recognize the error rates that's been discovered but I think most folks would agree that you know the term fraud is really used much too loosely. I think everybody is certainly against fraud and well want to work collaboratively to eliminate that.

But I think given you know the problems, the historic problems with PMD claims, I think there still is you know a confusion and misunderstanding on what really is required. And I know that is part of the demonstration project to help fix that.

But on the education front, with the letter that's going to be going out to the physician, the certified letters, will there be educational material so that you know you take advantage of that direct contact with the physician where he or she will be getting some you know documents that will help them better understand the requirements and you know hopefully improve their ability to complete the – excuse me – documentation?

Melanie Combs-Dyer: This is Melanie. And we agree with you that physician education is really important. And we have done a number of things already along those lines. You are probably aware that I have been out to meet with physicians in almost all of the seven states but I haven't made it to all of them yet but I think I will shortly.

In addition, we are planning a Med Learn Matters article and we hope to have that up shortly. In addition, you're right, we are putting information in the

letters that are going out to physicians, linking them to the Web site where they can get more information.

Doris, is there any additional detail you can add about the letters?

Doris Jackson: With the letters, like Melanie stated, LCD is going to be – there will be a link there. So the reader can link on to the site to change the doc LCD which does identify what documentation would support medical necessity. In addition, there is also a link for the documentation checklist that the MLN article that also highlights documentation requirements and that will help the physician to determine what documentation he or she should be sending to the contractor to help determine medical necessity.

Don Clayback: OK. With that, I guess I think it's good to have that information. I would just suggest that you know to have that direct contact because I think you know in spite of the efforts, I know the outreach efforts that you've been doing, Melanie, along with some of the folks.

You know unfortunately, they touched on a very limited number of physicians and given that you know the time and expanse is going to be incurred to contact directly every single physician, I think by just referring the links, we all know that you know sometimes the time is not going to taken to go to a link and actually read the complete LCD.

So, hopefully you know we could come up with some sort of, as part of the letter, maybe a reminder to the physician or you know to highlight some of the key things that he or she would you know gather just by reading the letter that takes back then to go you know find the link and read the LCD and some of those things.

So I would – you know I certainly would suggest if there's an ability to do that, that that would help on the education front. And, again, you'd know you'd be contacting every single physician. So it's a great opportunity.

Melanie Combs-Dyer: Don, we really appreciate your suggestions. I think that the most important part of physician education that we're instituting here is that detailed review results letter. There's nothing like sort of having it hit you in the face

when it does. It's an individual beneficiary, one that you just saw a couple of weeks ago, now you're being told, no, it's not prior authorized. And right there, it gives all the details about what was missing. I think that's one of the best educational pieces that we could have put in place.

But I – we are absolutely open to additional suggestions. If people are aware of, for example, physician meetings or webinars that will have physicians in attendance of the appropriate specialties, I would love to go in and tell them about this program. And if you, guys, could just shoot an e-mail to our e-mail box and let me know about those dates and locations or the contact people for those meetings, I would love to go and talk to physicians.

Don Clayback: OK.

Melanie Combs-Dyer: (Adam)? (Adam), I think we're ready for our next question.

Operator: Your next question comes from the line of Gwen Jeffers, from Sheldon Medical Supply. Your line is open.

Melanie Combs-Dyer: Hi, Gwen.

Gwen Jeffers: Thank you. Good afternoon. I just have one fast question. As everybody know, I do send for the advanced determination for anything your group to withheld higher and all your high-end chairs. Will the fact find for your basic and your scooters be the same or will it be a different number that we submit these two? And will there be a prior authorization form like we have with the ADMCs now?

Melanie Combs-Dyer: So it's a two-part question and the first part is, is the fax number, the link going to be the same for ADMC and prior authorization request. And we have not yet issued those numbers. I think there is a place holder for them in the demonstration operations guide.

Right now, it's still blank. But probably by the next time you see this, the next time we have this call, we will still then know these numbers. And I don't know whether there will be separate numbers or the same numbers. But that will be looked to the demonstration operation guide for that information.

And in terms of a prior authorization form, we will not be issuing a form but we do have in the demonstration operations guide a list of the data elements that need to be included with your prior authorization request. That list the data elements that needs to be included can be found in Chapter 5, submitting a request, which appears on page seven, and it lists out the data elements that need to be included in your prior authorization request. They include the beneficiary's name, the health insurance claim number kick-in, the date of birth, the physician name, the NPI, the address of the physician, the name of the supplier, the supplier NPI, the supplier address, the HCPCS code and the submission date.

Gwen Jeffers: OK, very good. So, yes, because I filled out the other one when I sent for the ADMC and it has got all that on there. OK, well, thank you for your time.

Melanie Combs-Dyer: Thank you, Gwen.

Operator: Your next question comes from the line of Seth Johnson, from Pride Mobility. Your line is open.

Seth Johnson: Yes, thank you, Melanie and Doris and others. Just clearly a great deal of concern that continues to exist with the PMD demo and I guess my question is since CMS is not changing any of the requirements and is simply changing the review of the documentation from the back end to the front end, how do you believe this demonstration will address the underlying problem with the high error rates and physicians inadequately documenting the medical need for the equipment absent some type of template or tool or guide to help physicians better document the medical need in line with Medicare's expectations?

Melanie Combs-Dyer: Well, right now, only a small number of PMDs are selected for review. After the prior authorization request process goes into place, every single PMD in these seven states for Medicare beneficiaries will be reviewed by the DME MAC.

They will either be reviewed prior to delivery and that is our preference, or in those situations where the supplier chooses not to avail themselves of the prior authorization process, they will be reviewed after the claim, after the item has

been delivered and a claim has been submitted so what we will call prepayment review.

So by going from the limited amount of review that we have today to basically 100 percent review going forward, we believe that that will have a dramatic impact, we hope, on the improper payment rate.

In addition, we think that the detailed review results letters will provide excellent education opportunities for the providers. Those physicians who may not have seen exactly what it was that they were doing wrong or what was missing in their documentation will now be able to see that.

And not following post-pay review you know a year after the fact, but just a few weeks after the patient has been there for the face-to-face visit. So we believe that there's great hope that this prior authorization process will impact the improper payment rate in these seven states.

Seth Johnson: Right. And I guess the real concern is looking at the high error rate – I think as you outlined in your opening, 80 percent error rate – the concern is that when the demonstration begins to look at 100 percent of these claims in these seven states if you have an 80 percent error rate, as you outlined, the way prior authorization typically works is the beneficiary does not receive the product until after the prior authorization request has been agreed to by the payer. So the concern is that beneficiaries with a medical need will be denied access to these products 80 percent of the time.

Melanie Combs-Dyer: Well, we believe that those beneficiaries that – where there is no documentation of medical need will not be receiving the item. But in those situations where they do have a medical need and it's documented in the medical record, they will receive the PMD. And they'll receive it in a timely fashion because we have shortened the review time from the normal 60-day time period to a pretty rapid 10-day turnaround time.

Seth Johnson: Right. I hope you're right. You know the real concern is that you know clearly, it's not that patients don't have a medical need. I think the audit recovery rate would show that, but you know the real issue is physicians

sufficiently documenting the medical need the first time. So just a concern more than a question.

Melanie Combs-Dyer: Thank you for sharing, Seth.

Operator: Your next question comes from the line of Denian Rown from the Academy of Neurology. Your line is open.

Denian Rown: Hi. I just have a quick question. You mentioned that the DME MAC has 10 days to approve a prior auth request. That's 10 business days or calendar days?

Melanie Combs-Dyer: It's business days.

Denian Rown: OK. Thank you.

Melanie Combs-Dyer: You're welcome.

Operator: Your next question comes from the line of Elizabeth Heatherwick from Custom Rehab Solutions. Your line is open.

Elizabeth Heatherwick: Yes, it's Elizabeth Heatherwick. Thank you for your time today. My question as a physical therapist is in the past physicians have availed themselves in our services to help corroborate and document the medical necessity. Is the process going to be changed at all for the prior authorization process? Are they going to require our documentation upfront to support physicians? And will this help lessen the burden on physicians if we get involved sooner in the process?

Melanie Combs-Dyer: There is no change in any of the documentation requirements. I will, however, share with you that there have been a number of situations when I've been out doing this physician education that a physician, usually a family practice physician or maybe an internist, will tell me you know "Gee, I don't order these things very often. It's hard for me to remember what it is that I'm supposed to document during my face-to-face evaluation."

And I remind them that they can refer the patient to a licensed clinical medical professional who can help conduct part of that mobility evaluation and then

return that – their findings – their evaluation findings to the physician who can then complete the face-to-face examination.

So while there is no change in the requirements, I do believe that we're getting the word out to more and more physicians about how they can use physical therapists and others to help them in documenting that face-to-face evaluation.

Dr. Brennan, are you still on the phone? And would you like to chime in a little bit about the physical therapist role here and whether that's changing in the prior authorization program?

Stacey Brennan: I think you said it very well, Melanie. That's not going to change. And our policy articles have always referred to the fact that a physician may refer the patient to the certified medical professional which includes, of course, physical therapists or occupational therapists who often do have training in mobility evaluation.

So we do hope that that will be an option that will be considered especially by general physicians as they're feeling uncertain about completing the face-to-face.

Elizabeth Heatherwick: Yes. And just as a last comment, that might be some piece of information to keep the process less overwhelming for physicians to make sure that that option is spelled out for them.

Melanie Combs-Dyer: Elizabeth, I'm going to have Amanda Byrd speak to what information might be included on this point in the letters that we're sending to the physicians.

Amanda Byrd: Thank you. As Melanie mentioned earlier, we're sending the letters to practitioners who have recently ordered these Power Mobility Devices. And in that, there is a line about being able to refer the beneficiary as Melanie and Dr. Brennan just discussed, for that piece for the face-to-face encounter. So it's another way for us to help to get the word out.

Melanie Combs-Dyer: Thank you.

Operator: Your next question comes from the line of Ricky Savage from Preferred Home Medical. Your line is open.

Ricky Savage: Hello. I think one of the aggravations that the physicians and clinicians, OT and PTs are having is that in the LCD it requires that a cane and walker be ruled out as well as a manual wheelchair. And I think that rule was originally probably drafted to target certain companies that were going after people with CHF and COPD.

You know when you have a patient that's a bilateral amputee or, say, a C3-C4 incomplete quad, the doctors are finding it very aggravating to rule out adaptive aids they say are obvious as to medical necessity. Can that be better addressed?

Melanie Combs-Dyer: This is Melanie, and I think most physicians have a very easy time writing a couple of lines in the progress notes to address that issue. But let me turn it over to Dr. Brennan.

Dr. Brennan, can you speak to that?

Stacey Brennan: Well, I think I would refer you back to the National Coverage Determination with the algorithm which does talk about mobility-assistive equipment decision tree.

And I think we need to remember that amputees, whether bilateral or not, often are able to utilize a manual wheelchair. And that kind of opportunity needs to be or information would come through by using this algorithm for purposes of making that decision in terms of the clinical person doing that face-to-face exam.

You know also we have amputees who use prosthetics and who are, in fact, not interested in having power wheelchair or even a manual wheelchair. So I think that it's, actually, I thought very well-written, very well-thought out mobility-assistive equipment guideline in NCD.

And I do feel that physicians understand it and it doesn't take a lot of verbiage to get across if a person is an amputee why they're not going to be able to use a cane whatever it is.

But each – I want to emphasize that every beneficiary's unique. Every – we are looking to have obviously the right opportunity to supply for each beneficiary for their unique needs, what mobility-assistive equipment they are going to use and benefit from using.

Ricky Savage: OK. And I agree with you on the bilateral amputees because that does present more options for the lack of PMD sometimes. But, again, the one that's more aggravating to the physician that I dealt with was on the patient, it was the C3-C4 complete quad.

And you know I know that these doctors are getting pushed to do more with less, just like all of us, and you know his aggravation was, "Why am I having to document a cane or a walker for somebody that's a complete quad?"

And all I could do, as what you just said, was point out the rules in the Medicare manual to him. But just for whatever, some of them are aggravated in the sense that they're having to document things with patients that are complete quad.

Melanie Combs-Dyer: I understand. Thank you.

Operator: Your next question comes from the line of Julie Piriano from Illinois Association for Medical Equipment Services. Your line is open.

Julie Piriano: Thanks, Melanie. My question is the operational guide now says that the 14-digit prior authorization tracking number will be appended to the claim which we greatly appreciate. My question is when the demonstration project goes live some time this summer, will CMS have system edits in place, they'll crosswalk this 14-digit PA tracking number with the beneficiary's Medicare number, the supplier's NPI number and the physician's NPI number so that we could ensure appropriate adjudication of the claim and expenditures from the Medicare trust fund?

Melanie Combs-Dyer: Yes. I'm sorry. Did I answer that wrong, Amanda?

Amanda Byrd: With just one caveat, it does have editing against it. It does not necessarily edit for the prior authorization request. It does not necessarily edit against the supplier's NPI number.

Julie Piriano: Is there a reason why it wouldn't crosswalk or edit against all three?

Melanie Combs-Dyer: I'm not sure I understand the question.

Julie Piriano: Well, in order for this demonstration to ensure that the supplier that has received the prior authorization request, affirmative decision and tracking number then submits that with their claim and it's paid, from a fraud, waste, and abuse prevention perspective, if it doesn't edit against the supplier's (NPI) number that submitted the request and subsequently submits the claim, what's the value of proceeding with the demonstration until such an edit would be in place to ensure appropriate expenditures from the trust fund to the supplier?

Melanie Combs-Dyer: So is your question, is the beneficiary allowed to get a prior authorization request from one supplier and then take that approval number and go to a different supplier and get their equipment? Is that your question?

Female: No, that's a whole separate question. The question is supplier A submits the request, receives the affirmative and the tracking number and then subsequently submits the claim with that tracking number appended. If there isn't a system edit in place that would kick out the claim, if it's – if it's not appended to the appropriate supplier or the appropriate tracking number isn't appended with the crosswalks, the beneficiary, the supplier, and the physician, what's the value proceeding with the demonstration until such time that system edits are in place to ensure that the tracking number is for the appropriate claim?

Melanie Combs-Dyer: We believe that we have the appropriate edits in place to prevent fraud or improper payment.

(Adam), I think we're ready for next question.

Operator: Your next question comes from the line of Walter Gorski from American Association for Homecare. Your line is open.

Melanie Combs-Dyer: See, I promised you'd be able to get back in, Walt.

Walter Gorski: Good. I'll be coming back in again, I think.

Melanie Combs-Dyer: No problem. Go ahead.

Walter Gorski: This isn't meant to be a "gotcha" question, but I think it's building on something that Seth Johnson mentioned with respect to testing this program considering that the error rate is so high.

Have you sat down with physicians and have run or are you planning to sit down with physicians and run through this program to make sure that they understand it and so you might – I mean, we're trying to point out some of the problems that we see.

I'm curious if you're planning to do that with the physicians and with all due respect to the medical directors who might be on the call, I would argue that if they're the ones who are looking at this, they are quite frankly, overqualified because they know the policies so well.

Melanie Combs-Dyer: We have explained this to as many physicians as we can get to listen to it. We have done YouTube videos. We have done webinars. We have done as much outreach as we can.

We believe that the letters that we are getting ready to send to physicians will be helpful. We believe that the Medlearn matters article that we are getting ready to issue will be helpful, and we believe that the detailed review results letters that we will be sending to physicians will be helpful education.

Walter Gorski: Well, I would like to suggest that when the draft stamps are pulled all off these documents, that you might want to sit down with some physicians, I think that what we think as education materials, all the things that CMS has put out, all the things that we have done, quite frankly, haven't addressed the problem, which is the high error rate.

So maybe sitting down with some physicians – because I – it sounds like you've done a lot of things but, I mean, not sat down with physicians to find out what their take is on this, I think that would be really helpful. Thank you.

Melanie Combs-Dyer: Thank you. Thank you for your suggestion, Walt.

Operator: Your next question comes from the line of Patrick Yager from Health Care Equipment. Your line is open.

Patrick Yager: Thank you. And Melanie, and just kind of following up on what Walt said I think what Seth was talking about earlier, my concern are – or may there is no concern, when you consider what the error rate data looks like if I submit a prior authorization and I get an unfavorable consideration for the prior authorization, in other words, the prior authorization is denied and I have to then go back to the physician or go back and get the documentation that I'm told is missing, is that going to be considered an error? Is that going to be considered fraud?

Melanie Combs-Dyer: If you submit a prior authorization request, you are not submitting a claim.

Patrick Yager: OK.

Melanie Combs-Dyer: And prior authorization requests will not be selected by the CERT contractor.

Patrick Yager: OK. (Inaudible).

Melanie Combs-Dyer: If after you receive the non-affirmative prior authorization request, you chose to deliver the item and submit a claim, that claim will be denied. And if CERT chooses that claim for review, they will recognize that the documentation was insufficient to meet to the Medicare coverage requirements and that they will score it as not an error because the DME MAC made the appropriate decision on that claim when they denied it.

Patrick Yager: (OK). OK, thank you.

Melanie Combs-Dyer: You're welcome.

Operator: Your next question comes from the line of Ricky Savage from Preferred Home Medical. Your line is open.

Ricky Savage: Yes. On the face-to-face visit for the doctor, I think the rule was intended for patients to go to the doctor and have a face-to-face visit. How do we with Medicare, address patients that go to strictly to a rehab hospital via an injury? And while they're in the rehab hospital, how does the doctor document a face-to-face exam for Medicare in that situation?

Melanie Combs-Dyer: Dr. Brennan.

Stacey Brennan: Oh, hi. I mean I think that's actually a possibility of occurring definitely from time to time. But the rehab physician who would generally be carrying out this functional assessment is probably one of those physician specialty types who has been specially trained to complete this evaluation, and that record, as long as it's identified as being a face-to-face evaluation for mobility evaluation for choice of mobility or power wheelchair can certainly be used.

It has to meet all of the other requirements in terms of signature and dating and everything that you will read and have read in the policy, of course. But that certainly could to be utilized.

Ricky Savage: OK. Well, this particular physician does meet the criteria that you explained, but his question is – does he need to specifically stay during an evaluation that this the face-to-face occurring while in the hospital because usually when you go to a doctor it's a chief complaint and you put the patient here for face-to-face visit.

So how does he need to document face-to-face during the rehabilitation stay so that when (inaudible) to Medicare that they see it's face-to-face (inaudible)?

Stacey Brennan: Well, I think …

Ricky Savage: Because we had one denied because his doctor didn't put face-to-face but they were in the hospital during that time. It was assumed.

Stacey Brennan: Well, I think when I've read these kinds of evaluations and I know you've read them too it's often kind of transcribed and it looks like a consultation letter from a specialist. And it always does have an opportunity there at the beginning of the consultation note to have that spelled out.

And so, I would just remind the rehab specialty doctors just like, for instance, a physical therapist to be sending their write-up back to the prescribing doctor to point out that the purpose of this is for assessment of mobility assistive equipment. OK? I don't think that would be difficult but it does have to indicate that as you mentioned.

Operator: Your next question comes from the line of Walter Gorski from American Association for Homecare. Your line is open.

Walter Gorski: Thank you again.

Female: Hello (inaudible).

Walter Gorski: Hi, guys. On page, I think it's page 10 of the operational guide, chapter seven. You're addressing the issue of how to handle an incomplete request.

The document really doesn't describe how the physician should amend his medical record to address the missing information. Currently, I think addendums – we're seeing cases where claims are denied because addendums aren't permitted. So under the program, will the physicians be permitted to use addendums to update the record? And if not, will the beneficiary be forced to go back to the physician again for another face-to-face and start the paperwork process all over.

Melanie Combs-Dyer: This is Melanie and we can certainly add here to chapter seven a link to the PIM language about addendums that talks about if there is going to be an addition made to the medical record within a short period of time, from the time that the visit occurred or the encounter occurred.

Clearly, if it has been a long period of time between when the physician saw the patient and the need to add the additional information, the patient may need to go back and see the physician a second time.

But we believe that there could be situations where the physician really did evaluate something, really did gather some information and just forgot to document it and in those situations, you're right, the addendum language in the program integrity manual would apply and we can certainly add a link to that here in chapter seven. Thank you for the suggestion.

Walter Gorski: OK. And just to follow up. I just – I know Dr. Brennan is on the call. I think that's something that we hope the medical directors could talk about internally and educate their review staff because we're seeing claims that are denied because a doctor made a mistake – let's say made a date mistake, crossed it off, followed the PIM and that the claim was denied because it was amended, so, anyway, thank you, Melanie.

Melanie Combs-Dyer: Sure. And Walt, if you – I'm sorry, Dr. Brennan, go ahead.

Stacey Brennan: And – no, and I hear what you're saying Walt. And I will carry this back to the group and be sure to have us discuss it (inaudible) education.

Melanie Combs-Dyer: And to both of you – both to Walt and to Dr. Brennan, if you believe that there is something about the PIM that is not clear, or something that we could put – make clearer, just let me know and we'll try to develop some better language there.

Stacey Brennan: Good.

Operator: There are no further questions at this time.

Melanie Combs-Dyer: Walt? You want to come on back in? (Inaudible).

Operator: Oh, we do have a – we do have a question from Debra Silvers from Hoveround Corporation. Your line is open.

Debra Silvers: Yes, hello. Thank you. Thank you very much for taking the call and having this call today. I do have some additional information I'd like to add on to Walt's question.

Melanie, you addressed it, and I believe that Dr. Brennan also emphasized that the PIM does have some information in regard to addressing addendums. However, you're saying a short period of time. And, of course, in the case of these prior authorizations, it's going to be at least bare minimum 10, maybe even 15 or 20 days since the doctor first saw the patient when we would be going back to the physician.

I guess my question is what the definition of a "short period of time" and is it within that 45-day timeframe will an addendum be permitted?

Melanie Combs-Dyer: I don't know. I'd have to go back and look at what we say in that program integrity manual provision. I don't know that we define a short period of time.

Dr. Brennan, have you guys talked about this?

Stacey Brennan: We have not. And hi, Deb. I think that's a good question. And I do also feel like we need to do some research on that and get back to you about it, because I don't think it's clear and – "a few days" – you know how is that interpreted. So I think we're going to have to postpone a definitive answer for you, Debra, on that one.

Melanie Combs-Dyer: We'll add that.

Debra Silvers: OK.

Melanie Combs-Dyer: We'll add that to our agenda for the next open-door forum call. Thank you.

Debra Silvers: All right, thank you very much.

Operator: Your next question comes from the line of Julie Piriano from Illinois Association for Medical Equipment Services. Your line is open.

Julie Piriano: A quick question – you've got a clear indication as to what (inaudible) basic codes are in included in the demonstration, but in the (inaudible) operation guide there isn't any guidance with regard to what the process might be for a beneficiary that either elects to upgrade to a group two PMD or has prescribed

to group two PMD or a group four power wheelchair without power seating options.

And I'm wondering if additional guidance will be provided once this is no longer draft when those situations arise.

Melanie Combs-Dyer: I'm not familiar with the upgrade power seat. Amanda, do you – is this an issue that you know.

Amanda Byrd: We will come back. We'll provide information on this at the next call.

Julie Piriano: Thank you.

Melanie Combs-Dyer: Thanks, Julie.

Operator: Your next question comes from the line of Seth Johnson from Pride Mobility. Your line is open.

Seth Johnson: Yes, hi, again. Just one quick question – would you consider testing the prior authorization demo in one state, evaluating its success prior to phasing in the demonstration to nearly half of the PMD market?

Melanie Combs-Dyer: No. We plan on (inaudible) with the prior authorization of power mobility device demonstration in all seven states at the same time in the summer of 2012. We originally had planned on starting at one state and then adding another state and then another state. We were told that at that time that it was confusing to physicians and suppliers. We made the change to do all seven states at once. And that's where we are.

Operator: Illinois Association for Medical Equipment Services. Your line is open.

Julie Piriano: The operational guide has been updated. We appreciate that. Noticed that it's still in draft form – do you have a date or projected date when the operational guide will be finalized? And will all of the – you know the guidelines, the documentation requirements, the properties and procedures be finalized prior to sending out the letters to physicians and suppliers, if that's coming sometime soon?

Melanie Combs-Dyer: We will always be making improvements to the guide. So even after it is finalized, just like our program integrity manual and all the other manuals in Medicare, they will be constantly open to being clarified or updated. That being said, we will take off the draft stamp and mark it as final and, in effect, on the start date of the demonstration.

Operator: There are no further questions at this time.

Melanie Combs-Dyer: Come on, Walt. You said you had a whole bunch of questions. Now, where are they?

Operator: Your next question comes from the line of Elizabeth Heatherwick from Custom Rehab Solutions. Your line is open.

Elizabeth Heatherwick: Elizabeth Heatherwick again. A quick question – for those patients that decide that they want to do (self-pace) or upgrades, where will that be in the prior authorization request form? If the patient wants to do elevated seats, which is not a covered benefit, where – where would that be documented? Do you still need to do the beneficiary notice or how is that handled?

Melanie Combs-Dyer: I think that we will have to add some language on that. My guess is that – that it's going to be whatever is in the (LCD) today, whatever the normal, current rules are. But we'll make sure that we confirm that and that we state that somewhere in the demonstration operational guide.

Elizabeth Heatherwick: Thank you.

Melanie Combs-Dyer: (Adam), any other questions?

Operator: We have no further questions at this time.

Melanie Combs-Dyer: All righty, well, I'd to thank everyone who participated today. Let me refresh your memory that we have gotten our Paperwork Reduction Act number approved by OMB. So that means that we're getting very close to announcing a start date. I would encourage everyone to check back to our

Web site at least once or twice next week and look for the announcement of the start date.

Again, it will be announced officially and formally in the Federal Register notice when it goes on display. And (in 30) days, after the display is when we're expecting the start date.

Thanks, everyone, for participating today. We look forward to our next call. Who here knows the date of our next call?

(Inaudible) or Amanda?

Amanda Byrd: It is Wednesday, August…

Melanie Combs-Dyer: Twenty-ninth?

Matthew Brown: That is correct. August 29th.

Amanda Byrd: Thank you.

Melanie Combs-Dyer: Thank you very much.

Operator: This concludes today's conference call. You may now disconnect.

END