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PWC Prior Authorization Demonstration Project – Opening Statement

I am Doctor Paul Hughes, the Medical Director for the Durable Medical Equipment Medicare Administrative Contractor, commonly called a DME MAC, and my geographic area of responsibility is Jurisdiction A. Jurisdiction A is one of four DME MACs and encompasses the northeastern states from Maine to Washington DC. I have been the Medical Director for this region since 1995. I work for NHIC, which contracts with the Centers for Medicare & Medicaid Services to administer this jurisdiction since 2006. New York is the demonstration state in our region.

My primary responsibilities revolve around the development and implementation of Medicare coverage policy. This role requires that I be involved in many aspects of NHIC's operations including routine claim processing, appeals, medical review and provider education.

I have been asked to speak briefly about the preparations NHIC has made to implement the Prior Authorization for Power Mobility Devices demonstration project. For convenience, I would like to separate the discussion into two parts, payment policy and operations.

First, payment policy. Reimbursement for power mobility devices is set out in several sources. There are statutory requirements arising from the Medicare Modernization Act implemented by CMS' Final Rule in 2006. These provisions require an in-person visit and a medical exam in addition to specific requirements for the creation of the prescription and the provision of these documents to the DME supplier.

CMS' National Coverage Policy creates the foundation for the medical coverage rules. It allows for the coverage of mobility assistive equipment for beneficiaries with mobility deficits that impair their ability to accomplish activities of daily living within the home. This policy guides coverage for all mobility equipment - from canes and crutches to walkers to manual wheelchairs - all the way up to power wheelchairs. To make a decision about which device is appropriate, CMS' national coverage policy requires a systematic evaluation of the beneficiary by their treating physician in order to determine which item optimally meets the beneficiary's mobility needs. In addition to this CMS national policy, the DME MACs also have a local

coverage policy for Power Mobility Devices. This local policy pulls together both the statutory and national policy requirements, organizes the nearly 60 individual power mobility codes into five groups of similar products, sets out criteria for each group and explains the documentation requirements and coding guidelines. In other words, the local policy takes coverage and payment information from various sources, adds additional necessary details for proper claim submission and incorporates those into one document.

The major concern I hear raised by suppliers is whether the DME MACs will be able to review the anticipated request volume in a timely manner. Our staff is knowledgeable and experienced in looking at claims for power mobility. These requirements have been in place, unchanged, since 2006 when CMS' regulation took effect. All DME contractors have performed numerous reviews on power mobility devices since that time to identify problems. In addition to standard power wheelchairs, we have all reviewed many complex rehabilitation power wheelchair requests under Advanced Determination of Medical Coverage, usually referred to as ADMC. In Jurisdiction A, we review an average of 240 requests per month under this program. These complex products must meet the same basic coverage requirements as the products covered by the demonstration project in addition to the requirements necessary to determine coverage for the options and accessories needed to address the needs of these patients. This demonstration project does not change any of the applicable coverage rules thus we do not anticipate issues in this area. In fact, the project's focus only on coverage criteria for the power wheelchair base simplifies the review for our staff. We do not anticipate that our review staff will have any difficulty in reviewing power wheelchairs of any type, including the numerous options and accessories used with them.

Another issue I hear mentioned is that some suppliers and physicians may not be familiar with all of the policy requirements. The contractors have produced numerous education resources about this policy, ranging from "Dear Physician" letters discussing the coverage criteria and the need for quality documentations, to Question & Answer documents and articles, webinars and in-person seminars, and CERT and Medical Review error analysis. In addition to the materials provided by the contractors, CMS' Medicare Learning Network has also published a variety of materials addressing power mobility coverage.

Next, I would like to discuss operations. I know that some in the DME supplier community are concerned that the volume of claims may be too large to review in the allotted time of ten business days. Based upon historical claim volume, we initially expect 25-30 new requests per day for the types of power wheelchairs included in the demonstration. In

anticipation of this project, we have increased our nursing staff and assigned our more experienced personnel to handle the anticipated volume. Based upon historical power wheelchair audit data, we anticipate that approximately 50% of the initial submissions will not be approved. Likewise, based upon appeals data we expect the about 50% of resubmitted requests will not be approved. Once the demonstration is operational, we anticipate a total volume of 50 to 60 new and resubmitted requests per day from this project. We have sufficient additional staff to allow flexibility to deal with variations in volume. In the non-review areas resources have also been adjusted to allow for additional workload in written and telephone inquiries and in the production and mailing of response letters.

Finally, I would like to discuss errors. Regardless the source of the audit, the types of errors identified are consistent. For example, our most recent Jurisdiction A report, published in July 2012, showed a charge denial rate of 54%. The most common denials issues were:

- 33% - Insufficient documentation. This includes both a failure to meet the statutory requirements to perform the face-to-face as well as incomplete or poorly documented examinations.
- 23% - Problems with the 7-element order. This is the statutorily required prescription. Problems include missing elements, illegibility and the prescription was created before the face-to-face was completed.
- 19% - Specialty exam. Missing financial relationship attestation.
- 14% - Detailed Product Description. This is a document produced by the supplier for the physician's signature. It serves as the prescription for all of the separately billable items. Problems included nodetaile product description submitted and the items billed did not match the items ordered.
- 9% - Home assessment. None submitted or not signed and dated
- 4% - Proof of delivery. None submitted or delivery ticket did not match claim.

Many discussions of errors focus upon issues related to the quality of physician documentation and the DME supplier's inability to get the physician to improve. While physician documentation is an important factor in audit findings, it is not the only one. Many other errors occur. Often these others are more within the supplier's direct control either because they create the documentation or because there is an opportunity to screen for mistakes and have them corrected before submission. In this most recent review, most errors fell into this latter category. This pattern of errors is not unique to this particular report. Our review experience demonstrates that errors would drop significantly if attention were directed to some of these non-medical record issues.

In summary, I believe that NHIC is well prepared to perform the work necessary to meet the requirements of this demonstration project.

Thank you for the opportunity to share this information.