U.S. Senate Special Committee on Aging

"An Examination of Prior Authorization Requirements for Power Mobility Devices"

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Chairman, Kohl, Ranking Member Corker, I appreciate the opportunity to appear before the U.S. Senate Special Committee on Aging to discuss prior authorization requirements for Power Mobility Devices. My name is Dr. Stephen Peake and I am the Medical Director for the Senior Care Division of Blue Cross Blue Shield of Tennessee, an independent licensee of the Blue Cross Blue Shield Association. My focus today will be on our Medicare Advantage product which we refer to as Blue Advantage and our strong commitment to utilization management and the use of prior authorizations. In particular I will be focusing on utilization management and the use of the prior authorization process for Power Mobility Devices. I will highlight the successful tools we have implemented through these programs. I will also illustrate some of the problems we have encountered while using these tools. Currently, our Blue Advantage Product has approximately 33, 000 enrollees with an average age of 71 of which approximately 55% are female and 45% are male. Blue Cross Blue Shield of Tennessee has been offering Blue Advantage to the citizens of Tennessee since 2006.

Plans such as Blue Advantage were established by Congress and became a reality on January 1, 2006. The guidelines that we must conform to as a MA plan are outlined in the CMS Manual, Managed Care (Pub. 100.16) which allows for increased flexibility in administering beneficiary benefits as long as they do not result in the beneficiary receiving less than traditional Medicare benefits. One aspect of this flexibility is the ability to perform utilization management, which allows us as a MA plan to require prior authorization of services.

Prior authorization allows us to determine if in fact a requested service is medically necessary and thus reasonable and necessary by reviewing the documentation against the hierarchical requirements set forth by CMS. We feel strongly that properly applied utilization management protects, first and foremost, the beneficiary from unnecessary risks, but also helps to protect the system from fraud, waste and abuse.

I was asked to share our experience with requiring prior authorization on Power Mobility Devices. CMS has commented extensively both directly and through the Medicare Administrative Contractors (MACs) on the documentation requirements for Power Mobility Devices. National Coverage Determination 280.2 Mobility Assistive Equipment (Effective May 5, 2005), Local Coverage Determination 23613 Power Mobility Devices (Revision Effective 08/05/2011) and related Policy Article for Power Mobility Devices (Effective January 2009) and a Provider Update dated September 2010 *POWER WHEELCHAIRS AND POWER OPERATED VEHICLES-DOCUMENTATION REQUIREMENTS* co-signed by all 4 Durable Medical Equipment Medicare Administrative Contractor's Medical Directors. Also the Office of the Inspector General commented about Power Mobility Devices in the August 2009 report *POWER WHEELCHAIRS IN THE MEDICARE PROGRAM: SUPPLIER ACQUISITION COSTS AND SERVICES.*

Yet CMS continues to point out that the majority of claims for power mobility devices do not meet the documentation requirements for coverage.

At Blue Cross Blue Shield of Tennessee we in Blue Advantage require strict adherence to the documentation requirements for a Power Mobility Device as outlined in the above listed documents. For example, coverage is allowed only if the beneficiary has a mobility limitation that limits their ability to perform Mobility Related Activities of Daily Living **in the home,** such as toileting, feeding, dressing, grooming and bathing in customary locations **in the home, not elsewhere**. The documentation must indicate that the beneficiary's mobility limitation cannot be overcome with an optimally fitted cane, walker, or wheelchair: in other words, do they really require a Power Mobility Device?

Also, it is required that physicians perform a face to face examination and the physician "shall" document the examination in a detailed narrative note in their chart in the format they use for other entries, and that the note clearly indicates that a major reason for the visit was a mobility evaluation- a requirement that is far too often not met. In addition, many suppliers have created forms which have not been approved by CMS. The one we see most commonly is the Texas Academy of Family Practice Mobility Evaluation Form, a form Blue Advantage does not recognize for use in the required face to face examination. CMS even commented that this form was not adequate in the September 2010 Provider Update, referenced above. However, we continue to see suppliers completing this form and having the physicians sign it and physicians utilizing this form as the face to face mobility examination described above. In fact, if you go to the Texas Academy of Family Practice's web site www.tafp.org it clearly states this is not a CMS approved form. In addition, the supplier must supply a detailed 7 part prescription but is prohibited from completing any portion which must be completed by the prescribing physician -- yet again we see what appear to be disparities in the hand writing on the form and the prescriber's handwriting. Lastly, an in-home assessment, which is often omitted, must be completed to make sure there is room for effective maneuverability, as the primary intent in obtaining a Power Mobility Device is to alleviate barriers to the performance of Mobility Related Activities of Daily Living **in the home, not elsewhere.**

In a one year interval Blue Cross Blue Shield of Tennessee received 397 request s for power mobility devices, the majority of which were for power wheel chairs. Per CMS regulations, if the initial request is denied, the supplier can request a reopening with additional information. Both the prescribing physician and beneficiary can appeal, and the prescribing physician can request a peer to peer discussion. By incorporating utilization management and requiring prior authorization for Power Mobility Devices, 24% of the requests were found not to be medically necessary. In 2010 CMS published data estimated $606 million was spent on power mobility devices.

If in fact the implementation and utilization of a prior authorization program mirrored Blue Cross Blue Shield of Tennessee's Blue Advantage's experience the potential savings could be significant.

In conclusion I personally applaud CMS for initiating this demonstration project and would welcome it in the Great State of Tennessee. I appreciate the time you have allowed me to share on how we at Blue Cross Blue Shield of Tennessee's Blue Advantage Plan approach prior authorizations of Power Mobility Devices. I welcome any questions you may have.