Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare's Prepayment Review and
Prior Authorization Demonstration Project for Power Mobility Devices
Monday December 5, 2011
2:00pm- 3:30pm Eastern Time
Conference Call Only

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for **providers** to 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.

The Prior Authorization demonstration will be implemented in two phases. During the first phase (the first three to nine months), the Medicare Administrative Contractors will conduct prepayment reviews on certain medical equipment claims. The second phase, for the remainder of this three-year demonstration, will implement prior authorization, a tool utilized by private-sector health care payers to prevent improper payments and deter fraud.

To read more about the Demonstration visit: http://go.cms.gov/cert-demos .
Participants may submit questions prior to the Special ODF to pademo@cms.hhs.gov by Friday December 2, 2011, 5pm ET.

We look forward to your participation.
Special Open Door Participation Instructions:
Dial: 1-866-501-5502 & Conference ID: 29845811
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 beginning on or around Wednesday, December 14, 2011.

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/ .

Thank you for your interest in CMS Open Door Forums.

Audio File for this transcript:
http://downloads.cms.gov/media/audio/MedicarePrepaymentReviewandPriorAuthDemo120511.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar
December 5, 2011
2:00 p.m. ET

Operator: Good afternoon. My name is (Sheila) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Prior Authorization Demonstration Project for Power Mobility Devices for Providers 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, please press the pound key. Thank you. Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Thank you, (Sheila). Good afternoon. My name is Barbara Cebuhar and I work in the office of Public Engagement here at CMS. The purpose of this Special Open Door Forum is to provide an opportunity for providers to hear a little bit more about the Medicare Prior Authorization Demonstration for Power Mobility Devices, and to get an opportunity to ask more question.

The slides for today's discussion are available at the following Web site. I'm going to read it twice, so, you may wish to write this down. It's http://www.cms.gov/cert/download/pmd_powerpoint_v14_final.pdf. If you're at your computer, you can go to http://www.cms.gov/cert/download/pmd_powerpoint_v14_final.pdf. [Ed. note: this website is no longer available. Please check www.go.cms.gov/cert-demos for the most recent downloads and information]

There maybe questions that occur to you after this Open Door Forum, if so, you are welcome to send them to pademo@cms.hhs.gov. Just note that this e-mail address is not monitored 24/7 and so the best way to get information is to go to the Web site and check the frequently asked questions by going to www.go.cms.gov/cert-demos, to see if they've been answered.

On this call, we will first go through an overview of the demonstration then, open the call to questions. The operator will then instruct you how to get in line to ask your question. I'd also like to remind you that there will be a transcript and an audio recording of this Special Open Door Forum on the special open door forum Web site on or around Wednesday, December, the 14th.

I'd like to take the opportunity to introduce Melanie Combs-Dyer who is the Deputy Director of the Provider Compliance Group here at CMS. She will provide an overview of the demonstration and after the presentation and the discussions about the slides, we will open the call to questions from you. Thank you again, for joining us and you can access the slides by going to the Web site. Melanie, the floor is yours.

Melanie Combs-Dyer: Thank you, so much, Barb. Again, my name is Melanie and I am the Deputy Director for the Provider Compliace Group here at CMS,and I work in the Office of Financial Management. And one of the main responsibilities of the Office of Financial Management is to look for improper payments in the Medicare fee for service program.

And as you can see from slide two, we estimate that each year the Medicare fee for service program issues over $28 billion in improper payments. And that equates to an error rate of about 8.6 percent.

Now, the good news is that that's down from 10.8 percent the prior year, but we really would like to get to 5.4 percent. So, we've got a ways to go. And some people wonder why we allow so many improper payments in Medicare, why can't we stop them. It's important to keep in mind that Medicare receives over 4 million claims every day. That's not just power mobility devices, that's everything, but still there is no way that every one of those claims can

be stopped for human review. Instead, we have to select a very small number of claims that we want to subject to more complex review.

So, slide three talks about some of the new corrective actions that we are planning for this year to help us get to that lower error rate for the future. Typically, our corrective actions are doing more prepayment review or doing more provider education. But this year, in our demonstrations, you'll hear that we've got some new tools in our toolbox.

All three of these new demonstrations will begin on January the 1st, of 2012. And the first one is called Recovery Auditors Prepayment Review Demonstration. That's the demonstration that will happen in 11 states and is mandatory. And initially those recovery auditors will be focusing on short inpatient hospital stays. They'll be expanding to other review areas after January or February, but they're going to be starting with the short inpatient hospital stays.

The second demonstration is called our A/B Rebilling Demonstration and this affects hospitals, is a voluntary demonstration. It will be available to the first 300 hospitals who sign up nationwide. And it will allow those who receive a Part A denial for certain types of hospital stays, typically short stays where there are the particular denial reasons to rebill those claims.

If medically necessary services were provided in the outpatient setting but they were billed in the inpatient setting, the hospital will be allowed to rebill.

And then the third demonstration is the one that we're here to talk about today and this is the one called the Prior Authorization of Power Mobility Devices. And this is going to be in place starting January 1st for a beneficiary who resides in the following seven states, Californian, Illinois, Michigan, New York, North Carolina, Florida and Texas. And it will be mandatory. This is not a voluntary program. This is going to be a required program.

On slide four, you can see the definition of Power Mobility Devices. It's basically all the scooters and power wheelchairs with the exception of the Group 3 complex rehab power wheelchair with power option, but most of the other scooters, POV and power wheelchairs are included.

There are two phases of the demonstration as you can see down this slide on slide five. And in Phase 1, we are planning to do a 100 percent prepayment review on all first month PMD claims. [Ed. note: this means the first claim submitted per beneficiary for dates of service after the start of Phase I.]

Now, it would be all of claims where there's a purchase, so for those – scooters and other things that it would just be, you know, for that claim. But if it was a monthly rental claim, which I know many of them on the list are (capped rental) items it would be for the first month's claim.

So, again, for Phase 1, it would be a 100 percent prepayment review starting with the first month's claim where the purchase was on or after January 1st in one of the seven states. Phase 2 is our Prior Authorization phase.

Slide six talks about the timing for this. We are anticipating publishing a federal register notice, probably in the next week or so, announcing the demonstration. And then, Phase 1, which is our prepayment review phase, will start on January 1st in all seven states. And it will end when Phase 2 begins. So, we are expecting Phase 1 to last somewhere between three months and nine months.

Phase 2, we're going to bring up in a staggered approach. We're not going to bring up all seven states at once we'll bring up a couple of states at a time. And we will certainly be doing continuous education of all providers and suppliers in those states to make sure that everyone really understands the rules. And then we plan to end the demonstration three years after we begin in December of 2014.

Slide seven, again, shows you the states where the demonstration will be occurring. Again, it does not pertain to where the supplier is located. It doesn't pertain to where the physician is located. It pertains to where the beneficiary's permanent residence is. If they are Snowbirds and they spent part of their time in Florida, but the other part of their time, they spent in Missouri, they will not be part of the pilot, so long as Missouri is where they have listed as their permanent residence with Social Security Administration.

We chose these seven states because they account for over $250 million of the roughly $600 million spent annually on PMD. So, by limiting our demo to these seven states but choosing the seven states that had the biggest bang for the buck, we were able to get the 43 percent of the total expenditures for PMD.

Now, a lot of people have been asking us why did we choose these codes and why did we choose prior authorization?

We chose to focus on this area of claims because we have, despite our efforts to educate of the supplier community and the physician community for many years about the documentation that needs to be present in order for Medicare to cover these items, we continue to have a very high error rate. We even had our review contractors doing prepayment review and they have still been unable to get the error rate down to an acceptable level.

Most recently the error rate for power mobility device is at 75 percent and that's unacceptable. We are never going to be able to get our national error rate down to where it needs to be if power mobility devices continue to have an error rate of over 75 percent. Something has to change.

One of the reasons why we think prior authorization might work is that it helps to move the responsibility to the ordering physician or practitioner. That's really who has to determine medical necessity. It's not the beneficiary watching the ad on TV for the power mobility device and thinking, "Oh, I think I need one of those so, I can go to the Grand Canyon, too." And it's not the supplier, of course who wants to sell as many as possible, it's really the physician or the practitioner who's ordering the device, that's who really has to determine the medical necessity.

And by shifting the – to a prior authorization program, which is where the medical documentation is reviewed before the item is delivered to the patient's home, we think it really helps to sort of set the stage for making sure that the right patients are receiving this equipment and that our dollars, our tax payer dollars in Medicare, are being spent properly.

In addition, it allows us to use a private sector technique. When we begin to research this a few months ago, we begin to learn that almost every private insurance company in America uses prior authorization for some form of durable medical equipment, some use it for all kinds of DME. TRICARE uses it.

Lots of other insurance companies, most Medicaid state agencies use it as well. Medicare was one of the few insurance programs in America that did not have any form of prior authorization and we felt like it was time to give the demonstration a try and see if this tool could help us.

It also really helps us to reduce our pay and chase syndrome that's where we – the claim comes in, it gets paid and then after the fact, the recovery auditor or some other contractor chooses the claim for review, finds out that it's not medically necessary and then the supplier has to repay the improper payment.

So slide nine gives you a few more details about Phase1, which is our 100 percent prepayment review phase. Again, it begins with claims where the date of service, which is usually the same as the delivery date, is on or after January the 1st, 2012. So, if there's a beneficiary who's first month's rental is December and their second month's rental is in January, they will not be impacted by this, only those who have a first month's rental claim January or after will be impacted. . [Ed. note: this means the first claim submitted per beneficiary for dates of service after the start of Phase I.]

The Phase 1 and Phase 2 will both be using the same coverage policy as today. We are not creating any new rules here. These are the same rules that have always been in place.

And the – in Phase 1, the DME MAC will send an additional documentation request, (we sometimes call them ADR) to the billing suppliers for 100 percent of these claims. And most DME MAC will begin to accept Electronic Submission of Medical Documentation or esMD transactions starting in January. It's not a requirement but it is something that we are encouraging

suppliers to use not only for PMD documentation but for any documentation that they want to send in to their suppliers.

esMD will also be available to many of the MAC, so any physicians who are interested can get more information from the CMS Web site.

Failure to submit the completed documentation package will result in a denial. So, Phase 1 is pretty much like today, except that it won't be a small number of claims that are subjected to review, it will be 100 percent of claims that will be subjected to review.

Slide 10 talks about Phase 2. And again, Phase 2 will begin in April or later, depending on how we stagger the states, and we don't yet know which state is going first and which one is going second. But this will move up the requirement to gather the documentation and review that documentation before the patient gets the items delivered.

In Phase 2, the ordering physician or practitioner will submit a prior authorization request including the progress notes that document the face to face exam. These are the seven element orders and any other medical documentation that they think will help support the need for the power mobility device for their patient. And they'll send all that to the DME MAC.

The DME MAC will review the request and post mark a notification of the written decision within 10 days and that notification of their decision will go to you, the physician practitioner, as well as to the beneficiary and the supplier. Again, the DME MAC will make that decision within 10 days.

If the – if the DME MAC decision is to not approve the request, then the physician or the practitioner can resubmit an unlimited number of times but the DME MAC will have a longer time to review this resubmission. Each subsequent request the DME MAC will have 30 days to review.

And anytime the decision is to not approve, the DME MAC will provide a detailed explanation as to what was missing from the package or what policy requirement was not met.

I'll just take a second to remind folks, I think a lot of beneficiaries forget that the DME benefit in Medicare is an in the home benefit. We've certainly put out lots of educational materials to try to remind folks of this but it's really tough when beneficiary see those ads on TV for people going to the Grand Canyon or going to Disney World in their new scooters or their new power mobility devices, they think that, you know, when they have trouble walking long distances, they too might benefit from one of those devices.

But that's not really the authority that Congress gave us. W when the Congress wrote the DME benefit, they said that the only people that qualify for durable medical equipment are those that need the device in the home.

And so, if you can't document that the patient needs the power mobility device to get from their bed to their bathroom or from their bed to the kitchen or to perform other activities of daily living then they don't meet the Medicare criteria and you shouldn't be ordering it and we shouldn't have to go through the whole process.

But in those situations where, the patient does meet the criteria we're hoping that by putting in place the prior authorization process, we will simplify things and make it much easier for everyone involved.

Slide seven points out that there will be rare circumstances where we would allow the provider to request and expedite a review. Very hard to imagine emergency situations where a patient would need to have the wheelchair in 48 hours but if those situations came up they could apply for that and get their decision in 48 hours, instead of 10 days.

And we are encouraging suppliers to wait until they receive the prior authorization decision from the DME MAC before they deliver the items to the patient's home and before they deliver the – before they submit the claim to the DME MAC.

Now, slide 12 goes through a couple of potential issues that may come back to you if you submit a request for prior authorization and it gets denied and what you can do in that kind of situation?

So, for example, if the detailed denial letter for your prior authorization request comes back to you and says, "We deny your prior authorization for beneficiary, Mrs. Smith, because the order was written before the face to face exam." Well, then the solution that you may choose is to simply write a new order and submit a new request.

If the denial reason is because more than 45 days has elapsed between the face to face exam and the written order, then you may need to conduct a new face to face exam and write a new order and then submit a new request.

If the denial reason is because there was one or more elements that was missing on the order, then you can write a new order, making sure that you – that the new order contains all seven elements and then submit a new request.

If the denial reason is because the coverage criteria were not met and that – remember that the detailed review results letter will specify which criteria were not met, then you can remind yourself, refresh your memory about what the policy is, remembering that it's the DME is covered by Medicare only for use in the home.

And then you can review the documentation that you sent in with the prior authorization request making sure that you didn't leave out any documentation that would have helped to prove your point and you can – if you missed some documentation, you can send in new documentation and a new request.

And as the insufficient documentation exists, you could always conduct another evaluation of the beneficiary and document, you know, for example, which ADLs the patient cannot perform without having a power mobility device in their home. Conduct a new face to face exam and then submit a new request.

And you may also find that you have an incomplete face to face exam. In that case, you may need to create an addendum to your face to face exam documentation or if you needed to, you could always conduct another in person visit with the patient.

The next slide talks about the appeals process in Phase 1, which is our prepayment review phase, all the current appeal rights apply to those claims and in Phase 2 the prior authorization phase, we will not really have an appeal process for the prior authorization package because you could submit those as many times as you like. You can just keep resubmitting them until your documentation is sufficient to allow coverage or in the case of a denied claim, all the current appeals rights exist.

Slide 14 talks about the new physician reimbursement that will be made. There'll be a new G-code G9156 and you can submit it after – on a regular claim to your A/B MAC and you will submit it once you have the prior authorization tracking number which you'll get from the DME MAC. And you can only submit one G-code per beneficiary per PMD. So, even if it takes you a couple of times to resubmit the package, you only get to bill for the G-code once.

We're going to do everything we possibly can to make sure that we're very clear about what you need to submit in that initial prior authorization package to minimize the paperwork and hassle factor for you. And that code is not subject to co-insurance or deductible. The purpose of that code is to at least provide some small compensation to you for the additional time spent preparing and submitting the prior authorization request.

So, the next slide walks through a couple of scenarios. In scenario one, the prior authorization request is submitted by the physician or practitioner who has ordered the device and if the DME MAC decision is affirmative, they approved the prior authorization package, then the supplier can submit the claim and the DME MAC will pay the claim so long as all the other requirements are met. There could be situations where a claim would be denied because they duplicate or because of Medicare secondary payer issues, but for the most part we would expect that claim to be paid.

In the second scenario, a prior auth submitting physician or practitioner has submitted a prior authorization package but the DME MAC decided to not approve it. In that case, the physician – either you could resubmit and keep resubmitting until you're sort of converting their scenario two into the

scenario one, or if the supplier chose to they could still submit a claim and DME MAC would deny that claim.

There are maybe situations where you chose not to submit a prior authorization request and in that case, what happens to the supplier depends on whether or not the supplier is a competitive bid supplier or a noncompetitive bid supplier.

If it was a case where there was no prior authorization request and the supplier still chooses to provide the item or the service to the beneficiary, excuse me, provide this – the PMD device to the beneficiary and submit a claim if they are competitive bid supplier then the DME MAC will send an ADR letter to the supplier and wait until the documentation comes in, review the claim and decide whether it's payable or not. And if it is payable, pay it at a normal rate.

If no prior authorization request comes in, and the DME supplier chooses to submit a claim anyway and it's a noncompetitive bid supplier, then the DME MAC will send the ADR letter, wait until the response comes back, review the claim and the documentation, and if it is payable, they will pay at 75 percent of the Medicare payment.

Slide 16 reminds you that the prior authorization demonstration uses the same coverage requirements today. There are no new documentation requirements placed on you or the supplier, we're simply requiring physicians and practitioners to submit that information earlier in the claim process. In this case, before the claim is submitted and hopefully before the item is delivered to the patient's home.

In addition, all advance beneficiaries notice procedures remain the same. And you could find all of the current requirements on the DME MAC Web site.

We anticipate that the impacts to the beneficiary will be fairly minimal. The PMD benefit is not changing and beneficiaries will receive a notification of the decision about their prior authorization request.

We support and encourage beneficiaries to always use suppliers who accept assignment and by beneficiaries using physicians who will use the prior

authorization process, it will give the beneficiary full notice before they actually bring that device into their homes, whether Medicare is going to cover it or not. And then they can make a financial decision.

So, slide 18 talks about what the documentation requirements are going to look like in Phase 1. The physician or practitioner in Phase 1 will conduct the face to face exam just like they do today, they will write the order just like they do today. They will receive a documentation request from a supplier, sometimes that may happen a month or two or three or four months down the road and they will respond to the supplier by sending them documentation of the face to face exam, relevant notes, and the seven element order.

The Supplier will conduct a home assessment just like they do today to make sure that the PMD device will fit in the hallways and through the doorways of patients home and submit a claim. And when they receive that documentation request letter from the DME MAC, they will forward it to you, the physician or practitioner and then, wait until you send them the documentation of the face to face exam notes and the seven element order.

And then, they will send the whole package to the DME MAC, the face to face exam notes, the seven element order, the detailed product description, the home assessment, the patient authorization and the proof of delivery.

But when we get to the next page of the Phase 2, you'll see that the documentation requirements, the order of things has changed a little bit. Now, we still have the physician or practitioner conducting the face to face exam and writing order but then, they will send with the DME MAC a prior authorization request including the face to face exam notes with the seven element order. And then the supplier will wait until they receive the notification from the DME MAC which will include a prior authorization tracking number if it’s been approved.

The supplier will then conduct the home assessment and they will keep on file the face to face exam notes and the seven element order from you and will submit anything that the DME MAC requests, such as a home assessment, the patient authorization or the proof of delivery.

Slide 20 goes over some to the more details about what you need to include in the face to face examination. Most people say that the most common reason for denial is that the physician is not documenting fully what's going on in the face to face examination. And so, we sort of included this checklist to make sure that you can see everything that really needs to be included in the face to face exam. And we have an even more detailed checklist that's available at one of our MLN Matters Articles. That is either already posted to our Web site or it will soon be posted to our Web site.

The next slide points out the elements of the seven elements written order.

And the next slide talks about what is included in the detailed product description. That's what the DME supplier will be sending to you that will let you know what HCPCS Code you're going to include in the prior authorization package.

So, on the next slide you can see in summary on page one is 100 percent prepayment review. It's mandatory, it applies to beneficiaries who reside in seven fraud and error-prone states, and it requires the suppliers to respond to the DME MAC documentation request. And it begins in all seven states with claims that have dates of service of 01-01-2012 and later. And it ends when the prior authorization phase begin.

Phase 2 our prior authorization phase affects beneficiary residing in those states, same seven states, and it requires the physician or the practitioner who's ordering the equipment to submit a prior authorization request to the DME MAC and that phase ends on December the 31st of 2014.

The next slide provides you with some contact information so that you can get to our Web site and so that you can send us an e-mail if you have any additional questions.

And then, the next slide has references about power mobility devices from our MAC.

What I'd like to do now is open up the phone to questions. And I got a number of people who are on the phone today who will be helping me out

with questions, particularly Dr. Hoover who is the Contractor Medical Director for the DME MAC in region C. CGS Administrators is the name of that company and we're very pleased to have Dr. Hoover with us here today.

In addition, we have Evelyn Blaemire who is our Advance Beneficiary Notification Experts. And in case any ABN questions come up, Evelyn is going to be helping me out with those.

So, let me turn it over to Barb, who can give the instructions for how to make questions.

Barbara Cebuhar: Thank you, very much, Melanie. I really appreciate the overview. (Sheila), could you give instructions to our listeners, please?

Operator: At this time, I would like to remind everyone, in order to ask an audio question, please press star then the number one on your telephone keypad. We will pause for just a moment to compile the Q&A roster.

Melanie Combs-Dyer: While we're waiting for the questions, I will read one that came in to our e-mail box. This question was, why can't prepayment reviews be supplier specific instead of across the board?

And we've actually tried that. We've tried that for a number of years. We try to do supplier specific education and supplier review but that didn't seem to do the trick. We still ended up with the very high error rate. And so that's why we've not – we're now going to try this prior authorization demonstration and see if we can get that error rate down through this new tool.

Operator: Your first question comes from the line of (PJ McKinney) from Wheelchairs Plus. Your line is now open.

(PJ McKinney): Hi. Thanks a lot. I really appreciate you guys taking the time to talk to us today. My question primarily is surrounding Phase 2 and regarding clarifying the provider involvement. Getting kind of a two part question here, part one is that when the physician submits to the MAC, how or can you better define how the equipment selection is clarified in order to justify the authorization for the specific equipment being requested?

We have to assume that in order to mitigate the fraud and abuse the program is intended to address a valid authorization [that] can only be determined if the person reviewing the request is able to determine specifically what is actually being requested?

It is very rare that physicians are going to know and understand the difference between a KO823 and a KO822 or so on and so forth, you know, and in some cases we have issues where physicians may not fully understand even the difference between a scooter and a power wheelchair. So, that's kind of part one.

Part two, relates to the same issue. One of the most well known recent abuses of course, several years ago was Operation Wheeler Dealer. In that case, the – a large part of the fraud was committed by dealers and physicians who partner together in an effort to defraud the system. This program appears to indicate a more definitive relationship between a physician and the provider.

So what measures have been put in placed to ensure that Medicare doesn't repeat this process of fraudulent behavior now that you're going to have specific physician or providers working in a much more closely or much more close environment.

And I guess kind of caveat to all of this is can you define practitioner when you're looking at the submission of the – of documentation to the MAC is either from a physician or the practitioner? Can you please define the practitioner as well? So, kind of a three part question.

Melanie Combs-Dyer: Yes. Lots of really good question there and I will take them each one by one. The first part of your question was, how will the physician or practitioner know the HCPCS Code? And that's a really good question. And we anticipate that unless there is a physician who sort of specializes in this and maybe they are a rehab physician and they order these things all the time, we are anticipating that after they write the seven element order in the medical records, they will send the face to face notes and the seven element order to the supplier.

And the supplier will complete a detailed product description which includes the HCPCS Code and fax that back to the ordering physician or practitioner. And then, from that information, the physician or practitioner will have enough information to fill out that prior authorization package. So, that was a very good question there.

(PJ McKinney): Let me ask you this, I apologize for the interruption, it states here on page 19 that the physician/practitioner is supposed to send in the face to face exam notes and the seven element order. There is no indication of a DPD being included in that original submission request.

Melanie Combs-Dyer: Right. And we are still working out the details. We are going to be posting, for example, more detailed instructions about what a physician needs to submit and in fact even a little flow sheet, flowchart of who sends what to whom, when. And when that gets posted, hopefully that will clarify but the physician does need to include the HCPCS Code and we'll make sure that we add that to future slides to clarify that.

(PJ McKinney): Thank you. And then of course part two and the practitioner definition.

Melanie Combs-Dyer: Yes. Now, the second question was, what are we going to be doing to prevent fraud? And I can tell you that we're working very closely with our friends that oversee the Zone Program Integrity Contractors, the ZPICs, the Fraud Fighting Contractors, and we will continue to share information with them and continue to, you know, really try to tackle the fraud wherever we find it.

And then, in terms of defining a practitioner, I would just say it's whatever the current definition of a practitioner is, we are not changing that definition. Dr. Hoover, did you want to add anything more on the definition of a practitioner?

Robert Hoover: In the Medicare statutes, you know, it talks about physician either an MD or DO, a nurse practitioner, physician assistant, or clinical nurse specialist, and those are as Melanie says, nothing is changing from our current definitions of practitioner.

(PJ McKinney): Thank you.

Barbara Cebuhar: Thank you. (Sheila), our next question please.

Operator: Your second question of it comes from the line of June Levey from DME Claim Services. Your line is now open.

June Levey: Hi. Yes. I just wanted to know, what is the anticipated processing time for this 100 percent prepayment review in Phase 1?

Melanie Combs-Dyer: We are still working out those details with our review contractors. We are hopeful that it will be shorter than the 60 days that contractors have today to conduct those reviews. And once we know exactly what that is, we will post that to the Web site. But I am hopeful that it would be less than 60 days.

June Levey: And will there be instructions put out on how to submit the information electronically with that?

Melanie Combs-Dyer: Yes. There certainly will be instructions on how to fax it in, if that's your interest. If you want to be truly electronic and use esMD, Electronic Submission of Medical Documentation, I would direct you to www.cms.gov/esmd. And if you have any questions, let me know, and I will get you in touch with the people who can help you do it in a truly electronic way.

June Levey: OK. Thank you.

Barbara Cebuhar: Thank you. (Sheila), our next question please.

Operator: Comes from the line of Kimberly Ross from Texas Academy Family. Your line is now open. Kimberly Ross, your line is now open.

Kim Ross: Sorry. I was on mute to protect you from the background noise. I apologize. My name is Kim Ross. I am working with the Texas Academy of Family Physicians and others. I'm a Healthcare Consultant. And I am also working with the American Medical Association, hang on just a second.

Sorry, you there – back. My question is, and Dr. Hoover, you may have been on some calls, I believe, with the academy on a clinical guide that we have

developed to try to reduce on the physicians side, the error rate that physicians make, since as I think everyone here is aware upwards of two thirds of these prescriptions are written by family physician but they only write one or two a year.

So, what guidance can the Medicare provide to the family physicians in very busy practices when they're going to be prior (auth) all of the – on the front end, so that they have some sense of, I understand that there's been some progress/discussion in terms of some kind of (sanity) guide. I think you now have a checklist but what can be done to not further delay or further complicate on the physicians side the error rates that come from the fact that they don't write many of these?

That's the reason that we developed the guide. I met with Medicare on a number of occasions on the subject on – and but I think a lot of progress and discussion throughout this process, but I think on behalf of the academy, the family physicians and I think even from the AMA we're very concerned about a supplier offer like this actually making things worst on the short end and pinching down the ability to actually get the right care to the right place and the right equipment at the right time.

So, has there been discussion about something in the way of a heads up and obviously if I'm being practical on the short run but some kind of transparent standards as how are we going to conduct prior (auth) at that time that they're actually doing this so they kind of know what the rules are. Will there be the ability to work with the physician communities on the development of some kind of guide that kind of helps them on the front end when they're making this face to face examination and going through the documentation process?

Melanie Combs-Dyer: This is Melanie. I will start the answer and I will turn it over to Dr. Hoover. We are always open to looking at ways that we can improve the educational materials that we put out to make it really clear, what it is that we want physicians to do. And we look forward to working with you on developing that.

That being said, a number of folks have asked us particularly on the supplier side, if we could create a forum for physicians to use. And we have found that forums typically made things worse, because physicians will often time put short answers in the forum and then they end up with more denials than they would have if they just submitted a medical documentation where at least there's a little bit more explanation as to why the patient needed the item.

But the short answer is yes, we're open to working with the physicians to try to put out more educational material about exactly what it is that they need to document to prove the medical necessities – to prove that all of the coverage requirements are met for the PMD that they're ordering for their patients. Dr. Hoover, do you want to add anything to that?

Robert Hoover: Yes. Thanks. Hey, Kim, it's good to hear from you again. I think, you know, all of the DME MACs have educational materials posted on our Web site in terms of the coverage criteria, the policies, and so forth, there is a specific dear physician letter, each one of the DME MAC has this. It was published in the local part B carrier, A/B MAC contract or Web site entitled, the "Power Wheelchairs and Power Operator Vehicles Documentation Requirements".

That is a three page document that kind of goes back through what specifically the physician needs in terms of their documentation. Most have heard me say it before, the evaluation of a patient for the power mobility device is really a, you know, a third year medical student physical diagnosis class type of evaluation.

And that involves, you know, what is the patient's current ambulatory needs, what's the past history of their ambulatory problems and what impact do other comorbid condition have on their ambulatory ability? If they have existing mobility assistive equipment, you know, why is that piece of equipment no longer serving the beneficiary?

It's a very step wise approach that's set out in the national coverage determination and in our local coverage determination this step wise approach meaning, you know, going from a lower level piece of equipment to a higher level, you know, working your way through why a cane, why a crutch, why an

optimally configured manual wheelchair, why a walker, or POV are not adequate for the patient before moving on to a power wheelchair.

In listening to Melanie talk about the efforts of CMS. Melanie you may want to talk or have (Leticia) talk a little bit more about, you know, some of the plans that we've heard discussed as far as physician outreach. I know there are – there have been number of discussions about proactively reaching out to various physician organizations.

There has been some discussion about open door forums and, you know, in person type of meetings that CMS is contemplating in each of the areas where the demonstration projects are taking place. I know there are not firm details on that at the present time, but I know from discussions with CMS and also for DME MAC contractors that there is a significant amount of education for – specifically for physicians and other practitioners that might order these items in the coming weeks before the prior authorization process is implemented.

Melanie Combs-Dyer: Thank you, Dr. Hoover. This is Melanie again and yes, I – (Ken) if you or anybody else is on the phone from a physician group from a physician organization, if you would – if you have ideas about clinical guides or checklists or any other kind of educational material that you think CMS should consider, we are open to hearing about it and you can send it – your suggestion to our Web site – I'm sorry, to our e-mail address and we would be happy to have a conversation with you about, what it is that we can do. Perhaps you may find that the materials that we have already developed, you could post up on your Web site or we could work together to develop something additional that physicians might find helpful.

And Dr. Hoover is correct. I am going to be going out on the speaking circuits and talking in person probably in each of the seven states. And so, if you are aware of any gatherings of physicians, who would be impacted by this demonstration, please also write to those e-mail address, pademo@cms.hhs.gov and let me know when it is and where it is and how many people you are anticipating will attend. And I can also do conference calls. So, you know, large groups, small groups, whatever it is that you think

would be helpful, please let me know. I am really anxious to get out there and try to get the word out to physicians.

Kim Ross: Melanie three comments and I don't want to – I don't want to monopolize all the time. Dr. Hoover and his colleagues are very aware of the [guide that was] several years in development and been posted off and on for some time. The clinical guide developed by the Texas Academy using a number of rehab and our physician experts as well in it's development. And working through that and concerns of – and trying to get away from it ever falling in the trap of being a checklist in that regard.

They have also developed and I believe that Dr. Hoover's colleagues have actually reviewed and have been at one conference call with his colleagues with regard to a video now that supports that and provides more of a guide as well. We would share those freely with any and everyone who wants to look at and evaluate it.

In fact we approached Medicare because we wanted to get some sense of it's fairness and accuracy since it is a daunting challenge when you're talking about a huge number of prescribers but extremely low volume per annum of those types of units from these physicians in very busy practices. So, it is a communication challenge, as we've all known over the years and we try to work on this together.

A second aspect of that is we, the Texas Academy Family Physicians, Melanie, can provide you and/or your designees, audiences and all of those states with all those family practice chapters or any other aspect from the physician side of this without difficulty and can setup lines communication, would come into you, to taking a look at or talking to your counterparts within the reviewer community about that guide itself. We do not – we agree with them that it cannot nor should it be a checklist.

Finally, the third question has more to do with patterns of where these errors occurred. It is not clear to us although we've had some productive conversations as where are the abundance of these errors evolving from or the – can you identify certain places, because if we do develop some kind of a guide, we want the guide to reflect and it come that in where those errors may

be occurring because of the physicians own misunderstanding of what is a fairly complicated process.

It is our initial understanding that a lot of these come from the short end of things. Dr. Hoover's already alluded to just the physicians they're not completing or filling/answering all the questions, leaving boxes empty or overlooking certain steps, which of course there is a communication problem.

But I welcome your insights as I know all the family physicians around this country would like to know how you reduce that particular area that just comes from, you know, the charting and the documentation process alone?

Melanie Combs-Dyer: Yes. I do believe that much of the error is driven by that missing or absence of documentation and I don't know that I have a handle on how much of this is because the patient just doesn't meet the criteria and perhaps they arre sort of asking or begging their physicians to write them a prescription and there is really no there and there that patient perhaps doesn't –

Kim Ross: Yes.

Melanie Combs-Dyer: – meet the criteria, but the physician, you know, at the – at the demand of the beneficiary, their patient, they're going ahead and writing the order versus how much is the patient really meeting the criteria, but the physician is failing to document all the right things.

Kim Ross: Sure. It's a dilemma that we've discussed with your colleagues in compliance off and on even in Baltimore at your offices over the last several years and I very much understand that that's hard to distinguish between a social prescription as the one that's medically necessary but isn't documented properly and wanted to – we would very much want to close that gap, so the physician gets it right the first time on both those accounts.

Melanie Combs-Dyer: Yes. Just one final thing before I turn it over to take the next question, I will try to gather as quickly as I can from each one of our DME MAC periodically throughout this demonstration as much as I can in terms of statistics for the patterns of denials that are occurring and try to put that information out or our Web site or out to you and other physician group, so

that we can all learn and we can all tailor our education going forward to those problem areas for physicians in terms of their documentation.

Kim Ross: You got sort of an intel we can certainly push that by all delivery mechanisms that physicians our academies had to communicate with their physicians.

Melanie Combs-Dyer: That's great. Please, make sure you send us your contact information to pademo@cms.hhs.gov.

Kim Ross: OK.

Barbara Cebuhar: Thank you, Mrs. Ross.

Kim Ross: Thank you.

Barbara Cebuhar: (Sheila), our next question please.

Operator: Comes from the line of (Barbara Enderly) from (Benson's Home Health). Your line is now open.

(Barbara Enderly): Thank you. Good afternoon. Earlier you were discussing different scenarios where physician could resubmit documentation and in your wording you said the physician could add an addendum and send it in. I was under the impression that addendum were not allowed in medical records?

Melanie Combs-Dyer: I probably use the wrong term there, perhaps late entry would be better words for me to use. This is where you would come back, you know, maybe two days after you had seen the patient and now you've got the notification that you had you left something out and you could create a late entry.

I'm not talking about doing anything that's illegal. I'm talking about the kinds of entries that you would normally make in a medical record when you remember that there is some information – important information that you've left out and you list the properly document that you really did ask the patient to walk in certain distance and you forgot to write down how far they could walk or whatever other piece of information you accidentally left out of the documentation.

(Barbara Enderly): So, then the physician could just write it in their as the late entry as long as it doesn't state addendum?

Melanie Combs-Dyer: Anything that you do that meets the state law about how you add a late entry to the medical record, whether it's a hospital record, or it's a face to face examination, or anything else that you're doing – anything that you're doing legally, the review contractor will consider.

(Barbara Enderly): Is there a time frame that they can add the late entry?

Melanie Combs-Dyer: I can tell you that we have instructions in our program integrity manual that says if it is more than a few days, you know, if you're talking about months after the facts, the delayed documents of late entries made to the medical record, we instruct our contractors to refer those to the fraud department. We think that people who remember, you know, six months after the fact, that they did something during an exam perhaps aren't remembering correctly, but if it is a day or two after you've seen the patient, it probably makes more sense.

Dr. Hoover, did you want to add anything about late entry?

Dr. Hoover: So, I think, you know, we rely upon the contemporaneous medical record to make our determinations, you know, what's documented at the time of the patient's visit, physicians occasionally as Melanie says, has to recall additional information as long as that is dated and timed appropriately, marked as an addendum to the office visit.

You know, obviously from the medical legal standpoint, you don't go back and alter a record that you've already created, but there are mechanisms for correcting records and adding information to a record. I will add the caveat that the further that it gets away from the date of service or the date of that original note, the less weight is tend to be given to that, because of recall issues and other complicating factors.

So, you know, an addendum to an office visit, recalled four months later is obviously more suspect than a note that may be made within, as Melanie says, a day or two after the initial office visit.

Barbara Cebuhar: Thank you, (Ms. Enderly). Our next question, please, (Sheila).

Operator: Comes from the line of (Lori Sears) from Excel Medical Supply. Your line is now open.

(Lori Sears): OK. I have a few questions and just one comment about the discussion that we just had on the addendum of note. Is there any way we can get some further clarification on that, less in formability more so in all the other observed reviews that we've had lately, that's becoming a real big issue for us.

Melanie Combs-Dyer: Sure. We will put out on our Q&A list within the next few days, the citation to the program integrity manual that talks about late entry.

(Lori Sears): That would be great. That really does come into play on a daily basis for us. OK. Regarding Phase 2, can you address how other licensed medical professionals referring to, you know, OTs and PTs primarily are going to be on in this process the way that it's laid out in page 19 and I know there was some clarification to this, but the physician or practitioner submitting for that authorization before you have the detailed description, et cetera, and nowhere does it show when the physician chooses to refer a part of that face to face evaluation out.

Also, on that same regard, when it comes to the detailed product description, sometimes when we're doing a power chair, one of the reasons that we're doing it, is because there was a changed in condition with, for an example, someone needs a new seat and the new seat, a custom seat can't be accommodated on the existing chair.

So, it's a whole picture kind of issue and the way that this is laid out is that the prior authorization will be reviewed based on the base only and all the rest of the components of the chair which are sometimes, you know, this is important, and certainly more costly, are going to be reviewed at some other time, whether it's on an audit, on review, or whatever, and it just makes sense to have all that process done at one time.

Melanie Combs-Dyer: I'll take part two first, and then I'll ask Dr. Hoover to address part one.

For part two, what about the new fee or other accessory, if their prior authorization program for both phases, Phase 1 and Phase 2, are limited as you said to the base, so for any of the accessories, we will continue to address them on a targeted review basis if the supplier – I'm sorry, if the DME MAC sees that there is a higher error rate with a particular supplier or particular item or particular accessory or an OIG report before it comes out and says that, you know, we're having big trouble with foot rests or whatever and then we can do some targeted review for those areas, but they will not be included in the prior authorization program Phase 1 or Phase 2.

Any questions about that before I go back to your first question?

(Lori Sears): No, only the comment that I don't like it. I think it should – it makes sense to me to do it the way that the advance determine process has done now.

Melanie Combs-Dyer: And I will tell you that the advance determination of process will continue to be in effect. In fact, some people have asked if we could expand the ADMC program. For those of you who don't know the Advance Determination of Medicare Coverage or ADMC, is a voluntarily process that today physicians can use to submit for certain codes, I don't know that it includes all of the PMD codes, or requests to have a decision made about whether Medicare coverage requirements are met. And as, (Lori), is suggesting, I believe it includes some of the accessories as well as the base unit.

And then, once the decision comes in, then the beneficiary can decide, you know, that they want to get the item or they don't. And so, ADMC will continue to be in place for the codes that is available for today and you can watch our Web site to see if ADMC gets expanded. ADMC is really not part of this demonstration but it maybe impacted somewhat by this demonstration.

Now, onto your first part of your question, which is how will it work in Phase 2, when the ordering physician or practitioner wants to make a referral to an OT or a PT. Dr. Hoover, can you talk about how that might work?

Robert Hoover: Yes. We made some mechanism outlined in the local coverage determination for a track for physician to what to do or elect not to do the actual examination itself and so, there is an opportunity for them to refer out the face to face examination to a license – other licensed medical professional like a physical therapist or an occupational therapist.

So, I would encourage you to take a look at our local coverage determination and the related policy article for that information. We also have information about that in our Dear Physician Letter and talks about how that process works for the physician that chooses to refer out the face to face examination and what their – what the treating physician's obligations are when they get that report back.

Barbara Cebuhar: Thank you, very much. (Sheila), our next question please.

Operator: And your next question of four, comes from the line of (Lorraine Greathouse) from Medco, Inc. Your line is now open.

(Lorraine Greathouse): Yes. So, you've already answered my question as far as the addendum and the timeframe on that and everything. This today was supposed to be for the practitioners pretty much and I was just wondering how much of a response that we did get from practitioners.

Melanie Combs-Dyer: Well, there is no way for me to really know, except by listening to calls that have come in and it does sound like a number of the people who had been asking questions, have either worked in physicians offices or they represent physician organizations like (Ken Ross) earlier. How about you? Are you a physician?

(Lorraine Greathouse): No.

Melanie Combs-Dyer: There is no other way for us to know other than to ask each questioner whether they are physician or an ordering practitioner, but we're very hopeful that of the folks who are listening on the phone today that the majority of them are physicians or who are practitioners.

(Lorraine Greathouse): OK. Thank you.

Melanie Combs-Dyer: Yes.

(Lorraine Greathouse): Good bye.

Barbara Cebuhar: Thank you. (Sheila), our next call.

Operator: Comes from the line of (Heather Marie) from National Seating. Your line is now open.

(Heather Marie): I have kind of a two-fold question. My first question is, according to this – in your presentation on page 15, that if the physician does not submit a prior authorization request and the supplier bills [a]claim – and the supplier is the competitive bid supplier, the supplier will just get an ADR request. Correct?

Melanie Combs-Dyer: That is correct.

(Heather Marie): OK. So if we have a physician that refuses to submit a prior authorization request, it would not alleviate us as the supplier to be able to submit that claim?

Melanie Combs-Dyer: Correct.

(Heather Marie): Correct, right? OK and then –

Melanie Combs-Dyer: I would just add there. You could ask the beneficiary if they would be interested in submitting an ADMC request even if the physician isn't willing to do it.Perhaps the patient can gather enough information from the physician and submit an ADMC request. So that at least they would have some information before that item got delivered to their homes whether or not Medicare will be covering it.

(Heather Marie): OK. So that kind of leads me into my second part of my question which I know with ADMC typically they do not review for changing conditions type of equipment, you know this prior to the five years of useful lifetime. So I'm curious to know if the prior authorization on the basis going forward will take into account if there's been a change in medical condition or not?

Melanie Combs-Dyer: Dr. Hoover did you understand that question? If so do you want to answer it?

Robert Hoover: Gee, I mean I was trying to follow it, could you repeat it again, please.

(Heather Marie): Sure. I've been told numerous times that ADMC doesn't – they simply review the medical documentation against the policy and they really don't take into account if the beneficiary has had another chair on file that may not be five years old but they've had a change in medical condition to warrant a new base. So I'm wondering if this new prior authorization process will be looking at those cases as well, taking into account the change in medical condition?

Melanie Combs-Dyer: But let me try to answer that one and then Dr. Hoover can tell me if I get it right. I believe that whether it's an ADMC review or it's a prepay claim review in Phase 1 or is a prior authorization review in Phase 2, in all cases the DME MAC would be reviewing all the documentation that gets sent in with all the information that they already have on file about that patient and how many other devices the patient may have in their home. Dr. Hoover is that correct?

Robert Hoover: Yes. I mean, we go back to your original statements Melanie in that there is no – as far as how claims are reviewed or the policies or anything related to the claim review, the type of claim review that we do today at CGS and I think I can speak for my other DME MAC colleagues.

The type of prepayment that review that we would do today on a KO823 or an ADMC on a complex rehab chair is no different today that it would be next February or next April with respect to the medical documentation that we're looking at and comparing that to the requirement to the local coverage determination.

It's exactly – it will be exactly the same process from a claim review standpoint. So nothing about that is changing, the policy is not changing or anything. I can speak as I say for jurisdiction C and our nurses when they do an ADMC request, they do look at the documentation, they do use claim history that is available to them as far as what existing equipment the patient

may have in their home and certainly if it's a walker and we're now seeing a request for a power wheelchair, one of the things that we would be looking for in the medical documentation is what's changed.

What is the medical condition that cause the patient to be able to use a walker three months ago when it was paid for by Medicare and now we're getting a request for a power wheelchair, that will be a key piece of documentation for example that we would want to see. What changed in the beneficiary's medical condition such that the walker that they get three months ago, no longer serves their need for mobility and they need a power wheelchair.

Melanie Combs-Dyer: (Heather) does that answer your question?

(Heather Marie): It does. I just have one follow up, I guess, question. Is there a point in this process where the supplier could submit the prior authorization request on behalf the beneficiary?

Melanie Combs-Dyer: Can the supplier submit a prior auth request on behalf of the beneficiary, is that your question?

(Heather Marie): Yes, like you said earlier is the physician refuses and the beneficiary – the beneficiary could submit it before the equipment is delivered to them. If the beneficiary doesn't have the means to do that, can a supplier submit for prior authorization request on their behalf?

Melanie Combs-Dyer: Let me look into that and I will get an answer back out onto Web site in the next Q&A document that gets posted. OK?

(Heather Marie): Thank you.

Melanie Combs-Dyer: (Inaudible).

Barbara Cebuhar: Thank you, (Heather). (Sheila) our next question, please.

Operator: Your next question comes from the line of (Gwen Jeffers) for Sheldon Medical Supply. Your line is now open.

(Gwen Jeffers): OK, thank you very much. Over hearing you had mentioned that the prior authorization is going to be for the base only but yet the DPD (detailed product description) is required which would lift all the parts. So, it's kind of confused on that.

Melanie Combs-Dyer: Yes. The prior authorization is for the base only and hopefully the detailed product description would be clear as to which one of the HCPCS Codes is the base and the physician will take that code and put it on the prior authorization.

(Gwen Jeffers): So the DPD will not be submitted from the physician?

Melanie Combs-Dyer: We're – I'm anticipating that it would not be although I'll take that down as a question, we'll post that to the Web, I – certainly they would have to submit the HCPCS Code. If they don't – if the physician does not submit the DPD, they have to submit the HCPCS Code because there's no other way for us to know what device the physician is asking that the patient have.

(Gwen Jeffers): So you do require the – for the base only and therefore you would know which group and classification type of chair is being requested, correct?

Melanie Combs-Dyer: That's correct.

(Gwen Jeffers): OK. And my only other question is statement question. You guys are going thorough all of this which I have no problem with. You're going through Phase 1 then Phase 2. I'm looking at Page 16 or 15, excuse me, your scenarios are either submitted affirmative, submitted not affirmative but you are still allowing companies to submit and provide chairs. Why is that?

It's (LPH) where it says, you know if no PA was submitted, you're still allowing it and to me that's still leaving a door open that I guess to me is partly closed.

Melanie Combs-Dyer: Well, we are hopeful that between the prior authorization program and the ADMC progress that's available to beneficiaries and suppliers that we would – we'll be about to cover all situations. And the beneficiary will be able to

know before the item is delivered to their home whether or not Medicare covers it.

But we recognize that there are a lot of details that may need to be worked out and that's why we're doing this as a demonstration in a limited number of states and we'll look back at the end of three years and conduct an evaluation and see sort of what worked and where improvements could be made. If this is positive, if we're able to reduce the error rate, we may consider expanding this nationwide and we can consider making that kind of a change at that time.

(Gwen Jeffers): OK. So, because I mean the ADMCs basically are for your K5, your tilting space, and your higher end not your basic and your scooters. So those still, if a DME Company wanted to, could provide that without the physician getting the PA, chancing if their paperwork is correct.

Melanie Combs-Dyer: I'm sorry can you repeat the question.

(Gwen Jeffers): Basically I know that the K5, the E1161, and your high end are available for ADMC at the time. With this non-submitted allowed for the PA, can still be submitted basically your scooters and your basic power wheelchairs could still be provided without a PA?

Melanie Combs-Dyer: We are hoping that a prior authorization will be obtained for all of them.

(Gwen Jeffers): OK.

Melanie Combs-Dyer: But if you find a physician who is not willing to go through the prior authorization process.

(Gwen Jeffers): Yes.

Melanie Combs-Dyer: – you could do the ADMC process or you could just take your chances at submitting a claim and if you're not a competitive bid supplier, you know taking the 25 percent hit.

(Gwen Jeffers): Yikes, OK, well thank you very much.

Melanie Combs-Dyer: Yes. Thank you.

Barbara Cebuhar: Thank you. (Sheila) our next question, please.

Operator: Your next question of three comes from the line of Gianna Rodriguez for University of Michigan. Your line is now open.

Gianna Rodriguez: Yes. Hi. This is Dr. Gianna Rodriguez, I actually work with the University of Michigan and I run a wheelchair seating clinic. And I really don't have a question but I do have a suggestion. I recommend that for physicians, I mean it's no problem with me because I know the whole process and how to, you know go all through all of this.

But for other physicians, you know who do not practice in physical medicine and rehabilitation that you – I strongly encourage that you come up with a form that can facilitate this prior authorization. I know you've not had very good luck in the past but I think that if you come up with a form that's detailed enough for the physicians to fill out and that's simple to fill out. I think this will definitely facilitate, you know the whole process, any comments on this?

Melanie Combs-Dyer: Thank you, Dr. Rodriguez for your suggestion. We will certainly consider it and in fact if you would like to send us a form that you recommend, we certainly will consider it.

But our experience has been in the past, if it is a form that is a substitute for the physicians medical record documentation, it tends to hurt more than it tends to help. If it was a form that just says, you know put the patient's first name here, and the last name here, and the HCPCS here, and then make sure you attach the progress notes and the details written orders, that might not be bad for a form but if it was a replacement for the face to face exam, that tends to create more denials rather than fewer denials.

Gianna Rodriguez: Yes. I don't mean to replace the face to face exam but to, how should I say, to facilitate the face to face exam because I already foresee the problems with all this, you know I do this and you know it's lucky for us that we have the clinic going and we have you know we're knowledgeable about all this but I'm like 1 percent of the whole system that is aware of this.

So, you know I don't know, I think you might want to think about different ways to facilitate the PA for physicians.

Melanie Combs-Dyer: So, thank you. We appreciate your suggestion and please send us an e-mail and let us know any other ideas that you might have.

Gianna Rodriguez: OK. Thank you too.

Operator: Your next question comes fro the line of Doug Harrison, The Scooter Store. Your line is now open.

Doug Harrison: Good afternoon. Thanks again for taking all the questions on all this. There in the slide there is some additional G-code for the work done by the physicians to submit the prior authorization data package. Can you share the OMB control number with this for that data collection?

Melanie Combs-Dyer: I don't know that we need to have one for a G-code. Is that what you mean?

Doug Harrison: For – no, well not for the code but that collection by the physicians. I just wondering – you'd mentioned on one of the prior call that was – if this had gone through am OMB approval process. Is there a control number for that that we can reference or look at the rest of that?

Melanie Combs-Dyer: Let us get that to you, I don't think we have it here in the room but we can get it to you.

Doug Harrison: Great. OK, thank you.

Barbara Cebuhar: (Sheila), do you have any other questions?

Operator: We have one more question in queue from (Christine Stephen) from the Mobility Solutions. Your line is now open.

(Christine Stephen): Hi. My first question is you had just stated that if the doctor refuses to send in for prior authorization in regards to like the KO – KO823 or scooters, the lower code, that we had the opportunity to go through ADMC, currently

that is not the case. There are particular codes that you are allowed to go through to ADMC, primarily the higher codes, manually tilt wheelchairs. So, I just want a clarification on that, that's my first question.

Melanie Combs-Dyer: So, we have been asked to expand the ADMC programs. We are considering doing that, if we do it would be outside or separate from this demo but obviously it will have an impact on this demo. And so any changes that we make or expansion that we make or new codes that we add to the ADMC programs we certainly will put out in the Q&As for this – on this Web site.

(Christine Stephen): OK. My second question is will the physician receive a detailed description for or reasons for the denial if it's – if the –

Melanie Combs-Dyer: Yes.

(Christine Stephen): – request is denied?

Melanie Combs-Dyer: Yes.

(Christine Stephen): They will and –?

Melanie Combs-Dyer: Yes.

(Christine Stephen): – mail?

Melanie Combs-Dyer: Did you say by mail?

(Christine Stephen): Yes.

Melanie Combs-Dyer: Yes, it will be a paper letter.

(Christine Stephen): OK. So they will receive ii. Maybe the quantitative measurement or something's missing, it will be detailed to the physicians so then that way –

Melanie Combs-Dyer: Yes, it will be actually be exactly which pieces of paper we're missing or which elements, you know if it's a seven element order instead of just saying

that it wasn't complete it'll tell you which element of the seven elements weren't included.

(Christine Stephen): OK. To follow that up and we were talking about late entries, so physicians send in the request and you had said in – on your slide that it will take 10 days but after subsequent re-filings or request could take up to 30 days. Would that be a suitable amount of time to go back and have a late entry from the physician?

Melanie Combs-Dyer: I think if – maybe 10 days would be OK but if you're talking 30, or 60, or 90 days, you may have another visit.

(Christine Stephen): So, then Medicare will pay for another face to face visit with the physician?

Melanie Combs-Dyer: Dr. Hoover, you know the answer to that question?

Robert Hoover: I know that in terms of the G-code being billed by the physician there's – it's a onetime billing of that G-code. I think in terms of the face to face visit and going back and seeing the physician again, since the DME MACs don't pay – we're not – we do not have jurisdiction for paying for that E&M code, I mean that would be under, you know a part B local carrier and A/B MAC contractors rules as far as frequency of visits and that type of thing. But as far as I know there shouldn't be an issue with seeing the physician again.

(Christine Stephen): OK. So, outside of 10 days it saying it would be probably too long so that denial took 30 days then an addendum to say, "Oh yes, we did talk about that based on your letter would not be sufficient", that another visit should apply?

Melanie Combs-Dyer: This is Melanie and I would say at this stage of the game, you know try to use your judgment, try to do any late entries in the medical records as quickly as possible. And if it's been a number of months, you now consider a second visit.

(Christine Stephen): OK. And if I can just ask a question, your statistics are very high with the improper payments. I was just curious if this statistics includes the improper payment that were overturned at the ALJ-level?

Melanie Combs-Dyer: This would have been what is reported by the (CERT) contractor, the comprehensive error rate testing contractor, so they would include any appeals that had been received or processed by this cutoff date for the (CERT) reports but not necessarily all the appeals that, you know can go up to three years after the fact

(Christine Stephen): OK. And my last question, thank you, is your prepayment review, the 100 percent – the appeal process will still be available for that. Is that correct on the first phase when we get the prepayment?

Melanie Combs-Dyer: Appeals are always available for claims, appeals are never available for prior (auths) or ADMCs.

(Christine Stephen): Perfect.

Barbara Cebuhar: Thank you.

Melanie Combs-Dyer: Yes.

Barbara Cebuhar: Thank you.

Operator: There are no questions at this time. I turn the call back over to the presenters.

Barbara Cebuhar: Thank you very much, (Sheila). I am really grateful for everybody's attention today. I just want to make sure that folks know that a transcript and a recording of today's call will be available starting Wednesday, December the 14th at the following Web site, so I'm going to repeat it' it's http://www.cms.gov/opendoorforums/05_odf_specialodf.asp#topofpage. So you could look there to get a copy of the transcript and the recording of today's call.

We are very grateful for everyone's attention today, just a reminder that if you have comments or if you would like to post additional questions, you need to send it to pademo@cms.hhs.cgov. Thank you all very much. (Sheila), I think we can close the call today.

Operator: This concludes today's conference, you may now disconnect. Presenters, please stay on the line.

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