CENTER FOR MEDICARE & MEDICAID SERVICES
Special Open Door Forum:
Medicare Prior Authorization Initiatives

Moderator: Jill Darling
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Operator: Ladies and gentlemen, this is the Operator. Today's conference is scheduled to begin momentarily. Until that time, your lines will again be placed on a music hold. Thank you for your patience.

Good afternoon. My name is (Shirley) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Medicare Prior Authorization Initiative Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. If you should need assistance during the call, please press star zero on your telephone keypad and an operator will come back on the line to assist you. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Shirley) and good morning and good afternoon to everyone and thank you for joining today's call on the Special Open Door Forum of Medicare Prior Authorization Initiative. My name is Jill Darling and in the CMS Office of Communication.

We'll keep this call to an hour, three o'clock Eastern Standard Time but it may go less, which is fine.

I'll now hand the call over to Connie Leonard who's the acting Deputy Director of Provider Compliance Group.

Connie Leonard: Thank you, Jill. Hello everyone and thank you for joining the call today. We are today going to provide a little more information on some of the new prior authorization processes that we announced on Thursday, May 22nd.

On May 22nd, we announced that we have put out a proposed regulation 6050 on the prior authorization of DMEPOS items and that is available for comments and so we'll talk about that slightly today. We really need people to respond in writing following the process of that line in the federal register.

We also announced on May 22nd that we are expanding the prior authorization of power mobility devices demonstration. And this was – what CMS categorizes today, it's a simple demonstration that's currently ongoing in seven states and we are going to be expanding up to 12 states and we'll talk about that a little bit more today too.

We believe that this is a very successful demonstration that in the very beginning some of you on the line may remember that you did not want this, and you want no part of it, you thought it was the worst thing that was going to happen to Medicare.

And today, CMS believes that for the most part, most suppliers actually like the demonstration and would like to be a part of it. So we think that's been very successful and we're hoping to leverage the success of that demonstration to some of the lessons learned and the best practices and the two new efforts that were put in forth from a demonstration or a model perspective.

And then there are the – prior authorization process for non-emergent hyperbaric oxygen therapy and a prior authorization process for repetitive scheduled non-emergent ambulance transport. And the keyword there for all of our prior authorization processes so far has been non-emergent. Everything that CMS has put forth has been a non-emergent category. We are – have not and at least from the near future that intend to delve into emergency services to make prior authorization perspective.

So today, we want to provide you guys with a little bit more information. I'm going to begin with the prior authorization of repetitive scheduled non-emergent ambulance transport. And I chose that one to begin with because we expected new model as we're calling it internally to begin in the fall of 2014.

In the future, we will have – if everyone know, today's call is just us giving you additional information. We went forth with the announcement then we have some questions that were submitted into a mailbox. But because of a diverse audience and the diverse nature of what we're discussing, we didn't want to take questions (inaudible) from the audience. But in the future, we will hold a specific call for some of these topics and provide other alternatives for the audience to get questions to us if it happens.

So the prior authorization of repetitive scheduled non-emergent ambulance transport is exactly what it sounds like. The A/B MACs or the Administrative Medicare Administrative Contractors are going to review the prior authorization request for repetitive scheduled non-emergent ambulance transport service under fee-for-service only.

So we're only talking Medicare fee-for-service. We're not talking Medicaid, we're not talking Medicare advantage, this is only Medicare fee-for-service. And that's very important because we do get lots of questions about how is this going to impact Medicaid or how is this going to impact Medicare advantage, this is only for fee-for-service.

And another very important distinction to mention and this is for all of the prior authorization demonstrations that we have going on is that what we are doing is nothing more than what we're doing today except we're doing it a little bit earlier.

Today, the Medicare Administrative Contractors or MACs review claims primarily on a prepayment basis. Sometimes they do with the post pay or we have other contractors who might be a post pay. But post pay could be some time – it could be up to three years after the claim has been paid.

Prepay review is a little bit better for CMS and for the provider because it's immediately after the services were provided but still those services were

provided with prior authorization in terms of Medicare because this is different in private industries, commercial payers in Medicaid, in Medicare advantage it could be different. I think there's lots of difference definitions of the word prior authorization and different interpretations. But for CMS and for Medicare fee-for-service, it's just that we are reviewing the documentation, reviewing the medical record before the service is provided.

So we get asked a lot of times in these prior authorization demonstrations. Is there going to be a form? No, there's not going to be a form. It's the same documentation to support the need for the service, the support that medical necessity that you would supply for any prepayment review, or a post payment review to any Medicare contractor. It's the same documentation that's necessary to get a prior authorized OK to go ahead and do that service. It's not an approval of the claim, it's not a guarantee that the claim would be paid because there could be some edits or something else that max it off, but it's at least more than you're getting today.

And those providers, when they really get into it and see if it's going to work and that is not impeding care, they actually like that. They want to get that assurance from that, "We're OK to provide a service and we're meeting the necessary requirements."

So what is a repetitive ambulance service? Well, it's defined as medically necessary ambulance transportation that has furnished three or more times during a 10-day period, or at least once per week for at least three weeks. So again, it's scheduled, it's repetitive and it's not something that's needed on an emergency basis.

Typically, repetitive ambulance service is needed by beneficiaries receiving dialysis. That's probably the one that comes to everyone's mind or it could be (loomed) on a cancer treatment also.

As I mentioned, we think the model will begin in the fall of 2014. No specific dates yet. So again, as we do more open door calls, we'll provide additional information to the public in advance that you are not going to hear that tomorrow we're going to begin. Out on CMS Web site, we'll post a lot of

information and we'll keep having these calls and these dialogues with the industry.

Another big point that we want to make sure everyone understand that these demonstrations are very small. So when we're talking about the non-emergent ambulance transport demonstration as well as the hyperbaric oxygen, they're very small, each in three states. Again, we're starting this small. What we're testing is, what we're trying to model in the administration is will this type of prior authorization process work in the Medicare part of the environment?

So again, back to the non-emergent ambulance transport, it's in three states; New Jersey, Pennsylvania, and South Carolina. If you are in any of the other 47 states or territories – of the United States, you are not included in the non-emergent ambulance transport demonstration. Even if you want to be, you cannot be included. It's only for New Jersey, Pennsylvania and South Carolina. And the location, it states somewhere that the ambulance has (thrashed). So it's not – where the beneficiary resides, it is where the ambulance is garaged. And that happens sometimes just based on the borders and such that we do know that happens.

As I mentioned, the coverage and documentation requirements are not being changed. The policies that are in place today for ambulance transport are still in place... No new requirements, no new documentation requirements are being required; it is only that we are reviewing the information earlier in the payments process.

If you have questions about the current requirements, you can go to the A/B MAC Web site and they certainly have links for ambulance suppliers and suppliers in general and providers and you could certainly get those information to you or there'll be an e-mail later on and you can certainly add on our Web site so e-mail us if you have questions about the current requirements.

But again, no new documentation requirement has been created. There's not going to be a new form. There's not going to be a new requirement. It's the

same requirements that you're used to today that the MACs are reviewing all today.

So how does the prior authorization process works for ambulance? The provider or the supplier or the beneficiary because that's the key point here, typically, at least in the PMD demo, we received our request from the provider or the supplier of the DME or the physician ordering DME. But the beneficiary could. We allow them to submit their prior authorization request. It doesn't happen much, but it's a possibility.

And so what do they need to submit when they come into the prior authorization? They need the physician certification statement, they need the documentation from a medical record to support the medical necessity of the repetitive scheduled non-emergent ambulance transport, they need information on the origin and destination transport, and they need any other relevant documentation the CMS say by the A/B MACs across that prior authorization.

And this is the key and I know that it could be slightly different in each of the states but CMS will work to make it as consistent as possible. But if that initial request is denied, you can resubmit and keep resubmitting until you provide all the necessary documentation. There is an unlimited amount of resubmission. So it is not a one stop, one shot and then you're denied forever. You can keep resubmitting while you are again getting the documentation that you need for the approval.

So with non-emergent ambulance transport, we're certainly not going to need a prior authorization request for every single trip. Fill the prior authorization request and again it has to be justified by the beneficiary submission and may affirm up to 40 roundtrips or 80 trips in total per prior authorization request in a 60-day period. So we're looking at the prior authorization in a 60-day period of time for up to 40 roundtrips.

We do reserve the right to have this provisional affirmative prior authorization decision which may approve those on the less than 40 roundtrips. So just because it's been affirmed, it does not mean you're already – you're going to

automatically be granted the 40 days, it just means that's the maximum that we could approve up to. And again, as I just said, an affirmative decision can be for all the part of the requested number of trips. And if it goes beyond that 60-day period of time or beyond 40 roundtrips, an additional prior authorization request will be required.

In the power mobility device demonstration, CMS made every effort with the MAC to complete the review and post mark those decision letters within 10 business days and we're very happy to report that for the most part they were able to meet those requirements in that demonstration. We are going to continue the statement requirement in the ambulance non – repetitive scheduled non-emergent ambulance transport demonstration. So the MAC, the A/B MACs will made every effort to review the request if that's on the decision list within 10 business days.

Subsequent request should request again that have been resubmitted to A/B MAC who make every effort to review the request to post mark the decision letters within 20 business days. Again, so far, we don't expect an issue with the A/B MACs meeting those timeframe. And we always allow a situation for emergent circumstances. And in those particular cases, the A/B MAC will make reasonable efforts to communicate a decision within two business dates of receipt. And that's within two days to oversee of all of all applicable Medicare required documentation.

We have received questions about what is emergent, how can I submit an emergent circumstance request? And we will get additional information out on our Web site again with certainly enough time that providers know before the model and the demonstration begin as to what is necessary in those emergent circumstances.

So again, that was going to happen in New Jersey, Pennsylvania and South Carolina. We expect it to begin this fall, the fall of 2014. The request can be submitted by the provider or supplier or the beneficiary and right now it is a three-year model. So if we begin in the fall of 2014, we should expect that somewhere along the way in the fall of 2017, this particular model will have ended based on the – our current data.

We do have a separate e-mail box just for the repetitive scheduled non-emergent ambulance transport. Again, it is different than the mailbox that we had for this open door forum. So either mailbox is appropriate, we did not want to have three or four different e-mail boxes so we only use one. But the one specific for ambulance is ambulance P as in prior, A as in authorization @cms.hhs.gov (ambulancePA@cms.hhs.gov) and that is on our Web site.

So if you are t on the CMS Web site and we did have the link on the open door forum and ask and I believe is the link to the – for demonstration Web site and where we have on the left hand side, you can click on the particular model that you're interested in and on that page we have the fact sheet, we have some frequently asked questions, we have the press release announcement and we have a link to this mailbox.

In the near future, we will post some additional slides just so and again at high level overview. And as we get more detailed information for the (public), we'll continue to use that to get information to you as well as forum such as these and also forums with the Medicare administration.

Time check! We are bound to get closer.

So that was ambulance. So that was repetitive scheduled non-emergent ambulance transport.

So moving on, we have the next model or pilot that we announced on May 22nd was the prior authorization of non-emergent hyperbaric oxygen or HBO, as I'll probably call it, therapy. And this one again, it's a very small model that we are going to do in three states. Those three states are Illinois, Michigan, and New Jersey. And again, it's only those three states. So the other 47 and the other territories, these were the only ones that are impacted by this demonstration.

And then sustain a very similar process that what I just described for ambulance except this model will begin in the early 2015 and the model will continue for three years. And it's the same as I have said before, the A/B MAC or the A/B Medicare Administrative Contractor will review the prior

authorization request for a non-emergent hyperbaric oxygen therapy under fee-for-service.

There are only 15 covered clinical conditions for hyperbaric oxygen therapy, only six are available for prior authorization. They are the preparation and preservation of compromised skin graft; chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management; osteoradionecrosis as an adjunct to conventional treatment; and if I'm butchering some of these clinical terms I do apologize, I am not a clinician. So I apologize with that.

Soft tissue radionecrosis as an adjunct to conventional treatment; actinomycrosis only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; and diabetic wounds for the lower extremities in patients who meet the following three criteria. The patient has Type 1or Type 2 diabetes, who also has a lower extremity wound that is due to diabetes; patient has a wound classified as Wagner grade III or higher; and the patient has failed an adequate course to wound therapy as designed in the NCD.

And again, that's a lot of these here that we don't expect you guys to remember but again it is out in the Web site, it's in the fact sheet and the frequently asked questions and we'll just decide about them in the near future so that you guys can recommend the slides too. But again, only six of the 15 covered clinical condition.

As I stated in the ambulance model, the documentation requirements are not changing. The model is not creating any new documentation requirement. We're only going to be looking at the claim earlier in the process. So the coverage policy intervention, documentation requirement intervention, and the timeframes for HBO therapy are unchanged. Again, the only thing (added) when I looked at it before the services are provided and not after, and again if you go to the current A/B MAC Web site to get the current requirements for HBO therapy.

So how does the process work? Well, very similar to the other process. The provider or the beneficiary can submit a prior authorization request. They're going to submit the documentation from the medical record to support the medical necessity. And any other related document as seen in that state by the A/B MACs to process the prior authorization. And as always, as with the other – the ambulance transport and the PMD demo actually, unlimited resubmissions are allowed. It could be a non-affirmed prior authorization request to come back – comes back to you, unlimited resubmissions are allowed.

So HBO in some ways similar to ambulance transport. So we are not going to do every single treatment or every single time that something comes in. So what are doing is the provisional affirmative prior authorization decision may affirm up to 36 courses of treatment in the ER. If additional sessions are needed in an excess of 36 treatment, a new prior authorization request maybe submitted and again from the beneficiary. Same review timeframes that I was talking about with the ambulance. The A/B MAC will make every effort to review the initial request and post mark the decision letters within 10 days business days.

Upon submitted request, the A/B MACs will make every effort to review the request to post mark the decision letters within 20 business days. And then again, the same thing with the emergent circumstances, the A/B MAC will make reasonable efforts to communicate a decision within two business days and receive all applicable Medicare required documentation. And again, we'll just get additional information on our Web site about how one would qualify for an emergent circumstance.

So in summary, the hyperbaric oxygen therapy model will begin in Illinois, Michigan, and New Jersey. It's a three-year model expected to begin in early 2015 and the request can be submitted by the provider, the supplier, or the beneficiary.

And one question we are often asked is, "How would that request get to us? Is it going to be a necessary – do we have to fax it? Do we mail? Is there going to be a special forum, a special portal?" And typically, prior authorization

request can be received via fax, so that's probably the fastest way sometimes. It can be mailed if a provider would wish to mail. And they can also use the Electronic Submission of Medical Documentation or what we call esMD process. An esMD is something that I do believe or many of us prior would use in the PMD demo.

And again, there's something that – somewhat equivalent to a fax, I would call it an electronic fax maybe but again it's much more entertaining to send it with a mail and that's (inaudible) as well. It is available to providers. For more information about that is on our Web site and we can handle more detailed questions about, you know, how to get this in when we have individual open door forum.

We will be having individual open door forum in the near future hopefully, in the next one to two months on both the repetitive schedule non-emergent ambulance transport as well as the non-emergent hyperbaric oxygen therapy.

If you have questions in the meantime, we would suggest that you send them into the mailbox and I neglected to give you the mailbox for the hyperbaric oxygen therapy. But it is hbo, so H as in Henry, B as in boy, O as in office and then P as in (Pro), and A as in authorization, no spaces @cms.hhs.gov. Or the e-mail box that was in the open door forum and will also work too. They'll both get it to us.

The more questions that we have in advance; the more questions that we can answer when we have the open door forum call and so we can assure that we have the answers to you at a point in time. We will also take questions from the audience when we have a very specific open door forum on both the repetitive schedule non-emergent ambulance transport as well as the non-emergent hyperbaric oxygen therapy.

With that, I will turn it over to (Dan Schwartz) and he is going to give you an update on the expansion of the prior authorization, the power mobility device demonstration and 6050.

(Dan Schwartz): Thank you, Connie. So to some extent what you'll hear is fairly similar to what Connie said on the demonstration and have to piggyback on it so and

hopefully we go into a little bit of detail on the power mobility device expansion since it's already in place.

So as Connie said the durable medical contractors in this case – as Connie said actually we're talking about exclusively Medicare fee-for-service. Here again it is not Medicare advantage, it's not – anybody else. It is exclusively Medicare fee-for-service. And the DME MACs where the Durable Medical Equipment Medicare Administrative Contractors have the folks to – will be reviewing the prior authorization request as they do right now.

And this prior authorization or power mobility device demonstration has actually been in place in a number of states since September of 2012. The states that it currently exists in are; California, Florida, Illinois, Michigan, North Carolina, New York and Texas. As Connie said we have received generally positive feedback from suppliers who like the assurance that the claims will be paid.

So what are we expanding to and where? So we do want to expand in the late summer early fall for orders written in 12 additional states. Those additional states are Arizona, Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri and Washington; so sometime in the late summer or in the fall for those 12 additional states.

So what codes are we talking about here, what is being prior authorized under the prior authorization demonstration for power mobility devices? So here, we're talking about all power operated vehicles, the codes are KO800s or KO802 and KO812. All standard power wheel chairs which is KO813 through KO829, all groups two complex rehab power wheel chairs which is KO835 through KO843, all group three complex rehabilitative power wheel chairs without power options which is KO848 through KO855, pediatric power wheel chair KO890 through KO891, and miscellaneous power wheel chairs which is KO898, with groups three complex rehabilitative power wheel chairs with power options which is KO856 through KO864 are excluded.

No prior authorization decisions will be made for any code not on the list. If a DME MAC receives a prior authorization request for code not on the list, they will not review the request and they will not issue a decision letter.

As Connie said with the other demonstrations with the power mobility demonstration and the expansion that the same coverage of documentation requirement exist as before: The national and local coverage provisions are unchanged, documentation requirements aren't changed, timeframes for the order delivery or (visit) are unchanged, and you can find more information about those current requirements on DME MAC Web site.

So under the PMD demonstration, our contractors will continue to look for a prior authorization request to the DME MAC which includes face to face evaluation documentation, the seven element order, the detailed product description and any other medical documentation to support the coverage requirement. Again, similar to what Connie mentioned earlier.

The DME MACs will review it and post mark a notification of a prior authorization decision within 10 days and they'll affirm or approve the request or in the alternate they would not affirm the request. If they would not affirm that request, the DME MAC will provide detailed explanation outlining, what's the specific policy requirements were not met.

Again, here, unlimited request maybe submitted. And the DME MAC will review subsequent requests in case of a non-affirmation if there's a resubmission, within 20 days. Again, there's also a process for an expedited review in an emergency type situation.

I just wanted to also mention that CMS has devoted significant resources to ensure that that 10-day timeframe has been met and as Connie said that has been working successfully. CMS also uses experienced clinicians who are actually – who are reviewing the claims as well just so you know sort of who's looking at it.

In this current demonstration, if the – if there's an approval – if approved, if the claim would be paid at a 25 percent reduction, if it is a non-competitive it

has a supplier and they submit a claim – they did not submit a prior authorization request, let me sort of go back and restate that a little bit better.

If somebody who has not submitted a prior authorization request – and therefore the DME MAC would not have a decision to make, the supplier – if they would decide to submit a claim, a contractor would actually receive that claim, develop it, review it, and if it will be payable- then that 25 percent reduction would apply if it's a non-competitive bid supplier. This sort of may be one that might be of interest.

Moving on, I think – although as far as sort of – the feedback that we get and sort of our oversight, we do have frequent meetings with the DME MAC to be sure that those things are running smoothly. We do some spot checks on the DME MAC decisions just to ensure that everything is as appropriate.

As Connie said for the prior authorization demonstration as well, submitters can submit a prior authorization request via fax, mail, or electronically via desMD. And again, there's more information about that on our Web site.

So let me just sort of start a little bit the initial demonstration states with California, Illinois, Michigan, New York, North Carolina, Florida and Texas, the additional ones are Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri, Washington, and Arizona. And the demonstration ends, this demonstration ends and the expansion ends for all orders on or after August 31st of 2015.

As far as sort of where to send additional questions for this demonstration, you could send them to either the e-mail that was listed in the announcement, or to PAdemo@cms.hhs.gov. Capital P, capital A, d, e, m, o, those four letters are lowercase @cms.hhs.gov. And the CMS demonstration Web site is http://go, and this is lowercase, go.cms.gov/ capital P, capital A, capital D, lowercase e, m, o and there's sort of a hosting information there with a lot more detail that you maybe interested in. There's also links and references to frequently asked questions and other useful information.

Again, I just wanted to make clear that the expansion requirements or the expansion – the requirements in the expanded demonstration are no different

from the requirements in the initial demonstration. It is the same. We're just adding additional states.

I just wanted to thank everyone for your time and I will turn it over to Maria Ciccanti.

(Maria Ciccanti): Hi everyone. By now, you're hearing a theme emerge and I hope that you bear with me, I'm the last speaker so and then you can sleep for the rest of your afternoon.

Thanks for taking time out of your day and dialing in. We really do appreciate it. As Connie mentioned, we are currently under rule making for a proposed prior authorization process for certain DMEPOS item regulation. And as you likely know, we're not able to talk about provisions for any regulation while we're under rule making. So rather than reading from the press and the fact sheet you surely have already read, I'll just aim to give you a summary of the provisions that hopefully touches some of the thoughtful questions that we received in advance to today's meeting.

Before I begin, I do want to again encourage you – the first time for me and multiple times by Connie- to submit your comments to the regulation at regulation.gov. When you get to that site, there'll be a search engine and just put CMS-6050-P and it'll take you right to the button where it says Comment, you click that and then you submit your comments there. We are particularly very interested in hearing from you. And we encourage you to send us your ideas and thoughts. Your comments and your ideas will help shape the development of the final.

So here we go. As you're aware, the proposed rule would establish a prior authorization process for certain DMEPOS item. DMEPOS items that may possibly be subject to prior authorization must meet specific criteria to be included in what the proposed rules calls the Master List.

Items included on the master list must have an average purchase price of $1,000 or an average rental fee schedule of $100 or greater. And the item was subject to OIG or GAO report published 2007 or later, or appears in the

comprehensive error rate testing annual improper payment report appendix, also known as a CERT report appendix. DME projected over payment.

Now, some of you have asked why certain items were not included on the master list since it appears on the surface that it meets the criteria that we set out and I just explained.

To clarify, there are certain items on the DMEPOS Fee Schedule – that are not typical fee schedule for DMEPOS items. In other words, they have special payment rules. And items that may meet – two of the three criteria may have not have met the payment criteria because that item might have been subject to a payment rule, a special payment rule. Having said that, we again encourage you to submit to the regulation.gov site, your thoughts or ideas around the issues and questions you submitted about the criteria for Master List.

The proposed regulation describes the proposed prior authorization process and similar to what you've heard already, the proposed process would essentially require the requester to submit all the relevant documentations for a review before the items was delivered. And again as earlier stated, no new documentation requirements are created by the proposed regulation. The proposed process simply requires this documentation to be provided earlier in the process.

Prior authorization request receiving an affirmative decision will be paid as long as all other requirements are met. Some of you have asked if claims for which there was an affirmative decision could be subject to audits in the future. Well, if all the paper and all of the required documentation were received and there's no apparent aberrancies, then in general we can say that those claims for which there's an affirmed prior authorization decision attached would not to be subject to future audits.

And again, the caveat is if there's a suspicion of fraud, or if there's some other type of aberrancy that becomes apparent in a data analysis, then of course – it's possible that that claim would be subject to another audit, but minus those situations, generally, no.

The proposed regulation process states that claims for which there's a non-affirmative prior authorization decision as well as claims for which no prior authorization decision exists will be denied. The regulation also proposes that requestors may resubmit the prior authorization request an unlimited number of times, similar to what has s already been described.

Decisions on the initial request would be communicated within 10 days and resubmissions for the request would be processed within 20 days. Included, as earlier described in the pilot, is a proposed expedited review process where a decision is communicated within 48 hours. The regulation proposes that the expedited review process only be used when applying the standard timeframe may jeopardize the life or health of the beneficiary. And again, and I'll say this a couple of times more, we encourage you to send your thoughts about this as well on regulation.gov Web site.

The Master List in the proposed regulation has 134 items. If finalized, we don't expect to require prior authorization for all items on the list. Instead we propose to implement a prior authorization for a subset of the Master List. And in our creative style, we have named this subset of items from which prior authorization would be required The Required Prior Authorization List. We proposed to notify the public of The Required Prior Authorization List in a 60-day notice published in the federal (register) prior to the implementation.

And again, we encourage you to send us your thoughts about The Required Prior Authorization List. For example, we're interested in hearing from you about the number of items on the initial required list, the frequency in which we would add the items to the list et cetera. Again, we do value your input and look forward to your comments and suggestions. Submit your comments again at regulation.gov and enter when you get to that site on the search engine CMS-6050-P to access the comment button.

And thank you so much for your time. We do look forward to hearing from you through your comments.

Connie Leonard: Thanks Maria. As you can see, there is a lot of terrific updates that CMS has tried to learn from the best practices and the experiences from the last year

and a half of the power mobility device demonstration. And, you know, we believe it's been successful, we hear from the industry that it's been successful. And we want to try to implement that stuff in other areas as much as possible.

But we do want to hear from you. So as Maria said, there's a formal way to submit comments on the 6050, but want to hear your feedback and your thoughts on the expansion, on the hyperbaric oxygen therapy, on the non-emergent repetitive schedule the ambulance transport, we want to hear your feedback and your thoughts. So we try to answer most of the questions that we received in so far. So we do know that there's some level of angst out there about this new process. This is new.

So that's understandable but we – it is the most common question that we are asked these is, "Can we get prior authorization for this or for that or some other items?" So we certainly do believe it's something that the industries are looking for.

Maria made a very good point that I wanted to bring up. She was talking about the future audits and what the impact of prior authorization is on the availability of that claim, that service for a future audit. And what Maria said did not just go for enroll but it goes for most if not all of the prior authorization affirmation.

Outside of some outliers, some oversee, you know, that claim that has an affirmed prior authorization decision is not typically reviewed again by a Medicare Administrative Contractor or a recovery auditor. So that gives the provider, the supplier some peace of mind that three years later, that CMS isn't going to be coming back to look for the claim and that's the piece that I think most providers and suppliers once they understand how it works, once they understand that it's not going to provide an impediment to access of care for their patient that they like, they want to get, you know, they don't want to have to worry that three years down the road the recovery auditor or Medicare Administrator Contractor is going to be coming looking for documentation and second guessing their – like what they did three years ago.

So we do believe this is a good thing. We have good area for CMS to go into. We are going very small. As you can see, just in three states in each model and then the expansion is really just an expansion of the current demonstration. So we believe we're going to have an opportunity to listen to the industry, to listen to the providers to get their feedback, to see how it's working, you know, to speak if it's necessary and to get best practices so that as we move forward and if in the future there's more opportunities for CMS to touch other areas and the more experience we have, the better.

So we encourage you to look on our Web site and the open door forum and active sites for the future open door forums on the hyperbaric oxygen therapy and the repetitive schedule none-emergent ambulance transport prior authorization models. We will also be using our education effort to get the word out with the Medicare Administrative Contractors to the bulletins and the articles that CMS releases and so – and our Web site. It's a great source for everyone to go and get additional information.

Until then, please, if you have questions that we didn't get to today, please let us know. Again, we love to be able to answer questions in the near future through a future open door forum or education efforts. The more questions we can answer, the better off everyone is. And next time around, we will absolutely take questions from the audience to see what the events we need.

And for that, I'll turn it back to Jill.

Jill Darling: Thanks, Connie. Thank you everyone for joining today's call and have a wonderful day.

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

END