

**Centers for Medicare & Medicaid Services
Special Open Door Forum:
Medicare's Prior Authorization for Power Mobility Devices Demonstration
Wednesday, March 21, 2012
3:00pm - 4:30pm Eastern Time
Conference Call Only**

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

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

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

- The CMS has completed a separate Paperwork Reduction Act (PRA) notification for this demonstration.
- The CMS has removed the 100% Pre-Payment review phase (formerly Phase 1).
- The CMS will allow suppliers to perform the administrative function of submitting the prior authorization request on behalf of the physician/ treating practitioner.
- This demonstration will begin only after an OMB PRA control number is obtained. The CMS anticipates the start of this demonstration will be **on or after June 1, 2012**.

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

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

We look forward to your participation.

Special Open Door Participation Instructions Dial: (877) 251-0301 & Conference ID: 54397724
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 Open Door Forum will be posted to the Special Open Door Forum website: http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading on or around March 22, 2012 and will be available for 30 days.

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 Transcript:

<http://downloads.cms.gov/media/audio/022312SODFPriorAuthofPowerMobilityDeviceDemo54397724.mp3>

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Barbara Cebuhar

February 23, 2012

3:00 p.m. ET

Operator: Good afternoon. My name (Dean) and I will be your conference operator today. At this time, I would like to welcome everyone to the Medicare Prior Authorization for Power Mobility Device (PMD) Demonstration conference call.

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

Ms. Barbara Cebuhar, you may begin your conference.

Barbara Cebuhar: Great. Thank you very much, (Dean). I really appreciate everybody's help today. Good afternoon. My name is Barbara Cebuhar. 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 suppliers and physicians to hear a little bit more about the Medicare Prior Authorization of Power Mobility Device demonstration. And be given an opportunity to ask more questions.

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 email address is not monitored 24/7. And so the best way to get information is to go to the website which is go.cms.gov/PAdemo to see if they have been addressed.

Some responses to the questions will also be posted to go.cms.gov/PAFAQ2012 keyword PMD and there will be questions addressed throughout our future open door forum calls.

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 would also like to remind you that there will be a transcript and a recording of this Special Open Door Forum on the Special Open Door Forum website in about two weeks.

I would like to take the opportunity to introduce our speakers for today. Melanie Combs-Dyer is the deputy director of the Provider Compliance Group here at CMS. (Amanda Burd) is a health insurance specialist and Doris Jackson is a health insurance specialist as well. They will provide an overview about the demonstration.

After the presentation, we will open the call to questions from you. Thank you, again for joining us. Melanie, the floor is yours.

Melanie Combs-Dyer: Thank you, Barbara. I appreciate it. I would like to let folks on the phone know that there is a lot of information that we'll be talking about today. But there are no slides that are posted to our website to go along with this call, we

maybe be posting some slides later on this week or perhaps next week that folks may find helpful to summarize the things that we're talking about during this call.

Again, the website is go.cms.gov/PAdemo, and that's a capital P and capital A. And I also want to let folks know that we are planning on having monthly open door forum calls. So thinking about the kinds of things that you are hearing during today's call, if there are certain topics or issues that we don't cover and you want us to cover on our future calls, please let us know. Either when we open up the phone line later on during this call or by sending us an email and letting us know what you would like us to cover at the next call.

Again, please hold your questions until the end and we will open it up and take questions from anybody. In addition to questions, we're open to suggestions or insights or ideas that you guys may have about how to improve the demonstration.

I want folks to know that one of the primary reasons that we are conducting this demonstration has to do with fraud. Power Mobility Devices have had a high rate of improper payment and incidents of fraud historically. The states that we have chosen for this demonstration has historically demonstrated a high evidence of fraud.

This demonstration seeks to develop improved methods for the detection, investigation and prosecution of fraud in order to protect the Medicare trust fund. Improper payments are a big problem in Fee For Service Medicare. Our group estimates that each year, the Medicare fee for service program issues more than \$28 billion in improper payments. And yes, that's billion with a B.

That equates to an error rate last year of 8.6 percent of all the dollars that were paid out last year, were paid out in error. The good news is that that 8.6 percent error rate is down from our 2009 error rate of 10.8 percent. The bad news is that it's still pretty short of (above) this goal of 5.4 percent. So we still have ways to go to get our error rate down from the current 8.6 percent to our goal of 5.4 percent.

As we try to reduce those improper payments, you need to keep in mind that Medicare receives over 4 million Part A and Part B claims everyday. That's a lot of claims. And there's no way that each and everyone of those claims can be stopped for human review. Instead, the Medicare Fee For Service Program works in a way that most of those claims are paid automatically only going through some automated edits to check for the fee schedule and things like that. And very few of them are subjected to human review.

Now, some people have asked, what is your definition of Power Mobility Device? How do we know– if the things that we are supplying or the things that we are ordering for our patients are addressed by this demonstration?

If you go to our website go.cms.gov/PAdemo, you will be able to find a list of all the HCPCS codes that are covered by this demonstration.

I would also like to remind people today that the same coverage requirements that are in place today are the same requirements that will be in place for the demonstration. We are not creating any new documentation requirements for physicians, practitioners or suppliers. We are simply asking that the information be submitted earlier in the process.

Today, we wait until the claim has been submitted. And then sometimes, we request that that information be submitted to Medicare. Now, we will be asking that that information be submitted before the item is delivered to the patient. So nothing changes about what documentation you have to keep on file. We're only changing the point of time in which it will be submitted.

In addition, all advanced beneficiary notice procedures with all those ABN procedures. They all remain unchanged, nothing new in terms of ABN. And all of the current coverage requirements and billing requirements can be found on the MAC website, Medicare Administrative Contractors, to process the claim.

CMS is planning on issuing a Federal Registered Notice on or about May of 2012 announcing the actual start date of this demonstration. We're expecting that the demonstration will begin for orders written on or after June 1, 2012.

We're not firm on that date of June 1, 2012, that will be announced in the Federal Register Notice that we're expecting to come out in May.

And we are also expecting that all the states will start at approximately the same time due to some contractual differences between them. There might be a slight difference when some states start versus others. But it's approximately the same time we are expecting the demonstration to begin in our seven demo states.

CMS is planning to conduct lots of provider outreach and education with suppliers, physicians, practitioners and beneficiaries. We welcome any suggestions, if you all know of meetings that are happening or ways that we can call in and participate in meetings with suppliers or physicians or beneficiaries in these seven states anytime between now and June. Or really even any time after the demo has started, we are open to trying to come up with as many outreach opportunities as we can find.

The demonstration will last for three years. It will end about three years after it begins at all seven states.

So where will the demonstration be occurring? Well the beneficiaries residing in seven error prone and fraud prone states are the ones that will be subject to this demonstration. The seven states are California, Illinois, Michigan, New York, Florida, North Carolina and Texas.

And keep in mind that when we say beneficiaries residing in, we're talking about the address for the beneficiary that they have reported to the Social Security Administration. So if they happen to live six months of the year in one place, and six months of the year in the other place. Wherever they tell Social Security they live, that's the place that we will look to and trying to figure out whether they are in this demo or out of the demo.

And we, again, chose these states because they are the most error prone and fraud prone for PMD. And they account for about 43 percent of the total PMD expenditure.

A lot of folks asked why we are conducting the demonstration. We're really conducting this demonstration for a number of reasons.

So primarily, it so that we can develop improved methods for the detection, investigation and prosecution of fraud. And we are really focusing on error prone claim type. The error rate for Power Mobility Devices is over 80 percent according to recent a OIG report. You can find a link to that report on our website.

We also want to try using private sector methodology to protect the Medicare Trust Fund. Fee for Service Medicare has really never had a prior authorization program. So we're hopeful that this procedure, prior authorization is used by Medicaid and many private sector insurance companies may be helpful to protect the Medicare Trust Fund.

We also hope to reduce the "pay and chase" syndrome that we so oftentimes see where the payment is made to the supplier. And later, it's found out that it's an improper payment through opposed post pay review either by the MAC or by the RAC. We would like to try to pay it right at the beginning, rather than paying and then chasing down the improper payments later.

Now, I would like to talk for a moment about some changes that we have adapted to our demonstration in response to industry feedback. This demonstration was originally announced in November of 2011. And we published a Paperwork Reduction Act or PRA package addressing both our normal medical review and this demonstration. We published that PRA package in December, and we got a lot of comments about this demonstration in response to that December 2011 PRA package.

I would like to summarize four of the main concerns, and the changes that we are making to the demonstration in response to those concerns. So the first concern was that supplier's maybe financially impacted by 100 percent pre-payment review. In the original demonstration, we proposed having a two phase demonstration.

In phase one, we would be asking our MAC to conduct a 100 percent pre-payment review. In other words, the item would be delivered to the patient's

home. The claim would be submitted to Medicare. Medicare would stop every one of the claims and send a letter to the supplier asking for documentation. The documentation would come in and it would be reviewed. And then a decision would be made about whether that payment was appropriate or inappropriate.

Followed by phase two, which would be the prior authorization phase of the demonstration. In prior authorization, before the item gets delivered to the patient's home, paperwork would come in documenting the medical necessity of the PMD and documenting that the other coverage criteria were met for that particular patient. And the decision would be rendered before the item was delivered to the patient's home.

A lot of suppliers suggested in their comments that the 100 percent pre-payment review phase of the demonstration would be quite onerous and burdensome because they would be out the money for so long while the 100 percent pre-payment review was occurring and the item has already been delivered to the patient's house. They encouraged us to jump straight to prior authorization.

So the change that we made to the revised demonstration is just that, we are eliminating the pre-payment review phase at which we used to call phase one. And the entire demonstration now is going to be prior authorization. There will be no 100 percent pre-payment review phase in our revised demonstration that begins on or after June 1.

The second major concern that was raised by folks to our PRA package in December was that the ordering position may not be in the best position to actually submit the prior authorization request paperwork. No one questions the physician or the treating practitioner is the right one to conduct the face to face exam and document the patient's medical condition. The question was, who actually had to submit the prior authorization request?

In the original demonstration, we said that that request package had to be submitted by the physician or treating practitioner. It could not be submitted by the supplier. We have now changed our physicians there as well. The

revised demonstration will allow either the physician or treating practitioner or the supplier on behalf of the physician or treating practitioner to perform the administrative function of submitting the prior authorization request.

And you will hear us talk more in detail in just a few moments about the submitter. When we talk about the submitter we're talking about either the physician or treating practitioner or the supplier. And it doesn't have to be one way or the other. The physicians and suppliers can work out on a case by case basis who actually submits the prior authorization request.

The third concern that was raised by many was that there were going to be different start dates for the prior authorization phase of the program. Some states would be under phase one, the 100 percent pre-payment review for just a couple of months before they jump over to prior authorization. While other states might be at phase one, 100 percent pre-payment review for many months before they switch over to prior authorization.

So in our revised demonstration process, that problem has really gone away because we're jumping straight to prior authorization for all demonstration states. So all states will be starting the prior authorization demonstration at approximately the same time.

The fourth major concern where we made a change had to do with the concern that limited notice was given to physicians and suppliers about the start date of the demonstration. We originally were proposing to start the demo on January 1st of 2012. And folks said, hey, you just told us about this starting in November and we didn't really even get details about it until December. And then January 1 start date is just way too soon.

And so, our revised demonstration as you have heard us say later start date. It will be June 1, 2012 or later. And CMS has also submitted a separate PRA package. You heard me earlier say that we had submitted a PRA package that combined our normal medical review work and our demonstration. We have now separated them out and we submitted a separate PRA package.

It is out for comment now. The comment period for that PRA package closes on April 3rd at midnight. And anyone who is interested in seeing that or

maybe even submitting some comments, can find a link to that PRA notice on our website.

In addition, we plan to issue a federal register notice announcing the start date of our demonstration. We are expecting that that will be sent out some time in May announcing the June 1 or later start date. And we plan to send certified letters to suppliers who have supplied a beneficiary with the PMD in the past couple of years in these seven states. And to physicians and practitioners who have ordered PMD for beneficiary in these seven states.

At this time, I'm going to turn the floor over to (Amanda) to tell us some more details about the program.

(Amanda Burd): Thank you, Melanie. I would like to go through the details of the prior authorization process. As Melanie have discussed before, the treating physician or treating practitioner or supplier on behalf may perform the administrative functions of submitting a prior authorization request.

It's important to keep in mind that requirements mandating physician or treating practitioner origination must continue to be completed by the physician or treating practitioner regardless of which entity is functioning as the submitter. The same is true for the suppliers, requiring supplier origination must continue to be originated by the supplier regardless of which entity is functioning as the submitter.

I want to keep in mind that a submitter, so the ordering physician or practitioner or the supplier, on their behalf, can perform the administrative function of submitting a prior authorization request to the DME MAC. That prior authorization request must include the progress note documenting that they (shape) examinations as well as the seven element order and the detailed product description. Further, it shall include whatever at a medical documentation is necessary.

When the DME MAC receives that documentation may will review the request and post mark notification of the decision within 10 days. That notification of the decision will be provided to the physician or treating practitioner, as well as, the beneficiary and the supplier.

The DME MAC will render one of the following decisions. They will either affirm the prior authorization request or they will not affirm the prior authorization request. In cases where the prior authorization request is not affirmed, a detailed written explanation outlining which specific policy requirements were not met will be provided. That notification will be sent to the practitioner, supplier and beneficiary.

If the prior authorization is not affirmed, the submitter may resubmit a request. If the request is resubmitted the DME MAC will have 30 days to review subsequent request. There are unlimited request for resubmissions allowed and there is no timing on how those resubmitted request must take place.

Suppliers should receive a prior authorization request decision from the DME MAC before the supplier delivers the item and submits the claim. In very rare circumstances, a 48 hour expedited review is set up for emergencies. In a situation where a practitioner indicates clearly and with rationale that the standard routine time authorization of 10 days will seriously jeopardize the beneficiaries life or health, the contractor will conduct and expedited review.

The expedited request must be accompanied by the required supporting documentation for the request to be considered complete, thus engaging the 48 hours for review. Inappropriate expedited request may be downgraded to standard request.

At this point, we would like to talk about resubmissions and appeals. As I mentioned for non-affirmative prior authorization request, unlimited resubmissions are allowed. For denied claims, all current appeals still apply.

I would like to go through the scenarios that we just alluded to. There are four scenarios. The first scenario is that a prior authorization request is submitted. When the MAC reviews it, the decision is affirmative. The suppliers then submits the claim. The DME MAC will pay the claim as long as all other requirements are met.

In the second scenario, a prior authorization request is submitted, however after reviewed by the DME MAC, it is determined to be non-affirmative. The supplier may chose to resubmit the prior authorization request. However, if a claim is submitted with a non-affirmative prior authorization decision, the DME MAC will deny the claim.

In the third scenario, a prior authorization request is not submitted. If a supplier who is a participating competitive bid supplier submits the claim, the claim will have the medical documentation to support its request. The DME MAC will review that supporting documentation and if payable for a competitive bid supplier, it will be paid at the normal rate.

In the fourth scenario, the prior authorization request is not submitted. The claim is submitted by a non-competitive bid supplier. As with the previous example, where there was no prior authorization decision, the claim will have the medical documentation to support it, requested. When it is received, it will be reviewed. If it is deemed to be payable, it will be paid at 75 percent of the Medicare payment.

Important to keep in mind that this can start three months after the demonstration begins and is applied to all claims in the series.

The next thing is the physician reimbursement. If the physician or treating practitioner is the entity who is submitting the initial prior authorization request for the beneficiary, they may fill a G-code 9156 for the initial submission. That G-code is billed to the AB MAC with the prior authorization tracking number on it. There is only one G-code per beneficiary, per PMD, even in cases of resubmission.

This code is not subject to co-insurance or deductible. This G-code is intended to partially compensate the physician or treating practitioner for the additional time spent if he or she is the entity submitting the prior authorization request. For beneficiaries, it's important to keep in mind that the PMD benefit is not changing. All same coverage criteria apply.

The beneficiaries will receive notice of the decision on the prior authorization request. And CMS encourages beneficiaries to use suppliers to accept assignments for PMD.

At this point, I would like to turn it over to my colleague, Doris Jackson to go through the rules and responsibilities in the submission.

Doris Jackson: Thank you, (Amanda). Good afternoon. My name is Doris. I will be talking about the roles and responsibilities of the physicians or treating practitioner and supplier with submitting the prior authorization request for PMD.

First, I would like to share with you that the documentation for Power Mobility Devices have not changed. The current LCD explains thoroughly what documentation CMS requires for payment approval. The physician, treating practitioner and the supplier, each play an important role to facilitate that Medicare Beneficiaries receives the correct Power Mobility Device.

The physician or treating practitioner is required to conduct the face to face examination. The face to face examination must state the reason why the patient is there to see the physician. For example, the physician can state mobility examination or the patient may says wheelchair. Correction, the patient will say, "I need a Power Mobility Device."

Additional, documentation should include the present condition and relevant past medical history including symptoms that limits ambulation, diagnosis that are responsible for symptoms, medication or other treatments for symptoms, progression of ambulation difficulty overtime, other diagnosis that may relate to the ambulation problems.

The distance patient can walk without stopping, pace of ambulation, ambulatory assistance currently used, changes in the patient's condition that currently requires the PMD, the description of the home setting and ability to perform, activities of daily living at home. In addition to the history, there should also be a physical examination actually documenting the patient's mobility needs.

The physical examination should include the patient's height and weight, their cardiopulmonary examination, their strength and range of motion of their extremities. In addition, the neurological examination may also be included discussing the individual's gait, their balance and coordination.

Keep in mind, all the items that I just mentioned that should be in this face to face examination does not necessarily fit every patient. The physician can use his judgment on what items that should be incorporated and then the documentation for their individual patient.

In addition, the physician or treating practitioner must also write the seven element order. For the seven element order to be valid, it must be written after the face to face examination has occurred. And once again, for that order to be valid it must include the seven elements. The patients name, description of the item ordered, example: power operated vehicles, power wheelchair, Power Mobility Device or some other device more specific.

The date of the face to face examination should also be included, the diagnosis, condition related to the needs of the PMD, diagnoses/condition related to the need for the equipment, the physician or treating practitioner's signature and the date of the physician or treating practitioner's signature.

The supplier's functions are as important as the physician or treating practitioner. The supplier keeps one file and must have available upon request the following documentation. The face to face examination that was completed by the physician or treating practitioner; the valid seven element order; and the detailed product description.

The detailed product description must be completed by the supplier and reviewed and signed by the treating physician. It must contain the HCPCS code for the base and all options, and accessories that will be separately built. Narrative description of the item, the manufacturers name and model number, and suppliers charge for each item, Medicare fee schedule allowance for each item. Physician's signature and date signed, and date stamp to document received date.

The supplier also is responsible for the home assessment and proof of delivery. In addition, the supplier is responsible for submitting the claim to the DME for payment.

At this time, I would like to reiterate what Melanie and (Amanda) stated about the submitter of the prior authorization request. CMS understands the industry's concern that the ordering physician may not be in the best position to submit the prior authorization request. Therefore, CMS has revised the demonstration process so that the supplier on behalf of the physician or treating practitioner may perform the administrative function authorization request.

The submitter which may be the physician, treating practitioner or supplier must forward to the DME the following documentation. The face to face examination, their valid seven element order and the detailed product description for determination to be made on the prior authorization request.

At this time, I will now turn the discussion back to Melanie to summarize the presentation.

Melanie Combs-Dyer: Thank you, Doris. In summary, we've told you where the demonstration will be occurring for beneficiaries in California, Illinois, Michigan, New York, North Carolina, Florida and Texas. We told you when the demonstration will begin. It will begin for orders for PMD written on or after June 1, 2012. And we don't yet know the exact the start date, that will be announced in the future but we are anticipating that will be approximately June 1, 2012 or later.

We talked about who can submit the prior authorization request. It was the physician or practitioner or the supplier. And we talked about when the demonstration will end, on or about May 31st of 2015 that is three years after the start date.

Next, I would like to remind you of where you can go to get more information. I want to let you know again the email address. If you have any questions that occurred to you after this call is over, you can email them to PAdemo@cms.hhs.gov. And if you want to see a response to your answer

you can either come back to this call next month and we will give you more details about that momentarily.

Or you can check out our FAQ website, to get there you go to the main CMS website and you look for the word FAQ in the upper right hand corner. When you click on, you will be taken to the FAQ page where you can search on the keyword PMD. And that will bring up all the questions and answers that has come in so far.

Most importantly, you should keep in mind the demonstration web address that's go.cms.gov/PAdemo and P and A are capitalized, go.cms.gov/PAdemo.

I will also tell you that we are trying to set up a broadcast email, sort of like Listserv that has not yet been set up. But when we do get it set up we will be posting information to our website and talking about it in the future call.

Again, we're planning on having monthly open door forum calls just like this one. The next one will be on March 21st and then approximately monthly thereafter until we get to June.

I will also encourage you, anyone who has questions about the documentation requirements, to visit each one of our MAC websites, you can find links to them at our main page. And in a moment, I will be turning things back over to Barb Cebuhar to begin our Q&A session.

But before I do that, I would like to read a few of the questions that have come in to our email box in the last couple of days. And then I'll have folks around the room help me answer them.

The first one is, how long will Medicare have to approve or deny the prior authorization request? (Amanda)?

(Amanda Burd): There will be 10 days to postmark the decision on the initial prior authorization request. And 30 days to postmark decision on resubmissions of request.

Melanie Combs-Dyer:OK. So 10 days for the initial one and 30 days for each subsequent request. The second question is, will there be a fax line for the prior authorization request too? (Amanda), what's is that fax line?

(Amanda Burd): There will be fax line set up and there are operation details that are forthcoming.

Melanie Combs-Dyer:And I will remind everybody who is on the line, electronic submission of medical documentation (esMD) is a new way for folks to submit documentation to some of the DME MAC. I'm not sure if all of them are accepting it yet. That is in place, it has been in place since September for some of our DME MAC. That would be a way that you can submit your documentation, in response to a documentation request.

It's unclear yet whether esMD is going to be allowed for prior authorization request. But if between now and June while we're doing normal medical review, if you want to use the esMD system to submit a response to a documentation request. Or if you are in a situation where you chose to not follow the prior authorization process but submits a claim anyway you may get the documentation request and you can respond to it by using esMD.

But again, the fax lines for the prior authorization request will be open at some point on or after June 1st. And we will be giving you more information about those fax lines to the four DME MAC in future calls then post it to our website in the future.

The next question is, what if they deny the prior authorization request stating that a certain document was not submitted when we know we sent it? This happens with appeals sometimes. And when we call the customer service representative, they find the document but they tell us there is nothing we can do, which level of appeals. So will there be a resubmit option if Medicare makes a mistake and denies the prior authorization? (Amanda), can people resubmit if they get a non-affirmative prior authorization request?

(Amanda Burd): Yes, unlimited resubmissions are allowed.

Melanie Combs-Dyer: And the final question that's coming in from this questionnaire is, will prior authorization help the claim to be pay any quicker?

And I'll take that one. It's kind of depends. We will certainly still have the normal claims processing floor which requires that we can't pay a claim any faster than a certain number of days.

But in those situations where a claim today might be selected for medical review and the documentation request goes out and the supplier has 45 days to send in the documentation and then the contractor has 30 days to review that documentation. Prior authorization will certainly speed things up in those cases. Those suppliers who go through the prior authorization process will have their answer to whether or not all the coverage requirements are met before they even deliver the items to the patient's home.

But when the claim comes in for that item, assuming that all the other coverage criteria are met or that claim will be paid as soon as the law allows us to pay the claim, without stopping for any additional documentation request.

Another question is regarding additional document review request on K0823 code. When the prior authorization for power mobility device demonstration begins, will additional documentation request for this code cease? It would seem that the prior authorization process would eliminate the need for additional documentation request and pre-payment review of this code.

Assuming that that code is one that's on the list, I'm assuming that it is although I haven't looked it up. Yes, assuming that you chose to go through the prior authorization process and we would encourage you to do so. Once you get an affirmative prior authorization decision you would likely not be receiving any additional documentation request. Unless it was just something that was not reviewed during the prior authorization process.

And again, that's only for those states where the demonstration is in place. If you are in one of these seven states, you would likely not receive an additional documentation request. Assuming that you may have gone through the prior authorization process and have received an affirmative decision.

If, of course, you opt to skip the prior authorization process and you want to go through the normal pre-payment review process, you can. You would, however be subject to the 25 percent payment reduction unless you're a competitive bid supplier.

Amanda anything you want to add to that? Or Doris anything you want to add to that answer?

The last question before we open it up to the group comes from someone named Scott. And he asked, I would like to know if this will be a true prior authorization process and not be similar in design to ADMC. For those of you who don't know ADMC, is the Advanced Determination of Medicare Coverage. It is a voluntary process that available for some items of DME.

If our request is not approved, will suppliers have the ability to immediate a resolution for approval and not be faced with any issues regarding having to wait to resubmit? For example, an unfavorable ADMC would mean a supplier has to wait 60 days to resubmit. (Amanda), if someone chooses to resubmit, how long do they have to wait before they can submit their resubmission?

(Amanda Burd): They do not have to wait. There are no timing from the resubmission.

Melanie Combs-Dyer:OK. So that is our final question that came in to our mailbox. We would now like to – Doris, do you want to add to that?

Doris Jackson: Yes, I did.

Melanie Combs-Dyer:Thank you.

Doris Jackson: Keep in mind that the DME MAC contracts will be providing detailed denial letters. So you will know where you were lacking with your documentation so you can get the correct information so that second resubmit hopefully will be an approval.

Melanie Combs-Dyer:Excellent. Thank you. That's a good point. Barb, I will turn it back over to you to kick us off for our Q&A session.

Barbara Cebuhar: Thank you, Melanie. (Dean), would you like to instruct people how to get in the queue, please?

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

Your first question comes from the line of Chris Rice from Diamond Respiratory. Your line is open.

Chris Rice: Hi. Thanks for taking my question. I'm confused about, you said that a tracking number would be issued for each claims or for each prior authorization. Then you also said that the physician needs the tracking number to build the details. So how does that all work out? And can you talk about the mechanics of the program as far as how we would physically, you know, there are cover forms or how would we physically send a prior authorization to you?

Melanie Combs-Dyer: There will be a fax cover sheet that will be posting to our website before too long. Or actually maybe the MAC when we're posting it to their website and have a link to their website. And you will use that fax cover sheet, it will tell you the fax number that you need to submit the documentation to.

And assuming that it's an initial prior authorization request, 10 days after the submission of the prior authorization request a letter will go in the mail to physician, to supplier and to beneficiary indicating what the decision is. And it will have the – assuming that it's an approval, it will have the tracking number. Will the tracking number also be included for denials, (Amanda)?

(Amanda Burd): Yes, the tracking number will be provided for all decisions, affirmative or non-affirmative.

Melanie Combs-Dyer: Chris, did that answer your question?

Chris Rice: I think so. So just to clarify, the only way to get the tracking number is to wait for 10 days and then the doctor can bill for his part of the service?

Melanie Combs-Dyer: Yes, that's correct.

Chris Rice: OK. Thank you.

Barbara Cebuhar: Our next question, please, (Dean).

Operator: Your next question comes from the line of (PJ McKinney). Could you please state your organization? Your line is open.

(PJ McKinney): Hi, this is (PJ McKinney) from Wheelchairs Plus in Florida. I have several questions. I guess I'll start with this one and then I can chime in again and try to catch up again on another question later.

But one of my questions was, currently 120 days requirement for final delivery of product after the face to face examination is complete. If there are issues with the face to face examination, and those face to face are appealed by one of the entities involved either the provider or physician or what have you. How is that going to affect the 120 days requirement of final delivery? And is that going to be applicable during this process?

Melanie Combs-Dyer: This is Melanie. One-hundred-twenty days to deliver requirement does not change. So we would hope that any resubmission that need to occur would happen fairly quickly.

(PJ McKinney): Well, I guess my point being is that if there is a 30 day, OK so the initial is 10 days then you have a 30-day. Then if there is additional information and you are looking at another 30 days you're basically cutting half the time. So is there an allocation or a possibility or suggestion or discussion that could be had regarding that 120-day dating from the completion of the face to face in the event that there are legitimate appeals moving forward?

Melanie Combs-Dyer: When you say appeals, I think you mean a resubmission of the prior authorization request, is that correct?

(PJ McKinney): Sure.

Melanie Combs-Dyer: Yes. Appeals are only after you have delivered the item and you have submitted the claim then that involves the appeal process.

(PJ McKinney): I was using the wrong terminology.

Melanie Combs-Dyer: No problem. Yes, if you want to submit another prior authorization request the second or third or fourth, you certainly can. And I guess until you get up to that 120-day mark. And then I suppose patient would need another face to face visit.

(PJ McKinney): OK. Thank you.

Barbara Cebuhar: Our next question, (Dean).

Operator: Your next question comes from the line of Laurie Watanabe from Mobility Management. Your line is open.

Laurie Watanabe: Hi. Thanks so much for having this open door forum. I am Laurie Watanabe, the editor of Mobility Management Magazine in California.

I wanted to know what team at CMS anticipate with DME MAC will be making to accommodate this new process for power mobility devices?

Melanie Combs-Dyer: This is Melanie again. And we have been working with the DME MAC very closely. They are all aware of the changes that they need to make to get set up and to get their fax lines ready to receive more faxes. They are all set and ready to go.

Laurie Watanabe: So they're getting additional training and additional staff, and all of those things?

Melanie Combs-Dyer: Yes. Remember that it's the same coverage requirements. There's nothing new about the coverage requirements. So it's very similar to how they're today. But, yes, they will certainly need some additional staff. And they're all busy hiring up now.

Laurie Watanabe: OK. Thank you.

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

Operator: You next question comes from the line of (Cathy Weiss) from Standing Company. Your line is open.

(Cathy Weiss): My concern is that we work with DME in all the various states. And when we have a Medicaid program that requires that we do an appeal when an item is denied. What will be the process?

Melanie Combs-Dyer:(Cathy), I'm not sure I understand your question. You're talking about a Medicaid patient who also has Medicare?

(Cathy Weiss): Right. When Medicare primary, there are some states that will pay in full providing that Medicare has denied. But they will only do that after we have appealed for Medicare. And when Medicare still denies it then they will pay. What will be the process if it's denied by Medicare? What is that process?

Melanie Combs-Dyer:OK. So what I think I hear you saying is that you really want to receive a denial from Medicare so that you can turn around and bill Medicaid, is that correct?

(Cathy Weiss): Correct. But we have to receive their denial on the appeal as well?

Melanie Combs-Dyer:OK. So, just to make sure I'm following this. You are it is required that you submit your claim to Medicare, get a denial from Medicare then submit an appeal and get a Medicare appeal denial. And then and only then are you allowed to bill Medicaid, is that correct?

(Cathy Weiss): Correct.

Melanie Combs-Dyer:So I guess you would fall into scenario number two that (Amanda) talked about earlier. And that is you will submit your prior authorization request. I think I would suggest that if you know already that you don't meet the coverage criteria. For example, I know that there are some Medicaid program that cover PMD even if the patient does not need it inside their home which is a Medicare coverage requirement.

So if that's the situation you know that the only reason that the patient needs the PMD is so that they can participate in the community go grocery shopping

or go to medical visits or whatever. And that Medicaid would cover it under that case but it does not meet the Medicare requirement you should probably indicate that in the fax cover sheet when you send the information in.

You will then get a non-affirmative prior authorization decision. You can then deliver the item to the patient, submit a claim, receive your denial, go through the Medicare first level appeal process and get that denial. And then, I suppose you can follow whatever Medicaid's processes from there.

(Cathy Weiss): OK.

Melanie Combs-Dyer: Does that make sense, (Cathy)?

(Cathy Weiss): Yes, it does.

Melanie Combs-Dyer: OK. I might suggest that you send us that question to our email box to make sure that we can post that answer out to our frequently asked questions page. You may not be the only person that is dealing with some dual eligible Medicaid, Medicare beneficiary. And we would like to make sure everyone knows exactly what to do there.

(Cathy Weiss): We'll do. Thank you.

Barbara Cebuhar: Thank you, (Cathy). Our next question please, (Dean).

Operator: Your next question comes from the line of (Nicky Layton) from Dream Software. Your line is open.

(Nicky Layton): Yes. Thank you for taking my question. My question revolves around the earlier statement that the process would follow the prior authorization format that had been used by private insurance industries in the past. Most of those private insurance companies do a 48-hour turn around time and they utilize electronic submission using a standardized format.

I was curious as to why Medicare did not install that same process to automate this process because it seems very difficult to process this much paper work.

Melanie Combs-Dyer:(Nicky), this is Melanie. And we are looking at adding an electronic submission component to our system in the future. We will not have that in place by June 1st but we will certainly try to get that in place as soon as we can after that. We will probably be piggybacking on to our esMD system, the Electronic Submission of Medical Documentation system.

And so, I would encourage anyone who is not familiar with the esMD to go check out our website, www.cms.gov/esMD. And we will be providing more information in future calls about when we think that electronic format maybe possible. There is a fairly long lead time to get the approvals needed for those standards to operate through esMD.

So, it is likely that we are sometime away from having that in place. But I hear you, I think it is important that we're moving in an electronic direction. And we will get there as soon as we can.

Anything else from Doris or (Amanda) on that? But thanks to, (Nicky). I appreciate it.

(Nicky Layton): Great. Thanks.

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

Operator: Your next question comes from the line of Cheryl Carlyle from Duramed Mobility. Your line is open.

Your next question comes from the line of (Don Clayback) from (NCART). Your line is open.

(John Clayback): Thank you. This is (Don Clayback) from (NCART). Melanie, a couple of questions. Thanks again for having this forums. I think they will certainly be helpful.

And I guess maybe to start with a comment, I think we all agree that the area, the PMD arena needs more attention and needs some additional improvements for a lot of reasons. I do feel compelled to make a statement though the

constant mention of fraud. I think we all agree that fraud needs to be prevented and we need to put some additional controls to combat that.

But I do think that many of the errors around the PMD claims stem from documentation, questions or confusions. And I know we'll be talking separately about that in terms of how we can improve that. But two questions on the actual process; one is, what type of safeguard will the prior authorization, the granting of that, how will that help suppliers down the road in terms of post-payment reviews? That's one question.

And the second one is, the details in terms of the actual forms that are going to be used and some of the things that you've outlined today. When will those be available so that the education, you know, can begin with the physicians and suppliers, you know, with the actual forms and other things that will be used from June 1 to thereafter?

Melanie Combs-Dyer:OK. So let's take your question separately. Your first question was, what kind of safeguard is in place to prevent a supplier from getting chosen for post-pay review even after they have gone through the whole prior authorization process.

And the answer there is, for the medical necessity and the kinds of issues that are being reviewed during the prior authorization process you will not be subject to post-payment review for those purposes by the MAC or the RAC.

It's possible that that claim could get chosen by the contractor. It's also possible that that claim might be chosen by a fraud fighter like a ZPIC or PSC. But the MAC or the RAC will not choose that claim for those purposes.

Now, there could be other requirements that are not reviewed during the prior authorization process. And I'm going to see if Doris or (Amanda) can help me think of an example.

(Amanda Burd): For example, the home assessment.

Melanie Combs-Dyer:The home assessment. If a MAC were to, let's just say the OIG came out with a report and said, "You know, home assessment, I'm checking to make

sure that the hallways are wide enough for the PMD." That's something that has been a problem and there's a lot of improper payment because this home assessment is not occurring.

It's possible that MAC could chose to perform some post-payment review to check for the home assessment. Home assessment is not something that is checked for during the prior authorization process. So it's possible that in those situations, those claims could be selected for that kind of review. But hopefully, that would be a much shorter review. Hopefully, you've got that home assessment in place on file. It's nothing that you have to write to the physician and try to track down, and that sort of thing.

So we really do believe that having in place this prior authorization process will make life easier for suppliers in terms of the post-payment reviews they might be subject to.

(Don Clayback): OK, great. And then, in terms of the question would be around the medical necessity which is what MAC would be reviewing on. But there would be other audits though that might not suffice that somebody get a comment and second guess what the MAC staff determine in terms of meeting medical necessity?

Melanie Combs-Dyer: Only in the case where your claim is randomly selected by the CERT contractor. Or of course, if you're selected for review by the fraud fighters.

(Don Clayback): OK.

Melanie Combs-Dyer: Your second question was, when will more details be available? And we will certainly give you an update on that on March 21st, our next call.

(Don Clayback): OK. Would that be in terms of the actual format? I guess what I'm getting is that if it goes into effect June 1st, is the intent that there will be, you know, like a 60-day period that everybody will have the forms and be able to start implementing them within their own business so that they will be ready to go June 1st? Or do they have kind of a timeline in terms of how much advance notice will be given?

Melanie Combs-Dyer: We will try to get out those fax cover sheets before the next call, at least in draft so that you can give us your suggestions or ways that we can improve their fax cover sheet. And then we will try to get the final fax cover sheets out as soon as possible.

(John Clayback): Great. Thank you.

Barbara Cebuhar: Thank you, (Don). (Dean), our next question.

Operator: Your next question comes from the line of Michael Bonner from the University of Michigan. Your line is open.

Michael Bonner: Thank you for taking my call and for hosting this call. I appreciate that. You have mentioned on there, that there will be a three-month time period where the 25 percent reduction will not occur. Will that be based on service state or just a specific calendar date?

Melanie Combs-Dyer:(Amanda)?

(Amanda Burd): The three months window is based on the start date of the demonstration. Dates of service that is three months after the start date of the demonstration, the payment reduction could apply in those cases.

Michael Bonner: OK. I would suggest that we consider three months, you know, from the service date or something more specific to the service date. For example, if we are getting ready to deliver a chair and it goes beyond that three months so June, July or August. We're delivering September 1st then I would be subject to 25 percent reduction even though maybe at that time, you know, the pre-payment was not even an option. Do you follow me?

Melanie Combs-Dyer: The 25 percent payment reduction is a penalty for failure to go through the prior authorization process. And the reason that we are delaying it for three months since the beginning is sort of warning. There may be people who weren't aware of the prior authorization process. It sort of puts them on notice. It reminds them, hey, you know, starting on such and such a day, you will be subject to a 25 percent reduction.

So it will go into effect three months after the start date. So let's just say that the start date is June 1, does that mean June, July, August or September so September 1, starting September 1 the payment reduction would be in effect for everybody. We do not anticipate changing it up and having a separate date for everybody based on individual dates of service. It will be on or about September 1st for everyone.

Michael Bonner: OK. Could you provide training information then including especially to the physician and the beneficiaries that, you know, they're maybe subject to have to go through this process before their chair can be delivered because it could delay? So if we started the process prior to June when it is available, and they were getting ready to deliver that after September 1st, I don't think I should have to take a 25 percent reduction just because it wasn't available at that time. Does that make sense?

Melanie Combs-Dyer: Let me clarify, it is that the three months grace period, the demonstration is based as of the date of the written order. So the grace period would also be based as of the date of the written order in regards for the start date of the demonstration. So let me say it and make sure that I've got it. We're just going to pretend for the moment that June 1st is the start date for the demonstration.

So that means that folks will have to get it, if they want full payment. They've got to go through the prior authorization process of orders written for beneficiaries residing and one of these seven states through June 1st. And the grace period for the 25 percent payment reduction goes from June 1st until the end of August. And September 1st orders written on or after September 1st that don't go through the prior authorization process will be subject to the 25 percent payment reduction.

First of all, (Amanda), did I say that right?

(Amanda Burd): Yes.

Melanie Combs-Dyer: And Michael, was that clearer?

Michael Bonner: Yes. So it's going to be based on the physician's order not on the service date?

Melanie Combs-Dyer: Yes. And we will try to make that very clear on our handouts. I actually like the way that you kind of walked us to a date. Perhaps, we can change some of our – the way that we present that in our slides and actually put a date to say that the payment reduction applies only on or after – for orders written on or after approximately September 1st.

Michael Bonner: OK.

Melanie Combs-Dyer: I think I make it a little clearer for people. So thank you for helping us recognize that.

Michael Bonner: Yes. That makes better sense. Thank you. How do I, get the outreach call for example to our state association?

Melanie Combs-Dyer: Why don't you gather some information and send it to us in an email. If you are having a meeting of a large number of physicians or suppliers or beneficiaries in one of these seven states sometime in the next year, gather the information and send us the contact information and the date, if you know it. Send it to our email box and we will get back to you.

Michael Bonner: What email would that be sent to?

Melanie Combs-Dyer: (Amanda), you can probably do it right at the top of your head.

(Amanda Burd): That's PAdemo@cms.hhs.gov. Again, PAdemo@cms.hhs.gov,

Michael Bonner: OK. And then I want to just left a comment, I'm curious why the unlimited amount of request are being allowed versus similar to the ADMC where you get two requests per six months. And, you know, I might get burned at stake for this question by our providers but to me unlimited request allows additional fraud by unscrupulous suppliers that would just continue to repeatedly pump these things in until they get an approval.

Melanie Combs-Dyer: Well, we have heard from a number of people like one of our earlier questionnaires. I think it may have been (Don Clayback) who was suggesting that part of the problem at least that's driving the improper payments is

confusion on the part of physicians or suppliers about what exactly needs to be sent.

And so, we were hoping that by allowing the unlimited resubmission, we would not clog up our appeals department but rather allow our suppliers and physicians multiple attempts to gather the right pieces of documentation or make sure that the product description has a signature of the physician or whatever the other requirements are.

And we're hopeful that we may see the number of resubmissions go down over time as physicians or suppliers really begin to understand our rules better and learn what it is exactly do they have to do to comply. That coupled with the detailed denial letters that you heard Doris talked about. We're really hopeful that by spelling out exactly what was done wrong, physicians and suppliers overtime will be able to get it right.

And maybe we will get to the point where most of the prior authorization request can be handled in the first submission.

Michael Bonner: OK. Thank you.

Barbara Cebuhar: Thank you, (Michael). Our next question please, (Dean).

Operator: Your next question comes from the line (Scott Welch) from (JT) Medical. Your line is open.

(Scott Welch): Hi. Thanks for taking my call. My question was already asked and I wasn't paying attention during the retracted question instructions. So I have a request geared towards Complex Rehab, when can we get a G-code for our ATPs?

Melanie Combs-Dyer: What is an ATP?

(Scott Welch): Assistive Technology Professional. You know, when you're dealing with Complex Rehab it does take a lot of time to do a proper evaluation with the client. And there's a lot of cost associated with that. And the traditional answer that's all inclusive in the HCPCS code for your payments but I'm throwing this out there as you're structuring this whole new system that at

some point it seems fair and reasonable that there is some formal reimbursement for that clinical expertise to be involved in the evaluation.

It is a requirement to have an ATP for certain groups of wheelchairs.

Melanie Combs-Dyer: It's my understanding that physicians to make those referrals can enter in to whatever kind of business relationship they want to with those professional ...

(Scott Welch): No, I'm referring to CMS and allowing suppliers to bill for their ATPs time. Similar to as you would allow a physician to bill for their time involved in the paperwork in processing that.

Melanie Combs-Dyer: If you send me that request by email, I will certainly forward it on to our payment policy folks. I would suspect that they would say that the payment for that kind of work is already built in to the fee schedule. But perhaps, they would consider reducing the fees and then adding on some additional payments for those professional. So feel free to send me that email and I'll pass it on to our payment policy expert.

(Scott Welch): OK. Thank you.

Barbara Cebuhar: Thank you, (Scott). Our next question please, (Dean).

Operator: Your next question comes from the line of (PJ McKinney). Your line is open.

(PJ McKinney): Hi. Thanks. This is my second question. I appreciate you guys spending so much time on this question and answer session. In the very beginning of the conversation or the presentation, you had indicated that there was an error rate of 80 percent or I believe it was over 80 percent. Was that an accurate statement?

Melanie Combs-Dyer: Yes, 80 percent and it's an OIG report.

(PJ McKinney): OK. So based on the information, does CMS expect to see a similar number of initial denials on this PA process?

Melanie Combs-Dyer: Well, we are hoping that perhaps by reminding people upfront that they have to go through this prior authorization process. If it will make them pay a little bit closer attention to the rules and, maybe after the deterrence effect perhaps they'll recognize that they don't need the coverage requirements and therefore they won't go through the process.

Except in those situations like we had an earlier questioner who knew that she didn't meet the Medicare coverage requirements, but for dual eligible patients, they needed to go through the process so that they can get the denials so that they can bill Medicaid.

(PJ McKinney): I understand. Yes.

Melanie Combs-Dyer: But you are absolutely correct that there could be a high number of non-affirmative prior authorization decisions at the beginning, yes.

(PJ McKinney): Based on that information, and probably that should take up additional time to continue to go down this line of questioning. Based on that initial indication on that information, we all know as an industry that a vast number of those denials are clinical issues and not medical issues in nature.

And as a result, are there going to be certain requirements that CMS is going to put in place regarding the review process to ensure that the information is complete and accurate. In other words, what is the requirement of the people actually reviewing these requests?

Melanie Combs-Dyer: We will be hiring an evaluation contractor who will be writing a report at the end of the demonstration sort of looking at the way that the demonstration works, and what worked well and what didn't worked well. And I would anticipate that there will be some sort of accuracy check or some kind of re-review of some of the works that the MACs are doing to check on that.

What I can tell you is that the cert contractor who does a random sample of reviews has found very few problems with the Medicare Administrative Contractors not following the proper review procedures, overlooking or perhaps not considering a piece of documentation that they should.

And instead, they find that the majority of the errors are coming from situations where the physician or the supplier is not submitting the documentation that substantiates the coverage requirements for PMD where met.

(PJ McKinney): OK. Would it be possible then for CMS to develop since this is a pilot project, if you will? Would it be possible that request that CMS provide those of us in these states say bi-annual or annual report during the demonstration projects so that we can have a better understanding of the progress that's being made in these areas?

Melanie Combs-Dyer: I don't think so. We are only budgeted for our evaluation contractor to produce one report at the end. But certainly, we want to hear from you throughout the demonstration if you believe that the MAC is making a mistake. And it's not just happening, you know, every once in a while but it's a routine mistake that the MAC is making. We certainly want to hear about it and we will keep our email address open for the entire link of demonstration.

And if that occurs, please let us know and we will get results right away.

(PJ McKinney): Thank you.

Barbara Cebuhar: (Dean), our next question. We probably have time for about three or four questions. Thanks.

Operator: Your next question comes from the line of Cheryl Carlyle from Duramed Mobility. Your line is open.

Cheryl Carlyle: Hi, everybody. Thank you so much. I tried this before but somehow my phone got disconnected so I had to call back in. My question or I guess frustration is, and I might have missed this. Who is actually going to be making the decisions as to the medical necessity in documentation? The physicians are providing for this prior authorization as to whether it meets guidelines or doesn't meet guidelines.

Melanie Combs-Dyer: It will be the DME MAC. It's the same organization that today you submit your claims to and are making the review determinations today.

Cheryl Carlyle: OK. This is not good because we have non-clinical people challenging physicians who are clinical people who are answering the questions appropriately. But because that person might be following a form that the DMAC have provided, it's all opinion base. All of my denials which have been three for the whole year were specific to – the doctor didn't give enough information that really wasn't provided or requested from the doctor on the initial request on the emails.

It was someone's opinion that there wasn't enough information there, and all of those questions were answered and all of my claims were paid. So my suggestions, and I don't understand why we're not doing this is to utilize a medical necessity template for physician. And you guys are going to draw this up. We don't get to do this. No other supply gets to create their own forms. This is something that CMS draws up to educate the physician on exactly what specific pieces of information you are looking for.

You know, again I think I brought this up in a different call or another call. You can ask me, is it raining outside? I can answer, no or yes, that answered your question. But if someone else is looking at that specific answer it may not be enough. I might be missing 10 more that the person wanted to see. So we still haven't really hit the mail here.

You know, all of these confusions and, you know, first time prior auth going through. If these physicians understand exactly the terminology and the way you want them to answer these questions then we can eliminate a lot of these frustrations and a lot of this confusion for CMS and your provider, and the patient, and the doctor.

So, are we talking about possibly doing a template for medical necessity so these physicians will know exactly what you're looking for?

Melanie Combs-Dyer: Duramed, I'm sorry, I missed your first name. But you asked two different questions there. The first one is about the clinical qualifications that the DME MAC reviewer.

Cheryl Carlyle: Yes, (ma'am).

Melanie Combs-Dyer: And the second one is the suggestion that CMS adopts the medical necessity templates or forms. I'm going to take each one of those questions separately.

First, I'm going to actually ask someone on the call to help me answer the first one. Dr. Hoover is the contractor medical director at one of our DME MAC. Dr. Hoover, are you on the line? And can you answer the question about these clinical qualifications of the DME MAC reviewer?

Robert Hoover: Yes, certainly. This is Robert Hoover. I'm the Medical Director for the Jurisdiction C DME MAC at CGS Administrators. We have nurses, BSNs that participate in our complex medical review. Most of them have experience in home health or med surg. We also have an occupational therapist that is on staff that does a number of our reviews for PMD.

She does a lot of our advance determination on Medicare coverage. So, in medical review, all of our staff that will be reviewing these claims for medical necessity, our clinical staff that have a background and training in mobility assistive equipment.

Cheryl Carlyle: But Dr. Hoover, it's never been this way. And the statement that you just made was we have one OT to handle 3,000 claims that might be coming in, in one day.

Robert Hoover: No, don't ...

Cheryl Carlyle: Who handles the overflow on that? I'm sure we don't have all nurses sitting out there. And my situations where I have non-clinical people looking at these records in making these determinations for our patients.

So if it's going to get better, that's wonderful. But my problem is again there's really no format or guideline as to how – again if this nurse has a different opinion as to how that question should be answered, does it make it wrong if the doctor's answer in uncertain way but they have answered the question?

Robert Hoover: Let me go back to your first statement. The folks that we have in medical review that are doing our complex medical review had been required, it has been required contractually by CMS for as long as I have been a medical director, which goes back to 1998, for us to have registered nurses conducting these reviews.

At one point, we did have LPNs that were doing some of the reviews. But I know now in medical review, and it's been this way for a number of years. Our complex medical review, the folks that will be looking at the medical necessity documentation are in our jurisdiction, registered nurses. And we have one occupational therapist that also works in our medical review department that does power wheelchair, but all of the nurses.

And we have also specifically trained group of nurses in jurisdiction C that will be doing the prior authorization request. This isn't something new for any of the DME MAC in terms of the clinical background and training of the folks that are doing our complex medical review.

Melanie Combs-Dyer: Thank you, Dr. Hoover. This is Melanie again. I want to jump to the second question that Duramed asked. And that was the suggestion that CMS create a form or medical necessity template to help educate physicians about exactly what it is that they need to document during the face to face exam.

And first, I want to remind everyone that there are local coverage determinations for PMD that very clearly lay out exactly what needs to be documented in the record. And I would encourage people to go there. We have also produced a Medlearn Matters or checklist on things that the physician needs to include during the face to face exam.

But to get to those specific question or a suggestion that CMS develop a medical necessity template, I can tell you that we are currently exploring the possibility of working with electronic health record vendors to develop some prompts or some reminders that could be actually put into the EHR that would remind the physician as they are going through the E&M visit, the face to face visit for PMD about the kinds of questions that they need to be asking and the kinds of information that they need to be documenting.

And if anyone has any suggestions about how we can set that up or how to best communication EHR industry, vendor industry, please send me your suggestions to our email box. Otherwise, we will work to our colleagues at the Office of the National Coordinator for Health IT to try to reach out to those EHR vendors.

I know that we're running short on time. So let me ask ...

Barbara Cebuhar: We have time for one more question, Melanie.

Melanie Combs-Dyer: Thank you, Barbara.

Operator: Your final question comes from the line of (Christie Carlin) from Travis Medical. Your line is open.

(Christie Carlin): Thank you very much for taking my call. I do have a clarification question for you. You were talking about the prior authorization timeline of 10 days. Can you please clarify if that is business days or calendar days?

Melanie Combs-Dyer: It's business days. And we will clarify that by putting out Q&A on that and making the website as clear about 10 business days.

(Christie Carlin): OK. Thank you very much.

Barbara Cebuhar: Thank you all very much for joining today's call. I want to make sure that folks know that a transcript and a recording will be available in approximately two weeks at the Special Open Door Forum website.

You can get there by going to www.cms.gov/opendoorforums, plural, and select the Special Open Door Forum for this date. I would also like to remind you that you will have an opportunity to hear another presentation and ask questions about the power mobility device demonstration on March the 21st, 2012. That will be held from 3:00 to 4:30 p.m. Eastern Time. Please check go.cms.gov/PAdemo for update.

There will also be other calls which are scheduled for the same time that's 3:00 to 4:30 p.m. Eastern Time on April 26th, 2012, May 31st, 2012, June 28,

2012 and July 27, 2012. Please let us know if you have any questions by going to PAdemo@cms.hhs.gov.

Thank you again for joining this and sharing this information about the upcoming sessions with your colleagues. Thank you very much. (Dean), we are ready to close the call.

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

END