Centers for Medicare and Medicaid Services
Special Open Door Forum:
Prior Authorization Process for Certain DMEPOS:
Implementation for the First Two Items for Prior Authorization
Moderator: Jill Darling
March 21, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Kim) 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 Prior Authorization Process for Certain DMEPOS: Implementation for the First Two Items for Prior Authorization Open Door Forum.

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

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Kim). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. Thanks for joining us today for the Special Open Door Forum.

Before we get into the presentation today, I have some announcement. This Special Open Door Forum is not intended for the press and the remarks are not considered on the record. If you a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And now, I'll hand the call over to Melanie Combs-Dyer, who's the Director of the Provider Compliance Group.

Melanie Combs-Dyer: Hi. And thanks, everybody, for joining …

(Audio Gap)

Melanie Combs-Dyer: … (Forum). This is the second in a series of Open Door Forum Calls on the Prior Authorization Process for Certain Items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies or as we'd like to call it DMEPOS. We previously announced the first two codes; both of them are power wheelchair codes subject to this new prior authorization process. We're in the process of planning additional open door forums. One is going to be where we will walk through some actual case examples with one of the DME MAC medical directors and another where we will be soliciting your comments about the documentation and policy requirements for this power wheelchair.

CMS is committed to launching the narrowly tailored DMEPOS Prior Authorization Program in an open and transparent manner that serves and protect patients as well as the health care providers that care for them. We have the opportunity to learn from the patient provider and supplier experiences, and we welcome your feedback as a critical part of this process. We look forward to an ongoing dialogue to help us gather feedback and learn how the program can best meet patients' needs.

To enhance this dialogue and to support the program's transparency, we're working on improving our DMEPOS Prior Authorization Web site, and we're posting helpful tools for patients, suppliers, and physicians. These resources aim to improve transparency, protect access to care, and support direct engagement with patients, suppliers and physicians. We've also established a new dedicated mailbox for DMEPOS Prior Authorization, which is listed at the end of the slide.

We look forward to hearing your feedback. And now I'll turn it over to Amy Cinquegrani.

Amy Cinquegrani: Thanks, Melanie, and thanks, everyone, for joining the call. Again, my name is Amy Cinquegrani and I'm with the Provider Compliance Group in the Center for Program Integrity at CMS.

Before I start with this slide, I'm going to walk everyone on how to actually get the slides on our Web site in case you haven't found them. We've done a lot of changes to our Web site. So, I just want to make sure that everyone has the correct address. If you go the cms.gov, you'll click on the menu titled Research, Statistics, Data & Systems. From there, click on Medicare Fee-for-Service Compliance Programs. And after that, on your left-hand menu, all the way at the bottom, you'll see the menu option titled Prior Authorization for Certain Durable Medical Equipment, Prosthetics, Orthotics, Supplies Items. And then – so scroll all the way down to the bottom in the Downloads section, and the Open Door Forum Slides should be the first download in that section. And they have today's date on them, 03/21/2017. They were updated earlier today from the slides that were presented at last week's open door forum. We made a few updates and a few improvements based on the feedback that we got. So, hopefully, everyone now has the current slides.

So, I'm going to pick up on slide three of the presentation with our purpose. The purpose of the presentation today is to provide an overview of the prior authorization process for the first two items subject to the new required prior authorization. And this is authorized in statute at Section 1834(a) (15) in Title 18 of the Act, and it's codified at 42 CFR 405.926 and 414.234. And we usually refer to this as the CMS 6050 rule. You may see that on some of our materials in the download section, and sometimes we use that when I'm talking about the rules that authorized this program.

Moving on to slide four, some more background information about the prior authorization process. It's the process through which a request for provisional affirmation of coverage is submitted for review before an item is rendered to a Medicare patient and before the item is submitted for payment. That helps to make sure that the Medicare coverage criteria, including payment and coding rules, are met before the items are rendered, and is the preliminary finding that a future claim for the items submitted to Medicare likely meets all of Medicare coverage, coding and payment requirement.

And moving on to slide five, we have a little bit of history of the program. We published the regulation, which guides the program, as I mentioned, CMS 6050, in December of 2015. And this created the list of items frequently subject to unnecessary utilization and potential candidates for prior authorization, which we refer to as the Master List. CMS may select items from the Master List to be subject to required prior authorization as the condition of payment. And so, the existence of an item on the Master List alone does not mean that the item is subject to required prior authorization. The rule also requires that CMS announce through a Federal Register Notice the items which will be subject to the required prior authorization process, which we did for these items on December 21, 2016. And just to reiterate, prior authorization of these items on the required prior authorization list is a condition of payment.

Moving on to slide six. We have the Who and the What that are affected by this program. The Who are the DME suppliers and Medicare patients who use these particular items. And the What, we have the two code definitions that are going to be subject to required prior authorization under this program, the K0856 and K0861, which are both group 3 power wheelchairs.

Slide seven. We have the Where and the When. We're beginning this initially in the four states, Illinois, Missouri, New York, and West Virginia. And these are states that are based on the patient's permanent address. And doing this limited rollout gives us a chance to work out any processing or operational issues prior to further expansion. We do this a lot. And when we're starting different programs, whether it's a demonstration or a permanent program, we like to have a limited rollout to try to work out the kinks before any expansion.

So, that's what we're doing now with these initial four states. And so, all applicable claims in those four states for the two wheelchair codes must have prior authorization request on file prior to furnishing the item to the Medicare patient and prior to submitting a claim with the date of service on or after March 20, 2017, which was yesterday. So, that's the main date to remember in this program.

Moving on to slide eight. Why we're doing prior authorization? We think prior authorization is great for a number of reasons. It allows the supplier to know earlier in the process whether Medicare will likely pay for the DMEPOS items; and it allows the patients to know prior to receipt of the item whether Medicare will likely pay for the items, so there are no surprising bills or payments; and it allows the DME MACs to assess the medical information prior to making their claims determination to provide that provisional feedback on the item that's going to be delivered to patient.

Slide nine, this is our Why Not slide. We get a lot of questions aligned on accessories. So, we're hoping that this helps it clarify some of the questions on specifically why accessories are not separately prior authorized under this program. So, as I mentioned, before, all codes subject to the required prior authorization process must be identified on the Master List as part of that CMS 6050 rule. And for the inclusion on the Master List, an item has to meet a number of criteria - it has to have a fee schedule purchase amount of $1,000 or greater or have a rental fee schedule amount of $100 or greater, and this will adjust annually. And it has to be subject of either an OIG report, a GAO report, or a Medicare Fee-for-Service Improper Payments Rate Report or the Appendices. So, those criteria have to be met. And the wheel chair accessories do not meet these criteria, they are not included on our Master List to choose items from. So, they are not separately eligible for prior authorization under this program.

Slide 10 has a little bit more information about accessories. So, even though they are not separately subject to prior authorization, the DME MACs do consider them in making their coverage determination. So, when the specialty evaluation supports the need for the specific options or accessories that are needed to address a patient's particular limitation, these accessories and options will be considered as a whole, as part of the prior authorization request. And so we have some examples of things that are included. And, you know, that would be included in that coverage decision, and that would not be included in the coverage decision.

So, things that would be included, you know, seating, tilt and recline options, head control interfaces, sip-n-puff, a joystick other than standard joysticks, multi-hand control switches, and seat cushion would be included as part of that overall prior authorization request. And accessories that would not be included are headrest, the hip and trunk support, some electronics, the leg rest, and batteries. And the particular DME MAC LCDs actually have more specific information on that and list out the specific codes. So, please consult that LCD if you have questions on a specific item.

So moving on to slide 11. Even though this required prior authorization process is new, a lot of things aren't really changing. The coverage policies aren't changing, the documentation requirements currently aren't changing, our same contractors, our DME MACs that do our typical medical review, the – they'll do the prior authorization reviews, and the advanced beneficiary notices of non-coverage, policies surrounding those ABNs, and the claim appeal rights for the claims themselves - those aren't changing. Really, the only thing that is seen from the program is when we require the documentation to make those provisional decisions. And that is required upfront before the item is delivered and before it is billed

So, the next few slides have some information about what needs to be included in the prior authorization request content. So, we're on slide 12 now. The request needs to identify the beneficiary or the patient's name, their Medicare number, their date of birth and address; the supplier information; the submission date; the particular HCPCS code that's being requested; the request needs to indicate if it's an initial prior auth submission or if it's a resubmission; and if this is an expedited review, if you are requesting this review because waiting the normal time frames for review would likely endanger the patient, then you would need to indicate why and give some supporting information there.

Slide 13, this has some of the information that the contractor requires as part of its coverage decisions to be able to process the prior authorization, such as the detailed product description, the attestation statement that shows that there's not a financial relationship between the supplier, the RESNA Assistive Technology Practitioner Certification and their involvement in this review,

and then also the home assessment if it's available at the time of prior authorization. We note that the prior authorization should be before the item is delivered, and most likely this would not be applicable for this request.

And then lastly, on slide 14, this is information that would come from the physician or the practitioner; the documentation from the medical record that would support the medical necessity of that particular item such as the Seven Element Order, the face-to-face examination, and that specialty evaluation, which would be performed by an LCMP.

Slide 15 has information on how you can actually submit your prior authorization request. This can be submitted by either the supplier or the patient, and it can be mailed or it can be faxed currently beginning in July 2017. It can be submitted through our esMD, the Electronic Submission of Medical Documentation System, and we have a link if you want to know more about that. And then although it's not available now at some point in the future, it's possible that the DME MACs could accept these requests through their provider portal. So, that would be an individual DME MAC's contractor determination.

And so now, I'm going to turn the presentation over to Dr. (Scott Lawrence) to pick it up on slide 16.

(Scott Lawrence): Thank you, Amy. So, again, this is Dr. (Scott Lawrence). I am with the Provider Compliance Group out of the Center for Program Integrity as well. We're going to start with slide 16 where we talk about the review time frames. So, initial requests should have a postmark for a decision within 10 business days, whereas the resubmitted request, these are those that have had been requested, a non-affirmed decision was sent, and then they are being resubmitted. These should have a new decision within 20 days. Expedited requests are also available for situations that could jeopardize the life or health of the Medicare patient, and these decisions will be communicated within two days.

Moving on to slide 17. The detailed decision letter, the MACs will send the requester of the prior authorization a letter providing their decision either

affirmative or non-affirmative. Medicare patients can receive a copy upon request, but the MACs may also send these letters voluntarily. If the request is non-affirmed, the letter will provide a detailed explanation for the decision. The decisions on individual accessories are not going to be included in the decision letter.

Moving on to slide 18. This discusses the Unique Tracking Number. When decision letters, either affirmed or non-affirmed, are sent back, they will contain a Unique Tracking Number (or UTN). Claims submitted must include the UTN in order for payment to be received.

Moving on to slide 19. Claims for which there is an associated provisional affirmation prior authorization decision will be paid in full so long as all the appropriate documentation and all the relevant Medicare coverage and clinical documentation requirements are met, and the claim was billed and submitted correctly. Generally, claims that have an affirmative prior authorization decision will not be subject to additional review; however, CMS contractors, including the Zone Program Integrity Contractors and Unified Program Integrity Contractors, may conduct targeted pre- and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process. In addition, the Comprehensive Error Rate Testing contractor may also select claims for review as part of a random sample.

Moving to slide 20. A requester can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request. There is an unlimited number of resubmissions that are allowed; however, a non-affirmative prior authorization request decision is not appealable. So, again, I will say you can resubmit an unlimited number of times until the problems are cured. Detailed decisions for the non-affirmation will be provided in the letter so that it should help you have as few resubmissions as possible. A requester can, however, forego the resubmission process, provide the DMEPOS item and submit the claim for payment, but that claim will be denied, although appeal rights are available in that situation.

Moving to slide 21. As described in codes within the Federal Register, 405 and 414, if an item is selected for required prior authorization under the program, then submitting a prior authorization request is a condition of payment. With the codes at issue, K0856 and K0861, these are the first two codes to have been selected for the prior authorization program out of the Master List. Therefore, claims for items subject to the required prior authorization submitted without a prior authorization determination and their corresponding UTN will be automatically denied.

Slide 22 contains a chart that gives a process that we like to call a "swim lane" chart for what the beneficiaries' responsibilities are, what the provider or practitioners' responsibilities are, and the suppliers' responsibilities are, as well as the DME MAC or the contractor that handles the claims. It gives all the documentation that are needed to be prepared and sent, which will mostly be handled by the supplier. As we've said before, beneficiaries or the patients, Medicare patients, may submit their prior authorization package, but they still will need to have all the critical elements in their submission in order for it to be considered. So, it would be take a bit of sophistication on their part, but that is available as an option; mostly it would be suppliers.

Moving on to slide 23. DME MACs have special tracking for requests that are not approved due to documentation errors, where the patient may otherwise meet Medicare's coverage (for these curable errors). Suppliers with these documentation errors receive individualized education and are encouraged to resubmit their request to ensure that their patients receive the necessary item for which they are covered.

On slide 24, we have a chart explaining how the outreach for the non-affirmed request can work in the special tracking decision tool. Again, there are a few steps here, and what we're really trying to determine is, was the request non-affirmed on the prior auth. If it was non-affirmed, was there enough documentation submitted to fully evaluate the request both from the physician provider and from the supplier. If there was not enough information, then does any of the medical record indicate the patient might meet coverage criteria for the item. They go through this process to see. So, obviously, if

there is a small error that's more curable than large errors, the system is mapped out and you could see that on slide 24.

So, moving to slide 25, we have a couple of possible scenarios. If the prior authorization is submitted and the DME MAC or the contractor gives an affirmative decision, then they can submit the claim with their UTN and the claim will be paid as long as all the other requirements are met. If the prior authorization request is submitted and the decision was non-affirmative, there are two possible actions. You can still submit the claim with the non-affirmative decision, but that claim will be denied. They can, however, fix the problem that was detailed in the non-affirmative decision letter and then resubmit the request. Then the review for the resubmission will render a new decision, and the process will go on until all the requirements are met, they get an affirmative decision, and the claim is paid. If however, they do not get a prior authorization request or they do not submit one and they submit a claim, the claim will automatically be denied.

Moving on to slide 26. It's important to know that for the patient, the Medicare patient that the impact is not going to change. The benefit is not changing. The patient will know, however, earlier in the process if a payment will likely meet the coverage requirements, which is a comfort to them. The Medicare patients may receive their prior authorization upon request. But, again, the contractors may elect to voluntarily send that decision to them anyway. Dual eligible coverage is not going to change, and private insurance coverage is not going to change.

Moving to slide 26 (sic slide 27). The oversight that CMS will have with an independent evaluator to analyze the impacts of prior authorization will be included. The (eligibility will get impacts) on the patient care, access to service, and overall expenditures and savings. CMS will also conduct regular reviews of the contract of the DME MAC prior authorization decisions. And CMS will discuss its findings with and seek feedback from the MACs during regularly scheduled meetings throughout the process.

Moving to slide 28. We have the information on how to contact your different jurisdiction contractors. So, we have New York and Missouri, which are

handled by Jurisdictions A and D; Noridian has those contracts, and then Illinois and West Virginia are handled by Jurisdictions B and C; CGS has those contracts. Web links are there are on the slide.

On slide 29. You have the CMS resources. We have a link to the Local Coverage Decision. This is the Policy and Policy Article for the Power Mobility Devices as well as the link to our Web site -- hopefully, everyone was on and has the slides with the Prior Authorization System -- and then the mailbox for feedback.

Slide 30. To summarize, we're dealing with two codes that we have chosen out of the Master List for group 3 power wheelchairs, the K0856 and the K0861. This will happen in Illinois, Missouri, New York, and West Virginia to start. The submissions begin as of yesterday, March 20. So, their system is now in place and submissions can be made by either the supplier or the Medicare patient, though we presumed it will be supplier for the most part. There will be no extra consideration for the patient submission. All the required documentation must be submitted in either case.

And that concludes the presentation portion of our meeting and we are ready to open for question.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for question. If you require any further follow-up, you may press star one again to rejoin the queue.

And your first question comes from the line of Diana Escalera with Academy Medical Equipment. Your line is open.

Diana Escalera: Hi, good morning or good afternoon. We appreciate the detailing of all of the accessories that will be included in the PAR review. If it's not going to be included on the letter, however, how is that communication going to come back to the provider so they know if those accessories are shown approved?

Amy Cinquegrani: Hi, this is Amy. So, because the accessories will be part of the overall coverage decision, it will – you'll either get an affirmed decision or the non-affirmed decision. And although the letter will list reasons, the letter won't say that, you know, you're approved for this particular code versus the other code, but it will give an indication of the reason why. And so I'm going to ask, I believe, Dr. Hoover who is one of the medical directors from one of our DME MACs. He should be on the line if he has anything to add to that response.

(Dr. Hoover): No, I think you explained it nicely.

Diana Escalera: Just to clarify, it's an all or none. So, like the K0856, by itself, could in theory have been approved. But if the cushion was not, you would get a non-affirmed across the board and an explanation of why. Is that correct?

Amy Cinquegrani: Hi, this is Amy. Yes, that's correct. The letter will still detail the reason. It just won't provide a separate, you know, decision on one accessory versus, you know, a different accessory.

Diana Escalera: OK, so it's all or none?

(Off-Mic)

Diana Escalera: OK.

(Off-Mic)

Amy Cinquegrani: Correct.

Diana Escalera: All right. Thank you.

Operator: And your next question comes from the line of (Lorraine Anelos) with (SGS). Your line is open.

(Lorraine Anelos): Hi. I was just wondering if during the (post-pay) review is there are way to access what was submitted for prior auth. I'm calling from a UPIC, so for us to compare prior auth information versus post-pay information.

Melanie Combs-Dyer: This is Melanie Combs-Dyer, and we need to take questions from UPICs offline. If you would please shoot us an email or work through your COR to reach us, we'd be happy to answer your question offline.

(Lorraine Anelos): All right, thank you.

Operator: And your next question comes from the line of (Dorothy Debiel) with Rehabilitation Equipment. Your line is open.

(Dorothy Debiel): Hi, good afternoon. I submitted two requests already, both for K0861 and both of them came back. Your request is ineligible for the PAR demonstration for the following reasons. The beneficiary is not subject to prior authorization due to having a representative payee on file. However, the HCPCS code is eligible for ADMC. Now, according to what you guys are saying, without a UTN, a vendor can never get paid. So, what do I do in a case like this?

Amy Cinquegrani: Hi, this is Amy.

(Dorothy Debiel): Hi, Amy.

Amy Cinquegrani: So, for claims that don't require prior authorization, which would include the claims for rep payees, those can continue to go through ADMC. That's a great question and we should definitely add that to our FAQs that are on the website. So, the – sorry, just to add on to that, the DME MACs do have processes in place if you identify that your claim is – went through the ADMC process that they can work through that without the UTN.

(Dorothy Debiel): Hang up. No, I got to back in.

Female: Why?

Operator: And your next question comes from the line of (Sharon Brickman) with (Promises Group). Your line is open.

(Sharon Brickman): Good afternoon. Thank you for taking my question. I apologize, I'm totally confused regarding the accessories. I do understand that they are not a part of the current required (PA) list. I understand all of that, however, I'm

not very clear on if it is the base – one of the two codes said it is eligible. If the accessories are sent in with the (PA) request, they will be considered and or they will not be considered? From what I understand, they will be considered, it's just that in considering them, you'll spend a – so is it possible for the base to actually be approved and the accessories not to be? If that is the case, then the entire (PA) request will be denied, correct?

Melanie Combs-Dyer: This is Melanie. And I'll start the answer on that one and then I'll turn it over to Amy, and she can add a little bit and she may end up turning it over to Dr. Hoover to add a little bit more. There are two categories of accessories and you can see them listed in the slide and you can also see them listed in the Local Coverage Determination, the LCD.

(Sharon Brickman): Yes.

Melanie Combs-Dyer: And so, in the first set of accessories, those are ones that will be considered if they come in on a prior authorization request for a base.

(Sharon Brickman): Got it.

Melanie Combs-Dyer: And then the second set are ones that will not be considered for prior authorization. They'll just be ignored and no prior authorization decision will be rendered on those. Did I say that right, Amy?

Amy Cinquegrani: Yes, that sounds good to me. Dr. Hoover can feel free to jump in but the decision will be made on what comes in on the request so as a whole. So you won't get a decision that says, you know, the base is included, the joystick is approved but the sip-n-puff is not approved. Your letters will not look like that.

(Sharon Brickman): OK.

Amy Cinquegrani: The reasons will be outlined but you will not receive a code-by-code decision for each specific accessory. So, Dr. Hoover if there's anything else you want to add, go ahead.

(Dr. Hoover): Yes, this is (Dr. Hoover). I think it would be useful for these questions in particular if folks after the call would go out and look at the power mobility device local coverage determination because I think you will see – it will make a lot more sense about the accessories and how they are viewed in relation to the base wheelchair. For the codes that we're talking about, the coverage criteria are very intimately tied to the need for certain accessories.

Again, these are single power option, multi-power option, fairly complex wheelchairs that for the most part patients that need a tilt-in-space, that need a ventilator and some of the other coverage requirements that are there. So when you look at that PMD policy, you will see that the coverage criteria are tied to these accessories in the same way that these are solid seat pan, wheelchairs. There's – you know, in that type of chair, there is presumed to be a need for a specialty cushion, and that's why we'll be looking at the cushions as well. So, for example, if there's not a need for a tilt-in-space or a ventilator or specialty seating system, then it's not likely that it's going to be a base that's medically necessary either.

(Sharon Brickman): Make perfectly good sense now. I completely understand. I think I just kind of misunderstood it. So thank you so very much.

Operator: And your next question comes from the line of David Emery with Partners in Home Care. Your line is open.

David Emery: So, if we wanted to get a denial for an item that's covered such as a seat elevator so that we could give that written denial to an alternate paying source, would that cost a denial for the entire chair?

(Scott Lawrence): This is Dr. (Lawrence). Any submission that doesn't match the requirement in its entirety will get a non-affirm. If you submit without a prior authorization at all, you will get an automatic denial.

David Emery: OK. So, it's not possible to get a written denial for an alternate paying source then?

Melanie Combs-Dyer: This is Melanie. Do you mean a claim denial or do you mean a prior authorization non-affirm decision?

David Emery: It could be either, I guess. You know, a lot of alternate paying sources just require a written decision stating why a non-covered item was not be paid, but the way you're setting it up if we try to get a denial on a non-covered item if I understand correctly, it would deny the entire piece of equipment. So, how would we get a decision on a non-covered item?

Melanie Combs-Dyer: This is Melanie. Let me make sure I'm understanding. You want to submit a claim where part of it is paid by Medicare and part of it is denied by Medicare so that you can send the non-paid part to a secondary payer. Is that correct?

David Emery: Correct.

(Scott Lawrence): Most likely the way to make that happen will be to send separate claim. So, you'll have your claim for the portion of the wheelchair and any related necessary items in the prior auth. and then, if you know that items are not going to be covered, you could submit claims for them separately whenever you like and you'll get denials all day long. (This will be researched further)

David Emery: OK. All right, thank you.

Operator: And, again, to ask a question, please press star then the number one on your telephone keypad. Your next question …

(Crosstalk)

(Dr. Hoover): Melanie, this is Dr. Hoover. That last question maybe one that you want to address more completely in an FAQ after we have some internal discussion.

Operator: And the next question comes from Diana Escalera with Academy Medical Equipment. Your line is open.

Diana Escalera: Hi, again. I just wanted to follow-up on a question that we (hit off) last week. Is the PAR going to rule out same and similar equipment like the ADMC does?

Melanie Combs-Dyer: I don't think I can answer that one. Dr. Hoover, do you know the answer to that one?

(Dr. Hoover): Yes, I think when the claim is submitted there will be – you know, we have claim edit in our system looking at same or similar equipment.

Diana Escalera: Yes, but we're talking about PAR aways before you even order equipment. So at the PAR level, it will not rule out same or similar equipment? Is that correct then?

(Dr. Hoover): That's not part of the PAR review. Again, as we've seen in a lot of the publications on prior authorization, we're only rendering certain decisions about certain pieces of equipment. And so it still has to (pass all) of the other routine claim editing parameters, and one of those would be same or similar equipment.

Diana Escalera: OK. Is it being considered to be included in the PAR review because it is included in the ADMC review?

Melanie Combs-Dyer: This is Melanie. We'll take that one offline and try to put out an FAQ. I believe that Dr. Hoover is suggesting that it is not part of the prior authorization decision but we'll clarify that and put out a frequently asked question on that.

Diana Escalera: OK. And quick follow-up as well, another ADMC versus PAR question that was brought up last week. You guys said that it was going to be considered that the six months time frame that applies to ADMC, maybe also apply it to PAR on these codes in lieu of the 120 days. Is that still being considered?

Amy Cinquegrani: Hi, this is …

(Dr. Hoover): This is Dr. Hoover. We will be making that change.

Diana Escalera: Oh, so for sure, it will be six months not 120 days?

(Dr. Hoover): Yes.

Diana Escalera: Excellent, good news. OK, thank you so much. We appreciate it.

Operator: And your next question comes from the line of (Dorothy Debiel) with Rehabilitation Equipment. Your line is open.

(Dorothy Debiel): Hi, thank you. Back again on that representative payee, you've kind of didn't really answer my question. I know I can go for ADMC, but without a UTN, I'm not going to be able to get paid. There's no special modifier for this, so what does the vendor do to get paid because here I got two that basically I know I'm not going to get paid on even with the good ADMC when I get it because that's not my fear.

(Scott Lawrence): The MACs had provisions for the ADMC during this process, which will eventually won't be an issue so it should – it would have to be a manual process for them, but they should be able to accommodate your ADMC request.

Amy Cinquegrani: And this is Amy. Just a follow-up again, the claims in these four states with rep payees are not required for prior authorization, so there's not required to be a UTN on those claims.

(Dorothy Debiel): But, Melanie, what's the best way to find that out instead of wasting my time submitting?

Amy Cinquegrani: I'm sorry, find out what?

(Dorothy Debiel): How – that they have a representative. I've been submitting for PAs for two years on the first round and, you know, I never had this problem come up. My first two happened to have it. How would I know if a client has this so I don't go for approval, I just go for ADMC?

Melanie Combs-Dyer: Are you suggesting that you don't know if the patient has a rep payee?

(Dorothy Debiel): Correct.

(Crosstalk)

(Dorothy Debiel): … I only find out upon submission. I found out from you guys.

Melanie Combs-Dyer: We'll take that one offline and see if we can put out an FAQ. I had always assumed that a supplier would know if the patient had a rep payee.

(Dorothy Debiel): Yes.

Melanie Combs-Dyer: But thank you, (Dorothy), for helping us understand.

(Dorothy Debiel): Yes, no, I've been doing this for awhile now and I never got this before. And coincidentally, like I said, submitted two and the first two came back in the same envelope saying the same thing.

Operator: And there are no further questions at this time.

(Dr. Hoover): Melanie, this is Dr. Hoover. I was just told that we do check for same or similar equipment upfront with the par.

Melanie Combs-Dyer: Thank you very much Dr. Hoover. Again, we'll make sure that we put out FAQ that says that so that everybody on the line will know that, that is part of the prior authorization review process. Thank you, Dr. Hoover.

Last call for questions.

Operator: And there are no further questions at this time.

Melanie Combs-Dyer: OK. Well, thanks, everybody, for participating today. Again, we value your input. You're helping to improve the prior authorization process as we go. We really appreciate everybody joining in today, and we encourage you to check our FAQ list on the website. We also encourage you, if you have additional questions to submit them to our mailbox, and again we just want you guys to know that we're listening and we're doing everything we can to make this a smooth process for everybody. Thank you.

Operator: Thank you for participating in today's Prior Authorization Process for Certain DMEPOS: Information for the First Two Items for Prior Authorization Open Door Forum Conference Call. This call will be available for replay beginning at 5 p.m. Eastern Time today, March 21, 2017 through midnight on March 26. The Conference ID number for the replay is 85988828. The number to dial

for the replay is 855-859-2056. This concludes today's conference call and you may now disconnect.

END