

Centers for Medicare & Medicaid Services  
Special Open Door Forum:

Medicare's Prior Authorization for Power Mobility Devices Demonstration

Thursday, May 3, 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](http://go.cms.gov/PAdemo)

Participants may submit questions prior to the Special ODF to [pademo@cms.hhs.gov](mailto:pademo@cms.hhs.gov).

We look forward to your participation.

Special Open Door Participation Instructions:  
Please dial in at least 15 minutes prior to call start time.

Dial: (866) 501-5502 & Conference ID: 61960443

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.

An audio recording and transcript of this Special Open Door Forum will be posted to the Special Open Door Forum website on or around May 31, 2012:  
[https://www.cms.gov/OpenDoorForums/05\\_ODF\\_SpecialODF.asp#TopOfPage](https://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp#TopOfPage).

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/>.

**Future Special Open Door Forums Scheduled for Medicare's Prior Authorization for Power Mobility Devices Demonstration: 5/31/12; 6/28/12; and 7/27/12 at 3PM ET. Call information TBD.**

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:

<http://downloads.cms.hhs.gov/media/audio/050312SODFPriorAuthofPowerMobilityDevicesDEMO61960443.mp3>

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Moderator: Barbara Cebuhar  
May 3, 2012  
3:00 p.m. ET**

Operator: Good afternoon. My name is (Adam) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services: Prior Authorization of Power Mobility Device Demonstration Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you

would like to ask a question during that time, simply press star and then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Barbara Cebuhar of CMS, you may begin your conference.

Barbara Cebuhar: Thank you very much, (Adam). I really appreciate everyone's interest today and we are glad that you joined the call.

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 it's an opportunity for you to ask more questions. There may be questions that occur to you after this open door forum and if so, you can – are welcome to send them to capital P, capital A, demo – that's spelled [D-E-M-O @cms.hhs.gov](mailto:DEM-O@cms.hhs.gov). [PAdemo@cms.hhs.gov](mailto:PAdemo@cms.hhs.gov). Just note that this e-mail address is not monitored 24/7 and so, the best way to get information is to go the Web site, which is [go.cms.gov/PAdemo](http://go.cms.gov/PAdemo) to see if they have been addressed.

I just want to make sure that folks know that you can go to that same Website, which is once again is [go.cms.gov/PAdemo](http://go.cms.gov/PAdemo) and you can find the draft PMD demonstration operational guide, which can be found if you go to the left on that site and click on the Prior Authorization of Power Mobility Devices (PMD) demonstration tab. We will be referring to it often during this call.

There are some responses to the questions that will be posted to also [go.cms.gov/PAFAQ2012](http://go.cms.gov/PAFAQ2012) and then you can search on the keyword PMD and there will questions addressed through our future open door forum calls.

On this call, we will be going through the demonstration operations guide, then we will open the call to questions. The operator will then instruct you how to get in line to ask your question. I'd also like to remind you that there

will be transcript of this special open door on the special open door forum Web site in about two weeks.

I'd like to take the opportunity to introduce our speakers today. Melanie Combs-Dyer is the Deputy Director of the Provide Compliance Group here at CMS. Amanda Burd is a health insurance specialist and Doris Jackson is a health insurance specialist. They will provide an overview about the demonstration along with Dan Schwartz who is the Deputy Director of the Division of Medical Review and Education.

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

Melanie, the floor is yours.

Melanie Comb-Dyer: Thank you so much, Barb. Again, this is Melanie Combs-Dyer. I'm the Deputy Director of the Provider Compliance Group at CMS. We're the group that's running this demonstration. And I would like to say thank you to all of the attendees for today's call, but especially those suppliers and physicians that I have met on my recent travels to Chicago, to North Carolina and to New York. I really appreciate all the suppliers and physicians who have attended the sessions and met me face to face. Giving me lots of ideas and suggestions for how we can run this demonstration and get the word out to folks about how to make it a success.

The primary feature for today's call is going to be a discussion of our draft demonstrations operations guide. And once again, I'll give you that web address. It's [go.cms.gov/PAdemo](http://go.cms.gov/PAdemo). When you get to that page, go to the left and look for the link that says Prior Authorization of Power Mobility Devices PMD Demonstration.

When you click on that link, look to the bottom and you'll see a download section. And third from the bottom is a PDF file called PMD demonstration operation guide. This is what we're going to be talking about today.

The purpose of this operational guide is to document the details of our demonstration. You hear us answer lots of your questions on this phone calls and on the Web site in the FAQs but we really wanted to have sort of a one – a one-stop shop to lay out all of the details about the fax numbers that you should use and the links to the resources that you need to have.

The operational guide right now is a bit of a skeleton but nonetheless, we wanted to put it out early and get your input. We welcome your comments and suggestions especially if you can find areas where we are unclear in the language that's in the guide now. And we also welcome your suggestions about things that may be missing. We recognize that there's a lot that's still missing but you can still give us your suggestions.

And you can tell us those things, particularly those that are unclear – the ones that are missing, you can briefly mention to us and we'll try to add those sections and talk about them on future calls. Again, at the end of today's call, you can give us your comment or you can e-mail them to us.

To discuss the overview of the operational today, Doris will be discussing the first six chapters and Dan will be discussing chapter seven through the end. So let me turn it over, at this time, to Doris Jackson. Doris, the floor is yours.

Doris Jackson: Thank you. Good afternoon. This is Doris speaking now, reviewing the first six chapters. Chapter one is the power mobility device benefit. Basically, this chapter talks about what requirements are necessary for a Medicare beneficiary to receive the PMD. The beneficiary must be eligible for a defined Medicare benefit category. The item must be reasonable and necessary, match the diagnosis or treatment the patient is experiencing based on the malfunctioning of their body. All other applicable Medicare statutory and regulatory requirement.

The local coverage determine for each jurisdiction describes in detail the circumstances under which a PMD will be covered by Medicare. Medicare covers scooters and power wheelchairs jointly known as PMDs if it is needed

by a beneficiary to perform activities of daily living in the home if other devices such as a cane, walker, a manual wheelchair have not been sufficient.

Complete coverage and the documentation requirements outlined in the following policies; the National Coverage Determination for PMD. This item can be found on CMS' Web site and we do have a link in the manual if you're looking at it on your e-mail on the internet. Click on it and it will take you directly to that policy. And the same also for the local coverage determine policies for PMD. Each DME jurisdiction has the same LCD. So it's not different but if you go to any of the contractors' website, you will be able to find the policy.

Chapter two, basically just indentifies which codes are subject to the demonstration. The HCPCS code subject to the prior authorization demonstration are as follows; all power operated vehicles, all standard power wheelchairs, all group two complex rehabilitative power wheelchairs. There are particular K codes, I'm not just going to list them all right here because it is in writing if you have access to the document. – Then, all group 3 complex rehabilitative power wheelchairs without power options, all pediatric power wheelchairs and miscellaneous power wheelchairs.

Chapter three talks about the demographics of this study. Chapter three identifies the who, where and when about the demonstration. Who – who is subject to the PA request demonstration. I'm sorry – who may submit the prior authorization request? The physician, treating practitioner should submit the Prior Authorization request. The supplier may submit the request on behalf of the physician or treating practitioner and in this role they are performing administrative function of submitting the request.

The physician or treating practitioner must still complete the documentation of the face-to-face examination and the seven element order. Once again, the supplier is only performing the administrative function of submitting the request itself.

Where – what states are participating in the Prior Authorization demonstration. The seven states is based on the beneficiary's state of residence as reported to the Social Security Administration. The states are; California, Florida, Illinois, Michigan, New York, North Carolina and Texas.

If a beneficiary needs to update the address on file at Social Security Administration, they contact their local Social Security office or call at 1-800-772-1213. Also in the manual, we actually have the web addresses down for participants to click the link and it will take them directly to update that information also.

The when of this demonstration is, when will the demonstration start? This demonstration will start for PMDs when the seven element order is signed on or after the demonstration start date in 2012. The exact date will be published in the Federal Register. The demonstration will end for PMDs when the seven element order is signed on or before the date that we have determined starting the demonstration at 2015.

Chapter four; documentation requirement. The face-to-face examination must be completed by the physician or treating practitioner. That is the detailed process that physicians will have to do a thorough assessment of the patient, including in the physical examination and document the patient's limitations and ambulation – in ambulating and whatever other malfunctions that they may have that relates to their ability to ambulate independently.

We also have identified an MLN checklist that provides all the detail to assist the physician or treating practitioner as how to document the required items to help support the medical necessity for that equipment.

In addition, the physician or treating practitioner must complete the seven element order. In that order, there must be patient's name, a description of the item ordered – for example; power operated vehicle, power wheelchair, power mobility device or something more specific. The order must also include the date of face-to-face examination, the diagnoses, conditions related to need for

PMD, length of need for the equipment, the physician or treating practitioner's signature and the date of physician or treating practitioner signature.

In addition, there should be also – there must be a detailed product description. This must be completed by the supplier, and reviewed and signed by the treating physician. On this document there should be the specific Healthcare Common Procedure Coding System code for base and all options and accessories that will be separately billed; a narrative description of the item or manufacturer name and model name and number; the physician signature and date signed; and date stamp to document receipt date. In addition, additional documentation that is relevant to help secure and identify that the equipment is medically necessary should also be submitted with the packet.

Chapter five is submitting a request. The following data are to be included when the – when submitting the prior authorization request package; the beneficiary's name, the beneficiary's Health Insurance Claim Number, and date of birth; the physician's name, National Provider's Identifier number and address; the name of the supplier, the supplier National Provider's Identifier number and address, HCPCS Code and submission date.

The PA request package must include the following documentation; the face-to-face documentation, the seven element order, detailed product description, and other necessary clinical information to support medical necessity for the item.

When submitting the request for each state, there will be separate fax number and we will also provide the address of the contract of which the item should be mailed to. In addition, for esMD, the information can also be forwarded electronically to the contractor. That's the overall general procedure for submitting the request.

The DME MAC, once upon – once receiving the package, will make a determination as to being affirmed, not affirm or deem the package

incomplete. Chapter 5, 7 and 6 will go more into detail as to what the determination is and what action should be taken.

There may be a situation where a claim is denied – where claim needs to be denied for secondary insurance payment for the PMD, at that time the following process is to be followed; the submitter is to submit the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements are not met for the PMD, then a non-affirmative prior authorization decision will be sent to the physician and treating practitioner, supplier and Medicare beneficiary advising them that Medicare will not pay for the item.

After receiving a non-affirmative decision of the prior authorization request, a claim is submitted by the supplier to the DME MAC, it will be denied. The submitter or Medicare beneficiary may forward the denied claim to his or her secondary insurance payee as appropriate to determine payment for the PMD.

Chapter six; an affirmative request. The supplier should ensure that home assessment is complete. Deliver the item to beneficiary, document proof of delivery, get the patient's authorization, have all documentation available on request and submit the claim with the tracking number on the claim. If all requirements are met the claim will be paid.

The prior authorization demonstration has specific parameters for prepayment review. However other contractors, the CERT, ZPICs, RACs, et cetera may have parameters outside of the PA demonstration that will suspend the same claim for another type of review. If your claim is selected for review, guidance and directions will be provided on the additional documentation request letter from the requesting contractor.

I will turn the microphone over to Dan now.

Dan Schwartz: Thank you very much, Doris. I am Dan Schwartz, and I'll start with chapter 7 and I'll turn it over to Amanda once we get to chapter 12.

Chapter seven is discussing an incomplete request. And when an incomplete request is submitted, the DME MAC will provide notification of what is missing and the way they'll do that is through a detailed decision letter that is sent to all parties that are affected. The physician or treating practitioner may resubmit another complete package with all documentation required as noted in the detailed decision letter. If the claim is submitted by the supplier to the DME MAC for payment without having a prior – an affirmative prior authorization decision, then the result would be it will be denied.

Chapter eight – a non-affirmative request. We'll start with physician and treating practitioners actions and then we'll move on to supplier's actions. As far as physicians and treating practitioners go, they would monitor the beneficiary for a future submission and where the clinical condition of the beneficiary changes, they would complete and submit a new prior authorization request. They would use the detailed decision letter to ensure that the request package complies with all requirements and resubmit a prior authorization request, if it's appropriate.

As far as suppliers go, they would submit the claim with the tracking number for a denial and then all appeals rights would then engaged. This claim could then be submitted to secondary insurance.

Chapter nine – resubmitting a prior authorization request. The submitter should review the detailed decision letter that was provided to them. And the submitter should make whatever modifications are needed to the prior authorization package and follow the submission procedures.

Chapter 10 – claim submission. Claims in the series should be submitted with the prior authorization tracking number on the claim and they should be sent to the applicable DME MAC for adjudication. You should follow – excuse me. They follow the claim submission process based on the prior authorization decision determination.

Chapter 11 – the payment reduction. So if the claim is submitted without that prior authorization decision that we just mentioned, it will be stopped for

review. An additional documentation request – what we call an ADR will be sent. The supplier will have 45 days to respond to that ADR with all the requested documentation which the supplier can send then send via a fax, mail, or esMD and the details are provided at [www.cms.gov/esmd](http://www.cms.gov/esmd).

The DME MAC will review the claim and if the claim is payable the DME MAC will decide or determine if the supplier is a competitive bid supplier. Where they are a competitive bid supplier, the claim and the remainder of the series will be paid at the single payment amount.

If not, they're not a competitive bid supplier, the claim and the rest of the series will automatically be assessed a 25 percent reduction of the Medicare payment after coinsurance and deductible. This payment reduction is not transferable to the beneficiary or is it appealable. Beginning three months after the demonstration CMS will assess a payment reduction for noncompliance with the prior authorization package – process.

Now, I'll turn it over to Amanda to complete package.

Amanda Burd: Thank you. On chapter 12, the G-code. The G-code is intended to partially compensate the physician or treating practitioner where they are the entity functioning as the submitter. The physician or treating practitioner can bill G9156 after he or she submits an initial prior authorization request. The G-code is billed to the A/B MAC with the prior authorization tracking number on it.

Only one G-code may be billed per beneficiary per PMD even if the physician or treating practitioners must resubmit the request. This G-code is not subject to co-insurance and deductible. Further, the physicians may not bill the G-code in instances where the supplier is functioning as the submitter of the prior authorization request.

Chapter 13 – claim appeals. For those claims that are denied, appeals follow all normal procedure. For information consult the Medicare Claims Processing Manual 100-04, chapter 29 Appeals of Claims Decision.

This demonstration does not include a separate appeal process for a non-affirmative prior authorization request decision. However, resubmissions are allowed.

A non-affirmative prior authorization request decision does not prevent the supplier from submitting a claim. Such a submission of a claim and resulting denial by the DME MAC would constitute an initial determination what would make the appeals process available for the Medicare beneficiaries and suppliers to dispute the outcome of the claim.

And that brings us to the current draft operational guide for the power mobility device demonstration. Thank you.

Melanie Combs-Dyer: This is Melanie. And operator, could you please open the lines and give the instructions about how people can ask questions.

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

And your first question comes from the line of (Richard Bennett) from (Hedgemarks) Pharmacy. Your line is open.

Melanie Combs-Dyer: Hi, (Richard). Go ahead with your question.

Operator: And (Richard) your line would be on mute.

Melanie Combs-Dyer: (Richard), are you still with us? OK. Operator, why don't you go ahead and take the second call and perhaps (Richard) can get back in the queue.

Operator: And your second question comes from the line of (Judd DeMott) from Access 2 Mobility. Your line is open.

(Judd DeMott): Hello. We have been sending every single claim for two years and – for prior authorization and we don't do any ordering or delivering until we have our prior authorization and then a third of those [claims] have been pulled for a prepayment audit and all of those, we have successfully appealed and won and finally got payment. My question is this; what's the point of all these if it's still going to go into a prepayment audit?

Melanie Combs-Dyer: I don't think that you've submitting for prior authorizations with the Medicare Fee for Service Program because we haven't yet started our prior authorization program. It will start sometime in June. You're either referring to the Medicare Advance Determination for Medicare Coverage, the ADMC process or you're talking about a different health insurance company, maybe Medicare Advantage or Medicaid.

(Judd DeMott): No. You are correct, it's ADMC that I'm talking about. But we go through all the trouble of doing that just so that we can save everyone time and effort and yet, you know, they must be doing a flippant, cursory review of the original documentation because then ultimately, it's getting pulled for a prepayment audit. That should eliminate that need.

Melanie Combs-Dyer: In the prior authorization demonstration, your claims will be very unlikely to be pulled for a prepayment review by the DME MAC. The DME MAC would not be selecting the claim for prepayment review if you then do the prior authorization process, unless they're looking at something other than coverage or medical necessity.

For example, the home assessment is not part of the prior authorization request. That will not be reviewed up front and if there was a provider/supplier who had a pattern of submitting claims where there was no documentation of home assessment, they might be put on targeted prepayment review for production of the evidence that they actually conducted that home assessment.

Setting those cases aside, it's very unlikely that your claim would be chosen for a prepayment review by the DME MAC once the prior authorization program begins. So you should be very happy with the program.

(Judd DeMott): Well then, for the record, we are wholeheartedly in favor of this program and we'll welcome it and want it to happen, And the ADMC program ought to follow suit. And is this for complex rehab as well, is that correct?

Melanie Combs-Dyer: We will make a note of your request that we make the same change in the ADMC process. And then your second question had to do with whether or not this prior authorization process applied to certain codes. Can you say the names of the codes and we'll have someone look it up?

(Judd DeMott): Well, we can – we don't need to take that time here, we can sort that out later.

Melanie Combs-Dyer: OK. Great. Thank you very much.

(Judd DeMott): Thank you. Bye.

Operator: Your next question comes from the line of (Judy Fund) from Medical Service Co. Your line is open.

(Judy Fund): Yes. A few clarifications in chapter 11. That 25 percent reduction that have to do with the fact that the purchase price is paid because the patient is in the CBA and then the 25 percent reduction would be in the remaining – the first three months would still be paid at the full 100 percent and then the remaining months would be paid at the 25 percent reduction as that currently is or will all of the months of rental in the non-CBA areas be paid at the 25 percent reduction?

Melanie Combs-Dyer: OK. So, let me repeat your question and make sure that I'm understanding. You're talking about a non-competitive bid supplier and so they are not being paid the full amount in those situations where they choose not to go through the prior authorization process. And your question is, once

that non-competitive bid supplier is chosen for a review and all their claims will be chosen for a review if they don't go through prior authorization.

An additional documentation request letter will be sent, the supplier will send in the documentation, the DME MAC will review that documentation and if it is determined that the – that the patient qualifies for coverage of the PMD, your question is, is it a 25 percent payment reduction on the first – not on the first three months but on the subsequent months' rentals that come after that? Or is it that Medicare is not going to apply any kind of payment reduction for people who are coming through the prior authorization program for the three months. That when we introduced the payment reduction starting three months after the demo begins.

I don't know the answer to that but I'm going to see if perhaps Doris or Amanda or Dan do. Doris, Amanda, Dan – do you have any idea?

Amanda Burd: This is Amanda. The three months that was discussed is that there is a three-month grace period from the start of the demonstration until the payment reduction is a possibility. Meaning, if the demonstration started on June 1 for claims – excuse me, for seven element orders that were signed on June 1, then that's when the demonstration starts. The orders signed after September 1, assuming that June 1 is the start date, – if the order is signed after the three months grace period for PMDs, that do not through the prior authorization process, they will be subject to prepayment review and if it is outside of a competitive bid area, then it will be assessed for payment reduction.

(Judy Fund): OK. So the question then becomes, if it is in a competitive bid area, even if the supplier does not do the prior authorization process and they respond to the ADR and all of the documentation is there, they will not be assessed the 25 percent reduction just by virtue of the fact that they're in the CBA?

Melanie Combs-Dyer: Correct. Correct. The reason being because they are subject to a reduced pay for whatever is – has been determined to participate in the competitive bidding.

Judy Fund: OK. Then there was one other quick clarification. In the very first – in the very first chapter where the documentation was discussed, we talked about the date stamp action. It's chapter 4, the seven element order and the detailed product description. The detailed product description is that they stamp the document receipt, they – there's seven element order (inaudible) they have the date stamped the document receipt date?

Melanie Combs-Dyer: (Dan), do you know the answer to that one?

Dan Schwartz: No.

Melanie Combs-Dyer: No, you don't have the answer or no –

Doris Jackson: We'll double-check. We'll double check our policy and see because I'm not certain off the top of my head. So we'll just discuss that.

Melanie Combs-Dyer: (Judy), thank you for that suggestion. We will look into that and address that one way or the way in that version of the operational guide.

(Judy Fund): Thank you.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please press star and then the number one on your telephone keypads.

Your next question comes from the line of (PJ McKeeney) from Wheelchairs Plus. Your line is open.

(PJ McKeeney): All right. Thank you. I was questioning the 120 day dispensing requirement of power mobility devices once all the documentation has been received. So then we have 45 days to obtain the documentation from the physician-clinician and then once everything is set to go, we only have 120 days to have the item delivered and this authorization process is obviously cutting into that timeframe. Has there been a definitive clarification regarding the effects of that timeline specifically the 120 day limit relative to this prior authorization process.

Melanie Combs-Dyer: There is no change to the 120-day dispensing requirement or any of – any of the other timeframe requirements.

(PJ McKeeney): OK. So in the event that something is denied and the physician has to resubmit or do some documentation or whatever the case may be, we still only have 120 days from the original or from the date of authorization from the Medicare?

Melanie Combs-Dyer: Whatever the current rules are.

(PJ McKeeney): OK. Thank you.

Operator: Your next question comes from the line of (Gary Henderson) from DME Service in Texas. Your line is open.

(Gary Henderson): Yes. I had a question about the the base codes subject to the PA demo or – what about accessory codes?

Melanie Combs-Dyer: Amanda, correct me if I'm wrong or Doris, accessories are not part of the prior authorization program, only the base units are part of the prior authorization program, is that correct?

Doris Jackson: Correct.

(Gary Henderson): OK. So does that mean that DME MAC can hold up your claims, requesting documentation for an accessory if a base code had been approved through the PA?

Melanie Combs-Dyer: Accessories are subject to the normal prior – I'm sorry, the normal prepay and post-payment review process. We are looking at how the ADMC process might work in concert with the prior authorization process and we'll probably have some more details about that in the future.

So, for example, if you wanted to put your base through the prior authorization process and put your accessories through the ADMC process, how would that work? Two packages in one envelope, two packages in two separate envelopes – excuse me, we'll be getting details on that in the future.

(Gary Henderson): Why not just the prior authorization process to do all of it since you're building a single payer or item?

Melanie Combs-Dyer: Amanda or Doris, do you want to take that?

Doris Jackson: Can you repeat your question?

Melanie Combs-Dyer: Why did we not extend the prior authorization process to include accessories? What was our rationale?

Doris Jackson: It was not considered when we initially wrote about demonstrations.

(Gary Henderson): Do you see the potential issues that that could bring up with – if you're trying to build a chair for a, let's say, complex rehab chair for a specific patient?

Melanie Combs-Dyer: We will surely take your comment into consideration, take it back and reassess if necessary.

(Gary Henderson): OK. Thank you.

Operator: And there are no further questions at this time. I'll turn the call back to the presenters.

Melanie Combs-Dyer: Well, this is Melanie and I would like to thank everyone for their really good, detailed and insightful questions today. We encourage everyone to take a good closer look at the operational guide for the demonstration and we will be revising it probably before the next call. And so, if you find any other areas that are unclear or places where you feel like we need to add more details, please send us an e-mail. We really would like to hear from you and

we really do want to make this a very useful guide that really lays out all the details for this demonstration.

Thank you all for participating. And Barb, do you have any final thoughts before we close up?

Barbara Cebuhar: Thank you very much for joining today's call. I would like to make sure that folks know that a transcript and a recording with an mp3 will be available in approximately two weeks at the special open door forum Web site. You can get there by going to <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html> that's <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html?redirect=/OpenDoorForums/> and you can select the special open door forum for this date.

I'd like to remind you that we will have an opportunity to hear another presentation and ask questions about the power mobility device demonstration on Thursday, May 31st 2012. That call will be held from 3:00 to 4:30 pm Eastern Time. Please check [go.cms.gov/PAdemo](http://www.cms.gov/PAdemo) that's capital P, capital A, capital D-E-M-O for any updates.

There will also be other calls which are scheduled for the same time that 3:00 to 4:30 Eastern Time on July – I'm sorry, on June 28 2012, and July 27, 2012. Please let us know if you have any questions or ideas by going to capital P, capital A, DEMO at [cms.hhs.gov](http://cms.hhs.gov) [PAdemon@cms.hhs.gov](mailto:PAdemon@cms.hhs.gov).

Thank you again for joining us and sharing this information about the upcoming sessions with your colleagues. We appreciate your help. And (Adam), we are ready to close the call.

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

END