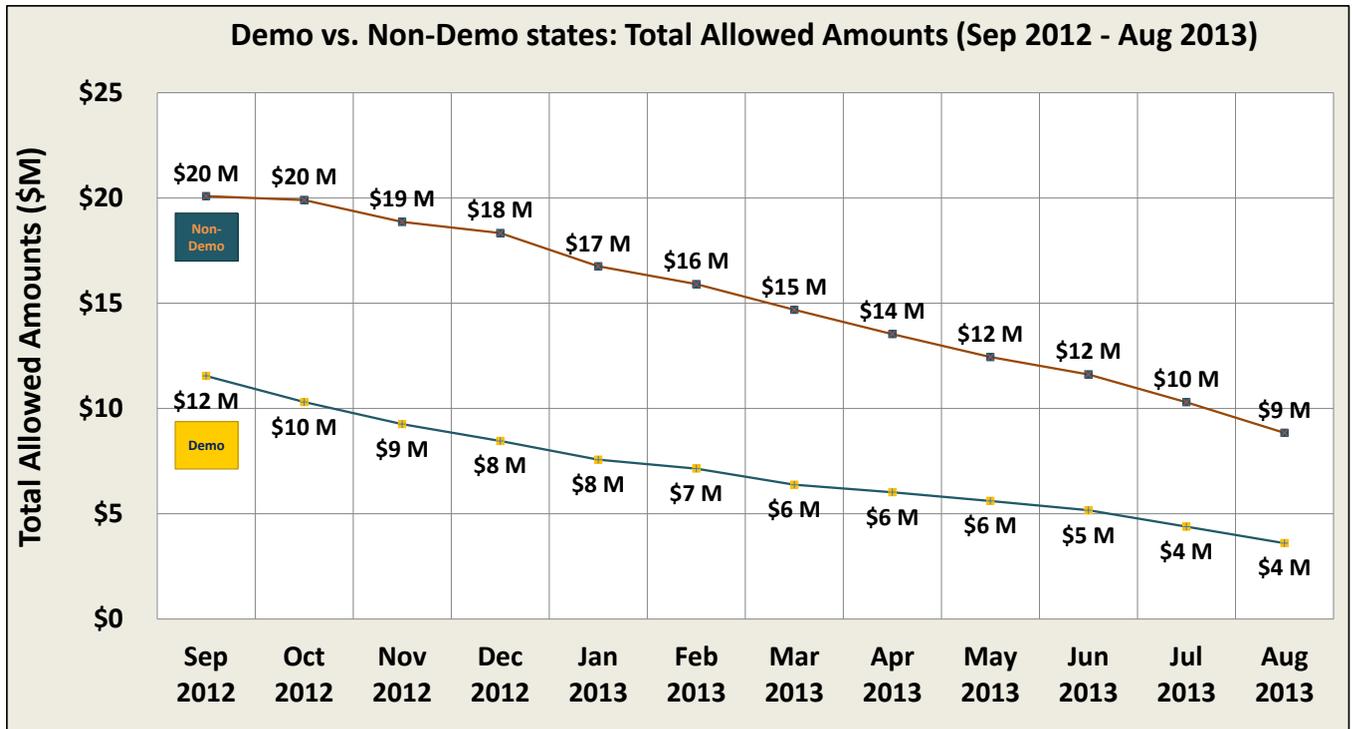


Medicare Prior Authorization of Power Mobility Devices Demonstration Status Update (posted 12/17/2013)

On August 31, 2013 the Medicare Prior Authorization of Power Mobility Devices (PMDs) Demonstration reached its one year anniversary. Since September 1, 2012 the demonstration has been in place in seven states: California, Illinois, Michigan, New York, North Carolina, Florida and Texas.

Preliminary Data

Since implementation, the Centers for Medicare & Medicaid Services (CMS) observed a decrease in expenditures for power mobility devices in the demonstration states and non-demonstration states. Based on claims submitted as of September 30, 2013, monthly expenditures for the power mobility devices included in the demonstration decreased from \$20 million in September 2012 to \$9 million in August 2013 in the non-demonstration states and from \$12 million to \$4 million in the demonstration states.



Data based on claims submitted from: 1/1/2011 - 9/30/2013

Monthly data refresh date: 9/30/2013 (STARS IDR)

We believe the decrease in overall spending is due in part to national Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers adjusting their billing practices nationwide (not just in the demonstration states) and reflects suppliers complying with CMS policies based on their experiences with prior authorization in the demonstration states. The decrease in spending can also be attributed to the continuous DMEPOS supplier education and outreach mechanisms implemented by the Durable Medical Equipment Medicare

Administrative Contractors (DME MACs) and CMS as well as other initiatives¹ to prevent fraud and reduce expenditures for medically unnecessary PMDs.

While we recognize that multiple factors contributed to the decrease in PMD expenditures, there was also a significant decrease in the number of beneficiaries receiving PMDs in the demonstration states after the start of the demonstration. We believe this decrease is because prior authorization is ensuring that only beneficiaries who meet Medicare requirements receive a PMD.

As of August 31, 2013, prior authorization requests were submitted for over 27,848 Medicare beneficiaries. The requests were affirmed for all beneficiaries who met all the requirements. Roughly 48 percent of requests were non-affirmed because the beneficiaries do not qualify for the benefit based on the documentation submitted, which illustrates the importance of this demonstration. The prior authorization provides more assurance to the beneficiary that the PMD is covered by Medicare and thus they may have minimal out of pocket costs, such as the usual copay.

Preliminary demonstration data on requests received, as of August 31, 2013, indicate:

- The DME MACs are conducting the prior authorization reviews timely (within 10 business days for initial submissions and 20 business days for resubmissions).
- 1,797 of the 27,848 prior authorization requests were submitted electronically through CMS' Electronic Submission of Medical Documentation program.

Preliminary demonstration data on claims submitted, as of August 31, 2013, also indicate:

- Suppliers submitted 16,005 claims without a completed prior authorization request. These claims were stopped and documentation request letters were sent to the provider. Upon review of the documentation, approximately 30 percent were denied, saving the Medicare Trust approximately \$10.3 million.
- Suppliers submitted 357 claims with non-affirmed request decisions. All claims were denied, saving the Medicare Trust Fund over \$350,000.
- Preliminary appeals data show 842 total second level appeals (known as reconsiderations) were received through September 25, 2013. Of those appeals 738 were decided: 719 fully reaffirmed the initial decision, 17 were overturned, one was partially affirmed, and one was dismissed. The adjudicated reversal rate on the number of appealed claims is low, approximately 2 percent. The total amount in controversy on decided appeals is \$911,978. Of this amount, the denial was upheld on appeal for \$876,909.

¹ Another factor contributing to the ongoing reduction in expenditures for PMDs would be the reduction in payment amounts, fraud and abuse associated with implementation of the DMEPOS competitive bidding program in 9 of the largest metropolitan areas in January 2011 and an additional 100 large metropolitan areas in July 2013. This program is reducing expenditures for approximately half of the beneficiaries receiving PMDs nationwide. Finally, the ongoing reduction in expenditures for PMDs can also be attributed to the elimination of the lump sum purchase option for standard power wheelchairs, which took effect on January 1, 2011. This change significantly reduces expenditures for power wheelchairs used on a short term basis.

- Overall, spending for PMDs has decreased by \$117 million (assuming that the monthly expenditures for PMDs would have remained constant at \$32 million per month) since the inception of the demonstration.

Feedback

Overall the industry's feedback has been positive. Several DMEPOS suppliers have suggested prior authorization helps their business by providing a more predictable cash flow and improved relationships with the ordering physician. These DMEPOS suppliers have expressed support for the demonstration and would like it to be expanded to other states and items.

Feedback from beneficiaries has been largely positive. Prior to implementation, CMS spoke to numerous Medicare beneficiary groups that expressed support for the demonstration. Also, the DME MAC customer service representatives were well informed and prepared to handle Medicare beneficiaries' questions prior to the implementation of the demonstration.

Further Efforts

The CMS will continue to monitor and evaluate the effectiveness of the demonstration and analyze demonstration data to assist in the investigation and prosecution of fraud and provide periodic updates. Based on the initial success of this initiative, CMS is exploring options for expanding the demonstration to additional states.