Power Mobility Device (PMD) Prior Authorization Demonstration: Q&A

1. General Information

Q1.1: When will more information be available? (Added 11/18/2011)

A1.1. By November 18, 2011, CMS will announce special Open Door Forums. During the Open Door Forums CMS will discuss the demonstration requirements.

Q1.2: When will the special Open Door Forum(s) be held? (Added 11/18/2011)

A1.2. There will be two Open Door Forums. One for suppliers will be held December 2, 2011. One for providers will be held December 5, 2011. Both will be conducted at 2pm EST.

Q1.3: What specific PMDs are subject to this demonstration? (Added 11/18/2011)

A1.3. Under this demonstration, for beneficiaries who reside in one of the demonstration states, CMS will require pre-payment review, and subsequently implement a prior authorization process, for the following items paid by Medicare:

- All Power Operated Vehicles (K0800-K0805 and K0809-K0812)
- All standard power wheelchairs (K0813 thru K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835 thru K0843)
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 thru K0855)
- All pediatric and Group 4 power wheelchairs (K0887 thru K0891)
- Miscellaneous power wheelchairs (K0898)

Group 3 complex rehabilitative power wheelchairs with power options (K0856 thru K0864) are excluded.

Q1.4: I have additional questions. Where can I send additional questions? (Added 11/18/2011)

A1.4. Additional questions on the PMD prior authorization demonstration can be sent to CMS at PAdemo@cms.hhs.gov.

2. Background

New Q2.1: Why will the prior authorization demo focus on PMDs? (Added 11/21/2011)

A2.1. PMDs are expensive items that are sometimes provided when not medically necessary. In addition this type of medical equipment has had a history of fraud and abuse. Consequently these instances contribute to Medicare's improper payments. Focusing on this item is a good opportunity to reduce waste and abuse.

New Q2.2: Is the fraud and abuse problem fairly well contained within the seven target states, or do you expect CMS to expand the program into other states? (Added 11/21/2011)

A2.2. The purpose of the demonstration is to determine whether prior authorization of PMDs is an effective tool. If it is effective, it may be expanded to other states.

New Q2.3: Is there a typical scenario for fraud and abuse around PMDs? (Added 11/21/2011)

A2.3 A typical scenario is Medicare paying for a PMD that is not medically necessary for a patient who was never examined by an ordering provider.

New Q2.4: Has CMS used prior authorization for any other categories of products or for medical or diagnostic procedures? (Added 11/21/2011)

A2.4. No, the Medicare Fee-for-Service (FFS) program has never used prior authorization. This is a common practice in other healthcare programs including private sector health plans and should provide valuable information about the design of a prior authorization model for the Medicare FFS program.

3. Operational Details of the Demonstration

New Q3.1: What criteria will CMS use to determine whether the PMD is reasonable and necessary? (Added 11/21/2011)

A3.1 Medicare's longstanding National Coverage Decision and Local Coverage Decisions describe the circumstances under which a PMD will be considered reasonable and necessary. The Medicare Learning Network (MLN) Fact Sheet linked below is posted to the CMS website and explains the detailed coverage criteria.
https://www.cms.gov/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf

New Q3.2: How will the prior authorization program be administered? Will you devote specialized staff to the program? (Added 11/21/2011)

A3.2. The prior authorization program will be administered by the same contractors that currently conduct medical review on PMDs (the Durable Medical Equipment Medicare Administrative Contractors). Clinical staff will be devoted to this program and trained to ensure consistency. In addition, we will employ private sector standards in our prior authorization program such as responding to providers within 10 days of receipt of a prior authorization package, providing responses that are specific about missing information and giving providers an opportunity to

resubmit the prior authorization package for re-review.

New Q3.3: In what cases could a physician or beneficiary request an expedited review? (Added 11/21/2011)

A3.3. Under our process, we expect requests for expedited reviews to be extremely rare. More information on this process will be provided in the future.

New Q3.4: Is there a specific list of medical conditions that would warrant the use of a PMD? (Added 11/21/2011)

A3.4. There is no specific list of medical conditions. Each case is reviewed based on the medical condition of the beneficiary at the time the PMD is ordered. However, Medicare does require that the ordering provider conduct a face-to-face evaluation of the patient before ordering the PMD.

New Q3.5: What percentage of requests do you expect will be denied? (Added 11/21/2011)

A3.5. CMS hopes prior authorization will eliminate the submission of requests for PMDs that are not medically necessary (and therefore not covered by Medicare). Postpayment reviews previously conducted by CMS and recently by the Office of the Inspector General (OIG) resulted in error rates around 80 percent. With this demonstration CMS anticipates that by involving the ordering provider in the prior authorization process these rates can be greatly reduced.

4. Outcomes

New Q4.1: What is CMS hoping to learn from the demonstration project on prior authorization for PMDs? (Added 11/21/2011)

A 4.1. This demonstration will test the use of prior authorization in the Medicare program. The purpose is to determine if it is a useful tool for preventing waste and abuse while ensuring appropriate beneficiary access to these products.