

Centers for Medicare and Medicaid Services
Special Open Door Forum
Prior Authorization Process for
Certain DMEPOS Implementation for the First 2 Items for Prior Authorization
Moderator: Jill Darling
March 16, 2017
2:00 p.m. ET

Operator: Good morning. My name is (Heidi) 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 Special Open Door Forum, Prior Authorization Process for Certain DMEPOS Implementation for the First 2 Items for Prior Authorization.

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 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Heidi). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. Welcome to today's Special Open Door Forum.

Before we get into today's presentation, one brief announcement from me, this Special Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are 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 is the director of the Provider Compliance Group.

Melanie Combs-Dyer: Greetings and thank you guys, for joining today. We really appreciate you taking the time to listen in. This is the first in a series of Open Door Forum calls on the Prior Authorization Process for Certain DMEPOS Items. Our next Open Door Forum call on this program is scheduled for next Tuesday.

We're also planning an additional Open Door Forum call 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 these power wheelchairs.

CMS is committed to launching this narrowly-tailored DMEPOS Prior Authorization Program in an open and transparent way. We really want to make sure that we're serving and protecting patients as well as healthcare providers that care for them.

We have the opportunity to learn from the patients, the providers and the supplier experiences, and we really do 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 program transparency, we're going to be working on improving our DMEPOS Prior Authorization website. We'll be posting useful tools and other information for patients, suppliers and physicians. These resources are aiming 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 the DMEPOS Prior Authorization Program and that mailbox is going to be listed at the end of the slide, and we really do look forward to hearing your feedback.

And now I'll turn it over to Amy Cinquegrani.

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

I'm hoping that everyone was able to find the slides for today's Open Door Forum. We did change our website in an effort to improve our communications and be able to post more information, and so there might have been a little mix up with what website would post on the announcement.

But if you were able to find our Medicare Fee-for-Service Compliance Program site, which is a few levels up from the old DMEPOS Prior Authorization website that was listed in the Open Door Forum announcement, if you were able to then find the Provider Compliance Program website, you'll see a new section on the menu on the left called Prior Authorization Process for Certain DMEPOS Items. And these slides should be the top document listed in the download section and they are titled Special Open Door Forum Slides. So hopefully everyone can find those.

The slides are a little lengthy and some of the bullets are long, but that was on purpose so that folks that were not able to listen to this call, or if you're listening to this call but don't have the slides, you'll be able to check the slides later and they can stand on their own with the information that's presented in them.

So I'm going to pick up here on slide 3 of the PowerPoint presentation with the authority for conducting this Prior Auth Program is authorized in statute in Section 1834(a)(15) and the regulation is codified at 42 C.F.R. 405.926 and 414.234, and we usually refer to this reg as the CMS 6050 rule, so you'll hear that throughout and some of our other documents in the download section were titled that.

So the purpose of today's presentation is to give more information on that, the processes are defined in those regulations and provide more sub-regulatory guidance on how you would actually submit and get approved for the prior authorization process for the first two items.

Moving on to slide 4, prior authorization is a process where request for provisional affirmation of coverage is submitted for review before an item or service is rendered to a Medicare patient and before the claim is submitted for payment. This helps make sure that all applicable coverage payment and

coding rules are met before the items are rendered. That provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the item or service would likely meet Medicare coverage, and coding, and payment requirements.

The CMS has announced through – sorry, I might have gotten the slides mixed up – thank you. We're on slide 4. I'm sorry.

The CMS announced, through recent regulation that the 6050 that I referred to earlier, a list of item which we called the Master List. These are items that are frequently subject to unnecessary utilization and they are potential candidates for prior authorization.

We can select items from the Master List to be subject to required prior authorization as the condition of payment. The existence of an item on the Master List alone does not mean that the object is required for prior authorization.

The rule also requires CMS announce through Federal Register Notice the items subject to require prior authorization, which we did and a notice was published December 21st, 2016, and just to reiterate again which we'll do several times throughout authorization, prior authorization of items on the Required Prior Authorization List is a condition of payment.

So moving on to the “who” and “what” of the program, who is affected? Suppliers and Medicare patients that submits these claims and use items for the two codes that are described below. These are the two first codes that we have announced that are subject to the required prior authorization process; K0856 and K0861, and they are both group 3 power wheelchairs. I won't read the full definition for you, but they're listed there on the slides.

On slide 7, we have the “where” and the “when.” We are beginning this initially in four states; Illinois, Missouri, New York and West Virginia. These states are based on the patient's permanent address.

Like we've done in previous new programs, we're doing a limited rollout which gives us a chance to work out any processing or operational issues prior to any further expansion. And this requirement is effective for dates of service on or after March 20th, 2017. So this means that all applicable claims in those four states for those two wheelchair codes must have a prior authorization request on file prior to furnishing the item to a Medicare patient, and prior to submitting a claim with the date of service on or after March 20th.

On slide 8, why are we doing this? We think prior authorization is great for a number of reasons. It helps the supplier to know earlier in the process whether Medicare will likely pay for a service or an item.

It allows the Medicare patient to know, prior to receipt of their items, whether Medicare will likely pay for the items, so there are no surprise bills or payments for the items. And it allows our contractors, the DME MACs, to assess the information that would be part of the claim prior to making a claim determination to provide provisional feedback on the item or service that's going to be rendered.

Slide 9, we have the "why not," and this is the question that we get frequently so we decided to include it here in the presentation. We listed the two codes that are subject to the required prior authorization process, the two wheelchair codes. Wheelchair accessories are not included in the prior authorization process, and so the answer to that "why not" question is, again, we go back to that Master List from the 6050 rule. All items must be part, must be identified on the Master List.

And there are a number of criteria that an item has to meet to be included on the Master List. It has to, has to have a fee schedule purchase amount of \$1,000 or more; or a rental fee schedule amount of \$100 or more. It has to be identified as the subject in OIG, GAO report; or identified on the Medicare Fee-for-Service Improper Payment Rate Report.

The wheelchair accessories currently do not meet these criteria, and so they are not eligible for prior authorization under this program. There are certain pieces of wheelchairs that are required to make the base functional; and

because they are parts of the base, they are not a separate process and so that review will be part of the full review for the base of the wheelchair.

Moving on to slide 10, although the timing with which the documentation is reviewed for prior authorization is different than a typical Medicare medical review, much of the fundamentals of this process are the same.

The coverage in the documentation requirements are the same; the same DME MACs which are CGS and Noridian will continue to perform the reviews; and policies around Advance Beneficiary Notices of non-coverage are unchanged, as well as appeal rights for a claim itself. So the same documentation that you're typically required to have and complete must be submitted earlier in the claim process.

The next few slides have the details about what actually needs to be included in the prior authorization request. So it needs to identify beneficiary information, the patient's name, their Medicare Number, date of birth, address, diagnosis. It has to have the supplier information. It needs to have the submission date, of course the applicable code for the wheelchair.

The request should indicate if it's an initial or a resubmitted review, and the request should indicate if the request should be expedited and the reason why. And we'll talk more about what would fall under an expedited request down later in the presentation.

On slide 12, we have some more information that needs to be included in the request. This would be information that's required by the contractor, such as the detailed product description and attestation statement showing there's no financial relationship, evidence of the ATP certification, information on the home assessment if that's available at the time of the prior authorization request. We know that most of the time we wouldn't expect at this point that the home assessment information would be available at the time of the request since the request needs to be submitted before the item is furnished.

And then lastly, the information that needs to come from the provider, so that's the information from the medical record to support medical necessity,

the seven element order, the face-to-face examination and show that there is a specialty evaluation performed by an LCMP.

And so on slide 14, we have some information about how to actually submit the request. The request can be submitted – most of the time, we would expect the supplier to submit it. The Medicare patient may submit it as well if they have the required information.

Right now the request can be mailed or faxed. Starting in July, the request can be submitted through the esMD, which is the Electronic Submission of Medical Documentation system. And at some point we hope that request can be submitted through the DME MAC portals. At this time, that's not available. Again, that's subject to change.

And I'm going to turn the presentation over now to my colleague, Dr. Scott Lawrence for some more information on the timeframe.

(Scott Lawrence): Thank you very much, Amy. So for timeframes, we have three different categories: initial requests, resubmitted requests, and expedited requests.

Initial requests have to be responded to within 10 business days. Resubmitted requests are allowed 20 business days; and expedited requests must be returned in two business days.

Moving on to slide 16, we'll talk about the detailed decision letter. The DME MACs will send the requester of the prior authorization, whomever it was that submitted the claim, a letter describing their decision, either affirmative or non-affirmative.

Medicare patients can receive a copy upon request; although, we understand that MACs may also send these letters voluntarily to the Medicare patient. If the patient request is non-affirmed, the letter will provide a detailed explanation for the decision, a non-affirmed decision.

Moving on to slide 17, we're talking about the Unique Tracking Number, UTN. Decision letters for both affirmed and non-affirmed decision will

contain a Unique Tracking Number, UTN. Claims submitted must include this number, the UTN number.

Moving to slide 18, when a prior authorization request is submitted and affirmed (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 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 any additional review; however, CMS contractors, including Zone Program Integrity Contractors (ZPICs) or Unified Program Integrity Contractors (UPICs) 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 (CERT contractor) may select these claims for review as part of its random sample. That does not change the affirmed or non-affirmed decision for the prior authorization.

Moving on to slide 19, when a prior authorization request is submitted but not affirmed, the requester can resolve the non-affirmed reasons described in the decision letter and resubmit the prior authorization request.

There are an unlimited number of resubmissions that are allowed so you can continue to resubmit and get detailed reasons why it's wrong and correct those errors and resubmit; however, the non-affirmative prior authorization request decision is not appealable. Again, this is because it's all happening before the claim was submitted - or a requester can forego the resubmission process, provide the DMEPOS item anyway, and submit the claim for payment, but the claim will be denied. Again, this is because the prior authorization is the condition of payment. All appeal rights, however, would remain available.

Moving on to slide 20, when a prior authorization request is not submitted, this is a situation where they submit the claim without going through the prior

authorization process. So as described in the 42 C.F.R. Sections 405 and 414 as described earlier by Amy, if an item is selected for required prior authorization under the program, then submitting a prior authorization request is a condition of payment.

The two codes, the K0856 and K0861, are the first two codes to have been selected for this prior authorization process. Therefore, claims for items subject to required prior authorization submitted without a prior authorization determination (and, therefore, without a corresponding UTN number) will be automatically denied.

We have on slide 21 a Request Process for Submissions flow chart, which, again, you will be able to access from the web, that basically explains the process between – for the beneficiary or Medicare patient, for the physician or practitioner, and the process that they have to undergo, and for the supplier in separate, what we call, “swim lanes,” and the process of who sends to whom and back and forth.

It also offers whether the beneficiary or the Medicare patient submits the prior auth, situations we don't see happening frequently, because all same requirements for the prior authorizations are needed, which means that they would have to gather all the documentation (which the suppliers know it's something that has to be done skillfully) or supplied by the supplier themselves. Once that gets sent, it will go through the process.

If it's a first submission, again, that will happen within 10 days. If it's a resubmission, no matter how many – which number it is in the process, there will be another 20 days that are allowed for that turnaround time to occur. Then, the notice of decision will be sent.

Moving to slide 22, we have Educational Outreach for Non-affirmed Requests. DME MACs have special tracking for requests that are not approved due to documentation errors. Sometimes they're called “curable errors,” where the patient may otherwise meet the Medicare's coverage criteria.

Suppliers with these documentation errors receive individualized education and are encouraged to resubmit their request to ensure their patients receive the necessary item for which they are covered.

Slide 23 has a diagram of the process for educational outreach for the non-affirmed requests, and basically states that there are three main steps. So the first step is if the request was not affirmed on the prior authorization. If it was not affirmed, then we determine if there was there enough documentation submitted to evaluate fully the request, both from the supplier and the physician or practitioner. If that is the case (that it did not have enough documentation) then we determine if any medical record indicates that the patient might meet the coverage criteria for the item.

We could have these tracking tools; again, you can see these slides on the web and hopefully it will make sense to you then, but we're glad to furnish this information.

Moving on to slide 24, we have a couple of different scenarios. This chart has prior authorization requests. An authorization request is submitted and there are two tracks that that can occur if they do submit the prior authorization request. One is that the DME MAC finds the decision as affirmative, meaning that they approved the request, in which case the claim will be submitted, again with the UTN that comes with the response letter, and then the claim will be paid, again as long as all the requirements are there because it's a provisional affirmation.

If, however, the submitted prior authorization request is found to be non-affirmative, meaning they do not agree; then there are a couple of options there. The supplier can still submit a claim, but the claim will be denied; or they can fix the problem, because, again, the detailed letter will be provided, and then resubmit and that's a process they can utilize as many times as need until they finally cure the errors and get it in. The review after that will be made, and it will either again be affirmed or non-affirmed. It will continue that cycle over and over again.

The final version on this particular chart is that a prior authorization request is not submitted, in other words the claim is sent through without prior authorization, perhaps there's no affirmation or non-affirmation decision which means no UTN. They submit the claim and the claim will become automatically denied.

Moving on to slide 25, we have the Medicare Patient Impact. The benefit is not changing, and this is an important point. Medicare patients will know earlier in the payment process if an item will likely meet the Medicare's coverage requirements. Medicare patients may receive their prior authorization upon request, but again the DME MACs have said that they may voluntarily send the responses to the Medicare patient, anyway.

The dual eligible coverage is not changing for people that are concerned with that; and private insurance coverage is not changing. So the benefit is not changing for the Medicare patient at all; it just allows for the process to happen faster, and in many cases may even provide a benefit – an added benefit to the patient - that they'll know beforehand that the item will be paid. They don't have to worry about that, because these are not inexpensive items.

Moving to slide 26, the CMS Oversight, we will contract with an independent evaluator to analyze the impacts of this process, including the impacts on patient care, access to service, and overall expenditures and savings.

CMS will also conduct regular reviews of the DME MAC on these prior authorization decisions. CMS will discuss its findings with and seek feedback from the DME MACs regularly during scheduled meetings.

We're looking at slide 27 where we have how to contact this people. We have four DME MAC jurisdictions, with just one state for each jurisdiction, so they can hone down the process and make sure they have it down pretty good. For New York and Missouri, that's going to be Jurisdictions A and D (as in dog) for Noridian. You can contact them at <https://med.noridianmedicare.com/>.

The other two would be Illinois and West Virginia which are Jurisdictions B and C respectively which is CGS; which is <http://www.cgsmedicare.com/>. Again, these are in the slides so you should be able to access them very easily.

Slide 28 is the CMS Resources. We have the Local Coverage Decision and Policy Article for Power Mobility Devices, and we have a link to that; the Prior Authorization website, which again has just been changed to improve the process. The only difference between this link and the link that you have on your meeting announcement is in the section that says – if you look through the URL address, it says “/Prior-Authorization-Initiatives,” if you just replace that with “DMEPOS,” D-M-E-P-O-S, that link will work, But the link will be available as described before.

This is our new mailbox, and you can access or send information and questions to that mailbox.

In summary, we have two codes, K0856 and K0861, which are both level 3 power wheelchairs. This will happen in Illinois, Missouri, New York and West Virginia. It's starting for services on or after March 20th, 2017, so just next week, and submissions have to be made by the supplier or the Medicare patient, but regardless of who submits, all the required documentation must be there to have an affirmed decision on prior authorization.

And that completes the presentation portion of our presentation and we would welcome questions if anyone has them.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then 1 on your telephone keypad. If you would like to withdraw your question, please press the pound key. Also, please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star-1 again to rejoin the queue.

Your first question comes from (Sarah Icahn) from Ocean Home health. Please go ahead.

(Sarah Icahn): Hi. Up until now we were submitting all of our group 3 files to ADMC, and with ADMC upon the letter, the determination letter, we have six months to deliver the chair with prior the K0816, the group 2 chairs and the basic group 3 chairs. You only have 120 days from completion of face-to-face to deliver the chairs. Will that now apply to the K0856 and K0861? If you can please answer that; thank you.

Melanie Combs-Dyer: Can you repeat that?

(Sarah Icahn): Sure. Our company, the process that we have gone through now with K0856 and K0861 is we would submit all those files for ADMC approval. And with the ADMC approval, part of the process is you have six months to deliver the chair from the date of the determination letter, and how will that be with the prior auth? I know with our other chairs that are submitted to prior auth, we only have a 120 days to deliver from completion of face-to-face.

Melanie Combs-Dyer: This is Melanie. I don't know the answer to that question, but we certainly will look into it and we will make sure that we post frequently asked questions with that answer, and we'll make sure that we also cover that at next week's Open Door Forum call. Thank you, (Sarah), for the question.

Operator: Your next question comes from the line of (Marla Thomas) from BCBS New Mexico. Please go ahead.

(Marla Thomas): I still have not been able to access the slide. Will there be an updated e-mail sent with the correct address?

Amy Cinquegrani: Hi, this is Amy. Sure. Do you know where the Fee-for-Service Compliance website is? Can you get to that?

(Marla Thomas): Fee-for-Service, under the CMS website?

Amy Cinquegrani: Sure. If you are – I'll do a quick walkthrough, we can make sure that we can get to block this out to everyone. But for people on the phone, if you are cms.gov and then you click on the Research, Statistics, Data and Systems up

at the top, one of the options under Monitoring Program is Medicare Fee-for-Service Compliance Program.

(Marla Thomas): OK.

Amy Cinquegrani: And then on the left menu, all the way at the bottom, the last one is Prior Authorization Process for Certain DMEPOS Items; that is our new website. And so you can see we have sub-pages for the different audiences. But on our main page down at the bottom, we're planning to do some clean-up as we realized our main page is a little long. But if you go to the download section on the main page, the first option is DMEPOS PA Open Door Forum Slide 3/16/17.

(Marla Thomas): Got it. Got it. Thank you.

Amy Cinquegrani: Hopefully everyone else could follow that too.

Operator: Your next question comes from the line of Paul Komishock from Pride Mobility Products. Please go ahead.

Paul Komishock: Sure. Thanks for taking my call. In the original PA demo for the K0813 up through the group 3 K0848, the affirmation decision letters and the non-affirmation letters also went to the physicians that were ordering the PMDs. And I noticed that in this particular demonstration, they are not going to the physician and I think a lot of people found that helpful that they went to physicians as far as keeping the physicians in the loop. Is there any reason why that was decided against in this particular process?

Melanie Combs-Dyer: This is Melanie Combs-Dyer and you are right that that is changed. Sometimes our lawyers make us do things that we don't necessarily always want to do. We have been checking in with the lawyers, so on whether it would be possible to make that information available to physicians, and they have indicated to us that if the physician requests that information, we can share it with them.

Paul Komishock: OK. So in this round, since physicians are not allowed to request the information, they are not going to be copied on the decision?

Melanie Combs-Dyer: If the physician requests the decision letter, they will be sent a copy of the decision letter.

Paul Komishock: All right.

Melanie Combs-Dyer: Thank you.

Operator: Your next question comes from the line of (Noe O'Neill) from Pro Med Consulting. Please go ahead.

(Noe O'Neill): I just wanted some clarification on two things that you already mentioned – excuse me – but I'm going to skip those because those were addressed. What I really wanted to know about the accessories that are related to specific base. For example, these are multiple prior options base which requires qualification for a prior option, will the chair be reviewed for the prior option as well? Because it seems you have to review it for the prior auth in order to determine if the base qualifies.

(Scott Lawrence): This is Dr. Lawrence. If the accessory is essential to the functioning of the chair with the base, then that would be something included with the prior authorization. Extra accessories, because they are not on the list and they are extra things, as long as the accessories are available for these items, would not be part of it. Did that answer your question?

(Noe O'Neill): Yes, it does. Still a little bit fuzzy on what essential operation of the device really means, but I would imagine that power tool requirement option would be essential with that definition, correct?

(Scott Lawrence): Yes. And things like control devices: like joysticks, you know, certain things that are essential for the wheelchair would be part of the process. Yes.

(Noe O'Neill): It sounds good. Thanks.

Operator: Your next question comes from the line of Josh Shields from BetaMed.
Please go ahead. Josh Shields, please unmute your line and go ahead.

Josh Shields: Yes, ma'am, can you – can you hear me?

Melanie Combs-Dyer: Yes, we can hear you. Go ahead.

Josh Shields: OK. Thank you. Sorry about that. He really touched on my question there in that – you know, at ADMC, they look at the entire chair and so really if – I think it would be helpful to the providers if we knew what options you are actually going to review when you take a look at the chair. You know, is the tilt and recline or, you know, the power elevating foot rest, you know, are those considered to be integral to having the multi-option. That makes sense if I understood your answer correctly that, yes, those would be reviewed as part of this PA process, is that correct?

(Scott Lawrence): Yes, I believe that would be correct. We don't have a formal list of these aspects of the chairs, but that is a correct assumption. And maybe we'll look to formalize that in the future, but we don't have one now.

Josh Shields: OK. Thank you, very helpful.

Robert Hoover: And Melanie, this is Dr. Hoover at CGS, I just unmuted my line. Going back to the question, a couple of callers ago, about the extension to six months for the prior authorization request like we do for ADMC, I think the medical directors and the work group that's been working on prior authorization has agreed that would probably be a good idea and will be looking at incorporating that into the – into the guidance.

Melanie Combs-Dyer: Thank you, Dr. Hoover. That helps to answer (Sarah's) question.

Operator: Your next question comes from the line of (Karen Olivero) from Home Medical Equipment. Please go ahead.

(Karen Olivero): Hi. Good afternoon. My question is – actually, I'm looking for clarification. I was speaking with a reviewer in the ADMC Department today and she had advised me that any of our existing claims that we have received affirmation

from ADMC, that they would still be honored after the 3/20 date, that we would not have to submit the dates for a prior and that – you know, again that the ADMCs would still enforced and honored after that 3/20 date. I'm just trying to verify that that is in fact accurate.

Amy Cinquegrani: Hi. This is Amy. Yes, that's true. We have talked with our DME MACs about that and they will still honor all existing approved ADMC decisions and still be sort of making the transition to not allowing ADMCs for codes for which prior authorization is required. But any existing decisions that are going to fall onto this timeframe, they can – they can override and allow those to pass through.

(Karen Olivero): Wonderful. Thank you.

Amy Cinquegrani: Sure.

Operator: Again, in order to ask a question, just press star then the number-1. Your next question comes from the line of Diana Escalera from Academy Medical Equipment. Please go ahead.

Maxine Paul: Hi. This is Maxine Paul with Academy Medical Equipment and I have a question on slide 9, the last bullet point. It says that wheelchair accessories do not meet these criteria and these aren't eligible for the prior authorization of this program unless they are required to make base functional. And I know we've kind of touched on this, but there are a lot of accessories that are over \$1,000, and for us we feel that that's a risk that those aren't being listed on the prior letter.

And if we could maybe potentially ask that that'd be, you know, a consideration so that we can know in fact that those high-dollar items will be looked at and reviewed and an answer – or affirmative answer will be given. Because later on down the road, when RAC looks at your claims and you have, you know, some denials at billing and then you have to go through reconsideration redetermination, it's helpful to have those listed on the letters so that we do not have to wait months and years to try to recover or fight these claims.

So when you said this is for the beneficiary and also the providers, that would very much help the providers and protect them from putting a lot of expense in equipment just to have it taken away years later and perhaps the patients passed away, because these are complex patients that, you know, have very high complex – a lot of different medical conditions.

But Dr. Lawrence, would you touch on that, because you did say that you would consider the higher claims to make this base functional, and I'm talking about molded seats. I'm talking switches, sip and puff, you know, the different expensive equipment that takes they require -- the patient to operate the base.

(Scott Lawrence): Yes, thank you, Maxine. Again, we will be reviewing the list and updating it as time goes by. We actually review the list regularly, but, things that are needed to control the base, like a sip and puff, things like that, would qualify, so it's just on a case by case basis. We do understand and we're sensitive to the list which is why we made the list in the first place, so thank you for your recommendations, and we agree, but it's a process we want to be sure we do in a careful way.

But, if we know that the item or the aspect like a control device will make the base functional, then that would be considered part of the process.

(Maxine): And, will that be on the letter, Dr. Lawrence?

(Scott Lawrence): The letter would describe whatever decision they make, and, again, it's a provisional -- they're provisional decisions, because it's all prior auth, but I do not know if the letter specifically will say -- maybe, Dr. (Hoover), are you familiar with the specifics of the letter itself?

(Dr. Hoover): Is my line unmuted? This is Dr. (Hoover).

Female: Yes, we can hear you, thanks.

(Dr. Hoover): OK, great, thank you. You know, my understanding and there are certainly people that are -- understand at (CGS) probably better than I do. My

understanding of the accessories that would be reviewed as one of the callers mentioned for the shares, there are coverage criteria related to the use of other types of equipment. So, if you need a ventilator or you need a tilt and recline system, that's part of qualifying for the base equipment.

It was my understanding that it would be specifically those types of accessories and the need for those accessories that we will be looking for when we look to approve the base, because, they're intimately tied together. I don't know that we would be necessarily looking at all options and accessories that come with the -- that are available for you use on this type of PMD. It would just be the accessories that are part of the coverage criteria for getting the base.

(Maxine): Well, thank you, Dr. (Hoover). My concern with that is I'll just take a molded cushion, if the therapist forgets to put there that the patient has orthopedic deformities and cannot accommodate an off the shelf cushion, then that's an automatic denial and you have to go back and get that corrected. But, if we're not seeing that automatic denial upfront or somewhere it's overlooked, down the road when an audit comes through they're going to take the money back and that puts us at risk. And, that's why all of our claims, we put through the ADMC process.

And, just like yesterday, I was talking to a review nurse about cushions, we had a polio patient that was Hoyer lifted and they denied the cushion. So, it gives you an opportunity to see and educate the nurses when they make a mistake as well.

(Dr. Hoover): Yes, this is Dr. (Hoover). I understand that. I think what everybody has to remember that the prior authorization process is not a one for one replacement of the ADMC process. It is a program that operates under a very different set of rules, those rules were outlined in the regulation that CMS has published including the list and -- of the master list of items that are subject or that could potentially be incorporated into our prior authorization program.

And, there are some different rules, there are some similarities, obviously, but it is not the same as prior authorization it works under some different rules

and then in the way that the regulation was written it has a albeit long list, but a limited list of things that can be reviewed for prior authorization. But, I think, your comments are well-taken and certainly as CMS, and I'm making an assumption on the part of CMS. But, as CMS and the DME MAC look at that master list we'll certainly remember the comment that were made here, and take that into consideration if the regulation gets revised.

Operator: Your next question comes from the line of (Paula Connick) from (NewMotion), please go ahead.

(Paula Connick): Thank you, a follow up question on the transition, if we've already set (Paula Connick) to ADMC, you said if we'd had an approval that that would be honored as the new auth for PA so we wouldn't need to resubmit it for this new prior authorization. If we submit a document to ADMC, but we don't have an answer yet, and we don't have that by next Monday, March 28th, will that ADMC unit still continue to process it? Will they send it over to the PA unit or do we as a provider need to resubmit it?

Amy Cinquegrani: Hi, this is Amy, if you don't have a decision on that by 20th, then you should follow up with your DME MAC and expect to submit a prior authorization request.

(Paula Connick): OK, thank you. Quick second question, the earlier question about sending letters to the physician to let them know if these were affirmed or not affirmed, you said the letter or the physician could request the letter, how would they do that? Do they have to call Medicare, do they call to MAC? How would they actually request that letter?

Melanie Combs-Dyer: This is Melanie and they would need to call the MAC and request it.

(Paula Connick): OK, thank you.

Male: And, one other point to keep in mind if they are accepting the prior authorization request now for items that would be furnished after the 20th, so if you have someone that you think is going to get their item after the 20th,

instead of the ADMC process, you may want to now start using the prior auth where it's appropriate.

Operator: Your next question comes from the line of (Erin Roy) from Majors Medical Services, please go ahead.

(Erin Roy): Yes, we're trying to figure out if these two codes are going to -- that we're now are having to require authorization for, is the fee schedule for those going to remain the same or are they going to switch over to capped rental items?

(Scott Lawrence): To the best of our knowledge, the fee schedule will be modified the same as it always has. There's no special change to the fee schedule due to this program.

(Erin Roy): OK, thank you.

Operator: Your next question comes from the line of (Vicky Motley) from Cleveland Clinical Foundation, please go ahead.

(Vicky Motley): Yes, when will this process streamline to other States outside of the four that should be starting on Monday?

(Amy Cinquegrani): Initially, in our federal register notice, we mentioned that it would expand nationally in July. But, we certainly want to make sure that the process is working appropriately, I mean, all operations are running smoothly in the first four States before that -- before we would operationalize that. So, CMS will send additional instructions, you know, if there's going to be a change either way to that.

(Vicky Motley): OK, thank you.

Operator: Your next question, comes from the line of (Diana Escalera) from Academy Medical Equipment, please go ahead.

(Diana Escalera): Hi there, this is (Diana) this time. I have a question about the -- when the patient has a patient representative on file under the (PAR) demonstration, you cannot -- you get, not a denial, but the (PAR) is not accepted when there's a

representative on file. When this goes nationwide in July, if it does happen in July, will that still be the case, will you still not be able to submit a (PAR) or is that going to be updated?

Amy Cinquegrani: Hi, for nationwide expansions then (Rep payee) claims will need a prior authorization request.

(Diana Escalera): OK, that makes it so much simpler, all right, thank you.

Amy Cinquegrani: Sure.

Operator: Again, in order to ask a question, just press star and then the number one. Your next question comes from the line of (Karen Olivero) from Home Medical Equipment, please go ahead.

(Karen Olivero): Hi. Mine actually is to Amy, I want to go back to that ADMC and how I was speaking with the reviewer and what (Heather) – Noridian had actually said to me was not that I had to receive the ADMC determination by March 19th. She said anything that was submitted prior to March 19th that they -- they would review it and that the approval would stand and that the equipment could be delivered after March 20th, not that I had to have the determination by March 19th.

Amy Cinquegrani: Hi, this is Amy. Thanks for that clarification, we really appreciate the flexibility that our DME MACs are giving for the transition from ADMC to prior auth process. So, that's great and I would follow that instruction.

(Karen Olivero): OK, wonderful. Thank you.

Amy Cinquegrani: Thank you.

Operator: And, your next question comes from the line of (Sarah Icorn) from Ocean Home Health, please go ahead.

(Sarah Icorn): What would constitute a (PAR) request to be an expedited request? What would qualify -- what criteria to you need to follow in order to file an expedited request?

(Scott Lawrence): For an expedited request, there has to be a life-threatening situation or some other emergency situation that can be well documented.

(Sarah Icorn): Thank you.

Operator: And, there are no further questions in the queue. My apologies, we have a question that just queued up from the line of (Erin Wingate) from (All Medical), please go ahead.

(Erin Wingate): Hey, this is a follow up on the expedited question, we have for a long time wondered if there were some kind of fast track for our ALS patients? Unfortunately, we have a lot that deteriorate or their need for different power mobility issue changed very quickly and we've lost a few before they were able to be provided their equipment. So, would an ALS diagnosis qualify for an expedited claim?

(Scott Lawrence): I guess, it would depend on the situation. There are different ALS levels of people who are experiencing ALS. So, if you submitted an expedited claim and, for whatever reason that documentation didn't support that it was really, you know, like needed to be done in two days, you still get a -- it would then convert to a regular submission and they still get a decision within 10 days for an initial submission.

So, you're pretty safe either way, but certainly if you feel that the person needs something in an expedited fashion, you know, go ahead and submit and give the proper documentation to support your position.

(Erin Wingate): OK, perfect, thank you. We've had lots of our neuro doctors have always asked why they don't just like have a fast track through their care submission request, so -- all right, thank you very much.

Operator: Your next question comes from the line of (Amanda Yoman) from Partners In Home Care, please go ahead.

(Dave): Hi, this is actually (Dave). I'm on the (ATP Partners). In regards to needing evidence of the (ATP) certification and involvement, in that past that is not

been acceptable for the therapist to simply write that the (ATP) attended the evaluation, so what would -- what would be acceptable to show the evidence of that?

(Scott Lawrence): There are criteria for the (ATP) that have to be documented, so you can look at the guidance, you know, that CMS has on their web that hasn't changed with the same criteria that they have. Dr. (Hoover), do you have any more specifics on the (ATP), the RESNA (ATP)?

(Dr. Hoover): Yes, the -- and we have an FAQ on our website and I believe Noridian does too under our power mobility devices kind of general guidance about documentation, their physician letters there, there's a whole host of resources available for PMD. What we're really looking for in a general sense for our reviewers and the way we train them is there has to be, you know, clear evidence to a third-party that the (ATP) was actively involved in person and in the fitting and selection of the wheelchair. And, just signing off on somebody else's evaluation is not acceptable.

When I have thought (ATP) is about this, I said, you know, you should have in most cases your own evaluation that you do. It's certainly helpful from corroboration standpoint to have -- if there's a physical therapist or somebody in rehab clinic that is documenting the evaluation, if the physical therapist, you know, list that, you know, Dr. (Hoover), and Physical Therapist (Smith), and (ATP) Jones were present for this evaluation or involved in this evaluation, that's good information.

But, I also anticipate that I would see that (ATP's) notes, because again we're talking about as we've heard on this call very complex patient that's part of the reason that we put that requirement in the (LCD) when it was originally written, you know, back 10 years ago, was to make sure that the Medicare beneficiary is protected that they have the most skilled people evaluating them and helping select the equipment, because these are very complex patients with complex sitting and positioning needs and needs for their wheelchair, so that's the basis for why we want to see this involvement.

(Dave): OK, thank you.

Operator: Your next question comes from the line of (Paul Comoshacks) from Pride Mobility Products, please go ahead.

(Paul Comoshacks): Thank you. One of the other small changes from the initial PA demo process in the cover page for the fax is, this -- in this new demonstration, there's a space for an ICD-10 code, the diagnosis, and also a place for the -- place service code, I was wondering if those two items were going to factor into your decisions at all?

So, in order words if somebody saw place the service skilled nursing facility, would that impact the decision or if you saw a diagnosis code that was clearly not neurological or a myopathy -- something like hip fracture, would that factor into your decision and would that factor in early on in the process or we do look at all of the documentation first and then look at those kind of after the fact?

(Dr. Hoover): Yes, all of the documentation will be considered in its entirety, the whole package has to be presented in order for it to get a decision, and especially an (affirmed) decision, so certainly the diagnosis, the place of service all of those things are part of the requirements and the entire record is considered as part of the prior authorization process.

(Paul Comoshacks): OK, thank you.

Operator: And, there are no further questions in the queue, I'll turn the call back over to the presenters.

Melanie Combs-Dyer: Thank you, this is Melanie Combs-Dyer and I just would like to thank everybody on the phone today, you guys have given us a lot of good information to think about, a lot of opportunities for improvement, some that we can implement, some that we may need to think about an update to the regulation at some point in the future, but we really do appreciate all of the feedback and information that we've gotten.

I just want to remind you that the mail box is open and ready to accept your comments and we would encourage you guys, if you think of anything after this call to shoot it to the mail box, we may not be able to respond to each individual person who is writing to the mail box, but certainly we will find that helpful in preparing our Frequently Asked Questions and getting our agenda set for our next call. Thanks, again, to everybody. We really appreciate your time today.

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

END