

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Coverage and Documentation Requirements for
Codes Subject to DMEPOS Prior Authorization-
K0856 and K0861 with DME MAC Chief Medical Officer
Tuesday, April 25, 2017
2:00 PM Eastern Time
Moderator: Jill Darling

Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Special Open Door Forum, Coverage and Documentation Requirements for Codes Subject to DMEPOS Prior Authorization conference call.

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

I would now like to turn the call over to Ms. Jill Darling. You may begin your conference.

Jill Darling: Thank you, (Amy). Good morning, good afternoon, everyone. Thank you for joining us today for the Special Open Door Forum. Before we begin, just 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 hand the call over to Amy Cinquegrani.

Amy Cinquegrani: Thank you, Jill. Hi everyone this is Amy Cinquegrani from the provider compliance group in the Center for Program Integrity at CMS. Thank you so much for joining our call this afternoon. This is the third Open Door Forum on this new prior authorization process for certain DMEPOS item. The first two item subject prior authorization under this program K0856, K0861 for group three power wheelchair.

The first two Open Door Forums on this topic were focused on the prior authorization process itself. And this one will focus on the Medicare coverage requirement for the power wheelchairs.

The slides that we are going to be going over are available on our DMEPOS prior authorization website. And you can find that by going to www.cms.gov. Click on Research Statistics, Data and System. And click on Medicare Fee for Service Compliance Program. And on the bottom on the menu on the left click on prior authorization process for Certain DMEPOS item. And our slides are available in the download section at the bottom of the page along with a download of the actual LCD and policy articles for Power Mobility Devices.

We are lucky to have Dr. Robert Hoover, who is leading our presentation today. Dr. Hoover is the chief medical officer for Jurisdiction C at the CGS Administrator. As a contractor medical director responsible for coverage, coding, claim review and technology assessment for DME, prosthetic, orthotics and supplies and the fee for service Medicare program.

Dr. Hoover started as a contract medical director in 1998 in the Jurisdiction D DME regional carrier. He is a board certified in internal medicine and is a fellow in the American College of Physician. Dr. Hoover also holds the masters in public health from the Medical College of Wisconsin. And now I'll turn the presentation over to Dr. Hoover.

Robert Hoover: Thank you, Amy. And welcome everyone to the CMS Open Door Forum to review the coverage and documentation requirements for the codes that are authorized as part of prior authorization. As Amy mentioned I am Dr. Robert

Hoover. I am the medical director at CGS Administrators Jurisdiction B and C contract. During today, we are going to talk about the kind of the top level citations for power mobility devices. We'll go through the LCD coverage criteria. And give a high level overview of the documentation requirements. And then go through some of the statistics that we've had to date in Jurisdiction B and Jurisdiction C for rejections and non-affirmations. And then we'll save some time at the end for some questions.

So we'll move on to slide three. So before we talk about the LCD and some of the other topics, we wanted to review kind of the high level citations for coverage of power mobility devices. They are covered under the DME benefit, but Congress added some rules with the Medicare Modernization Act in 2003 what's commonly known as Prescription Drug Bill. And these specifically related to Power Mobility devices. And this is where we get the face to face examination and the 7-element order, the written order prior to delivery for power mobility devices.

CMS implemented the MMA provisions with the citation that shown on your screen and this was published in the final rule in April of 2006.

Moving to slide four. In addition to the statutory and regulatory requirements, there is a national coverage determination that takes into account power mobility devices. And that's the mobility assistive equipment NCD that was published around the same time as the final rule back in 2006. (TMDs) are type of mobility assistive equipment, so if you look in the CMS internet only manuals and the National Coverage Determinations Manual, which is 100-03 under chapter one part four you will find the NCD 280.3.

And this NCD lays out the coverage criteria for multiple types of mobility assistive equipment in a hierarchical manner. In other words you move in a step wise process through a decision tree and I'll show that in a couple of slides from now.

The decision tree is set up to move from canes and crutches all the way through the various types of mobility equipment all the way through power mobility device.

Slide five, I am not going to go through all of the NCD requirements just the high level criteria. For example the basic coverage criterion is shown on your screen now, where beneficiaries that qualify for mobility assistive equipment regardless of type must have a mobility depth that does not allow them to participate in their mobility related activities of daily living or what CMS calls MRADL in their home.

And this last point is very important that in the home because it's one of the requirements of the durable medical equipment benefit that is the equipment must be required for using in the home that's not to say that it can't be used outside the home, but it must be required for use in the home as the primary location for coverage.

On slide six, recall that on the last slide I talked about the beneficiary having a mobility deficit or a limitation. And CMS defined the mobility limitation in the NCD as one of the three conditions on slide six. The beneficiary either can't accomplish the MRADLs entirely or they can't do it safely or they can't do it in a reasonable amount of time.

And these are the basic coverage criterion, when we get to the LCD that you'll see me reference and we'll talk about kind of peeling back the onion on the group three codes and in those coverage criteria, we incorporate as basic coverage criteria. This idea of a mobility limitation and the inability for beneficiary to accomplish their MRADL.

On slide seven, I just cut from the NCD this flow diagram that you see in the presentation, it really is a hierarchical approach. You have yes, no questions as you can see it, it lays out the coverage for mobility assistive equipment in this step wise approach. So you know, if you can't use this piece of equipment can you use that one. If you can't use that one is this next one appropriate and so forth as you move your way down and across through the

chart. So you are moving from canes and walkers to manual wheelchairs to power operated vehicles and then finally the power wheelchairs.

So getting to slide eight, I am going to cover the high point of the local coverage policy for power mobility devices or what I'll call PMDs at times in this presentation. And recall that DME MAC policy has three parts. We have the local coverage determination or LCD. We have the related policy article and now as of a couple of months ago our policies are starting to roll out with a document called the standard documentation requirement. So the three components, the LCD, the policy article and standard documentation requirements are linked at the end of all of the documents.

So if you are looking at the LCD for example in the Medicare coverage database, you'll see a link at the end to the related policy article in the standard documentation requirement. If you pull up the policy article, you'll see a link at the end to the LCD and the standard documentation requirement. And all three of those make up what we call a DME MAC policy.

The LCD has the clinical coverage criteria commonly referred to as reasonable and necessary R&N criteria. The related policy article has the statutory or CMS manual provision. And then the standard documentation requirement have quite obviously the documentation requirement.

The LCD for power mobility devices builds on the NCD to describe this specific coverage criteria for specific types of power mobility devices. So the next few slides we are going to focus primarily on the LCD coverage or R&N requirement. And as we talk about the LCD, I would strongly suggest that you open a copy of the LCD and follow along with that document rather than the slide. I think as we talk about the R&N criteria we are going to be talking about excerpts for the group three. And as I mentioned I think it's easier to follow along with these criteria when they are presented in the context. So I think it's easier to look at the policy as we are following along. And CMS did post that on the Open Door Forum site.

So if you don't have that available I would suggest after the call you may want to go back and have the slides available, but also look at it in the context of how it's laid out in the local coverage determination itself.

So for the LCD on slide eight, we are going to go over the coverage criteria, the R&N criteria meaning you have the mobility deficit. And then we are going to talk about the power options. And recall that as we talk about some of the accessories that go along with the base and I'll talk about that when we get to one of my slides with accessories.

Inherent to the coverage of the base is the need for certain accessories for these complex chairs, and so that's why I know that the topic has come up on past Open Door Forum and whether or not there would be a decision granted on accessory.

Note that the prior authorization is just for the base itself, but we also do take into account the accessories. We have to take into account some of the accessories when we are making a decision about the base because they are inherent to the coverage of the base. And you'll see what I am talking about when we get into this specific coverage criteria.

And then we talk about, I'll talk about some of the statutory and regulatory issues related to the documentation when we get into the documentation requirements.

So let's move into the LCD specifics on slide nine. The LCD for power mobility devices categorizes PMDs into groups. And those groups are based on the device's capability.

In other words as you move up in group number from group one through group five, you get chairs with stronger motors with beefier suspensions, more capabilities in terms of top end speed and moving on grades and that type of thing.

The codes in the current prior authorization program K0856, K0861 fall under group three as the single power option and multi power option chairs respectively. And one of the things you'll notice in the coverage criteria is a reference back to some of the group two products. Group three products build on the capabilities and coverage criteria for group two single power option and multi power option chairs. So that's reflected in the coverage criteria that you are going to see.

So on this slide, you have the coverage criteria from the LCD for the group three single power option, which is code K0856. And the multi power option, which is code K0861 PMD. So the group three PMDs when you are looking at the structure of the LCD itself fall under coverage criteria 5A and 5B. So criterion 5A on this slide is the first bullet and 5B is the second bullet.

So let's break down these coverage criteria on the next slide. And as I mentioned, it's sort of like peeling an onion because there are several layers of coverage when you start to get into this. So let's take the first bullet from that last slide. And I've repeated it here on this slide is that group criteria, group three criteria 4A and 4B are met.

So when we look at the coverage criterion 4A, that deals with the general group three criteria that's all group three chairs have to meet regardless of power option. So first you have to meet the general coverage criteria for all power mobility devices or what are those that means you have a mobility deficit limiting your ability to accomplish your MRADLs that a power operated vehicle won't work, that you can safely operate the wheelchair both from a physical and a mental capacity. The chair that you picked has the appropriate weight capacity because if you look at the different groupings even under the single power option, you have a single power option heavy weight. You have a single power option, very heavy weight and so forth.

So it has to have the appropriate weight capacity, you have to be willing to use the PMD that's selected. And when I use the word you, obviously I am referring to the beneficiary. So the beneficiary has to be willing to use the PMD that's selected. And then there are any other chair specific criteria.

So again, I am kind of hitting the highlight here to give you an idea of how these coverage criteria are structured. So that was criterion 4A.

If you go to criterion 4B, those are the covered diagnoses. And I use the work covered diagnosis. But you can think of these more as screening of editing diagnosis that we use in our claim editing systems because many of the qualifying diagnosis that we have listed in the policy, some of these neurological conditions or myopathic or skeletal deformities that are translated into ICD-9 codes.

These diseases have wide spectrums of manifestation. So it's really going to depend on the treating practitioner's documentation about the disease severity. And that specific individual's limitations that are manifested as part of that disease when it comes to coverage and the mobility limitation. So you just need to make sure that the referring physician and the treating practitioner have good documentation, clear documentation about the beneficiary's limitations.

So we go to the next slide, next slide 11. And this slide, we are going to breakdown that second bullet from slide nine. And the second bullet is recall that the second bullet on slide nine address both the single power options or code K0856 and the multi power option code, K0861.

So for the group three single power option code K0856, it follows the coverage criteria for group two single power option chairs. So you either have to require an alternative drive control or you need power tilt or power recline seating system. And then that's criterion 2A and 2B. And then, excuse me, that's criterion 2A.

And then criterion 2B you have to have both three and four. Criterion 3 is the specialty evaluation and the ATP evaluation. And you'll see this thing kind of repeated over again in the next slide when we talk about multi power options. So again that bullet breaks down criterion 2A and 2B referencing back to

those group two single power option chairs. Coverage criteria are very similar. The alternative drive control or power tilt or power recline.

So when you look at slide 12, you'll see that next bullet for the multi power option chairs, you have to have criterion 3A and 3B. So 3A pick one either one or two and then criterion 3B you have to have both of those very similar to the single power option that we saw on the previous slide.

So criterion 3A you either have to the one of two, one being the need for a power tilt and reclining seating system or you need a ventilator mounted on the chair. And again this relates to the multi power option and the type of harnesses and controllers that are incorporated into the K0861 multi power options wheelchair base.

On slide 13, we are going to get into the accessories. And you just heard me talking about the single power option, the multi power option. The coverage criteria there as far the need for an alternative drive control. The need for tilt and recline or tilt or a recline, a ventilator.

So on this next couple of slides, I am going to talk about the accessories. And this is as I mentioned earlier in the talk it's been a big topic of discussion on prior calls with regards to prior authorization process. The prior authorization program is specifically for the chair base that's what was authorized and statute that's what's in the regulation that is the only thing that the DME MACs are allowed to give an affirmation or a non-affirmation on.

Accessories while not included as part of prior authorization, as you can see from the past few slides, they are integral to the coverage of the base equipment. So by necessity those accessories are going to get reviewed too, but they are technically not subject to prior authorization.

So what I've done on slide 13 is list some of the accessories that are reviewed as part of the chairs based medical necessity review. Again recalling those coverage criteria the need for tilt and recline or tilt or recline the alternative drive controls.

Looking at slide 14, you see some of the specialty seating cushions. And again I've had questions from providers about, you know, why are we looking at these seat cushions as it relates to the chairs base and prior authorization. And that's because recall codes K0856, the group three single power option and code K0861, the multi power option are solid seat chairs. So the need for the base is also predicated on the need for a specialty cushion. And we have those cushions listed here and the coverage criteria for those cushions are found in the wheelchair seating LCD and its related policy article. Just like a lot of the accessories that you saw on the previous slides alternative drive controls, the tilts and recline and so forth are found in the wheelchair options and accessories LCD and related policy article.

So we are going to switch gears now and move to slide 16 and talk a little bit about the documentation requirement. On slide 16, I have the list of documents that are required to be submitted as part of the prior authorization process. You see six items there, the request form, the face to face examination and any other medical documentations that might be appropriate and pertinent for the beneficiary's case. The 7-element order. The specialty examination, the ATP evaluation and then the detail product description.

When you look at the power mobility devices LCD and related policy articles, we have a couple other documents that we talk about in the policy and that's proof of delivery in the home assessment. Obviously since this is prior authorization and the vast majority of the cases were not going to have proof of delivery, we are not going to have a home assessment. So those are two documents that aren't required as part of the prior authorization submission. But you are going to need to have those in your files in the event that there is audit in the future.

Slide 17 shows the elements of the prior authorization request form. Each one of the DME MAC has this form on their site as a – under their prior authorization page. We complete this form in its entirety and these are all the details that you should be prepared to provide.

Slide 18, the face to face examination. Again, I mentioned, the Medicare Modernization Act in my first slide in the face to face evaluation. I didn't go in depth on the face to face examination because on the DME MAC websites and I'll give those websites at the end of the presentation. We have multiple bullets and articles about the face to face exam. The timing requirements. The 7-element order and detail product description, which I am going to talk about in the next couple of slides.

You know, we probably spent an hour just talking about documentation related to the face to face exam. However I think this slide really summarizes it to say that, you know, the face to face exam should paint a picture of the patient's current mobility limitation and why lower level types of mobility assistive equipment are not appropriate for the patient.

Again we are talking about the power mobility device policy, but it's guided by this hierarchal step wise approach that we see in the national coverage determination that requires you to consider canes, crutches, walkers, manual wheel, you know, optimally configured manual wheelchairs before you move to a power mobility device.

So again, take a look at the DME MAC websites for more of this collateral information there is also a Dear Physician Letter that is out on all four of the DME MAC website that is a document that can be given to your referral sources, who want additional information kind of doctor to doctor about what kinds of things we are looking for when we look at face to face examinations.

I mentioned on an Open Door Forum it's been a number of years ago, but they were physicians that were asking, you know, I don't know how to write a letter of medical necessity. I don't know how to do a functional examination for a patient that needs a power wheelchair.

And you know, I remember kind of being incredulous on the call thinking all we are looking for is a basic third year med students examinations. You know, what are the upper extremity strength and neurological limitations same thing with the lower extremity. What kind of gait, balance that type of thing.

And you know, we try to ask for objective measurement. And again, objective there is a lot of ways to get objective measurements as far as upper extremity strength for example.

I've asked patients in the past, you know, I don't ask them when you go to the gym, can you curl 20 pounds. Often I'll ask the patients do you have difficulty holding a bundle of mail from your mailbox. Can you lift a gallon of milk out of the refrigerator and easily place it on the counter. You know, there are some ways other than a formal weight to assess somebody's objective strength. And those are the kinds of things that I recommend that physicians do it. It gives our reviewers a much better picture again painting a picture of that patient's mobility limitation. It paints a great picture for our reviewers when they look at medical record documentations.

Moving to slide 19. CMS requires a specific order prior to delivering. We call this in the PMD policy as 7-element order because it's an order that has 7-elements. And I list those 7-elements on the screen now. So you have the beneficiary's name, a description of item that's ordered and again this can be general or it can be specific. So you can have power wheelchair or power mobility device. Although we recommend power wheelchair and or it can be more specific a candy apple red or Jazzy 630 or something like that.

The data completion of the face to face exam, I highlighted completion because as I mentioned before we have a lot of material on our website about what it means to complete the face to face exam and I alluded to that on slide 18 as far as the face to face. Whether it's been referred out for completion, partial completion by another licensed medical professional. So again, I strongly encourage you to consult the DME MAC websites for more information about the timing of those kind of things.

But again these are the standard 7-elements that are required as part of that order. For group three, single power option, multi power options chairs, there is a requirement for a supplier ATP involvement. This is a RESNA certified individual, who has specialty training in the fit and furnishing of a wheelchair. It requires, the policy requires direct in person involvement.

And I've had questions in the past about, you know, why do you require this for this level of chair. And in my opinion I think it's obvious. These are complex chairs for complex patients. And because of that the DME RACs require that a DME supplier use a RESNA certified professional to assist the clinicians in the proper chair selection and fitting.

The wrong chair can do just as much damage as the disease process itself if the various accessories are not set up correctly. So we felt it was very important when this policy was being written back a decade or so ago that there had to be this involvement and it needed to be clear from the documentation that there was direct in person involvement with this process by the ATP.

Moving to slide 21, we have a detailed product description. Again this is very similar to other items of DME. For most items of durable medical equipment, we have what's called a dispensing order that's followed up with a detailed written order or a DWO. For power mobility devices, the wording a little different, but the things are pretty close to the same. There is a 7-element order and a detailed product description or a DPD.

The 7-element order is what we require before dispensing. And the DPD is what's required before billing the DME MAC. And I have on the screen now what's required for the DPD that said it's very similar to the detailed written order.

Slide 22, I put this in here to remind folks that upgrades are often used for power mobility devices. And this slide just highlight some of the upgrade process. I know in the past we had questions about billing upgrades as it relates to providing a group four chair, which are considered not reasonable and necessary. And so there are some suppliers that want to bill a group four chair as an upgrade. And I have that information here on your screen as far as the basics of the upgrade process.

Again this is just a highlight. The DME MACs have lots of information published on upgrades. You can find some of that information in our supplier manuals. And again those are on each contractor's website.

And the DME MAC also published an article. This was back in 2011, but it's still available on our website. It's still an active article today that has detailed information about modifier usage for upgrades and the situations when you use the GA and the GZ and GK modifier and so forth. So I encourage you to go out again the DME MAC websites are very good resources for some of this collateral type of information.

Slide 23 covers some of the key timelines. When you look at providing power mobility devices again there is really two key timelines that I've highlighted here on the slide. One is the 45 day timeline after completion of the face to face exam. The supplier has to receive the 7-element order and the face to face exam.

The delivery of the wheelchair within six months following an affirmative decision. I know some of you may have gotten letters in this early part of the prior authorization process that says that the wheelchair has to be delivered within six months from the face to face exam. We are correcting those letters now and I know at CGS, I am not sure about Noridian and what was in their letters. I know we had some erroneous information in our letters and that's now been corrected.

Again specifically the extension of the delivery to six months that's for both ADMC process and the prior authorization process. And we've updated our power mobility device LCD, the version that's out on the Medicare coverage database has already been updated with this new timeline information.

So moving to slide 24, we've now a little more than a month in on prior authorization at this point. And so I tried to put together for Jurisdiction B and Jurisdiction C some of the experience that we've had to date for those two Jurisdictions. We are calling Jurisdiction B the prior authorization state is Illinois. And so there is three options open to the contractor when a prior

authorization request comes in. We can either affirm it, non-affirm it or reject it.

So at the top of the slide, you see the top rejection for Jurisdiction B. They are either duplicate request. There is a rep pay on file or the claim was filed to the wrong jurisdiction. For the top non-affirmation reasons, we have a number of the technical (designs). And I would say for the most part in Jurisdiction B, we are seeing the clinical information about the patient is accurate and would result in an affirmation except for I think diligence on the part of the submitting provider for the prior authorization request. There is just some of these things that I have listed here in the bottom for bullets that need to be taking care by the supplier before the prior authorization request is submitted.

So a little better QA process prior to submitting the PA request would help eliminate some of these requirements, these issues here with non-affirmation.

Slide 25, we are going to go into the Jurisdiction C experience. Again Jurisdiction C has the state of West Virginia at this point. The top reasons for rejections in Jurisdiction C are a little bit different from Jurisdiction B. One that the beneficiary doesn't reside in a program state, which is West Virginia. And then we've had a number of faxing errors. We've had pages that have come in sideways, then unable to decipher they've been folded, faxing errors on the part of the submitting provider. The top non-affirmation reasons were also a little different in Jurisdiction C.

Again I point out this first issue about the ATP having direct in person involvement. As I mentioned on the previous slide, where I talked about the ATP involvement and the documentation. It really does, I think this is one of the critical points of providing group three chairs is that, you know, we have this expert that's involved as part of the clinical team that's integral to the clinical team in helping select the proper wheelchair. We are not looking for somebody that's just signs off on a process that's been done by somebody else.

What I often recommend to the ATPs is if they are in a multi-specialty clinic and you have a physiatrist or physical therapist, it's also working to do the wheelchair fitting that have the physical therapist actually dictate in their notes that as they often do at the start of the note that the fitting was done in the presence of Dr. Smith, the physiatrist, myself and you know, John Doe, the ATP from ABC Medical. But really we are looking for evidence of that direct in person involvement.

I'll also highlight bullet number three here in the reasons for non-affirmation and that the 7-element order was not written by the same physician practitioners completed the face to face examination. The Medicare Modernization Act and the implementing regulation require that the treating practitioner that performs the face to face exam also write the 7-element order.

We are seeing different names on the two documents quite frequently and that is also resulting in non-affirmation. So and then again the last bullet on the painting of clear picture. And again, we have a number of resources on our websites for educating referral sources.

We also have webinars that are provider outreach and education staff are doing on a regular basis. I know specific to Jurisdiction B and Jurisdiction C we have what are called our Medicare Minute videos that (Dr. Brennan) and I produced on a variety of topics both for suppliers and in our Medicare Minute MD series, a little longer segments on various policies and topics. And there is one out there for power mobility devices.

You could also tell your referral sources that the power mobility devices Medicare Minute is also available on the CMS website under the MedLearn Matters page. And it is available for continuing medical education credit. So it's free physicians just about every state required continuing medical education credit hours a minimum number per year or per two years. So that is out there on the CMS site.

Page 26 has some of the resources that are available. Some of these I've talked about on in this talk, the internet only manual 100-3 is the NCD

manual. And again the reference there is to the mobility assistive equipment NCD.

The PA operational guide is a very good document if you link to the CMS site. I didn't give the full citation there because it would have taken up the whole page for the URL. But if you search on the CMS webpage on the Medicare site just prior authorization, you'll get to the page that has the operational guide.

I mentioned the Medicare coverage database that houses the DME MAC policies and that our policy has three parts. They are all linked together in the document.

You can either go through the contractors' website to get to the local coverage determination or you can go through the CMS site on the coverage homepage and go through the Medicare coverage database. I personally think it's a little bit easier to go through the contractors' website and the links there that take you back into the Medicare coverage database.

The last two bullets on the slide are the root pages for both Noridian and CGS. Noridian being the Jurisdiction A and Jurisdiction B contractor. CGS administrators being the Jurisdiction B and Jurisdiction C contractor.

So that brings us to the end of our talk. Thank you for your attention and I'll take questions now. (Amy), if you want to open up the phone lines, we'll get going.

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

Your first question today comes from the line of (Thomas Robinson) of CMS.
Your line is open.

(Thomas Robinson): Yes. For the two groups, is it limited to just those two codes or that string? Like for instance is it just the K0861 or is it from K0861 to K0864 for coverage or the (inaudible)?

Robert Hoover: It's the two specific codes. It's K0856 and K0861.

(Thomas Robinson): OK, thank you.

Operator: And your next question comes from the line of Diana Escalera of Academy of, sorry, Academy Medical Equipment. Your line is open.

Diana Escalera: Hi. What doctor types besides the doctor physical medicine are able to complete the face to face without physical therapist involvement?

Robert Hoover: You know, I think we see ...

Diana Escalera: For example, neurologist.

Robert Hoover: Yes, I mean I think, you know, we don't specify in our policy as far as what type of physician. It's really, you know, determined by their training and their state scope of licensure I think in most states when you look at the licensing for physicians, there aren't any restrictions as far as you know, prescribing certain types of things.

Now, if you get into something for example a podiatrist our policy specifically does not allow podiatrist to prescribe power mobility devices and that's really related to their scope of practice when you go into each date and look at the scope of practice for a podiatrist that's treating the foot and ankle injuries. And when you get into power mobility devices and the coverage criteria specifically related to upper extremity strength and neurologic status and so forth, that's outside their scope of practice and training and so that would not be one. But in terms of you know, can an internist or a neurologist or

psychiatrist or somebody prescribe a power mobility device certainly they are able to do that.

And the referral to a physical therapist to complete the face to face examination is not a requirement. I mean we have that in there because we have some physicians who say you know, I only prescribe a power wheelchair every other year, I would prefer to have, you know, someone that does this more often help me with this. And so you know, that is in there that allows the physician to initiate the face to face or and have someone else complete it or have someone else completed in their entirety, but he has to review it in and agree and stay concurrent, so disagreement with the evaluation.

But in terms of you know, what type of physician it really has to do with their comfort level. Does that answer your question?

Diana Escalera: Is there any documentation – well, yes and no because we’ve had – we have dealt with miles in the past like when it’s been a neurologist. Is there any documentation, I know there is no requirement, but is there any recommended documentation that could be sent in with the (par)?

Robert Hoover: I don’t ...

Diana Escalera: You know to indicate to ...

Robert Hoover: ... again, without seeing – without seeing the denial, I don’t – I don’t know that your denial there was specifically because the person doing the evaluation was a neurologist. I can – I can say with pretty good certainty that wasn’t reason for the denial was the type of doctor that did the evaluation. It was more likely related to the content of the evaluation and you know, the way it was documented just didn’t support or didn’t paint a clear picture of the patient’s mobility limitation.

Diana Escalera: OK. OK, thank you.

Robert Hoover: Thank you.

Operator: And again, that is star then the number one on your telephone keypad to ask a question.

And you have a question from the line of (Teresa Torres) of AOTA. Your line is open.

(Teresa Torres): I was wondering if an order is non-affirmed, is there a number of times that the same order can be resubmitted.

Robert Hoover: If an – let me ask to restate your question, so if a prior authorization request is non-affirmed, is there a limit to the number of times that it can be resubmitted, is that correct?

(Teresa Torres): Correct, yes, sir.

Robert Hoover: There is not a limit. Unlike advanced determination of Medicare coverage or ADMC where you have a two-time limit and then you have to wait before it can be resubmitted. The prior authorization process allows an unlimited number of resubmissions.

(Teresa Torres): Do you get a specific statement of why it was not affirmed, so you'll know how what you need to resubmit?

Robert Hoover: Yes, there is in the non-affirmation letter there is very specific to why the chair was non-affirmed or if it was rejected you get information about that as well.

(Teresa Torres): OK, thank you.

Robert Hoover: Thanks, (Ms. Torres).

Operator: And your next question comes from the line of Tony Longo of Providence Health. Your line is open.

Tony Longo: Yes, I actually have a few questions kind of off topic and I was there more for L codes for orthotics. And I was wondering if you could just give me an idea of where I can go to submit those questions.

Robert Hoover: You know, my suggestion would be to contact provider outreach and education in your jurisdiction – in jurisdiction’s contractor. You know, look on the DME MAC. I don’t know where you are located, but look in your jurisdictions – on your DME MAC’s website and you can look under their educational resources they often live the contact e-mail address for questions. They’ll also have their educational schedule if they are doing a webinar for example on L codes that maybe a place for you to go to get your questions answered.

(Tony Longo): Thank you.

Robert Hoover: All right, thank you.

Operator: And again that is star then the number one in order to ask a question.

And we have another questions from the line of (Teresa Torres). Your line is open.

(Teresa Torres): Thank you. Now I understand that the other accessories such as the power tilt or a combination tilt and recline, this is a little confusing to me. You said and is considered part of the whole process. I understand that if you don’t get prior authorization for those devices. But what is the authorization of those devices then? Are they as it is now where the vendor bills it and then they just wait to see if it was in fact approved? If you could speak a little bit more back because that you kind of confuse me when you said that they are considered, but they are not really ...

Robert Hoover: So and I try to use those words very carefully. To not use the word authorized because this is the – the prior authorization program is for the base itself. So let me see if I can use words that will make it clear. So when you submit a prior authorization request, you will get a decision an affirmed or a non-affirmed or rejected a decision.

(Teresa Torres): On the base.

Robert Hoover: On the base, the K0856 or the K0861, that's your side of the fence. On my side of the fence in my medical reviews nurses when I am – when we are looking at documentation, we are looking at the documentation for the K0856 space, the mobility limitations and so forth. But we are also looking at the medical documentation related to let's say for example a power recline system on a K0856. So if there is no need for a power recline, there is no need for an alternative drive control. Then that K0856 is likely going to be non-affirmed because those requirements are inherent to the coverage of the K0856 space.

So let's say we – you get an affirmed response. The affirmed response means we are affirming the K0856 that's it. We are – we aren't putting in the letter that the power recline system is also affirmed.

So if you think of an affirmation as it although it's not. If you think of it as a guarantee of payment that you can think of it like we are guaranteeing, we are going to pay the base, but we are not guaranteeing that the recline is getting paid.

But I think if you – if you take the fact that the power recline is required to be medically necessary in order to pay for the base it is an all great likelihood the recline is going to be paid in addition to the base. But we can't put that in the prior authorization letter because we are only authorized – we are only authorized to prior authorized the K0856. I was trying to figure out a way to say without it's coming out kind of stupid.

(Teresa Torres): Yes. No, I understand that.

Robert Hoover: Does that make sense now?

(Teresa Torres): Yes, I understand that, but my question is what about the approval of the accessories? Does that go through the typical...?

Robert Hoover: You will find out – you will find that out when you submit the claim.

(Teresa Torres): OK.

Robert Hoover: And the claim gets adjudicated.

(Teresa Torres): So nothing really has changed regarding that aspect of it?

Robert Hoover: No.

(Teresa Torres): OK, all right. OK. Thank you.

Robert Hoover: Thank you.

(Teresa Torres): I just have one more question, but I can call back in if you want me too.

Robert Hoover: That's OK. Go ahead and ask your question while we have you.

(Teresa Torres): OK. But it's not a question, but it's a comment about the 7-element order having each one of the element having to be hand written by a doctor. I will tell you I've been screened it so many times as an OT trying to obtain that from the doctors. You know, in the past, a couple two years ago, you know, it was that maybe a doctor's secretary could fill out the components and the doctor sign it or the therapist fill it out and the doctor sign it. Now of course it has to all be in the doctor's signature. I mean the handwriting is that ...

Robert Hoover: It doesn't have to be handwritten. I mean, we will – we do take electronic orders and you know, with electronic health records that we see now and that you know, a lot of the medical facilities are using, you know, we accept a handwritten order. We accept an electronic order and that's acceptable.

(Teresa Torres): So my question is then if (Inaudible) prescribing specialty occupational therapist performing the evaluation and if I fill out the six elements and that five elements and the doctor signs his signature and the date, are you saying that's acceptable?

Robert Hoover: What I would say, you were talking about the physician's complaining that they have to handwrite the order.

(Teresa Torres): Right.

Robert Hoover: And that is not correct. That is an option is that they can take a pen out of their pocket and write on a piece of paper the 7-elements on the order. They can fill out a template. And in this day of electronic health records, they can sit down at their computer and type out the 7-element order or fill out a template on the computer if it's set up that way in their electronic health record. And electronically signed and dated and we accept that as well. But that has been again a question.

And what I would encourage you to do again on our website and all four DME MAC websites we address the issue of the 7-element order. The completion of the 7-element order, the use of template all of the questions that you are asking I think are handled in the documents that we have on our websites. And I would encourage you to take a look at that.

I know on the Jurisdiction C website, on the homepage, there is an icon down to the right hand side of a wheelchair. And if you click on that wheelchair it has all of our resources related to power mobility devices including completing the 7-element order and the methods for doing that, who can do that.

(Teresa Torres): OK, thank you very much.

Robert Hoover: All right, you are welcome.

Jill Darling: (Amy), we'll take one more question please.

Operator: Your last question for today comes from the line of (Sharon Bridman) of (Prometheus Group). Your line is open.

(Sharon Birdman): So that's OK my question was regarding the accessories and Dr. Hoover did an exceptional job explaining (inaudible), no questions. No further questions for me. Thank you.

Robert Hoover: Thank you, (Sharon). I'll get your payment for that nice comment to you shortly.

Jill Darling: All right, well. Dr. Hoover or (Amy), any closing remarks?

Amy Cinquegrani: This is (Amy). Nothing for me. Thank you so much to Dr. Hoover for presenting and to everyone for joining the call today.

Robert Hoover: Thank you very much. I appreciate it. It's been a pleasure.

Operator: Thank you for participating in today's Special Open Door Forum. This call will be available for replay beginning today at 5:00 p.m. Eastern through May 2nd at midnight. The conference id for the replay is 4591992. And the number to dial in for the replay is 855-859-2056.

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

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