

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Prior Authorization Process for Certain DMEPOS Required  
Prior Authorization of Pressure Reducing Support Services  
Moderator: Darling, Jill  
June 4, 2019  
02:00 PM ET

Operator: Good afternoon. My name is Thea, and I will be the 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 Required Prior Authorization of Pressure Reducing Support Services.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star and the number one on your telephone keypad. If you would like to withdraw the question, press the pound key. Thank you. I will now turn the call over to Jill Darling. Please go ahead.

Jill Darling: Great. Thank you Thea. Good morning and good afternoon everyone. Welcome to today's Special Open Door Forum. I'm Jill Darling in the CMS Office of Communications and before we get into today's presentation, I have one brief announcement. This Special Open Door Forum is open to everyone, but 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 do have any inquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov), and I will now hand the call off to Amy Cinquegrani.

Amy Cinquegrani: Hi everyone. This is Amy Cinquegrani. I am the Director of the Division of Payment Methods and Strategies, which is part of the Provider Compliance Group in the Center for Program Integrity at CMS. We're happy to present some information on the prior authorization process for support services today. Unfortunately, we are running into some technical difficulties with getting our slides up on our website. There's a chance that they could be available anytime between now and tomorrow. Hopefully, it's going to be sooner than later and if we get word that they're available while we're on the call, we'll certainly point them

out to you, but I believe on the special open door forum announcement for this call, there is a link to our prior authorization webpage and there's some additional information on that website that maybe helpful as you're following along today.

We do have an updated operational guide, which has some of the additional details for the prior auth. process for support services including some of the timeframes and other things that we'll be referencing during the presentation.

I believe that there'll be a transcript available of this later if folks want to go back and follow along once the slides are available, but we're just going to do our best to give as much information as we can. Just in case you don't have the announcement or you're looking for our regular prior auth. website, it's [go.cms.gov/dmepospa](https://go.cms.gov/dmepospa) and that's where our support materials are located and the slides will be located hopefully soon.

So the purpose of the call today is just to provide an overview of the prior auth. process for certain DMEPOS items and we have authority for this program through the Social Security Act. And we finalized a regulation, which is CMS 6050F and if you're interested in the actual code of federal regulation sites, they're at 405.926 and 414.234. And more importantly we'll go into some more specific details about the prior authorization process for the pressure reducing support services that has been added to the required prior authorization list.

Just for some additional background, prior authorization is a process through which a request for coverage is submitted before an item is provided to a Medicare patient and before the claim is submitted for payment. This helps make sure that all of our Medicare rules are met before the item is furnished and it gives some assurance in this preliminary finding that a future claim that's submitted to Medicare for these particular item meets Medicare coverage and payment requirements.

So this prior authorization process is primarily geared towards suppliers and Medicare patients. While patients are available to submit prior authorization requests, we expect that most of these requests will come from the DME suppliers.

So, there are five group-two pressure reducing support service codes that have been added to the required prior authorization list. I'm not going to give the full code descriptors, those are available on our website and if you have some of the additional support materials, but I'll just list the codes briefly. They're E0193, E0277, E0371, E0372, and E0373 and these are all group-two support services.

This prior authorization process is going to be implemented in two phases. We did that because we want to make sure that everything is working well in phase one, which is limited to only one state in each of the DME MAC jurisdictions. We want to make sure that everything is working well before we expand nationwide. We recognize that this is the first time that as part of this program, we will be requiring prior authorization for an item other than a power mobility device or a power wheelchair and so we recognize that there are some differences in this program than how the program has been working previously.

So, again we've chosen one state in each of the DME MAC jurisdictions to start out with for phase I. In jurisdiction A, it's New Jersey, jurisdiction B, it's Indiana, jurisdiction C, it's North Carolina, and jurisdiction D is California and like in typical DME claims processing, the states are assigned based on the beneficiary's address.

Phase I for the support services that we noted will require prior authorization for dates of service or dates of delivery after July 22, 2019. Phase II, which expands the requirement nationally is scheduled to begin October 21, 2019 and those dates were in our Federal Register notice that came out a few weeks ago, but primarily this call is geared towards that phase I process.

I did want to note that prior authorization of these particular codes for patients that have a representative payee, they are exempt for prior authorization. Or I should say is exempt during the phase I four state process. So once the prior authorization program becomes national as of phase II, then these representative payee exclusions won't apply and prior authorization will be required for all claims. So again just during this phase I four state rollout, rep payees are exempt from prior authorization.

Next, I just wanted to talk again about some of the benefits of the prior authorization process. It helps the suppliers know earlier in the process

whether Medicare will likely pay for the DME item, and helps the patients know prior to receipt of the item whether Medicare will likely pay for the item. And it allows an opportunity for the DME MACs to assess the medical information and different elements of the particular requests prior to making a claim determination, and they can provide feedback on the particular item that's to be furnished. And this really helps us get away from potential future audits and get away from that pay and chase auditing that can lead to appeals and cash flow issues. And so prior authorization really helps them avoid all that upfront.

Just as another reminder, during the prior authorization process, the coverage criteria, the different Medicare policies and documentation requirements, they're not changing. We're not requiring anything that's different that suppliers aren't already required to maintain for Medicare payment purposes. We just will require that information earlier in the claims process.

So, there's no new requirements. The same DME MACs that do medical review now and that review claims for payment now, they'll continue to conduct the reviews. And ABN policies and claim appeal rights are not, they don't change during this process either. So, there is important information that needs to be parked at every prior authorization request to make sure that it can be processed appropriately. The request needs to identify the beneficiary information, their name, their MBI, date of birth and address; the supplier's information needs to be on the request as well; the requester's information if it is different than the supplier, their name and contact information needs to be on the request; the date of submission, the particular HCPCS code that prior authorization is being requested for. The request needs to indicate whether it is an initial or resubmitted review. And the request needs to indicate if it is an expedited prior authorization request and the reason why it is expedited.

Some additional information also needs to be included from the prior authorization request and we believe that this information will likely be coming from the provider of the prescriber, the written order for the particular item and documentation from the medical record that supports the medical necessity of the item.

All of our DME MACs have coversheets that are available on their website for you to use when submitting your request and just I wanted to

mention that there's no particular form that suppliers are required to use in submitting this information. But there are checklists available and these coversheets that the MACs make available, they'll help ensure that you have everything that you need, and that helps again make sure that they can process your request appropriately, especially if you're requesting an expedited review when time is more of a critical factor.

So, as mentioned before, the supplier or the Medicare patient can submit the prior authorization request and again we assume that suppliers will be doing most of these requests, but it is available for the patient or beneficiary as well. The request can be mailed, it can be faxed, it can be submitted through esMD, which is the Electronic Submission of Medical Documentation system, or once it's available, it can be submitted through the MAC's provider portal, and we believe that all of these portals should be available for submission soon and the MACs can provide additional information about those timeframes.

So moving on to the review timeframes, again we realize that the support services on this process is a lot different than power wheelchairs, and we recognize that and we have the ability through our program to make adjustments to the timeframe if need be. And so for initial requests, actually both initial and resubmitted requests, the DME MAC will make a determination within five business days. And so a resubmitted request again is, you know, if you've submitted an initial request that comes back not affirmed or not approved, and we can talk a little bit more in a few slides about what those terms mean, but if your initial request is not approved, you do have the opportunity to resubmit as many times as necessary with additional documentation. And so the timeframes for those resubmitted request and those initial requests are both five days, there's no difference in the timeframe.

For expedited review requests, we recognized for these items there may be circumstances when an expedited review may be appropriate and that is when a prior authorization request that takes the normal decision timeframe could jeopardize the life or the health of the Medicare patient. And so in those cases, the DME MAC can make a decision within two business days of the expedited request. If you are submitting an expedited request, we really encourage you not to use the mail, hopefully folks will take advantage of some of the other processes to submit those requests and the DME MACs will also make sure that they're communicating their

decisions to you in a method that is more real time and gets you immediate feedback, so you're not waiting for a letter as well.

So again, we really hope that mail won't be a factor during those expedited requests, but it is available if one of the other methods doesn't work out. So now, I am going to turn the presentation over to Dr. Scott Lawrence to provide some additional information.

Dr.Scott  
Lawrence:

Thank you very much Amy. Actually, we're going to talk about the detailed decision letters. These are letters that the MAC will send back to the requester of the prior authorization to let them know whether the decision was an affirm or non-affirm as they agreed with the prior authorization request or did not agree with the prior authorization request.

Medicare patients can receive a copy of this letter upon request and the DME MACs may also just send them letters voluntarily depending on the MAC's own policies. Prescribing physicians can also receive a copy of decision letter upon request. If the request is not affirmed, the letter will provide a detailed explanation for the reason of the non-affirmation.

All of the claims will have a unique tracking number. Decision letters for both affirmed and non-affirmed decisions will contain the unique tracking number or UTN. Claims submitted must include the UTN in order to receive payment. Any claims that are sent without the UTN will be denied payment.

When a prior authorization is submitted and affirmed, claims for which there is an associated provisional affirmation for prior authorization 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 additional review. Your claims may be chosen, however, as a part of the CERT sample or by UPIC or other organization either if they're looking for fun or gaming issues or just as a random sample for other auditing purposes.

When a prior authorization request is considered non-affirmed, the requester can resolve the non-affirmative reasons, which is described in

the decision letter and resubmit the prior authorization request. An unlimited number of remissions are allowed, however, a non-affirmative prior authorization request decision is not appealable.

A requester can forego the resubmission process if they choose and provide the DMEPOS item and submit the claim for payment, but the claim will be denied. All appeal rights, however, are available under that scenario. As described in the CFR, the Federal Register sections 405 and 414, if an item is selected for required prior authorization under the program, then submitting a prior authorization request is a condition of payment.

Claims for items subject to required prior authorization submitted without a prior authorization determination and the corresponding UTN will automatically be denied. DME MACs have special tracking for requests that are not approved due to documentation errors where the patient may otherwise meet Medicare's coverage criteria.

Suppliers with these documentation errors receive individualized education and are encouraged to resubmit the request to ensure their patients receive the necessary item for which they're covered. For those who eventually see the slide deck, which we understand is currently trying to be pushed onto our website, the link is on the other documentation. We have a slide that has a flow chart of the process for this prior authorization of certain DMEPOS items, and it explains the responsibilities of the patient, of the certifying physician/qualified practitioner, the supplier, and the MAC and how the decisions and information would track back and forth between each other.

I would describe it, but I think that perhaps it would be better to just wait until you see it on your own, it makes a lot more sense that way. We also, on the slide deck, have another side, which gives the process for the decision tracking tool. And again, this is a situation where it will trace through what happens if it's affirmed or not affirmed and what the process could be to eventually get you through the tracking process. I will explain some scenarios to try and help understand how the prior authorization process will work. So if a prior authorization request is submitted and the MACs decision is affirmative, the supplier (or the beneficiary if they choose) will submit a claim and the DME MAC will pay the claim as long as all the other requirements are still met. In a

situation where the decision is non-affirmed when this prior authorization request is submitted, there are two options.

One is the supplier can submit the claim anyway, and the claim will be automatically denied and appeal processes are available; however, if they decide to resubmit (and again they are in an unlimited number of resubmissions that are available), they can fix the problem that was described in the detailed decision memo that's sent back and resubmit the request.

The MAC will then review the resubmission and render a new decision. In prior authorization programs, we had historically seen where the majority of these submissions are affirmed on the first submission and then the balances are mostly affirmed by the second decision, so 96% historically have been affirmed by the second submission - 80% being the first submission, 16% with the second submission.

So this is a pretty efficient process and the community education that MACs provide is very helpful to the suppliers in this process and so is really designed to get the prior authorization through for patients who need these items. This, however, prior authorization is not submitted, then there will be no decision by the MAC one way or the other because nothing is there for them to decide.

This claim is submitted and that will automatically be denied, but appeal rights are available through that process. To be clear on the impact to the Medicare patient, the benefit is not going to be changing. Medicare patients will know earlier in the process if an item will likely meet Medicare's coverage requirements. Medicare patients may receive a copy of their prior authorization decision upon request. Dual eligible coverage is not changing either and non-affirmed prior authorization decision is sufficient for meeting states obligations to pursue other coverage before considering. Medicaid coverage and private insurance coverage is also not changing.

CMS will have oversight over this project. CMS will contract with an independent evaluator to analyze the impacts of prior authorization including impacts to patient care, access to service, and overall expenditures and savings. CMS will conduct regular reviews of DME MAC prior authorization decisions. The CMS will discuss these findings



with and see feedback from the DME MACs during regularly scheduled meetings.

At this point, I would like to hand the call off to some of the medical directors for the MACs, and we're going to start off with Dr. Mamuya and Dr. Gurk from the MACs.

Fred Mamuya: Thank you, Scott. I think we'll start out by providing information on where you can find all the requirements for coverage for group II pressure reducing support surfaces (Group II PRSS), and then on the second part give a very high-level overview of what the policy is and as Scott indicated, it really hasn't changed.

So, if anyone on the call goes to the Medicare coverage database, the actual policy we are discussing today is LCD L33642. One of the things we remind everyone is that is not the only document one needs to read, one also needs to read the policy-related article (A52490), which contains all the nonmedical necessity requirements that also have to be met. Finally, the last document is also a DME MAC article (A55426), which outlines all of the standard documentation requirements for Medicare DMEPOS claims. These are the three documents that we would urge everyone to read.

This second part is a high-level overview of LCD L33642. As Scott pointed out, there's nothing changing in terms of coverage. This is a very old policy. It's over 15 years old, and I think it that since it became effective in October of 1993 very little has changed. There are three buckets under this policy, and there's one requirement that is applicable to all three buckets, which is to have a care plan by the treating practitioner that addresses all the other things that we know are required for wound healing.

The plan should address nutrition, moisture and incontinence control, appropriate wound care, turning and positioning etc. e Everyone who's on this call who has taken care of wounds will be familiar with those requirements. So that's the minimum and then after that minimum, we really have three buckets.

The first one is people with multiple stage II pressure ulcers located on the trunk of pelvis. They need to have been treated with a Group I PRSS

and have failed to improve over the past month. So, there's a 30-day requirement of being on a Group I PRSS, and taking care of all the other factors we talked about in terms of getting that wound to heal.

The second bucket is someone with very large or multiple stage III or IV pressure ulcers on the trunk of pelvis. Once again, an appropriate medical treatment plan needs to be in place.

The third bucket are beneficiaries who have received a myocutaneous flap or graft to a pressure ulcer on the trunk of pelvis within the past 60 days. It is required that they have been treated with a Group II or III PRSS prior to discharge from a hospital or nursing facility within the past 30 days.

The third bucket is perhaps where we might expect to see some expedited requests, since as you can see from this high level overview, it would be rare for Medicare beneficiaries in the first or second buckets to have reasons for an expedited request..

By the way as a general rule for the third bucket, coverage is usually limited to about 60 days from the date of surgery. I think this sums up a very high level overview of LCD L33642, and I'm sure there will be perhaps questions in the Q&A section. Dr. Gurk, is there anything I have missed before we turn it back over to CMS?

Peter Gurk: No. Thank you Dr. Mamuya. I think that was very well stated.

Fred Mamuya: CMS, back to you.

Amy Cinquegrani: Thank you very much. So, once the slides are posted, which we understand again is happening actively, you'll find information there with respect to the local coverage decisions as Dr. Mamuya was describing also with respect to how to reach the different MACs, Medicare Administrative Contractors that are involved with dealing with DMEPOS items. So in summary, we're dealing with five codes. They're all Pressure Reducing Support Surfaces, E0193, E0277, E0372, and E0373. We have two phases, and phase I we will start in California, Indiana, New Jersey and North Carolina.

Submissions can be submitted starting July 8, 2019 and the impacted dates of service will begin on and after July 22, 2019. These can be submitted by the supplier or the beneficiary, but all required documentation has to be submitted regardless of who we understand predominately suppliers will be sending in this information. Phase II will go nationwide. Submissions will be accepted by the MACs on October 7, 2019 with impacted service dates being October 21 and afterward of 2019. And again everything can be submitted that way.

We believe that the slides are up on the website and so if anyone is checking they can check that. CMS is also adding seven hick picks codes for power mobility devices, PMVs too require prior authorization list. These are K0857, K0858, K0859, K0860, K0862, K0863 and K0864. Prior authorization for these codes will be implemented nationwide beginning July 22, 2019.

Timeframes for prior authorization for PMVs will remain the same, 10 business days for initial submissions and 20 business days for resubmissions with two days being the same for expedited request. All hick picks codes previously added to the required prior authorization list will continue to be subject to the requirements of prior authorization. We do have a link to the prior authorization list in the slide deck and is available on the website as well.

Local coverage decisions and policy articles as were described by our medical directors for pressure reducing surfaces for group two are available at LCD-33642. Prior authorization website is [go.cms.gov/dmepospa](https://go.cms.gov/dmepospa) and feedback can be given to [dmepospa@cms.hhs.gov](mailto:dmepospa@cms.hhs.gov). There are hyperlinks in the slide deck for those who need them and also available in other documentation. Thank you very much for listening in on our presentation. This concludes the formal portion of our presentation and we will be opening up for questions.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star one on your telephone keypad. If you would like to withdraw the question, press the pound key. 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 one again to rejoin the queue. The first question will come from Andrea Stark with Mira Vista, LLC.

Andrea Stark: Good afternoon and thank you all for that informative presentation. I do want to commend CMS for making a change to the decision timeframe. I think a five-day turnaround timeframe alleviates a lot of concerns that we have in the industry with regards to this product proceeding. My first question for you is about the group two authorization process, and I would like to know whether or not we would be able to begin the authorization process towards the end of a group one support trial.

As a condition of payment and the LCD it requires a 30-day trial; however, if we wait until the end of the trial and then add a five-day additional delay for proceeding through the normal channels that could delay the patient from getting treatment and allowing those all service to continue to deteriorate. So, will there be an allowance to begin the authorization process say between 5 or 10 days prior to the exhaustion of the 31-day trial?

Amy Cinquegrani: Hi, Andrea. I think that's a great question. I'm going to ask the Medical Director to provide any additional information. I would think that in the documentation that's submitted in your request, you know, the timeframe, you know, reviewers should be able to see that it is coming towards the end of that 30-day timeframe and one would suspect that if you received an affirmative decision by the time the claim is submitted then that timeframe, the full timeframe would be exhausted. But I'm going to have the Medical Director please share if you have different thoughts and maybe this is something that we can provide some additional guidance on.

Fred Mamuya: No, I think you hit it on the nail. I think we certainly can make that connection in the records, so I don't think that will be a problem.

Peter Gurk: Yeah, this is Dr. Gurk. I agree.

Amy Cinquegrani: Thank you Dr. Mamuya and Dr. Gurk. I appreciate that feedback.

Robert Hoover: This is Dr. Hoover at CGS, Jurisdiction C. I think the caveat there is, it [the prior authorization request] needs to be done closer to the end of the 30-day period than the start of the 30-day period, you know not three days in. It would make it difficult because we are approving the medical

necessity of the support surface when we are doing our review. So, I mean, technically we're going to be looking at documentation that at the point that we're looking at it, they haven't met the failure to improve over the past month. So I would just encourage you to be closer to the end of the period.

Amy Cinquegrani: Certainly, and is there possibly discussions that might take place to solidify consistency as far as how close is 10-day leeway efficient to begin the process or 5-day to allow certainly five business days could be a week if it was started on a Friday. And so is 10 days, you're 20 days into the trial period, would that then be deemed acceptable by the medical directors?

Robert Hoover: [Multiple speakers] Noridian and CGS do work on consistent review guidelines and I think that's something we'd have to address internally and also address with CMS because like I said, we are technically approving something before it's reasonable and necessary according to the LCD.

Amy Cinquegrani: Certainly. Thank you.

Operator: The next question is from Sandy Freeman from Medo Lake Home.

Sandy Freeman: Hi. If we get prior authorization approved the first time around the initial, is that for 30 days and then will we need to get additional authorization thereafter?

Amy Cinquegrani: Hi. This is Amy. Well, I'll take a stab and you can correct me. Our prior authorization process is for initial rentals. So I think there is -- we wouldn't expect you to need another prior authorization decision for every subsequent month. Dr. Mamuya, is that what you were going to say?

Fred Mamuya: Yes, Amy. Thank you.

Amy Cinquegrani: Okay. Thanks.

Dr.Scott  
Lawrence: And this is Dr. Scott. So, I'm just going to add, if they already have the device, you won't need to prior auth. them using the same device, it would only be for new devices.

Amy Cinquegrani: So when we receive our initial authorization, will it have dates on it? The next we need to jump in from the claims processing perspective, but I believe that you can use your UTN you would use that on every monthly claim submission.

Sandy Freeman: Okay. Thank you.

Operator: The next question is from Karen Brand with All Saints Medical.

Karen Brand: Good afternoon. Actually you guys just answered my question. I had the same one as the previous. Thank you.

Operator: The next question is from Daniel O'Malley with Drive.

Daniel O'Malley: Hi. Thank you very much. Can you define under the coverage criteria large pressure injury or pressure ulcer I know in the past 8 square centimeters was kind of the standard and then also can you elaborate on will unstageable pressure ulcers also be covered? Thank you.

Fred Mamuya: I'll take a stab and then hopefully the other medical directors will rescue me I don't think I can give you a number on what large is. It usually depends on the clinical judgment of the reviewer and the totality of the medical record. This policy was written back in 1993 and perhaps we were not as precise, you know, with the wording as we perhaps should have been.

I think the key to the second bucket really is the fact that when you get into stage three or four that perhaps is a better differentiator than the unanchored "large", which can vary in terms of judgment. In this policy, I think we're going all the way back to 1993 did not have coverage criteria for an unstageable. As Scott indicated earlier, and I also indicated in my earlier remarks, we have not changed the policy. Whatever we have reviewed for in the past 15 years, we'll continue to do when it comes to coverage.

Daniel O'Malley: Thank you. Just following up on unstageable pressure ulcer on the trunk of pelvis as well.

Robert Hoover: This is Dr. Hoover. In LCD, we have ICD-10 codes that are covered. We do have some unstageable codes in there, and I think to follow up on what Dr. Mamuya was referring to about the "large", I mean we have not defined large because there's, as you know, more factors that we take into account when it comes to our pressure ulcer than just the surface area. We look at tunneling and undermining and factors such as that when our staff and the medical directors were reviewing these types of claims.

Daniel O'Malley: Excellent. Thank you.

Operator: The next question will come from Ryan Antao with Dusara Corporation.

Ryan Antao: Good afternoon. I've a couple of scenarios. One is if a patient or beneficiary has Medicare as a secondary payer, I would assume prior authorization would still be required to parallel the power mobility process. And I just want to confirm that if it's not discovered that the patient has Medicare secondary until after the item is provided. If we go through the appeal process, would we be looking at a percentage of the reimbursement that would be provided or would we be able to recover the complete reimbursement of that secondary?

And then also a change of supplier scenario if supplier A provides the group two support surface, which is then picked up and supplier B provides the support surface at a later date, would we need be requesting a new prior authorization under new UTN number or would we have to continue the existing one?

Amy Cinquegrani: Hi. This is Amy. I think a lot of those questions can probably be answered in the updated operational guide that was posted earlier today. I took some notes, so I'm going to try to see if I can hit on them. So similar to the PMD prior authorization process, the operational guide addresses different pair scenarios if Medicare isn't the only or primary payer. I think you also mentioned if someone has like retroactive Medicare coverage and we did add some information to the operational guide that we hope will address that as well.

If prior authorization for an item is required for payment and patient already has the item, but their coverage is retroactive, you will still need to go through that prior authorization process to ensure that the item is covered under Medicare and there are some specific guidelines in the operational guide that can help you when submitting that prior authorization request since it's a little bit different since the person already has the item.

And I think the last thing you mentioned was change in suppliers and we have that chart towards the end of the operational guide that I think should address this as well. If it's during the initial rollouts where are the initial fees of this process where there's only certain states applicable, it's going to depend on if the supplier is, you know, in the same state or is in a different state than is included in the first phase.

But typically assuming that prior authorization is required for both suppliers then the new supplier doesn't have to undergo a new prior authorization. The decision and the claim information stays with the beneficiary, but again I encourage you to review the information that's in the operational guide and I think that that should help clarify in case I didn't quite touch on all the nuances in your question.

Ryan Antao: Okay. Thank you.

Operator: Once again if you would like to ask a question, please press star one on your telephone keypad. Again, that's star one for any questions. We do have a follow up from Andrea Stark with Mira Vista, LLC.

Andrea Stark: Thank you. One short question and then another follow up question. The short question is under the PNB prior authorization process, the authorization was valid for delivery that would take place after six months after securing an approved UTN. The nature of support surfaces is slightly different and I did not see any updated operational guide a disposition on how long the authorization remains valid for delivery. Is there any guidance on whether that will be three months or 60 days, obviously sometimes patients are being admitted, they're in-patient in anticipation about patient may be delayed is certainly some timeframe



beyond a week to two weeks, possibly a month to two months would be needed, so that's the first, hopefully a short question.

Dr. Lawrence: This is Dr. Lawrence from CMS. I think these would be taken on a case-by-case basis, so when you send in your prior authorization at the appropriate timeframe, of course the current coverage rules and guidance don't change. So all those requirements would be met on the prior authorization request and then once the claim is submitted, if for some reason there is an extended period of time you may be reviewed, you know, or additional information may be requested by the MACs to try and to clarify the purpose for any kind of abnormal delay. So, I'm going to ask for the medical directors to weigh in if they disagree with that.

Fred Mamuya: No. I think you got it right, Scott. And part of the reason, Andrea, is that we're talking about conditions that change week to week in terms of wounds - if they're healing or getting worse - and so it would be a little unlikely to expect absolute stability for 60 days from a prior authorization to delivery. So, yes, it'll be case by case, at least that's my sense. And in those cases, most likely we might need additional clinical documentation.

Andrea Stark: Very good. And if I may ask one additional follow up question - three of the five HCPCS codes are considered mattress replacements and during the prior authorization review process, typically the DME MACs review for same and similar. If these beneficiaries are currently renting hospital beds with mattress, the MACs typically would deny the claim for support surface until the mattress is collected and the bed is down-coded. Typically, MACs reviewers are going to be evaluating for same and similar, so will the CMS direct reviewers to advice the conditional approval pending the pickup of a bed frame mattress by the supplier, and obviously contingent upon the down code of the bed with mattress.

Amy Cinquegrani: This is Amy. I'll take a stab and then I'll turn it over to the DME MACs. I think during the, you know, same as similar would be reviewed as they typically would and that would be something that maybe checked during the actual claim submission process. So, I wouldn't expect that that claim would get paid if there was still that first item out there, but medical directors feel free to jump in and we can issue some clarifying information if necessary.

Fred Mamuya: I think your sense is right, Amy. I don't think we can suspend rules that are based on the CFR regarding same and similar. And so, I think we would just need to take it case by case, but I think that upon review, Andrea, those rules will still be in play.

Andrea Stark: Okay and if I could just stop or suggest you while this is being developed if it would be possible to perform this same and similar query to document that there is a bed that is currently renting with mattress. If they are one of the three codes to alert the supplier that, you know, if it's not picked up, you know, it will cause future denial, but it would not cause denial of the authorization request due to the distance of that equipment because it's not really same and similar until the support surface is delivered and it would be expected to better address the patient's medical need to replace that existing standard mattress with these group two products.

Fred Mamuya: It's an excellent suggestion. Andrea will take it back to our staff.

Andrea Stark: Thank you, Dr. Mamuya.

Operator: And at this time, there are no further questions.

Dr. Scott: So, we would like to thank everybody for their time and their thoughtful questions and comments. We appreciate that all, and we'll consider discussing them and any things like that. Please look at the materials on the website so you can better familiarize yourself with the process. And thank you very much. This will conclude our special open door forum.

Operator: Ladies and gentlemen, thank you for participating in today's conference call, you may now disconnect.