

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Prior Authorization Process for Certain DMEPOS:
National Expansion of the First 2 Items for Prior Authorization
Thursday, July 6, 2017
2:00PM Eastern Time
Conference Call Only
Moderator: Jill Darling

Operator: Good afternoon. 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 National Expansion of the First Two 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 one 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. Before we get into today's presentation, I have one brief announcement.

This Special Open Door Forum is not intended for the press and the remarks should not be considered on 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 will hand the call over to Amy Cinquegrani.

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

This is our fourth open door forum on this subject, but we thought with the national roll out of the prior authorization requirement for the first two items that it was important to have another opportunity to talk about this issue and get everyone's feedback.

Hopefully, folks have found our slides, which were put on our website this morning. If you go to CMS.gov and click on Research, Statistics, Data and Systems, you'll find an option for Medicare Fee for Service Compliance Programs.

And then on the left-hand menu at the bottom, an option for Prior Authorization for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies item, and that is our main program website. And the slides are available in the download section at the bottom of the page.

So, starting off with Slide 2 of our presentation. We're committed to launching this prior authorization program in an open and transparent manner that serves and protects our patients and the providers that care for them.

We have the opportunity to learn from both the patient and the provider experiences. And we welcome your feedback as the critical part of this process and we look forward to an ongoing dialogue to help us learn how the program can best meet our patients' needs.

So, to help us do this, we're working on improving our DMEPOS prior authorization website, posting helpful tools for patients, suppliers, and physicians that can improve transparency, protect access to care, and support direct engagement with our stakeholders.

So, the next slide, we have some information on the purpose of this program. In the slide presentation today, we're going to provide an overview of the

prior authorization process for certain DMEPOS that we've established in CMS regulation 6050, and we've provided the CFR citation for you there. And to provide some additional guidance on the first two codes that are on the required prior authorization list.

Next slide. The prior authorization is a process, which a request for provisional affirmation of coverage is submitted for review before an item is rendered to a Medicare patient and before the claim is submitted for payment. This helps make sure that the Medicare coverage, payment, and coding rules are met before the items are rendered.

And this provisional affirmative decision is a preliminary finding that any future claims submitted to Medicare for that item would likely meet our coverage, coding, and payment requirements.

So, on Slide 5, we have a little bit more of the background of the background of the prior authorization process. We announced through our regulation 6050, which was published in December of 2015, the creation of what we call the Master List, which is items that are frequent subject to unnecessary utilization and that could be potential candidates for prior authorization.

We can select items from the Master List to be subject to required prior authorization. So, not everything on the master list would then be subject to that required prior authorization.

We announced the items that we choose for required prior authorization through a Federal Register Notice and we did that for the first two items, which was published on December 21, 2016. And the existence of an item on that required prior authorization list is a condition of payment. So, this is not a voluntary option like previous prior authorization demonstrations.

On Slide 6, we have a little bit more of the details about who this program would affect, and it affects suppliers and their Medicare patients. And we note that this is going to affect anyone who bills for one of the items on the required prior authorization list.

So, certain claims from patients who had a representative payee on file were actually excluded during the initial four-state roll out -- roll out, but that's not the case for the national expansion and all those claims will be included and will require prior authorization.

And so, the two codes that are on the required prior authorization list currently are K0856 and K0861, and these are both group 3 power wheelchairs and they're both codes which are not included in the current power mobility device demonstration.

And so, moving on to Slide 7, again, this is a nationwide expansion. The phase -- the first phase of this prior authorization program was effective March 20th for Illinois and Missouri, New York, and West Virginia. And now beginning July 17th, all new rental series claims for these two items will be required -- will require prior authorization.

Slide 8 has a little bit more information about the why. Why are we doing prior authorization? We think it's good for a number of reasons. First, it allows the supplier to know earlier in the process whether Medicare is likely to pay for the items. And similarly, it allows the Medicare patient to know prior to receipt of the item that Medicare will likely pay for the item.

And it also allows our contractors, the DME MACs, to assess the medical information prior to making an actual claim determination to provide any feedback on the item that's going to be rendered. So, this is, you know, more of an upfront process to ensuring that the items are meeting our criteria.

Slide 9 has some information about what's not included in the prior authorization process and that's separate accessories. So, to back up a little bit, when we talk about items that are on the master list in the required prior authorization list through their individual HCPCS code.

So, the wheelchairs itself currently are on that list. Different accessories are currently not part of that Master List. So, they are not able to be subject to separate prior authorization.

And so, for inclusion on that Master List, an item has to meet certain criteria that is in our regulation and that's on that Slide 9 there. And since the wheelchairs, again, don't meet those criteria, they're not eligible under this program.

Continuing on for the next slide, when the evaluation for the item, in this case the wheelchair, supports the need for specific options or accessories, this were considered overall as part of the prior authorization.

And so, this -- the next two bullets actually come right out of the policy, the LCD for power wheelchairs, and we have some accessory codes that can be included in order to make an overall coverage decision on the base, such as some power seating options, head controls, joysticks, and different hand control interfaces.

And then, again, we have some accessory codes that are not required in order to make that overall coverage decision for the wheelchair, such as headrest, certain support hardware, electronics, and batteries. And again, this comes straight from the policy for the particular item. So, we encourage you to be familiar with that policy.

About a month or so ago, we actually had a separate open door forum with one of the medical directors for the DME MACs that actually went over this policy. And so, we have on that prior authorization website that I went over at the beginning of the presentation.

In the download section, there's another link to the actual policy itself as well as the presentation that the medical director went over. And so, this is coming straight from that.

Moving on to Slide 11. Even though this is a new program -- relatively new program for the last couple of months, there's a lot of things that are not changing in the program. The policy is not changing. Documentation requirements aren't currently changing.

Our same DME MACs will continue to conduct the reviews. This time they'll just conduct the reviews on the front end before the item is rendered. And ABN policies and appeal rights are not changing.

So, again, we're not creating any new requirements in this program. We're just simply requiring that the documentation that suppliers and physicians are required to maintain be submitted earlier in the claim process.

The next few slides have some information about what should be in the prior authorization request, obviously, beneficiary information, supplier information, prescriber information, the particular code that's being requested for prior authorization.

And it's important to indicate if this is an initial prior authorization request or a resubmitted prior authorization request and indicate if the request is expedited. Dr. Lawrence, in a few minutes, will have some information about what an expedited request is.

The next slide has some information that is specific to these two codes, particularly information that's specific to Medicare coverage for these two codes, such as the product description, an attestation statement, evidence of RESNA ATP certification, their involvement in choosing the wheelchair, and then other things from the policy that would be needed to establish medical necessity of the item, such as the seven-element order, a face-to-face, and the specialty evaluation.

And so, moving on to the next slide. The prior authorization request can be submitted by the supplier or the Medicare patient if they have all of the information available, but we believe that in the majority of the circumstances it will be the supplier that's doing the submission here.

The request can be mailed. It can be faxed. It can be submitted through our electronic submission of medical documentation system, and if it's available through your particular MAC, a portal. And we do have a link at the bottom of Slide 15 for more information about esMD if that's of interest to you for submitting those prior authorization requests.

And now, I'm going to turn it on over to Dr. Scott Lawrence.

Scott Lawrence: Thank you very much, Amy. I'm going to start with Slide 16, review timeframes. As Amy had described, there are a number of different scenarios. So, you have the initial request of the DME contractor.

They are trying to make every effort to review the request by 10 days once it is received. Resubmission request, which may be sent with additional documentation or other corrections will receive answers within 20 business days. Expedited circumstances, if that can be proven, will be responded to within two business days.

Moving on to Slide 17, the decision letter. The DME contractor will send the requestor of the prior authorization, which is whomever has actually sent the claim for payment, and a letter providing their prior authorization decision, either affirmative or non-affirmative. Medicare patients can receive a copy upon request if they are not the requestor.

The MACs may also (or the contractors may also) send these letters voluntarily. Prescribing physicians may also receive their copy of their decision letter upon request. If the request is non-affirmed, the letter will provide a detailed explanation for that decision and decisions on any individual accessory codes are not going to be included in these letters.

Moving on to Slide 18, the Unique Tracking Number. So, decision letters for both affirmed and non-affirmed decision will contain the Unique Tracking Number or UTN. Claims submitted must include the UTN to receive a payment.

Moving on to Slide 19. Claims for which there is an associated provision affirmation for the prior authorization decision will be paid in full so long as all of the appropriate documentation and the relevant Medicare coverage and clinical documentation requirements are met when the claim is billed and submitted correctly.

Generally, claims that have an affirmative prior authorization decision will not be subject to additional review; however, CMS contractors, including Zone Program Integrity Contractors (or ZPICs), United Program Integrity Contractor (or UPICs), may conduct pre- and post-payment reviews to ensure that claims are accompanied by the documentation and also the Comprehensive Error Rate Testing contractor may also select as random -- through the random sampling.

Moving on to the next slide, number 20. The requestor can resolve the non-affirmative reason described in the decision letter and resubmit the prior authorization request. There's an unlimited number of resubmissions that are allowed; however, the non-affirmative prior authorization decision is not appealable or the requestor can forego the resubmission process and provide the DMEPOS item and submit the claim, but the claim will be denied, although appeal rights are available in that circumstance.

Moving on to Slide number 21. As described in the Federal Register for Sections 405 and 414, if an item is selected for required prior authorization under the program, then submitting the prior authorization request is a condition of payment.

In other words, it has to be done in order to get paid. Claims for items subject to a required prior authorization submitted without a prior authorization determination and the corresponding UTN will be automatically denied.

We'll move on to Slide number 22. Here is a sort of a flow chart describing the process for prior authorization and I will not describe it in detail. It's on the slide. I think it's self-explanatory, but it goes with the process of (putting) claim on Slide 22.

On Slide 23, we're going to talk about the educational outreach for non-affirmed request. So, DME MACs, the contractors, have special tracking for requests that are not approved due to documentation 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 that the patient receives the necessary item.

And again, you can do that as many times as you need, but our experience has shown it hasn't taken that many attempts. In fact, most people got their authorization through on their first attempt.

Moving on to Slide 24. We have another flowchart, which I won't describe in detail, but it explains how the special tracking decision will occur. And it shows that if there's a problem with the documentation, an outreach -- or an outreach has to be performed or not performed in how that would -- how that would occur so people can look at that as they're having trouble getting their affirmed decision.

Moving on to Slide 25. We have the different scenarios that are available for the prior authorization request. So, we have two that involved a submitted prior authorization request packet, one where the decision is affirmed, the claim is submitted with all the proper documentation, and the claim is paid. And then next, we have the submitted but the decision was non-affirmed. There are two potential paths there.

One is with a submitted claim anyway and get that claim denied automatically or the next is where they fix the problem if they're going to fight the decision letter, they resubmit at that time, hopefully, the decision is -- it goes through again and affirmed, and then they can follow through and get the claim paid. If they do not submit a prior authorization or request, that's the third one, they'll submit the claim and the claim will be denied.

Moving on to Slide 26, overview of the impact to the Medicare patient. So to be clear, the benefit is not changing. Medicare patients will know earlier in the payment process if an item will likely meet Medicare's coverage requirements.

Medicare patients may receive their prior authorization decision upon request or it may come automatically based on the contractors' practice where you

happen to live. Dual eligible coverage is not changing and private insurance coverage is not changing. So, the only one that's changing is when the documentation appears, everything else is the same.

Moving on to slide 27, the oversight by CMS. We will contract with an independent evaluator to analyze the impacts of prior authorization, including the impacts to patient care, access to service and other overall expenditures and savings.

We also will conduct regular reviews with the contractors for the prior authorization decisions that they make, and we will discuss its findings with and seek feedback from these contractors during regularly scheduled meetings.

On slide 28, you will find contact information for your particular jurisdiction or for (other) jurisdiction if you feel like asking them a question, it's all there anyway.

On slide 29, we have the resources here at CMS, so we have the local coverage decision and policy article link. We also have prior authorization website that Amy had described how to find earlier but there's a link for you there. You can cut and paste it if you don't have the hyperlink capability, plus we have a mailbox for feedback if need be.

Then on slide 30, we will summarize, so we had two phases to our process. Phase I is already through. It started on March 20th and it was for the four states, one in each jurisdiction; each contractual jurisdiction for Medicare. And the submissions were made by suppliers and beneficiaries.

Now the purpose for this call is we're getting ready to start Phase II which is now nationwide. Same rules apply otherwise with the exception of the rep pay as we described for the same codes, business for items that are delivered on or after July 17th, 2017 and again submitted by supplier, beneficiary for Medicare patients.

And that concludes the presentation portion of our presentation and open door forum. We're ready to accept questions if anyone have any. I will ask will you please speak loudly because for some reason our connection is a little bit on the quiet side today. Thank you very much.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please 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. And we'll pause for a moment to compile the Q&A roster.

And your first question comes from the line of Diana Escalera from Academy Medical Equipment, please go ahead.

Diana Escalera: Hi, there. I just wanted to get final clarification on the ADMC time frame. If the ADMC was submitted by June 30th and we received the ADMC approval after July 17th, can we still deliver with that ADMC approval?

Amy Cinquegrani: Hi, this is Amy Cinquegrani. That's a great question and yes, I believe that ADMCs will – when actually the DME MAC began accepting submissions for prior authorization, that at that point they would not accept any new ADMC requests. But for anything in the process, those would continue.

Doctor – I know Dr. Brennan from the CGS is on the call. Dr. Brennan, is that correct or do you have anything to add to that?

Stacey Brennan: As far as I know that is correct. In terms of – I know that there's concern about overlap but I don't think that we're going to have any difficulty with that.

I – if there's anything that you don't hear about when you think you should have by a certain time, obviously I think you're – you really should contact that particular MAC for your jurisdiction.

Diana Escalera: OK and as a follow-up, my bigger concern with this is those ADMC approval numbers are of course formatted very differently from the UTN. Do you know if the MACs are receiving any instruction for properly processing those claims, so they're not denying out because it's not a formatted UTN?

Amy Cinquegrani: Hi, this is Amy again. Yes, we have given the MAC instructions to manually process those claims for which there's an affirmative ADMC decision.

Diana Escalera: OK, perfect and I know – just to clarify, the cut-off was June 3rd as of yesterday has to be a PAR submission. ADMC submissions were not – are not going to be accepted, correct or not yesterday, Monday? Wow.

Amy Cinquegrani: Hi, yes, I believe that is the correct answer but that's – we'll make sure to confirm that and we can put that in our frequently asked questions.

Diana Escalera: Perfect, thank you so much.

Operator: Your next question comes from the line (Corinne Stevenson) with Centers for – of Elderly and I'm sorry the rest of that was not captured. Please go ahead.

(Corinne Stevenson): Yes, I wanted to ask a question about the wheelchair accessories. So if the wheelchair accessories aren't included in the prior authorization process, does that mean that if wheelchair accessories are provided they will go through the regular reimbursement approval process?

Stacey Brennan: This is Dr. Brennan. I guess I could try to answer that. Remember that because of the Group 3 power wheelchair whether it's the K0856, the single power option or the K0861 which is the multiple power option, they have certain criteria with them that must be met for the base to be approved which obviously does involve the accessories.

So, that's why – for the prior authorization does accessory need to be submitted in terms of what the base would require, you know, to power so to speak and – so there's medical need that has to be met for those particular items.

However, the prior authorization is not giving you guarantee or approval that those accessories are going to be paid for because that is not part of the process that you're getting the approval or rather the affirmation for.

So yes, my understanding is you would have to then submit those accessories separately. Is that your question, did I get that?

(Corinne Stevenson): Yes, so it's just a higher – a higher (threshold) that's already in place for those accessories, so that's separate and apart from what's required in this prior authorization process.

Stacey Brennan: Well, our nurses who do the prior authorization review are obviously looking at the policy and those medical necessity criteria.

I wouldn't say we're holding the accessories to a – truly higher consideration in either of the case, it's just – it's a little bit (complex) only in that. What you're getting the approval for is just the base but we can't give you ...

(Corinne Stevenson): OK.

Stacey Brennan: because it's – we're not instructed by regulation to give you approval for the accessory.

(Corinne Stevenson): OK, I got it. Thank you.

Stacey Brennan: I hope that helps.

Operator: And you another follow-up question from the line of Diana Escalera from Academy Medical Equipment. Please go ahead.

Diana Escalera: Hi there, this question is on a bit of a different vein, it's a very specific question with regards to the postural cushions or the positioning cushion, sorry. Can – and this is directed to the doctor, can you define for me what a postural asymmetry is?

Stacey Brennan: I'm sorry I was on mute. I actually think this is probably not the right venue to talk about the postural asymmetry in the medical necessity or what's needed in the face-to-face to demonstrate that.

I might – please remember the power mobility policy is the one policy that talks about (basis) but there's still wheelchair seating and of course there's the wheelchair option and accessory.

I know these are not the simplest policies to understand but what I might suggest is – this is Diana, right? Are you in a ...

Diana Escalera: Yes.

Stacey Brennan: ... Jurisdiction B?

Diana Escalera: We're in Jurisdiction D, like David, D.

Stacey Brennan: OK. I think, you know, if you have a question like that, the best thing to do is to submit that question to the provider call center or any of the four jurisdictions and our outreach and education consultants can get back to you and if they need to contact us, medical directors. I will say that the face-to-face in the case of a beneficiary can (meet) the complex wheelchair with specialty cushions.

What we expect for our nurses to be able to analyze would be a well-explained sort of picture of the patient's posture, any possible deformities that he or she might have. And frankly the complex medical – I mean the complex wheelchair people and their associations certainly have excellent physicians, nurses and physical therapists and occupational therapists who really do a good job at that.

But to get into the details of each cushion and what needs to be described specifically, I would ask that you kind of submit that question if you would.

Diana Escalera: Well, I think we're kind of trying to go over their heads (because) kind of some of the problems that we're having is like we'll have a patient who has

had a stroke and they're literally zero on one side, zero strength. And that's not being viewed as an asymmetry, you know, due to the severe weakness.

They don't have deformities yet but if they don't have a proper positioning cushion they're going to get one. So those are the types – I guess how do we kind of go over them to get direction to them from someone like you in order to help I guess is what we'll say.

Stacey Brennan: I think – well have you tried the call center for Jurisdiction D and ask for that. You know, they will certainly ...

Diana Escalera: Oh yes.

Stacey Brennan: ... you know if you don't feel like you got enough understanding from that answer, they – typically as they do at CGS where I am, elevate that question up to the medical review area and then up to our medical directors.

But you might try again and specifically say, you know, I had one answer but I need to ask it and get a deeper clinical understanding, something like that. And I feel sure the process will work for you.

Diana Escalera: OK, OK, thank you.

Operator: Your next question comes from the line of (Riccan Nebricht) from the Monroe Wheelchair. Please go ahead.

(Riccan Nebricht): Hi my question is the fact that your time frame in approvals, that's not going to slow down the process due to having all of the states now being nationwide. We're still going to have the same response time because (we're) already in the state of New York and doing the prior approval process.

Amy Cinquegrani: Hi, this is Amy. No, we don't imagine that it would. We've instructed our contractors with the time frames and we would expect that they should be meeting those time frames.

So if there's any times when they're not, then we would definitely appreciate you guys notifying CMS of that, but we believe that everyone is appropriately staffed and ready to handle the volume.

(Riccan Nebricht): OK, perfect, thank you.

Amy Cinquegrani: Thanks. I did just want to give a follow-up to Diana's initial question about the ADMC submissions. I was having trouble pulling up the actual instruction that we had given and I want to correct my earlier statement. We've actually instructed the MACs to process any ADMC request that has come in up through July 17th.

So up until that condition of payment kicks in for a prior authorization, ADMC requests will be – will be accepted up through that time frame. So, I think we initially said July 3rd which is the date that prior authorizations can begin to be submitted, but July 17th is when that condition of payment starts and so ADMC request can be sent up through July 17th.

Operator: Again if you would like to ask a question, just press star then the number one on your telephone keypad. Your next question comes from (Noel O'Neill) from Promed Consultants. Please go ahead.

(Noel O'Neill): Hi, good afternoon. How are you? I just have a follow-up question or it's a matter of clarification. The expansion of the Phase II it only affects the HCPCS code K0856 and K0861. The Group 2 standard power wheelchair will still be for the, I think 20 states correct?

Amy Cinquegrani: Hi, yes, this is Amy. Yes, this is – this prior authorization process is only for those two codes, the K0856 and K0861. The other power wheelchairs that are included in the power mobility device demonstration will continue under that demonstration.

(Noel O'Neill): Great. So the rep payee will – still applies for that demonstration, it's just no longer ...

Amy Cinquegrani: Correct.

(Noel O'Neill): ... applies to these two HCPCS, OK, makes sense, thanks.

Amy Cinquegrani: Yes, correct, thank you.

Operator: Your next question comes from the line of (Jill Vermeil) from Browning's.
Please go ahead.

(Jill Vermeil): Thank you. I have two questions, a clarification on the ADMC up until July 17th. Can we begin processing PARs now for the two codes?

Amy Cinquegrani: Yes, that's correct. The MACs are accepting PARs for those two codes beginning July 3rd.

(Jill Vermeil): OK, great. The second question please is what are acceptable reasons for expedited requests?

Amy Cinquegrani: So I think we – say instances where the life or the health of the beneficiary would be – would be impacted by waiting the full 10 days. I don't know if we want to get into specific circumstances as they can all be different. But I'm not sure if Dr. Brenna if you have anything to add to that?

Stacey Brennan: We try to follow what you just described and frankly in the many years that I've been working with power wheelchairs in this position, I can't remember an expedited request coming through, you know. So, I really can't elaborate more than what just said.

(Jill Vermeil): All right, thank you.

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

Amy Cinquegrani: OK. Thanks everyone for joining again. We hope that you've gotten some good information, and we have gotten some good feedback about things that we need to be more, clear in some of our instructions. And so we can work on incorporating those things into our frequently asked questions documents, into our operational guide and on our website.

So thanks again everyone. If there are additional questions, you can send them to our mailbox that's listed on the slide presentation and I think we can end.

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

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