

CENTERS FOR MEDICARE & MEDICAID SERVICES

Special Open Door Forum:
Medicare's Expanded Prior Authorization for Power Mobility Devices Demonstration
Tuesday, August 12, 2014
2:00 p.m. - 3:30 p.m. EST
Moderator: Jill Darling

Operator: Good afternoon. My name is (Tiffany) 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 Medicare's Expanded Prior Authorization for Power Mobility Devices Demonstration Special Open Door Forum.

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. Thank you.

You may begin your conference.

Jill Darling: Thanks, (Tiffany). Hello everyone. Good morning and good afternoon. Thank you, everyone, for joining today's Special Open Door Forum. My name is Jill Darling. I'm in the CMS Office of Communication. This call is scheduled till 3:30, so give or take, you know, if it takes that long, depending on the number of questions during the Q&A session, so be it.

I will pass this call onto Dan Schwartz to begin the call.

Dan Schwartz: Hello, everyone, and thanks for joining today. I think this is the second in the current series of Open Door Forum calls on the prior authorization for power mobility devices demonstration. The last one also had some other

demonstration activities associated with the call. But this – on this call, it is exclusively on the prior authorization for power mobility devices demonstration. And that will be the focus of my presentation. And that is the topic that I would ask for questions to be limited to at the end.

I wanted to thank you all for joining us on this rainy Baltimore Sunday – not Sunday, rainy Baltimore day. And I just would dive right in. I think when we last spoke we had not yet had a particular, specific date for an expansion of the prior authorization for power mobility direct devices demonstration. And we do now have a date and that date, I will announce as we go through the slides.

We also – I think that was – we also have a couple other sort of educational type things that we've been updating as the weeks have gone by since our last discussion, and we'll touch on those as well. In addition, those questions that have come into our mailbox that we received and been able – that we are able to adjust, I will touch on those. But I think probably it might be most helpful if we – for those of you who are new today to the demonstration or a refresher for those who are not new, we sort of do a little bit of an overview similar to what we did on the last call.

So, to that extent, let's dive right in. The demonstration, the prior authorization for power mobility devices demonstration, is for scooters and power wheelchairs. The initial sort of demonstration and initial states for that demonstration will continue. The initial demonstration started (for) written orders on or after September 1st of 2012. The states that were part of that additional demonstration were California, Florida, Illinois, Michigan, North Carolina, New York, and Texas.

So, as of October 1 and this is the date I referenced in my preface, October 1, 2014 is when the additional 12 states are going to be added. Those 12 states are Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington. So, the total – that brings the total to 19 states.

Sort of--So the question that maybe presents itself, you know, what's new? What's in this expansion? And the answer is just the additional states. The same coverage and documentation requirements exist as existed before. The NCD and LCD coverage is unchanged, documentation requirements are unchanged. Time frames for visits or orders, deliveries, that kind of thing are unchanged. We're not creating any new documentation requirements. It's just sort of earlier in the practice that's when prior authorization occurs is when we're requiring things. And those requirements can be found on our website, the DME MAC website, as well as CMS's.

So, ordering practice – the ordering practice physician or practitioner or supplier would be one submitting a prior authorization request to the DME MAC. It's sort of an either/or. The information would be the face-to-face evaluation documentation, the seven element order, the detailed product description, and other medical documentation that supports the LCD requirements.

How much time sort of is it issue here? How much time would be involved? The DME MAC will review the request and postmark notification of the written decision within 10 business days to the affected parties, which is the physician practitioner, beneficiary, and supplier. They will either affirm, which is sort of another word for approve, they're going to affirm the request or not affirm the request. If the answer is a non-affirmation, the DME MAC will provide a detailed explanation, outlining which specific policy requirements were not met.

This is also a significant point I want to make -- that unlimited requests may be submitted. So, it's not sort of the one – you don't just have sort of one opportunity. If for whatever reason, you do get a non-affirmation, you may resubmit it. The DME MAC for those subsequent requests (who) have 20 business days to consider and make a determination on those.

Let me just walk you quickly through a couple of the scenarios out that are – that may present themselves depending on an individual supplier situation. If a prior authorization request is submitted and the DME MAC decision is affirmative and the supplier chooses to submit a claim, the MAC will pay the

claims as long as all other requirements are met. However, if the – and obviously if it's not affirmative, if the prior authorization request is submitted and the DME MAC decision is not affirmative, did not affirm, the supplier would choose – and (if) the supplier chooses to submit a claim, the MAC, the DME MAC would deny.

But what happens if the claim is not submitted – if, excuse me, the prior authorization request is not submitted at all? The DME MAC obviously would not be making a prior authorization decision, where the supplier chooses to submit a claim and the supplier is a competitive to this supplier, the contractor of the DME MAC will develop the claim, review it, and if payable, will pay at the scheduled (amount).

If the prior authorization request is not submitted and the DME MAC decision prioritization would be not happening because there's nothing to review, the supplier – and the supplier then chooses to submit a claim and if it's not a competitive bid supplier, the contractor (DME MAC) would develop a claim, review the claim, and if payable, would pay at 75 percent.

And we sort of have an ongoing dialogue with our contractors; with the DME MACs, and we do continuously engage the stakeholders throughout the process.

We are in the process of engaging a contractor to do an evaluation of the demonstration and to provide us with an analysis of outcomes as well.

So, I guess, just one more time, in summary, on the overview, the initial demonstration states are California, Illinois, Michigan, New York, North Carolina, Florida, and Texas. The new states are Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington. The expanded demonstration begins October 1, for those additional 12 states, and the other states remain in the demonstration, and it ends for orders written on or after October 31st, 2015.

I wanted to give you some, I guess, contact information and additional resources as well. If you have a question then we invite you to submit those

to the prior authorization team. That is PAdemonstration – excuse me lowercase demo, PAdemo@cms.hhs.gov. That's PAdemo@cms.hhs.gov. We also have a demonstration website which is at go.cms.gov/PADemo.

And I guess the other sort of educational thing that I referenced earlier in my introductory remarks, we – there is an MLN Matters Article that has – is currently updated or in the process of being updated. And it's just sort to give an overview of the demonstration, which I just described, and an article with that as well. So if you sort to go to MLN Matters on the CMS website you should be able to find additional information as well. We're also going to be sending out letters and putting, posting those on our website. That's already in process which was for physicians and suppliers, again, relating to the demonstration.

At this point, I want to turn it over to Doris Jackson, who has a couple of additional piece of information and will just look at some of the questions that have come in. Doris?

Doris Jackson: Good afternoon. Once again my name is Doris Jackson. I will be talking briefly this afternoon about the prior authorization PMD demonstration operational guideline.

The purpose of the PMD operational guide is to interpret and clarify the documentation responsibility for Medicare-participating suppliers and providers when ordering a PMD for Medicare beneficiary. The guidelines are merely to assist and explain the documentation requirements that are set forth in CMS policies.

Apparently, we have on our website the documentation guideline which is dated April 2013. We are in the process of updating these guidance. The updates are merely just for the clarification about issues that we have noticed as a result of the demonstration going forward. So, once again, what's there now is still current. We're just going to update information as a result of us interacting with the suppliers and actually seeing denials for some of the requests. And we have just put more information in so it makes it easier for the suppliers to be able to meet the requirement.

In particular, there are two issues that has come to surface that we are totally looking at and giving more guidance. One of the issues or concerns, when a beneficiary moves from a demonstration state to a non-demonstration state and vice versa, if they are moving from a non-demonstration to a demonstration state, we are going to clearly spell out what the requirement documentations are needed in those scenario. So look forward to that information to be posted.

Also, we've received multiple questions concerning the pay representatives for Medicare beneficiary. This category of patients; are exempt from the demonstration. They still have to meet the requirements, but they do not have to participate in the demonstration. That is CMS' policy. So within the next week or so, you should see a updated version of the demonstration guideline.

That's all I have, Dan.

Dan Schwartz: So, I think that's all we've got and all we have from our end, but I think now we'd like to open up for questions. And anything you have, we welcome hearing from you.

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.

Your first question comes from the line of Patricia Moore with Scooter Warehouse. Your line is open.

Patricia Moore: Hi. I'm sorry but we could not understand the second issue that the last speaker just shared with us.

Doris Jackson: There are Medicare beneficiaries that have (pay) representatives who pay their bills for them.

Patricia Moore: OK.

Doris Jackson: When the supplier submits his claim, there's a certain, I'll say, code that's attached to identify their claim as being related, that the individual has a (pay) representative, they're exempt from the demonstration. They do not have to submit a prior authorization request. Just do what they normally do. Submit your claim and, of course, have your documentation available if you are subject to an audit.

Patricia Moore: OK, thank you.

Doris Jackson: You're welcome.

Operator: And, again, that is star one on your telephone keypad to ask a question. We will pause for just a moment to compile the Q&A roster.

Your next question comes from the line of Noel Neil with Pro-Med Consulting. Your line is open.

Noel Neil: Hi. I just have a quick question. Does the prior authorization exclude you from post-payment audit such as RACs and possibly CERT?

Hello?

Dan Schwartz: Yes, hello. I think also the answer, I think, as I referenced in the slide is the general the answer is yes. The only – so the information that would be reviewed is part of the prior authorization. (We sort of pictured that) additional, those additional audits, if there are sort of other things unrelated to – unrelated, you know, that could be considered. But as far as sort of the information reviews for prior authorization, that would generally be off the table.

Although, for CERT, that would not be precluded because CERT has sort of different requirements by, statutory requirements, that they would need to – if select – if randomly – if selected as part of the CERT audit, that would need to be reviewed from that end. But as far as sort of RAC, generally, the answer is no.

- Noel Neil: OK. And then, just a follow-up question to that, can the MAC then deny a claim that has been prior authorized whether – I don't know, I don't think they will select them from the (ADF). Are they exempt from (ADF)?
- Dan Schwartz: Yes. As long as the other payment rules are met, the answer would be no, they wouldn't be subject to any – so I think you're talking about additional documentation request?
- Noel Neil: That's correct.
- Operator: Your next question comes from the line of Stacy Lewis, with C.G. Medical Family Health. Your line is open.
- Stacy Lewis: I have a question in regards to chairs that we have in progress. How is that going to be handled as far as if we're in the middle of doing a chair and we can't submit the P.A. request until 10/1 and the chair is not able to be delivered until after 10/1? Are we supposed to hold the documentation and make the beneficiary wait? Or, you know, is there a way that we can submit those prior to but then be delivered after 10/1?
- Doris Jackson: The demonstration does not start – the expanded demonstration for orders written on or after 1 October 2014. So if you have started your process, just go ahead and continue your process because that would not be subject to the demonstration if the 7-element order was written before 1 Oct 2014.
- Stacy Lewis: OK. So, it's going to be – the date is going to be based on the 7-element order?
- Doris Jackson: Right. And if it's within that window on or after October 1, 2014.
- Stacy Lewis: OK. So, any 7-element order that is signed by the doctor after October 1st is subject to the demonstration.
- Doris Jackson: Correct.
- Stacy Lewis: Anything prior to will just submit the claim.

Doris Jackson: Correct.

Stacy Lewis: OK. Perfect. Thank you.

Operator: There are no further questions in queue at this time. I turn the conference back over to our presenters.

Jill Darling: All right. Well, thank you, everyone, for joining today's call. If you do have any more further questions for Dan or Doris, you have their email address on the announcement that was sent out, PADemo@cms.hhs.gov.

Thanks, everyone, for joining. Have a great day.

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

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