Prepayment Review and Prior Authorization of Power Mobility Devices (PMD) Demonstration

Provider Outreach and Education

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Improper Payments

- We estimate that each year the Medicare FFS program issues more than **$28.8 B** in improper payments (error rate 2011: **8.6%**).
  - Down from **10.8%** in 2009
  - CMS's Goal: **5.4%** by Nov 2012
- Medicare receives **4.8 M** Part A and B claims per day.
- Most paid based on automated edits without further review.

Three New Corrective Actions To Reduce Improper Payments

- All Demonstrations begin on January 1, 2012

- Recovery Auditors Prepayment Review Demonstration
  - 11 states (CA, FL, IL, MI, NY, NC, TX, OH, LA, MO,PA)
  - Mandatory
  - Short inpatient hospital stays, at first

- A/B Rebilling
  - Voluntary
  - First 380 hospitals to sign up (nationwide)

- 100% Prepayment Review & Prior Authorization of Power Mobility Devices (PMD)
  - Beneficiaries who reside 7 States (CA, FL, IL, MI, NY, NC and TX)
  - Implements a prior authorization process for applicable PMD provided to a beneficiary in the 7 states.

Definition of PMD

Included	
All Power Operated Vehicles	K0800 – K0805 K0809 – K0812
All standard power wheelchairs	K0813 – K0829
All Group 2 complex rehabilitative power wheelchairs	K0835 – K0843
All Group 3 complex rehabilitative power wheelchairs without power options	K0848 – K0855
All pediatric power wheelchairs	K0890 – K0891
Miscellaneous power wheelchairs	K0898
Excluded	
Group 3 complex rehabilitative power wheelchairs with power options	K0856 – K0864

The Phases

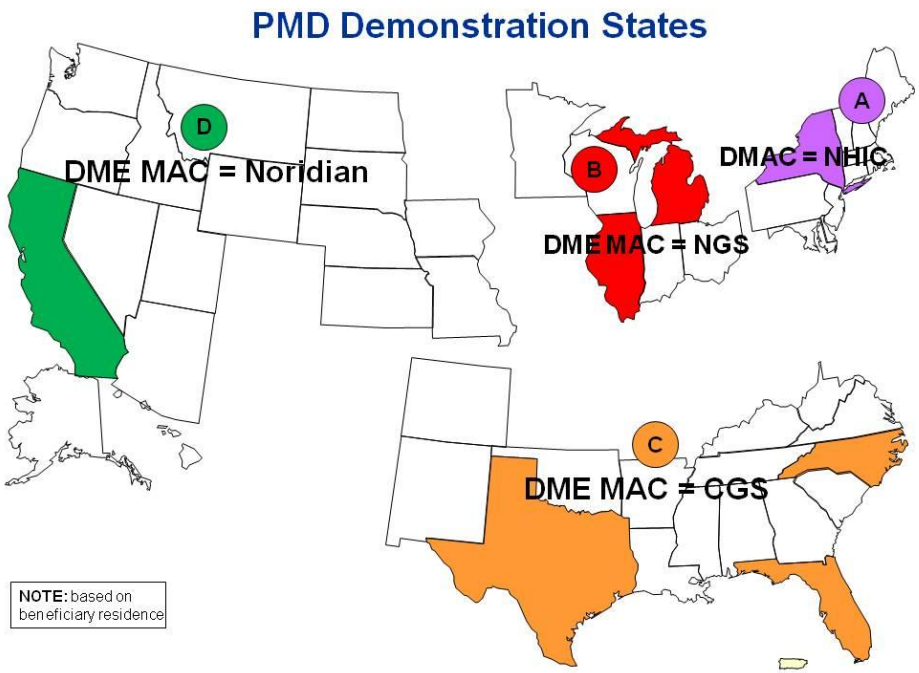
- Two-phase approach:
  - Phase 1:
    - 100% Prepayment Review on all first month PMD claims.
  - Phase 2: Prior Authorization.

When

- Federal Register Notice on or about December 16th to announce demonstration.
- Phase 1 (100% Prepayment Review)
  - Starts January 1, 2012 in all 7 States
  - Ends with the Implementation of Phase 2 (~3-9 months)
- Phase 2 (Prior Authorization):
  - Directly follows the completion of Phase 1
    - Rolled out on a State by State basis
    - Continuous Education of supplier, physicians/ practitioners and beneficiaries.
  - Ends December 2014 in all 7 States.

Where

- Beneficiaries residing in 7 error prone and fraud prone states: CA, IL, MI, NY, FL, NC and TX:
  - These 7 states account for $262M of the roughly $606 M spent annually on PMDs.
    - That is 43% of total expenditures.



Why

- Focuses **on error-prone claim type.**
  - Error rate for PMD: over 75%.
- Places **responsibility on the ordering physician/practitioner** to ensure medical necessity for these high-cost items.
- Uses **private sector methodology** to protect the Medicare Trust Funds.
- Reduces pay and chase syndrome by **stopping improper payments** before they are made.

Phase 1 (100% Prepay Review)

- Begins with first month's PMD claim submitted with date of service on or after January 1, 2012.
- Uses same coverage policy as today.
- DME MACs will send additional documentation request (ADR) on 100% of these claims to the billing suppliers.
  - Most DME MACs will accept electronic submission of medical documentation (esMD) transactions effective January 1, 2012.
  - Suppliers are encouraged, but not required to submit via esMD.
- Failure to submit complete documentation = denial.

Phase 2 (Prior Authorization)

- Ordering physician/practitioner should submit a prior authorization request (progress notes documenting the face-to-face exam, 7 element order, detailed product description and other medical documentation) to the DME MAC.

- The DME MAC will review request and postmark notification of a written decision within 10 days to:

  - Physician/practitioner
  - Beneficiary
  - Supplier

  - The DME MAC will affirm the prior authorization request or provide a detailed written explanation outlining which specific policy requirement(s) was/were not met.
  - If the decision is to not approve the request a physician/practitioner may re-submit (**unlimited requests** are allowed), if DME MAC does not affirm the prior authorization request.

- DME MAC will review SUBSEQUENT requests within 30 days.

Phase 2 (Prior Authorization)

- In rare circumstances a 48 hour expedited review for emergencies.
  - In a situation where a practitioner indicates clearly with rationale that the standard (routine) timeframe for a Prior Authorization Decision (10 days) could seriously jeopardize the beneficiary's life or health, an expedited review request is considered. The expedited request must be accompanied by the required supporting documentation for this request to be considered complete thus engaging the 48 hours for review. Inappropriate expedited requests may be downgraded to standard requests.
- Suppliers should receive a Prior Authorization request decision from the DME MAC **before** the supplier submits the initial claim.

Potential Issues with a Request

Problem	Solution
Order written before Face-to-Face Exam	•Write new order. •Submit new request.
More than 45 days between Face-to-Face exam and written order.	•Conduct a new Face-to-Face exam, •Write a new order. •Submit a new request.
Element on order missing	•Write a new order that contains all 7 elements. •Submit new request.
Coverage criteria not met (the detailed review requests will specify which criteria were not met).	•Remember that DME is covered by Medicare only for use in the home. •Review the documentation sent with the prior authorization request, consider sending more documentation. •If insufficient documentation exists, re-evaluate the beneficiary and document the missing information. •Conduct new Face-to-Face exam. •Submit new request.
Incomplete Face-to-Face Exam	•Must document an in-person visit for the purpose of documenting the need for a PMD (does not have to be primary). •Perform medical evaluation.

Appeals

- Phase 1 (100% Prepayment Review):
  - All current appeal rights apply.

- Phase 2 (Prior Authorization):
  - Unlimited resubmissions are allowed, for non-affirmative Prior Authorization requests.
  - All current appeal rights apply for denied claims.

Physician Reimbursement

- Physician/Practitioner can bill G9156 after submission of the initial Prior Authorization Request.
  - G-code is billed to the A/B MAC contractors with the Prior Authorization tracking number.
  - Only one G-code may be billed per beneficiary per PMD even if the physician/ practitioners must resubmit the request.
  - Code is not subject to co-insurance and deductible.
- This compensates physician/ practitioner for the additional time spent preparing and submitting a Prior Authorization request.

Scenarios

A prior authorization request is	The DME MAC decision is to	The supplier chooses to	The DME MAC will
Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met).
Submitted	Non-affirmative	Submit a claim	Deny the claim.
Not submitted	N/A	Submit a claim **(Competitive Bid Supplier)**	Sends ADR to supplier. Review the claim. If payable, pay at normal rate.
Not submitted	N/A	Submits a claim **(Non-Competitive Bid Supplier)**	Sends ADR to supplier. Review the claim. If payable, pay at 75% of Medicare payment.*

* Applies only to codes in the demonstration, not accessories.

Same Coverage Requirements as Today

- The Prior Authorization demonstration:
  - Does not create new documentation requirements for practitioners and suppliers.
  - It simply requires the Practitioners to provide the information earlier in the claims process.
  - All Advanced Beneficiary Notice (ABN) procedures remain unchanged.
  - Current requirements can be found on the MAC website.

Beneficiary Impact

- The PMD benefit is not changing.
- Beneficiaries will receive a notification of the decision about their prior authorization request.
- CMS encourages beneficiaries to use suppliers who accept assignment.

Documentation Requirements Phase 1

	Phase I
Physician/ Practitioner	1. Conduct Face-to-Face exam; write order 2. Receive documentation request from supplier 3. Send supplier documentation of: • Face-to-Face exam notes • 7 element order
Supplier	1. Conduct home assessment 2. Submit claim 3. Receive documentation request letter from DME MAC 4. Forward documentation request to physician/practitioner 5. Receive from physician/practitioner documentation of • Face-to-Face exam notes • 7 element order 6. Send DME MAC: • Face-to-Face exam • 7 element order • Detailed Product Description • Home assessment • Patient Authorization • Proof of Delivery

Documentation Requirements Phase 2

	Phase 2
Physician/ Practitioner	1. Conduct Face-to-Face exam; write order 2. Send DME MAC Prior Authorization request documentation including: • Face-to-Face exam notes • 7 element order • Detailed Product Description
Supplier	1. Prior Authorization tracking number from DME MAC 2. Has available on request from physician/practitioner documentation of • Face-to-Face exam notes • 7 element order 3. Keeps on file and available upon request: • Face-to-Face exam • 7 element order • Detailed Product Description • Home assessment • Patient Authorization • Proof of Delivery 4. Submit claim with Prior Authorization tracking number 5. If requested by DME MAC provides • Home assessment • Patient Authorization • Proof of Delivery

The Face-to-Face Examination

- State that the purpose of the face-to-face was to discuss the need for a PMD.
- History of present condition and relevant past medical history, including:
  - ✓ Symptoms that limit ambulation,
  - ✓ Diagnoses that are responsible for symptoms,
  - ✓ Medications or other treatment for symptoms,
  - ✓ Progression of ambulation difficulty over time,
  - ✓ Other diagnoses that may relate to ambulatory problems,
  - ✓ Distance patient can walk without stopping,
  - ✓ Pace of ambulation,
  - ✓ Ambulatory assistance currently used,
  - ✓ Change in condition that now requires a PMD; and
  - ✓ Description of home setting and ability to perform ADLs in the home.

- Physical examination relevant to mobility needs, including:
  - ✓ Height and weight,
  - ✓ Cardiopulmonary examination; and
  - ✓ Arm and leg strength and range of motion.

- Neurological examination, including:
  - ✓ Gait, and
  - ✓ Balance and coordination.

NOTE: Not all elements listed apply to every patient. Professional discretion is necessary to determine which items are required as part of the face-to-face examination.

The Valid 7-Element Written Order

1. Patient name

2. Description of item ordered
   - "Power operated vehicle"
   - "Power wheelchair",
   - "Power mobility device"
   - Or something more specific

3. Date of face-to-face examination

4. Diagnoses/conditions related to need for PMD

5. Length of need

6. Physician/practitioner signature

7. Date of physician/practitioner signature.

Detailed Product Description

- The detailed product description must be completed by the supplier, and reviewed and signed by the treating physician. It must contain:
  - ✓ Specific Healthcare Common Procedure Coding System (HCPCS) code for base and all options and accessories that will be separately billed;
  - ✓ Narrative description of the items;
  - ✓ Manufacturer name and model name/number;
  - ✓ Supplier's charge for each item;
  - ✓ Medicare's fee schedule allowance for each item (if no allowance, list "not applicable");
  - ✓ Physician signature and date signed; and
  - ✓ Date stamp to document receipt date.

Summary

- Phase I (100% Prepayment Review)
  - Mandatory
  - Beneficiaries residing in 7 fraud and error prone states
  - Requires suppliers respond to DME MAC documentation request
  - Begins in all 7 states with claims with dates of services on 1/1/2012
  - Ends when Prior Authorization begins

- Phase II (Prior Authorization)
  - Beneficiaries residing in 7 fraud and error prone states
  - Requires physicians/practitioners to submit a prior authorization request to DME MAC
  - Ends on December 31, 2014

For More Information

To contact the Prior Authorization Team:

Pademo@cms.hhs.gov

CMS Demonstration Website:

go.cms.gov/cert-demos

Follow Us on Twitter:

@CMSGov (Look for #pmddemonstration)

References on PMDs from the MACs

- Jurisdiction A: NHIC, Corp.

http://www.medicarenhic.com/dme

- Jurisdiction B: National Government Services (NGS)

http://www.ngsmedicare.com/wps/portal/ngsmedicare/home

- Juridiction C: CGS

http://www.cgsmedicare.com/jc

- Jurisdiction D:Noridian Administrative Services, LLC (NAS)

https://www.noridianmedicare.com/dme

Supplier FAQs

Practitioner FAQs

- Practioner's Frequently Asked Questions

Questions From the Audience