Power Mobility Device (PMD) Prior Authorization Demonstration: Q&A

1. General Information

Q1.3: What specific PMDs are subject to this demonstration? (Added 11/18/2011)

A1.3. Under this demonstration, for beneficiaries who reside in one of the demonstration states, CMS will require pre-payment review, and subsequently implement a prior authorization process, for the following items paid by Medicare:

- All Power Operated Vehicles (K0800-K0805 and K0809-K0812)
- All standard power wheelchairs (K0813 thru K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835 thru K0843)
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 thru K0855)
- All pediatric and Group 4 power wheelchairs (K0887 thru K0891)
- Miscellaneous power wheelchairs (K0898)

Group 3 complex rehabilitative power wheelchairs with power options (K0856 thru K0864) are excluded.

Q1.4: I have additional questions. Where can I send additional questions? (Added 11/18/2011)

A1.4. Additional questions on the PMD prior authorization demonstration can be sent to CMS at PAdemo@cms.hhs.gov.

2. Background

Q2.1: Why will the prior authorization demo focus on PMDs? (Added 11/28/2011)

A2.1. PMDs are expensive items that are sometimes provided when not medically necessary. In addition this type of medical equipment has had a history of fraud and abuse. Consequently these instances contribute to Medicare's improper payments. Focusing on this item is a good opportunity to reduce waste and abuse.

Q2.2: Is the fraud and abuse problem fairly well contained within the seven target states, or

do you expect CMS to expand the program into other states? (Added 11/28/2011)

A2.2. The purpose of the demonstration is to determine whether prior authorization of PMDs is an effective tool. If it is effective, it may be expanded to other states.

Q2.3: Is there a typical scenario for fraud and abuse around PMDs? (Added 11/28/2011)

A2.3 A typical scenario is Medicare paying for a PMD that is not medically necessary for a patient who was never examined by an ordering provider.

Q2.4: Has CMS used prior authorization for any other categories of products or for medical or diagnostic procedures? (Added 11/28/2011)

A2.4. No, the Medicare Fee-for-Service (FFS) program has never used prior authorization. This is a common practice in other healthcare programs including private sector health plans and should provide valuable information about the design of a prior authorization model for the Medicare FFS program.

New Q2.5: Why can't the pre-payment reviews be supplier specific instead of across the board? (Added 12/5/2011)

A2.5. CMS recognizes there are many honest suppliers. However, law enforcement indictments indicate widespread power mobility device (PMD) fraud. The Office of the Inspector General and the Government Accountability Office have also reported on the abuse of these items. In addition, the error rate for these items is consistently very high despite our previous efforts over many years to target problem suppliers with intensified review. To prevent fraud, waste and abuse CMS is taking bold actions to address this issue.

New Q2.6: Why did CMS choose these 7 states? (Added 12/5/2011)

A2.6: CMS is focusing the demonstration in the seven 7 High Risk States that were the target of DME Stop Gap Plan in the President's 2012 budget. These states also had high error rates for PMDs. CMS recognizes there are many honest suppliers. However, law enforcement indictments indicate widespread power mobility device (PMD) fraud. The Office of the Inspector General and the Government Accountability Office have also reported on the abuse of these items. In addition, the error rate for these items is consistently very high. To prevent fraud, waste and abuse CMS is taking bold actions to address this issue.

New Q2.7: How can 43% of claims be considered a demonstration project? Isn't a demonstration project limited to a small percentage of claims? (Added 12/5/2011)

A2.7: CMS is limiting this demonstration to seven states. CMS chose the states based on their high risk for errors, and fraud and abuse.

3. Operational Details of the Demonstration

Q3.1: What criteria will CMS use to determine whether the PMD is reasonable and necessary? (Added 11/28/2011)

A3.1 Medicare's longstanding National Coverage Decision and Local Coverage Decisions describe the circumstances under which a PMD will be considered reasonable and necessary. The Medicare Learning Network (MLN) Fact Sheet linked below is posted to the CMS website and explains the detailed coverage criteria.
https://www.cms.gov/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf

Q3.2: How will the prior authorization program be administered? Will you devote specialized staff to the program? (Added 11/28/2011)

A3.2. The prior authorization program will be administered by the same contractors that currently conduct medical review on PMDs (the Durable Medical Equipment Medicare Administrative Contractors). Clinical staff will be devoted to this program and trained to ensure consistency. In addition, we will employ private sector standards in our prior authorization program such as responding to providers within 10 days of receipt of a prior authorization package, providing responses that are specific about missing information and giving providers an opportunity to resubmit the prior authorization package for re-review. In addition, CMS will conduct extensive provider education as well as information to support the face-to-face examination requirement.

Q3.3: In what cases could a physician or beneficiary request an expedited review? (Added 11/28/2011)

A3.3. Under our process, we expect requests for expedited reviews to be extremely rare. More information on this process will be provided in the future.

Q3.4: Is there a specific list of medical conditions that would warrant the use of a PMD? (Added 11/28/2011)

A3.4. There is no specific list of medical conditions. Each case is reviewed based on the medical condition of the beneficiary at the time the PMD is ordered. However, Medicare does require that the ordering provider conduct a face-to-face evaluation of the patient before ordering the PMD.

Q3.5: What percentage of requests do you expect will be denied? (Added 11/28/2011)

A3.5. CMS hopes prior authorization will eliminate the submission of requests for PMDs that are not medically necessary (and therefore not covered by Medicare). With this demonstration CMS anticipates that by involving the ordering provider in the prior authorization process errors can be avoided up front.

New Q3.6: Is Phase 2 of the PMD Prior Authorization demonstration similar to the TAR that is needed for Medi-Cal? (Added 12/5/2011)

A3.6: CMS did not model this program on the Medi-Cal TAR. However, the Fee-for-Service prior authorization program for PMDs is similar to other prior authorization programs used by

Medicaid and private payer prior authorization programs.

4. Outcomes

Q4.1: What is CMS hoping to learn from the demonstration project on prior authorization for PMDs? (Added 11/28/2011)

A 4.1. This demonstration will test the use of prior authorization in the Medicare program. The purpose is to determine if it is a useful tool for preventing waste and abuse while ensuring appropriate beneficiary access to these products.

Retired Questions

Q1.1: When will more information be available? (Added 11/18/2011) (Retired 12/6/2011)

A1.1. By November 18, 2011, CMS will announce special Open Door Forums. During the Open Door Forums CMS will discuss the demonstration requirements.

Q1.2: When will the special Open Door Forum(s) be held? (Added 11/18/2011) (Retired 12/6/2011)

A1.2. There will be two Open Door Forums. One for suppliers will be held December 2, 2011. One for providers will be held December 5, 2011. Both will be conducted at 2pm EST.