Centers for Medicare & Medicaid Services
Special Open Door Forum:

Medicare's Prior Authorization for Power Mobility Devices Demonstration

Wednesday, August 8, 2012
2:00pm - 3:00pm Eastern Time
Conference Call Only

The purpose of this Special Open Door Forum (ODF) is to provide an opportunity for **suppliers and providers** to hear more and ask questions about the Demonstration. **This demonstration will begin for orders written on or after September 1, 2012.**

The Centers for Medicare & Medicaid Services (CMS) will conduct a demonstration that will implement a prior authorization process for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers.

CMS has received an OMB control number 0938-1169 associated with the information collection for this demonstration. CMS displayed a Federal Register (FR) Notice on August 1, 2012 announcing a September 1, 2012 start date of the demonstration (see download below). The start date of the demonstration is based on the date of the written order.

To read more about the Demonstration visit: go.cms.gov/PADemo

Participants may submit questions prior to the Special ODF to pademo@cms.hhs.gov .

We look forward to your participation.

Special Open Door Participation Instructions:

Dial: (800) 837-1935 & Conference ID: 18836561
Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website at http://www.cms.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) please visit our website at http://www.cms.gov/opendoorforums/ .

Future Special Open Door Forums Scheduled for Medicare's Prior Authorization for Power Mobility Devices Demonstration: 8/29/12 at 3PM ET. Call information TBA.

Thank you for your interest in CMS Open Door Forums.

Audio File for Transcript:
http://downloads.cms.gov/media/audio/080812PMDSODFID18836561.mp3

CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Amanda Burd
August 8, 2012
2:00 p.m. ET

Operator: Good afternoon, ladies and gentlemen. My name is (Aaron) and I will be your conference facilitator today. At this time I'd like to welcome everyone to the Centers for Medicare and Medicaid Services, Medicare's Prior Authorization for Power Mobility Devices Demonstrations 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'd 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.

(Ms. Melanie Combs-Dyer), you may begin your conference.

(Melanie Combs-Dyer-): Thank you very much. This is (Melanie Combs-Dyer. I'm the deputy director of the provider compliance group at CMS. And we're very happy to have all of you participating with us today.

I would imagine that all of you by now have seen the announcement of the start date of the demonstration. That is September 1, 2012. That means that any order that is written and signed by the physician on or after September 1

is subject to this prior authorization demonstration so long as it is for one of the HCPCS codes in the demonstration and it's for a beneficiary who resides in one of the demonstration states.

What we would like to do today is walk through our demonstration operational guide. And we've had a couple of version control problems today getting the right version up on our Web site, but the correct version is displaying now. It is again on our Web site, www – I'm sorry, go.cms.gov/PADemo . I'm going to say that one more time, go.cms.gov/PADemo , and the D in demo has to be capitalized.

Once you get there you should find a number of hyperlinks and a download section. And in that download section – let me look here – it's the last item on the list, it says (PMD) demonstration operational guide (8-8-12). That's the document that you should pull up and we're going to be reviewing today.

If you think of things that during this call that you think we have not specified in the operational guide and you think we should, please let us know during the Q&A session. You'll still a number of places where we are reserving for future use or we've put in a placeholder. That's thanks to you guys letting us know that we still need to get you an answer on how to handle a particular issue or topic.

So I will start now going through the demonstration operational guide. And then when I finish we can open it up for questions from the group. You will see a couple of changes to the table of contents. Then on page three is – I'm sorry, on page four is chapter two which lists the HCPCS codes that are subject to the prior authorization demonstration. And you see that we have a placeholder for the (PMD) accessories. We anticipate adding language to that section very shortly.

Chapter three starts on page five of the document. And we've just made a couple of editorial changes there, most notable in section C which is where we list the start date and the end date of the demonstration. Again, it is for (PMDs) where the order is signed on or after September 1, 2012, and the

demonstration ends for (PMDs) where the order is signed on or after September 1, 2015.

When you get to page six, chapter four, this is where we list out the three main documents that need to be included when you're submitting a prior authorization request. Again, these are not new. These are the same old documents that you have been submitting for (plain) review. That is evidence of the face-to-face exams, of the seven element order, and the detailed product description and any other relevant documentation that you believe would be helpful to those (DME MACs) conducting the review.

The new language appears in the sections about the face-to-face exam documentation. And we've created a section there to describe the tools and the interfaces that can assist physicians and practitioners in documenting a progress note. We often times call them templates. And this demonstration operational guide refers the reader to a PIM section that does not yet exist but will shortly. Once we get that language added we of course will update this demonstration operational guide to show that. It probably will go in section 3.3.2.1.1, and it will probably be titled something like progress notes and templates.

We also make reference to the work that we've been doing on the electronic clinical template, and there's a link to the Web page that describes the electronic clinical template and those data elements.

Finally in this section is a reference to the (late) entries in medical records section of the PIM, the program integrity manual. And we are working on an update to that section. That came as a result of a question that came up during a prior call here. And you all asked, you made reference to the PIM language that says that review contractors will consider late entries in medical records if they are made within a few days of the visit. And you asked what a few days meant.

We are working on getting that PIM section updated. And I would encourage you all to be on the lookout for that. We will likely post that to our

demonstration Web site once that gets finalized. And we anticipate that will be finalized before September 1.

The next chapter, chapter five, reorganizes some of the information that needs to be included in the prior authorization request package. We're not adding any information. We're just breaking it out into several sections. And then in section C you can see that we have now added the fax numbers and the street addresses, postal addresses, where you can mail your prior authorization requests.

I would note that the ESMD system, electronic submission of medical documentation, will not be available at the beginning of the demonstration. And that's intentional. We want to make sure that things are working right with fax and mail first. And at some point later on this fall once we're confident that everything is working smoothly with the plain old-fashioned prior authorization process using fax and the postal service then we will open up the ESMD system so that folks can submit their prior authorization request in PDF form through that mechanism.

The next few pages don't have a change. There's not another change until we – excuse me – get to page 12. This is where we, in the chapter seven, an incomplete request. There's a bullet that says the submitter may resubmit another complete package with all documentation required. That is if they receive a decision letter that says, sorry, you're prior authorization request was incomplete.

And we're adding now to this bullet the reference to the late entries in medical records PIM section. Again, that's (inaudible) which today continues to have the old language about addendums or late entries needing to be made within a few days of the visit. But again, we're planning on changing that language very shortly.

Next change comes in chapter 11, which appears on page 16 of my version. It's talking about the payment reductions. And in this payment reductions language it just adds that there will be a three month grace period before the payment reduction begins, meaning that the payment reduction will apply for

orders written on or after December 1, 2012. There had been some confusion and some questions about that. We think that sentence will help to clarify.

Chapter 13 is a placeholder for upgrades. This is a question that you guys asked last time, how is a prior authorization request supposed to be submitted for an upgrade. We will be getting you some language on that by the next version. It basically is going to say that you need to submit your prior authorization request for the item that is covered by Medicare and then follow the normal claim submission rules for how to go about billing and submitting your claim for the upgrade. But we'll have some clear language on that in the next version.

You'll then see on pages 20, 21, 22, 23 some new appendices, appendix A, B, C and D. And these now include the flow charts. These had been listed in a separate place in our Web site, but we thought it would be helpful to add them here to the demonstration operational guide.

So that takes us to the end of the demonstration operational guide. We do have some questions that have been submitted in writing. But let me first, before we get to those, go ahead and open it up and see what questions folks on the phone may have. Operator, can you explain to people what they can do to get in the queue to ask a question?

Operator: Certainly I can. As a reminder, ladies and gentlemen, if you would like to ask a question please press star then the number 1 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 1 again to rejoin the queue.

Your first question comes from the line of (Michelle Hamel) from (Mira Vista). Your line is open.

(Michelle Hamel): Yes, I have a question about the 14 digit prior authorization tracking number that's going to be provided on the response letters. If you have an incomplete response and you go to resubmit all of your documentation needed, does that

tracking number need to be just on the fax sheet or on each piece of documentation resubmitted?

(Melanie Combs-Dyer): (Amanda), can you answer that?

(Amanda): Yes. The prior authorization tracking number should be submitted on a claim. And that'll come from each decision, including if it's incomplete. If a request is deemed incomplete, the full and total request should be resubmitted back into the process.

(Michelle Hamel): OK. So there's no number that would need to be on the fax sheet or the documentation to indicate that this is a resubmission of an initial request?

Female: Correct.

Female: That's right.

(Michelle Hamel): OK. Thank you.

Operator: Your next question comes from the line of (TJ McInany) from Wheelchairs Plus. Your line is open.

(TJ McInany): Thank you. (With this question), several others in the industry have just been recently notified of an additional demonstration project that's happening in almost exactly the same states, Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, Missouri. This is called a recovery audit prepayment review demonstration project.

My concern is that this project is going to interfere with the what we're discussing today because it states that recovery auditors will review claims before they are paid to ensure provider complied with Medicare payment rules. So what's going to happen is you're going to prior authorize the base under this program but then we're going to be prepayment audited under this program. How are these two programs going to interact together?

(Melanie Combs-Dyer): This is (Melanie), and we have instructed the recovery audit contractors that they are to exclude power mobility devices in these states from their (last) prepay demonstration.

(TJ McInany): Did they respond positively to that request?

(Melanie Combs-Dyer): They are a contractor to us. We instruct them what they have to do.

(TJ McInany): Great. Thank you for the clarification.

(Melanie Combs-Dyer): Yes.

Operator: Your next question comes from the line of (Heather Blanchard) from (TXRPC). Your line is open.

(Heather Blanchard): You indicated that this will start with orders on or after September 1. Is that a seven element order signed on or after September 1 or is that a detailed product description signed on or after September 1?

(Melanie Combs-Dyer): That is a seven element order signed on or after September 1.

(Heather Blanchard): Thank you.

Operator: Again, if you would like to ask a question please press star 1 on your telephone keypad. Your next question comes from the line of (Don Clayback) from (Enguard). Your line is open.

(Don Clayback): Thank you. (Melanie), with the, looking at the operations manual in its current form, I think there's a concern that you know there's still some significant areas that are not complete yet and we're you know three weeks away from implementation. Have you got a sense of when the full manual will be finalized so people can use that in their training and education?

(Melanie Combs-Dyer): We envision that the operational guide will be sort of like CMS manuals. That is they are always open to improvement and revision and change. That being said, we do hope to be able to get all of those reserves for future usage out of the operational guide with language added there or references to the right place in the program integrity manual before the next open door forum call on the 29th.

(Don Clayback): OK. And I appreciate that, but again, I guess I would just reiterate you know all along we've been expressing concern about education and time to prepare you know and the fact that some of this still is in development I think may you know make things more difficult. So the sooner that's available I think the better it'll be for the program, so.

(Melanie Combs-Dyer): We will certainly try to get that out as soon as possible. I think you'll note that the majority of the places where we have reserve for future use are because we are changing the program integrity manual. We're making updates usually in response to questions or concerns that have been raised by the industry.

We don't want to stop. We don't want to put (pens) down too early. We want to make sure that we continue to make changes as changes are needed. And we'll make every effort to make as many changes as we can as quickly as we can.

(Don Clayback): Thank you.

Operator: Your next question comes from the line of (Walter Gorski) from AA Home care. Your line is open.

(Walter Gorski): Hi, (Melanie). I couldn't resist. I thank you for holding the open door. I want to piggyback a little bit on what (Don) had to say because a lot of the key facets that, I know you're working on the PIM and making those changes, but to (Don's) point, educating the – our ability to educate not only our staffs but for us to educate physicians with respect to I see there's some reference to the clinical template but there's nothing there that states that we will be able to use a paper template to help guide the physician through the medical record.

And also we'd like to make sure that you address the issue of whether the template can be included as a part of the medical record in those PIM sites because that's really a key issue. And so I know you probably won't answer that here but I'll hit star 1 to ask my other couple questions.

(Melanie Combs-Dyer): You can stay on the line, (Walt). We are hoping to go out with the PIM change that will address those paper templates any day now. So stay

tuned. As soon as it goes out in the PIM in final, we'll post it to the (PMD) Web site and update it in the demonstration operational guide.

(Walter Gorski): OK. Just two quickies. Can you refresh my memory as to how detailed the denial letters that go out to the physician? You talk to the person from (Mira Vista) about incomplete submissions. Will it state specifically what's wrong with the prior authorization that's submitted?

(Doris): Yes.

(Melanie Combs-Dyer--): (Doris), go ahead and then we'll have maybe (Dr. Hoover) jump in and add a little bit more. Go ahead, (Doris).

(Doris): Hi. The letters will be very detailed so that the prior provider who receives the notification and wants to resubmit, they will have specific items as to what was missing and what needs to be included. And that (tells the files in LCD) now. That's all stated in LCD so they can also use that reference also in conjunction with the letter that goes out from the contractor.

(Walter Gorski): And (Doris), that goes to the physician and the supplier?

(Doris): Yes.

(Walter Gorski): OK.

(Melanie Combs-Dyer): And (Dr. Hoover), (Dr. Hoover), would you like to add any on the subject of how detailed will the decision letters be when the decision is was incomplete or there was something that was missing?

(Dr. Hoover): Yes, I mean I know speaking for jurisdiction (C-, our letters will be very detailed as far as the type of information that is missing. There will also be in jurisdiction (C) a link to our – and I don't know if you've seen this, (Walt), on our Web site – the denial health aid or denial tool. It's there that has a number of drop-down boxes. It's divided up by the types of denials, whether it's related to an order or documentation or proof of delivery that gives – it mirrors the information that will be in the letter. But on the Web site it has additional information about how to correct those kind of mistakes along with

reference material with our LCDs, our dear physician letters and other things that we've published.

(Walter Gorski): Thanks, (Dr. Hoover). Will all the jurisdictions be identical with respect to what's missing?

(Melanie Combs-Dyer): They will not be identical but they'll be very similar. (Dr. Hughes), would you like to describe the level of detail that you guys will be including in your response letters?

(Dr. Hughes): Sure. I mean, (Walt), I think you're going to see equivalent levels of detail because frankly that's part of the instructions that all the contractors are receiving from CMS that we need to provide a detailed and specific explanation of when the, when the request fails to meet the standard. I don't think that we're going to use word for word identical explanation, but my understanding from the conversations I've had with MR) managers and the folks who have actually been doing the work on this is that there is a fair degree of equivalency in the level of detail and specificity that all the contractors are working towards.

(Walter Gorski): OK. Thank you, (Dr. Hughes). (Melanie), just urge CMS to hold more open doors on this demonstration after the August 29 deadline simply because we would like to have an update from CMS as to the statistical data, what percentage of claims are going through, what percentage of claims are being denied, where the big error is coming from. That would help us out in educating the supplier community and in turn the physician community. So thank you very much for letting me ask all my questions.

(Melanie Combs-Dyer): Absolutely, and we will try to schedule at least one more in September and maybe into October or November as well. Thank you for your suggesting, (Walt).

(Walter Gorski): Thanks.

Operator: Your next question comes from the line of (Heather Blanchard) from (TXRPC). Your line is open.

(Heather Blanchard): Thank you. We represent a large number of power wheelchair suppliers here in Texas. And there's a significant concern amongst those in the room here that all of the prior authorization requests from Texas, Florida and North Carolina will all be going into the same fax number. Has any consideration been given to providing three different fax numbers so that each state at least would have their own?

(Melanie Combs-Dyer): (Dr. Hoover), is that – that's your region, right?

(Dr. Hoover): Yes it is.

(Melanie Combs-Dyer): Would you like to speak to the concern that your fax machine might get overwhelmed?

(Dr. Hoover): You know I'm probably not the right person to respond to that. I mean I know we have you know we process 34 million plus claims a year or something like that. I mean the bulk of our, we get a lot of submissions electronically. We get a lot of you know ADMCs by fax.

I don't have specific knowledge about the capabilities with that one fax number, but I, my guess would be that there is some kind of internal telephone voo doo that allows it to go to multiple fax machines and be adjusted into the system. That's you know an electronic fax, so it's going to come in and be imaged electronically right out of the fax machine.

I don't think that's going to be an issue, but that's certainly one of the things that CGS will monitor. And if there is a need to do something with the technology so that we're able to accept more requests, we will certainly do that.

(Melanie Combs-Dyer): (Heather), thank you for question. And I agree with (Dr. Hoover). I think the voo doo in the telephone-fax systems are going to be able to handle the volume that we're talking about here. I think that all of our contractors have fax image capture systems. I don't believe they're relying on faxes that are printing out to paper. I don't think you're going to have trouble with trying to send faxes and getting back a busy signal.

But certainly if you do experience difficulty, make sure you give the (DME MACs) a call and (because) I'm sure, like (Dr. Hoover) said, they're going to be monitoring that and making sure that they take care of you.

Operator: Your next question comes…

(Melanie Combs-Dyer): Go ahead.

Operator: …sorry. Your next question comes from the line of (Michelle Hamel) from (Mira Vista). Your line is open.

(Michelle Hamel): Hi. I just wanted to go back real quickly. It's my understanding that with the initial request the contractors will have 10 days to send out their response letter from the date the request is received. And then with subsequent requests they'll have 20 days. And I'm just wondering how they'll identify when you submit everything new that it's a subsequent request.

(Melanie Combs-Dyer): (Amanda)? Are there any (CMD) medical directors on the line who want to – go ahead, (Amanda).

(Amanda): I mean it'll be – the contractors should have mechanisms in place in order to accomplish those time frames.

(Michelle Hamel): OK. I was just wondering if there'd be something special you would put on the fax cover sheet to say this is the second time I'm submitting this in, you know how they would identify that it's being resubmitted with you know all your documentation as opposed to it's the first time you're sending it in.

(Melanie Combs-Dyer): We have a call with (DME MACs) every week so we'll ask that question next week. And if there's anything special that they want to show up on that fax cover sheet we'll make sure that we add it to the appropriate section in the operational guide.

Female: And it wouldn't hurt for you to go ahead and to put on there that this is a second submission until you know we come back with something confirmed. But it wouldn't hurt.

(Michelle Hamel): OK. And is there a standard fax cover sheet that I may have missed that's available on the Web site for this?

(Melanie Combs-Dyer): CMS will not have one. (Doris), do you know…

(Doris): No.

(Melanie Combs-Dyer): …(when each) contractor will have one?

(Doris): I don't know if each contractor will have one, but if you look at the operation manual, we give you guidance as what information is to be included in the package. And it does have identifying information like the beneficiaries Medicare number that the (issuer has) made, who the supplier, who the physician is. It gives you identifying information so we know what things need to be there.

(Melanie Combs-Dyer): That's chapter five, section A like Apple.

(Michelle Hamel): OK. Thank you so much.

(Melanie Combs-Dyer): Yes.

Operator: Your next question comes from the line of (Tom Cruise) from (Upper Round) Corporation. Your line is open.

(Tom Cruise): Hello, (Melanie). This is (Tom). My question is regarding you had said that the your intentionally not using ESMD, and obviously that's a concern to us and to everyone I would think on this line in that you say you're going to wait to see how the postal service works and faxes work.

We kind of know how the postal service works. It is a delay of days. And relative to the fax and the difference between the fax and the ESMD is that with a fax we never know what the fax machine on the other side is doing. When I say that is that very often we find that the time and date stamp that's at the bottom typically of most faxes gets cut off which again is a very, very important, that date and timestamp is very, very important to the claim.

Relative to avoiding that and using the mail, we often see that the mail takes about five days or so to get to the (DME MACs) but then very often there's a delay within the mail room within the (DMEMACs) and up to seven days we've seen. And then we're seeing 10 business days to process which is really 14 you know 14 days and then 5 days for you to mail it back we're at 31 days.

And my question is we're seeing now that the ESMD is working very well for the ADRs. We know that it works on your side. We know it works on our side. I guess I just don't understand what reason whatsoever there could be to – you know fax technology dates back you know it's from the 1980s. And we're really going to be pushing to guarantee that we get the documentation to you properly. As I showed there, it could be up to 31 days that we go by mail.

How quickly, the question is how quickly can you get this ESMD working to ensure that we can get these claims turned around and trying to get these patients their products?

(Melanie Combs-Dyer): (Tom), thank you very much for the endorsement of the ESMD system. It's good to hear that things are working well on our end and on the suppliers' end and that folks like it, that it's providing an added value to the system.

You know we haven't heard a whole lot of people requesting ESMD for the prior authorization process. In fact you may be one of the first who has actually made that plea. I will certainly take it back to the folks who are planning the ESMD changes that will be necessary to allow the gateway to accept a prior authorization request into CMS and pass them along to the review contractor.

I'm pretty sure it's going to be at least a month, so it'll be at least October 1 before we could accept those prior authorization requests through ESMD. But I will make sure that I put on an agenda for our next open door forum call to give you an update on that. And if you're aware of others who really want us to move quickly on accepting prior authorization requests through ESMD, have them shoot us an e-mail. I think it would be helpful for us to see you know the level of interest that suppliers have in submitting prior auth requests through ESMD.

(Tom Cruise): (Melanie), thank you very, very much.

Operator: Your next question comes from the line of (Sylvia Tascono) from the Professional Medical. Your line is open.

(Sylvia Tascono): Hi, (Melanie). Thanks for taking my call. My question is with reference to the reviewers that will be evaluating the request prior authorization. I have some extensive experience at the (Regency ADMC) unit, and I have to complement them because they are really quite spot-on when they review these files.

And I guess my question is with reference to the consistency of the training of the reviewers that will be looking at these requests and how they will be trained to evaluate the documentation and whether or not those will be clinical individuals such as RNs, OTs and the like.

(Doris): Sure. Hi. This is (Doris) speaking. Yes, each contractor will have registered nurses that will be reviewing the request. And in addition if (PT or OT) is needed also, they would consult with (PT or OT) on staff to help them make those determinations. And of course they have our physicians also, the (CMDs) who will assist their clinical staff with the decision.

And the training, it's not exactly the same, but it is all similar with the same (inaudible) of everyone being able to accurately assess requests to make the appropriate determinations so the training is on the same level regardless of which jurisdiction that clinical reviewers work from.

(Sylvia Tascono): OK. And as a follow-up to that, since you know since these will be reviewed by clinical people, if a second submission is sent in will it be completely reviewed by a different individual or will it go back basically to the same reviewer that initially considered the file?

(Doris): I can't answer that for you. I do not know each individual contractors how they, their internal operations.

(Sylvia Tascono): OK. So we can expect some consistency with the training…

(Doris): Oh yes.

(Sylvia Tascono): …because – I'm sorry.

(Doris): Go ahead.

(Sylvia Tascono): The reason I ask is in the case of (ADMC) sometimes it does matter which reviewer considers the file. And I was wondering – and you know we as a supplier community are going to use the results of the prior authorization request for as a learning process on documentation and also pass that information on to the physician. So I guess my point is is it's extremely important to make sure that there is consistency used in the application of the LCDs amongst the reviewers in a particular jurisdiction.

(Melanie Combs-Dyer): (Dr. Witten), would you like to chime in on the issue of consistency among the reviewers? (Dr. Witten), are you on the line?

(Dr. Witten): Yes. I'll try, or one of my colleagues might. We, in fact just earlier today, the core contractors were on a call talking about the (inter reliability) calls and things we have on a routine basis among the contractors, and we have those internally as well.

I'm also not sure whether an individual resubmission would go to the same person. But we would expect that the processes being used will be things we want to review and should be very similar. Always when there's a review there's some potential reliability by the individual. But it's our intent to have these be – we'll use different types of checklists and things that should have been very, very similar from one reviewer to another. Does that answer the question?

(Sylvia Tascono): It does with reference to the procedural portion, but I think where the subjectivity is is in the actual findings of the face-to-face examination and the completedness of that portion of it. And you know it's really hard to determine sometimes if there is adequate documentation in terms of the examination portions of the face-to-face.

And I think that's where my concern lies is in some cases we have one reviewer who says that there isn't enough information, for example, regarding (MR inaudible) and another reviewer may consider the same file and feel it's adequate. So that's where my question came up with consistency. But I guess we'll just have to wait and see.

(Melanie Combs-Dyer): This is (Melanie). It certainly is our goal to be as consistent as humanly possible in this process. And if you find places where you think the review contractors are not being consistent, please let us know. We're always looking to try to improve.

(Sylvia Tascono): I appreciate it very much.

(Melanie Combs-Dyer): Thank you.

Operator: Your next question comes from the line of (Gerri McLan) from the Family Medical Supply. Your line is open.

(Gerri McLan): Yes, I have actually a fax cover sheet that was done in your March call from another region and I wondered if you were going to have that cover sheet. The concern is where the letters are going to be mailed to being that we have a billing location that receives all correspondence according to our (NSC) number versus our physical location. And I wasn't sure if the address we put on the cover sheet is where the letters are going to go, the authorizations are going to go, or are they going to our correspondence address like where our EODs and redeterminations and all go to?

(Melanie Combs-Dyer): (Doris), do you want to answer that one?

(Doris): Hold on for a second. Hi. This is (Doris). We're going to have to get back with you on that because there's some discussion as which address will actually show up from the system. So we're going to verify that information before we give a response to that question.

(Gerri McLan): OK. And there was a sample cover sheet that I believe I was in a region (C) seminar in Charlotte earlier this year and (Dr. Hoover) was actually there with (Melanie) and had mentioned maybe having that cover sheet available when

this opened up. And it's very neat and I hope that that's something that you're going to be able to provide to all the providers.

(Melanie Combs-Dyer): This is (Melanie) and we've decided that CMS will not be mandating any particular fax cover sheet. It will be contractor discretion. (Dr. Hoover), do you know what you guys are going to do?

(Dr. Hoover): Well it may be better for one of the medical review managers to speak up. I haven't kept up with the fax cover sheet issue. But I know you know speaking to the last caller's concerns about consistency, we have tried to make this as consistent as possible across all four jurisdictions, including I know at one time there was a lot of discussion about posting a fax cover sheet to our Web site. I don't know where that project is at this point but you know any places that we can be as consistent as possible, we will try to do that.

We've all kind of done joint training around (inter rated) reliability exercises to try to promote that consistency. I know we've you know we have a lot of discussion about power wheel chair claims and the issue of subjectivity always comes up when you're talking about you know using clinical judgment.

But we try to, in terms of training, I know in jurisdiction (C) one of our senior nurse reviewers does a fair amount of the training and she's got close to 20 years of Medicare experience in the area of (DME). I do some of the training as well. So you know we try to keep the number of trainers limited so that we you know can provide a consistent message. And you know we certainly appreciate any feedback that we can get.

And recall I think, too, that you know there is the option for appeals when the claim has been submitted. And I want to be clear on that. Not the prior authorization but when a claim is actually submitted, if that claim is denied there is always the appeals route for that claim, and you would have a different set of clinicians looking at the claim at that point, so.

(Gerri McLan): Oh thank you.

Operator: Your next question comes from the line of (Don Clayback). Your line is open.

(Don Clayback): Thank you. Two comments I just wanted to make, (Melanie), really under the heading of you know making sure we're all collectively doing as much as we can to make this process the most efficient. One would be to I think reiterate or support (Tom's) statement around the ESMD system. I think what you'll hear from suppliers, certainly I think the vast majority, is that you know there are a variety of problems that can be encountered with a fax system. And (Tom) outlined many of those. So I would encourage you to really try and make that a priority to get the ESMD system up in place so providers, suppliers, could make use of that as soon as possible.

And then the second point would just be on the fax sheet that we mentioned. I know there was discussion really at the start of the program about having a fax cover sheet. And while I understand the challenge with CMS issuing that, I think if the contractors could agree on one universal sheet that at least could be used, I think that would go a long way towards helping suppliers with the submission of claims. And I would suggest maybe helping the contractors with the actual processing of those.

So I think those are two important areas that hopefully there could be some more internal discussion on it. And as you said, you can give us an update on the next call.

(Melanie Combs-Dyer): (Don), thank you very much for the endorsement of ESMD again. I was looking at some statistics in the system this morning and I was surprised at how many, at how the volume is getting of ESMD transactions coming in through the (DME MACs). So suppliers must have been very busy getting signed up for ESMD and beginning to use it over the last couple of months.

So we will certainly work on trying to open up the ESMD system to prior authorization requests as soon as we can. And we'll certainly put on our agenda to talk to the (DME MACs) next week about whether any or all of them have chosen to create a suggested fax cover sheet. Again, it would not be mandatory but we'll find out if any of them have created it. And maybe we

can even put, if any of them have, we can put links from the operational guide to those fax cover sheets. So thank you for the suggestion.

(Dr. Hoover): And (Melanie), (yes), for those suppliers that are in jurisdiction (C), I had a note from one of our staff that I think is listening on this call, one of our medical review managers, and she indicated in an e-mail to me that we will have a cover sheet on our Web site.

And we'll have on our (JC) home page you know a clear icon or something there to access (PMD) demonstration information. I know currently on the jurisdiction (C) Web site there is an icon down on the lower right-hand side that's kind of a stylized wheelchair that says power mobility devices, documentation resources. That's where our denial help page is located.

We'll figure out something either through that page or somewhere well marked on our home page information that can be used for the (PMD) demonstration.

(Melanie Combs-Dyer): Great. Thank you very much, (Dr. Hoover).

(Don Clayback): And one thing just to add, (Melanie).

Male: Just to offer, I know the four jurisdictions have been discussing the fax materials. I think by the time of the next call that will have (gone) through and you'll be able to see something if not identical, very similar along the lines of what's being requested.

(Don Clayback): That would be great. And again, if between the four contractors if, although there may be some variance in format, if the data fields would be consistent that certainly will help suppliers that are in you know multi-state areas. So thank you.

(Melanie Combs-Dyer): Operator, do we have any more questions in the queue?

Operator: We're showing no further questions at this time.

(Melanie Combs-Dyer): Then let me read a couple of the questions that have come in through our e-mail. The first question is if a claim for one of the affected

(PMD) codes is submitted for a Medicare beneficiary who lives in one of the seven states and the provider physician did not obtain prior authorization in advance and the claim is approved on prepay review, and if the 25 percent payment reduction is applied, will the allowable be just on the (PMD) base codes? Or will the payment also be reduced on any options or accessories billed on the same claim, i.e., batteries. In other words, if the 25 percent reduction applies, will it only be applied to the base or to all options billed on the same claim?

Female: Hi. The payment reduction (is supplied to) the (PMD) codes in the demonstration code list. Only those codes will be subject to the payment reduction.

(Melanie Combs-Dyer): Any other questions on that before we go on to the next question? So the next question is will the prior authorization reviewers look at and consider same similar equipment received within the previous five years when reviewing a file as this will affect the coverage? These claims would be for new equipment due to a change in condition.

Female: This demonstration does not change any (existing on the timing), including those related to same or similar equipment. If the treating provider is requesting new equipment due to a change in condition, documentation should support the medical necessity for the new equipment.

(Melanie Combs-Dyer): Any questions on that? Operator, can you refresh people's memory about how to get in the queue to submit a question?

Operator: Certainly. If you would like to ask a question please press star 1 on your telephone keypad. And we do show we have a question from the line of (Sue Fitzsimmons) from (Confidence First). Your line is open.

(Sue Fitzsimmons): Thank you. Could you provide me with the initial Web site again, please?

(Melanie Combs-Dyer): Yes. It's go.cms.gov/PADemo . And I'll note that there is no www at the beginning. It's just go.cms.gov/PADemo . And you have to have a capital P, a capital A and a capital D.

(Sue Fitzsimmons): Thank you very much.

(Melanie Combs-Dyer): You're welcome. So the next question that came in by e-mail is if a prior authorization is requested and approved for a power mobility device from supplier A but the beneficiary decides they don't want to use that supplier and they prefer to use supplier B, would supplier B also need to obtain prior authorization? And would the first authorization for supplier A need to be voided? If so, how would this be done?

Female: (Although) CMS encounters beneficiaries approach to (CMD) from the suppliers who submitted the prior authorization request, CMS is not requiring a beneficiary to do so. It is the beneficiary's choice as to whether suppliers – as to what supplier will deliver the (PMD) and bill Medicare. The billing supplier must comply with all Medicare documentation and claims requirements.

Please note that the basic HCPCS codes still must be the same as the one that was affirmed in the prior authorization process. Also please remember there is the option for physicians to submit the prior authorization request. Before changing suppliers, CMS recommends that beneficiaries make certain that there is no contract or agreement with the supplier (since) submitting the prior authorization request that may make the beneficiary financially liable.

(Melanie Combs-Dyer): Any questions on that or any other topics?

Operator: Again, that is star 1 on your telephone keypad if you wish to ask a question. We're showing no questions coming in at this time.

(Melanie Combs-Dyer): OK, so we're going to take another one of the written questions that came in this week. On earlier calls it was stated that a 90-day grace period would be implemented. If so, for those claims submitted from 9/1/2012 to 11/30/2012 that do not have a prior authorization, will they still be subject to prepay review? If these claims are subject to prepay review, will this be at 100 percent? This information will help providers plan for any financial slow down.

Female: The 90-day grace period you are referencing is for the assessment of the 20 percent, 25 percent, excuse me, payment reduction. If a physician or

practitioner or supplier has not submitted a prior auth request prior to submitting the claim, the (claim) will be stopped for review. Payment reductions will be made for orders written on or after December 1, 2012 where the prior authorization process is skipped.

(Melanie Combs-Dyer): Any follow-up questions on that one?

Operator: Again, star one on your telephone keypad.

(Melanie Combs-Dyer): And the next question says will the 25 percent payment reduction penalty not be applied until after 12/1/2012 for claims with start dates of 9/1/2012 and after?

Female: The pending reduction begins for orders (ranged) on or after December 1, 2012 that did not first go through a prior authorization.

(Melanie Combs-Dyer): Next question, please clarify the start date. The guide says that it is the date that the seven element order is signed. But on some of the open door forum calls the start date was explained as the date of the face-to-face exam as entered on the seven element order. These are often two different dates. Which is correct?

Female: The dates the physician or treating practitioner signs the seven element order is the date the (DME MACs) reviewer reviews to determine if the request for power mobility device must adhere to the demonstration requirements. Therefore the demonstration (begins) for seven element orders signed on or after September 1, 2012.

Operator: Excuse me, speakers?

(Melanie Combs-Dyer): Operator, any questions come in?

Operator: We do. We have a question from the line of (Sylvia Tascono) from Professional Medical. Your line is open.

(Sylvia Tascono): Hi. Thanks, (Melanie). One more question. If an affirmative prior authorization is received in one jurisdiction but the beneficiary relocates to a different jurisdiction and chooses to receive that power mobility device, will

that prior authorization number be good in the other jurisdiction? Will it follow the patient?

(Melanie Combs-Dyer): (Amanda)?

(Amanda): The prior authorization tracking number should follow the patient.

(Sylvia Tascono): So it will be accepted by all jurisdictions even though it was not issued by their particular jurisdiction?

Female: Yes, that is our expectation. That's how the system is designed to work.

(Sylvia Tascono): Thank you.

Female: Yes.

(Melanie Combs-Dyer): Operator, any other questions?

Operator: We have no more questions at this time.

(Melanie Combs-Dyer): OK. I think at this stage of the game we will do a final request for questions. And if we don't hear any we will bring the call to a close. Final request for questions.

Operator: You have a question from the line of (Paula Koenig) from (ATG Rehab). Your line is open.

(Paula Koenig): Hi, (Melanie). This is (Paula). I'd like to go back. The question that you talked about where client had (seen) similar equipment, we do have requests for clients that need new equipment even though the previous equipment is less than five years old due to a change in medical condition. If that's presented with the new PA request, will those reviewers look at that and determine whether that change of medical condition is sufficient to justify the new equipment as they're reviewing that file? I didn't quite understand the earlier answer.

(Melanie Combs-Dyer): Does the – in those situations is a new order required by the physician?

(Paula Koenig): Yes. It's a whole new order, a whole new packet, new (everything).

(Melanie Combs-Dyer): And so if that order is written on or after September 1 then it would be subject to prior authorization and all the documentation needs to come in just like you would do if it was being selected for prepayment or post payment review. Whatever you would normally submit you should submit with your prior authorization request.

(Paula Koenig): I understand that. Would the reviewers look at it with the understanding that they have to consider whether there was a sufficient change in medical condition in addition to just meeting the guidelines as if it was a new chair? Because there is a different way of looking at those files.

(Melanie Combs-Dyer): This demonstration doesn't change any of the existing requirements. So if that's a current requirement and that's something that the (DME MACs) do today on a smaller sample of claims, they will apply that requirement for those prior authorization requests that come in during the demonstration.

(Doris): This is (Doris). Let me ask this also. The documentation should support the need for that chair, and I'm assuming it's an upgraded chair, it's a chair that requires – we'll just leave it as an upgraded chair compared to what the beneficiary has now. The documentation should support the medical necessity for that chair.

(Paula Koenig): Sure. It may be a weight gain. There may be other issues. It's not always additional options. I guess again my question sort of goes back to whether the reviewers would be accessing the common working file to recognize that there was (same) similar equipment and that they needed to give it that extra scrutiny?

(Doris): They will probably look at all the documentation that they have available to them. But once again, it's based on how the (progress) notes are written to support the medical necessity for that chair.

(Melanie Combs-Dyer): And yes, all of the (DME MACs) had access to the common working file. That's something that they could access if they needed to.

(Paula Koenig): OK. I just was wondering whether that would be a routine practice for them. If we could follow up on one of the other questions as well.

(Melanie Combs-Dyer): Sure.

(Paula Koenig): I was a little confused by the answer, again, if the patient wants to switch from provider A that submitted a PA request and got it approved and then they want to go to a different provider to get the chair, the new provider would generally be obtaining some of their own documentation. They may be able to access some of the earlier documentation. But they're going to end up with a different documentation packet than what provider A had.

So would provider B need to submit that for prior authorization? And if they do, is there a need to void the original PA or would it transfer over? I guess just interested in how that process (happens).

(Melanie Combs-Dyer): The prior authorization request follows the beneficiary and the HCPCS code. So long as the beneficiary is getting the same equipment with one supplier that they would have gotten with the first supplier, they can just take their prior authorization request number to the other supplier.

Now we are asking the beneficiary to check with the supplier and make sure that there's no other you know anything else that they need to be considering before they make that change. (Amanda), is there anything else that we should ask?

(Amanda): It's important to keep in mind that the billing supplier must comply with all Medicare documentation and claims requirements when submitting a claim.

(Melanie Combs-Dyer): Right. So all of that detailed product description within a certain number of days of the order and all that stuff, none of that changes. So just because you have a prior authorization request might not be enough. You still have to make sure that you have whatever all those other documents are that you would normally have to have. So there's no change in the requirement.

(Paula Koenig): OK. Thank you. One more quick question, does this apply to Medicare beneficiaries who have Medicare as secondary coverage, they have some other primary coverage first?

(Melanie Combs-Dyer): Whatever the normal rules are for Medicare as secondary payer would apply here. We think that if you're just looking to get a denial, you can submit a prior authorization request, you can get your nonaffirmative or incomplete decision, but you can deliver the item and submit a claim and get a denial. And then once you have that denial do whatever you would normally do through the prior authorization through your secondary payer route.

If you don't do it that way your claim will be suspended. You'll get additional documentation with it. It'll be a lot longer for you to get that denial.

(Paula Koenig): OK. But if we're expecting payment we still would need to go through the prior authorization process to avoid the prepay review on that secondary claim and to avoid the payment reduction?

(Melanie Combs-Dyer): You always have the option of either going through prior authorization or skipping prior authorization. If you go through prior authorization you will get a decision fairly quickly, in 10 days or 20 days or however long it takes for you to submit a complete package. Whether you want to get a payment or you want to get a denial, it'll be fairly quick under the prior authorization process.

If you choose to skip prior authorization then it will be the normal prepayment review. The claim will stop. You will be sent an additional documentation request letter. Forty-five days later the review contractor will begin reviewing that documentation. Sixty days after that they will issue you a decision.

So if what you're looking for is a quick denial so that you can bill secondary, we would encourage you to go through the prior authorization process.

(Paula Koenig): No, I was actually looking when Medicare was secondary. So they have a primary insurance that's going to cover the chair and they have Medicare as

secondary. I was just trying to be sure whether the whole PA requirement and process for this demo program would apply to those clients where Medicare is their secondary coverage.

(Melanie Combs-Dyer): I don't know how that works. How does it work today? Are those subject to prepayment medical review? You're submitting a claim to Medicare for payment, right?

(Paula Koenig): Correct. Correct.

(Melanie Combs-Dyer): Yes. If it's an order that's written on or after September 1 for a beneficiary in one of these states and you do not go through the prior authorization process then that claim will be stopped for medical review. If you want to you can go through the prior authorization process, but it's your choice. You can either skip prior authorization or go through prior authorization. Whatever works for you in a given situation.

(Paula Koenig): Just wanted to find out whether there was any exception or differences if Medicare was secondary and it sounds like there isn't.

(Melanie Combs-Dyer): Not that I'm aware of.

(Paula Koenig): So thank you very much. OK.

(Melanie Combs-Dyer): Yes.

Female: Thank you.

(Melanie Combs-Dyer): Well thanks, everybody, for participating on the call today. We're getting very excited that we're getting so close to our start date, and we really appreciate all the input that you guys have given us over these many months that we've now been having these open door forum calls.

We hope to put out a new demonstration operational guide shortly. And we do anticipate that we'll have some new PIM changes coming out in the next few days and weeks. So stay tuned, and we look forward to talking to all of you again at our next open door forum call which is on August 29. Thanks, everybody.

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

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