STATEMENT OF

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ON

"ELIMINATING WASTE AND FRAUD IN MEDICARE: AN EXAMINATION OF PRIOR AUTHORIZATION REQUIREMENTS FOR POWER MOBILITY DEVICES"

BEFORE THE

U. S. SENATE SPECIAL COMMITTEE ON AGING

SEPTEMBER 19, 2012

U.S. Senate Special Committee on Aging

Prior Authorization of Power Mobility Devices (PMDs) Demonstration

September 19, 2012

Ranking Member Corker, Chairman Kohl, and Members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce fraud and improper payments for power mobility devices (PMDs), which will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. I appreciate the opportunity to update you on the Prior Authorization of Power Mobility Devices Demonstration, which CMS began earlier this month. PMDs are a group of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) consisting of such devices as power wheelchairs and power operated vehicles (scooters).

Background

DMEPOS, including PMDs, are included under the Medicare Part B benefit. Medicare covers PMDs when a beneficiary has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living within the home and the limitation cannot be sufficiently and safely resolved by the use of a cane, walker, or manual wheelchair. These activities of daily living include feeding, dressing, and bathing in customary areas in the home.[1]

A physician/practitioner may prescribe a PMD to be paid by Medicare after they complete the face-to-face encounter process. During this process, the physician/practitioner assesses the beneficiary's medical condition and mobility needs and determines whether a PMD is necessary as part of an overall treatment plan. The ordering physician/practitioner sends a supplier the prescription for a power wheelchair and documentation from the beneficiary's medical record to support the medical necessity of the power wheelchair. Based on the prescription and supporting medical documentation, the supplier recommends a type of PMD for the beneficiary; the type must be approved by the ordering physician/practitioner. The supplier is also responsible for

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMDFactSheet07_Quark19.pdf

assessing the beneficiary's home environment before or during the delivery of the PMD to verify that the beneficiary can adequately maneuver the item in his or her home.

High Incidences of Fraud and Improper Payments

PMDs have had historically high incidents of fraud and improper payments. PMD suppliers also continue to be subject to significant law enforcement investigation.[2] Based on joint investigations by the Department of Justice (DOJ), CMS, and the HHS Office of Inspector General (OIG), in recent years numerous DMEPOS suppliers have been charged and convicted of defrauding the Medicare program and many have had their Medicare billing privileges revoked as a result of OIG investigations. Examples include the 20 DMEPOS company owners and marketers, most of them in the Los Angeles area, who were charged in 2009 with allegedly billing Medicare for more than $26 million in fraudulent claims for power wheelchairs, orthotics, and hospital beds.[3] More recently, a Louisiana man was sentenced to 180 months in prison for participating in a health care fraud scheme that defrauded Medicare of more than $21 million by billing for power wheelchairs, leg and arm braces, and other durable medical equipment that were never provided to beneficiaries and/or were not medically unnecessary.[4]

In addition, CMS noted in a 2011 Report[5] on improper payments in the Medicare fee-for-service program that over 80 percent of claims for motorized wheelchairs did not meet Medicare coverage requirements. Although CMS recognizes that many improper payments are not the result of willful fraud, this error rate represents over $492 million in estimated improper payments.

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/FR-Notice.pdf
[3] http://oig.hhs.gov/oei/reports/oei-04-09-00260.asp
[4] http://www.justice.gov/opa/pr/2012/August/12-crm-1032.html
[5] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

Prior Authorization for PMD Demonstration

The Affordable Care Act provided CMS with many tools to combat fraud, waste, and abuse in Medicare. In recent years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud.

To complement these efforts, the Prior Authorization of PMD Demonstration will develop improved methods for preventing fraud and will protect the Medicare Trust Funds from fraudulent actions and the resulting improper payments. This demonstration implements a prior authorization process for PMDs for people with Medicare who reside in seven States (California, Illinois, Michigan, New York, North Carolina, Florida and Texas). The demonstration began on September 1, 2012 for orders written on or after that date. This prior authorization demonstration will also help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. While CMS recognizes there are many honest suppliers, given the widespread law enforcement activity associated with PMD fraud, CMS is taking necessary actions to address these problems.

This demonstration employs an approach drawn from the private sector to protect the Medicare Trust Funds. Prior Authorization, sometimes known as "prior approval" or "pre-certification," is currently being used in other health care programs such as TRICARE, certain State Medicaid programs, and private insurance for many services and items including PMDs. However, unlike some other prior authorization programs, this program does will not automatically deny payment for a PMD if it did not go through prior authorization. With prior authorization, suppliers and beneficiaries will know before an item is delivered to a beneficiary whether Medicare will pay for the PMD. This helps ensure that Medicare pays only for PMDs that meet the longstanding coverage requirements thereby limiting fraud, waste and abuse. Further, suppliers and beneficiaries will know before the item is delivered if they will have to pay for the item. Currently, in many cases, if the item is not covered, Medicare beneficiaries will have to pay for the entire cost of the item because the PMD is delivered to the beneficiary and then Medicare denies the payment because the coverage criteria has not been met.

Prior Authorization Process

Under the demonstration, an ordering physician/practitioner or supplier submits a prior authorization request and all relevant documentation to support Medicare coverage of the PMD to a CMS Durable Medical Equipment Medicare Administrative Contractor (DME MAC). Currently, these requests can be submitted via fax or mail. Beginning later this year, requests can be submitted electronically. After receipt of all relevant documentation, the DME MAC conducts a review, and sends notification of the decision within 10 days to the physician/practitioner, beneficiary and supplier. The DME MAC either affirms (approves) the request or non-affirms (does not approve) the request. To be affirmed, the request for prior authorization must meet all applicable rules, policies, and National Coverage Determination (NCD)/Local Coverage Determination (LCD) requirements for a PMD.

If the review results in a non-affirm, the DME MAC provides a detailed written explanation outlining which specific coverage requirement(s) was/were not met. This notification is sent to the physician/practitioner, supplier and beneficiary. In the event of a non-affirm, a physician/practitioner or supplier may resubmit the prior authorization request an unlimited number of times. The DME MAC will make every effort to review any re-submissions within 20 days.

The demonstration does not create any new documentation requirements, but simply requires the information be submitted earlier in the claims process. CMS has worked to remind people of these longstanding requirements. Instead of reviewing the documentation after the item has been delivered, we now allow the paperwork submission prior to delivery. CMS has and will continue to provide extensive outreach and education to physicians/practitioners, suppliers, and beneficiaries to educate them about the demonstration and the prior authorization process.

All existing appeal rights remain unchanged under the PMD demonstration. If a PMD claim is denied under this demonstration, beneficiaries may appeal the claim denial. Beneficiaries and suppliers cannot appeal a non-affirmative (non-approval) prior authorization request.

However, suppliers have the option of (1) resubmitting the prior authorization request or (2) delivering the PMD, submitting a claim which will be denied, and then submitting an appeal.

There is also an expedited process for practitioners to request a 48 hour review in emergency situations. The DME MAC conducts an expedited review when the physician/practitioner indicates clearly, with supporting rationale, that the 10 business day timeframe for review of the prior authorization request could jeopardize the beneficiary's life or health. The expedited request must be accompanied by the required supporting documentation. Inappropriate expedited requests may be downgraded to standard requests. After conducting an expedited review, the DME MAC communicates a decision for the prior authorization request to the submitter within 48 hours of the complete submission.

Suppliers Who Do Not Submit a Prior Authorization Request

If a supplier submits a PMD claim without first seeking prior authorization, the claim will undergo prepayment review. As part of the review process, the DME MAC sends letters to the supplier requesting all documents to support the claim. Once the supplier has submitted all the necessary documentation, the DME MAC conducts a review of the documentation within 60 days. This is the standard time frame for prepayment review. If the DME MAC determines payment is appropriate, the payment is processed.

Starting December 1, 2012, payments will be reduced by 25 percent for suppliers not submitting a prior authorization request. This reduction is not subject to appeal. The 25 percent payment reduction does not apply to contract suppliers in competitive bidding areas.[6] If a competitive bid contract supplier submits a payable claim that has not been prior authorized for a beneficiary with a permanent residence in a competitive bidding area that is included in the supplier's contract, that contract supplier would receive the applicable single payment amount under its

[6] Note: Section 302 of the Medicare Modernization Act of 2003 (MMA) established requirements for a new Competitive Bidding Program for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Under the program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas, and CMS awards contracts to enough suppliers to meet beneficiary demand for the bid items. On January 1, 2011, CMS launched the first phase this program (Round 1 Rebid) in nine major metropolitan areas for nine product categories, including Standard Power Wheelchairs, Scooters, and Related Accessories. The nine metropolitan areas are: Charlotte, Cincinnati, Cleveland, Dallas, Kansas City, Miami, Orlando, Pittsburgh, and Riverside, CA.

contract and would not be subject to the 25 percent reduction. These suppliers must still adhere to all other requirements of the demonstration. (See Table 1). We do not reduce the payment to contract suppliers in competitive bidding areas in order to honor the contracts we signed with those suppliers.

Table 1:

	Prior authorization request is	The DME MAC decision is	The supplier chooses to	The DME MAC will
1	Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met).
2	Submitted	Non-Affirmative*	Submit a claim	Deny the claim.

3	Not submitted	N/A	Submit a claim	• Send a documentation request letter.
				• Review the medical record documentation for the claim.
				• If payable:
				  • For non-contract bid winner, pay at 75 percent of fee schedule.
				  • For contract bid winner, pay at single payment amount

*Supplier may choose to resubmit prior authorization request.

CMS Improvements in Response to Industry Feedback

CMS originally announced this demonstration on November 15, 2011 and received significant feedback from industry on the demonstration design. In response, CMS delayed the demonstration from its original January 1, 2012 start date and CMS made several changes to the demonstration to better assist suppliers in implementation. The CMS changes include:

- Removal of the 100 percent Pre-Payment review phase (formerly Phase 1) from the demonstration based on supplier concerns about the financial impact of pre-payment review;
- Reduction of the target review time for resubmissions to 20 business days (from 30 days).
- Authorization of suppliers to perform the administrative function of submitting the prior authorization request on behalf of the physicians/practitioners; and

- Provided physician/practitioners and suppliers an opportunity to comment and make recommendations on how to reduce provider and supplier paperwork burden associated with these demonstrations through a Paperwork Reduction Act (PRA) notice.

Outreach and Education

Prior to the demonstration start date, CMS conducted outreach and education including webinars, in-state meetings and other education sessions for suppliers, physician/practitioners and beneficiaries. In addition, physicians/practitioners and suppliers who have recently furnished or who have recently ordered a PMD for a beneficiary residing in a demonstration State were notified via certified letters about the demonstration prior to the start date of the demonstration. CMS published numerous educational materials to assist suppliers and physicians/practitioners on the policies and documentation requirements for PMDs.[7] CMS also conducted several open door forums on these policies, as well as the process and requirements for the PMD demonstration. We will continue to work to ensure that suppliers, physicians/practitioners, and beneficiaries are educated and have up to date information throughout the demonstration.

Development of the PMD Electronic Clinical Template

CMS recognizes the importance of consistency of documentation within this benefit and is developing an electronic clinical template as part of a physician's/practitioner's electronic health records (EHR). An electronic template that is part of the EHR is a good way to allow physicians/practitioners to have a standard method to document a patient's medical condition. This may help physicians/practitioners more accurately communicate why the PMD is medically necessary for a particular beneficiary. However, use of an electronic clinical template would not be mandatory to receive payment from Medicare, nor would the use of such a template guarantee Medicare payment for the PMD. CMS has developed an initial draft of the suggested electronic clinical template with data elements for a progress note documenting a face-to-face PMD evaluation. Stakeholders have been providing feedback on draft electronic clinical template including through a series of special open door forum calls.

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/PADemo.html?redirect=/CERT/03_PADemo.asp

CMS and the Office of the National Coordinator for Health Information Technology (ONC) intend to collaborate on the development of a strategy to develop a standard for the electronic clinical template for PMD progress notes. Ideally, this standard would be adopted by EHR vendors and, thus, enable physicians/practitioners to access the electronic clinical template as part of their EHR. Our goal would be for the electronic clinical template to be available in all 50 states.

Timing of the PMD Electronic Clinical Template- and the Demonstration

Some have raised the issue of whether the demonstration should be delayed until a PMD electronic clinical template for the clinical information is available. CMS does not believe it is necessary to delay the PMD demonstration until we develop an electronic clinical template. The PMD demonstration has not changed existing medical necessity policies and documentation requirements for furnishing PMD to Medicare beneficiaries. CMS published numerous educational materials to assist suppliers, and physicians/practitioners on the policies and documentation requirements for PMDs. In addition, a draft of the electronic clinical template is available on the CMS website[8] and there is nothing precluding any physician/practitioner from using this template as a tool to assist them in documenting the medical criteria necessary for CMS to approve payment for a PMD.

Conclusion

Prior authorization is an important tool that will help CMS reduce fraud and improper payments for PMDs, while continuing to ensure that beneficiaries have access to needed equipment. We believe this demonstration will help protect the Medicare Trust Funds by utilizing many of the same methods already used by private insurance plans and other programs to ensure payment accuracy.

We appreciate the Committee's interest in combating fraud, waste and abuse in the provision of PMDs. We thank you for your support and your efforts to educate suppliers,

[8] http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/ElectronicClinicalTemplate.html

physicians/practitioners and beneficiaries about the demonstration. I look forward to continuing to work together with the Committee to protect beneficiaries and the Medicare Trust Funds.