



Caring that Feels Right at Home

Via Electronic Submission:
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June 1, 2009

Attention CMS Desk Officer
Office of Information and Regulatory Affairs
Office of Management and Budget (OMB)
Room 10235, New Executive Office Building
Washington, DC 20503

RE: Agency Information Collection Activities: Submission for OMB Review, Comment Request [CMS-10116]¹

Dear Sir or Madam:

The American Association for Homecare (AAHomecare) submits these comments in response to the Centers for Medicare and Medicaid Services' (CMS') request for public comments on the paperwork burdens associated with CMS' rule on the conditions for payment of power mobility devices (PMDs). AAHomecare is the only national trade association representing every line of service within the homecare community. Our members include manufacturers and providers of power mobility devices who participate on AAHomecare's Rehab and Assistive Technology Council (RATC).

AAHomecare is uniquely qualified to submit these comments. RATC members are experts in the clinical needs of patients who require mobility devices, the technical design, function and performance standards of mobility devices, and the Medicare coverage, coding, and reimbursement rules pertaining to PMDs. Our comments are informed by the experience and training of the highly qualified RATC members who assisted in developing these comments.

As you are aware, the Paperwork Reduction Act (PRA) was passed by Congress to ensure that agencies scrutinize the paperwork burdens they impose on the public in order to minimize them. The paperwork burdens that agencies must address include: the need for the information collection and its usefulness in carrying out the agency's specific functions; the accuracy of the

¹ 74 Fed. Reg. 20318 (May 1, 2009).

agency's estimate of the documentation burden; the quality, utility and clarity of the information to be collected; and recommendations to minimize the information collection burden on the public.

BACKGROUND

The national coverage determination (NCD) for mobility assistive equipment contains a complicated algorithm for determining when a Medicare beneficiary who needs mobility assistive equipment may qualify for a PMD. CMS published the rule at issue in these comments on April 5th 2006. The rule specifies conditions for coverage and payment of PMDs which are defined as power wheelchairs and power operated vehicles (POVs). The rule governs the prescription, documentation, and furnishing of PMDs to Medicare beneficiaries. Importantly, the rule eliminated the requirement that PMD providers submit a certificate of medical necessity (CMN) to document the beneficiary's need for the device.

In place of the CMN, the rule requires physicians to furnish PMD providers with a prescription and extensive documentation from the patient's medical record to substantiate medical necessity for the PMD. Medical necessity is determined in reference to the algorithm contained in the NCD. Providers must maintain this documentation on file in the event of a Medicare audit. As we have stated in previous comments on this issue, we are concerned that the supporting documentation requirements contained in the rule are overly broad, making it difficult for a physician or provider to understand the scope of what CMS expects.

The rule requires physicians to: write a prescription for a power mobility device, document in the medical record the results of a "face-to-face" examination of the beneficiary, and provide the prescription and the supporting documentation to the provider within 45 days of the face-to-face examination. The prescription must contain the following elements: the beneficiary's name; the date of the face-to-face evaluation; the diagnosis and condition that the power mobility device is intended to modify; a description of the item, *i.e.*, a narrative description of the power mobility device; the length of need; the physician or treating practitioner's signature and the date the prescription was written. 42 C. F. R. § 410.38 (c) (1).

While the rule is highly specific about the requirements for the written prescription, the supporting documentation requirements in the rule are meaninglessly broad. The rule states that the physician is to provide "supporting documentation, including pertinent parts of the beneficiary's medical record (e.g., physical examination, diagnostic test, summaries of findings, diagnoses, treatment plans and/or other information as may be appropriate) that supports the medical necessity for the power mobility device. . . ." 42 C.F.R. § 410.38 (c) (2) (iii). Although CMS and its contractors have attempted to provide physician and provider education on documentation compliance, we believe that there continues to be confusion on the part of both physicians and PMD providers on what *information* substantiates medical necessity for the power mobility device. We are also concerned that CMS has consistently underestimated the paperwork burdens these documentation requirements impose on both physicians and providers. We address these issues in more detail below.

COMMENTS

The Documentation Requirements Are Too Broad And Impose Unreasonable Paperwork Burdens

AAHomecare appreciates the need for CMS to collect information that supports the medical necessity for a power mobility device. The rule however, does not tell physicians what information will support medical necessity. The documentation standard needs to be objective, measurable and correlate to functional level. There is no guidance with respect to the content or format of the documentation. Rather, the rule lists various pieces of the patient record that *could* contain relevant information, depending on the circumstances. Our members' experience proves that physicians do not usually chart with the level of descriptiveness that CMS and its contractors require under the rule and coverage policies.

This is borne out in notices that two of the MAC contractors have published since the last time that CMS submitted this collection of information for OMB review. In January 2008, the MAC contractor for jurisdiction A reported the results of a PMD audit showing that 86% of PMD claims in the audit sample were denied. Of the 86% that were denied, 61% were denied because the information submitted to support medical necessity did not meet policy criteria.² Similarly, late last year, the MAC contractor for Jurisdiction C published an article stating that: “[a] review of power mobility claims and ADMC requests submitted to Jurisdiction C *shows continued uncertainty regarding the various assessment and evaluation documentation requirements.*”³

We understand that the Medicare contractors are making efforts to assist providers and physicians with documentation compliance for PMDs, but the efforts vary in effectiveness from contractor to contractor. Even with these efforts, however, the coverage policies for PMDs are so complex and the medical needs of beneficiaries are so uniquely individual, that it remains difficult for physicians to document medical necessity to the level of specificity that meets the contractor's expectations on an audit.

CMS should identify with precision what content it expects physicians to include in the documentation and the format of the documentation. Without this specific guidance, the documentation is likely to be incomplete. The failure to provide specific guidance in this area further increases the paperwork burden of producing and obtaining the documentation because providers have to ask the physician or practitioner to provide additional documentation.

In addition, the Colorado Medical Society, the Florida Academy of Family Physicians and the Texas Academy of Family Physicians, which together represent approximately 18,000 physicians, have all proposed and supported power mobility clinical guides for physicians. State Medicaid programs have also adopted clinical guides for power mobility.

² DME MAC Jurisdiction A Power Mobility Devices Billing Reminder, posted January 11, 2008, available at: <http://www.Medicarenhic.com>.

³ DME MAC Jurisdiction C Insider, Fall 2008, available at: <http://www.cignagovernmentservices.com>.

CMS Has Underestimated The Paperwork Burden For The Documentation Requirements in the Rule

As you know, since the rule became final in 2006, CMS has requested OMB clearance for the paperwork burdens imposed by the rule a number of times. CMS' basic premise in these submissions is that the burden of providing supporting documentation in the medical record is similar to the burden associated with the CMN. As a result, CMS maintains that the paperwork burdens under the rule are more or less comparable to the paperwork burdens of completing CMNs. In the notice soliciting comments, CMS estimates that the burden currently imposed by the rule is somewhat lower than its previous estimate given an anticipated drop in claims volume for PMDs.⁴

AAHomecare has often raised its concern that CMS underestimates the burden to physicians and providers of completing CMNs. In this case, CMS has also understated the documentation burden imposed by the documentation requirements in the rule. Specifically, the rule requires physicians to examine the beneficiary and to record the examination in the patient record. The physician or physician's staff must identify the relevant portions of the record, redact information that is not relevant, copy the record and furnish it to the patient or the provider with a prescription. If the provider requests additional information, the physician must supply it. These requirements would at least exceed the time necessary to complete a CMN.

CMS' burden estimate also fails to include the time other clinicians are involved in assessing the patient. The evaluation itself is lengthy, and the written report of the evaluation could take up to several hours to complete. Finally, CMS addresses the burden on providers in receiving, reviewing, and storing the documentation. CMS concludes that the total burden estimate for *both* physicians and providers is only ten (10) minutes.

More importantly, CMS has not revised its estimate of the documentation burdens imposed by the rule despite OMB's direction to CMS in its terms of clearance dated October 16, 2006 that it monitor the paperwork burden to providers and physicians to determine whether they need to be modified.⁵ Despite this explicit mandate, CMS has not, to our knowledge, engaged in data collection or other activities that would support its current burden estimates for this information collection. In fact, we were unable to find CMS' Supporting Statement for the current submission. The only published Supporting Statement for this review was dated April 27, 2007.

OMB clearance of this information collection should be based on the Agency's agreement to continue to monitor the paperwork burdens associated with the rule. We recommend that OMB require CMS to reassess the paperwork burden estimates associated with this rule and provide meaningful support for the new estimates with a view towards modifying the rule to address the concerns we raised above.

⁴ 74 Fed. Reg. 20318.

⁵ See e.g., CMS Agency Collection of Information Activities: Submission for OMB Review: Comment Request, 74 Fed. Reg. 46085-02 (August 16, 2007).

CONCLUSION

AAHomecare appreciates the opportunity to submit these comments and is available to discuss them with you in greater detail. Please do not hesitate to contact Walter Gorski, Vice President, Government Affairs, (703) 535-1894 or waltg@aahomecare.org with any questions or comments.

Sincerely,



Tyler J. Wilson
President and Chief Executive Officer
American Association for Homecare