



***Via Electronic Submission***  
***<http://www.regulations.gov>***

June 28, 2012

Bridget Dooling  
Policy Analyst  
Office of Management and Budget  
New Executive Office Building  
725 17<sup>th</sup> Street NW  
Washington, DC 20503

**Re: Medicare Fee-for-Service Prior Authorization Demonstration Project for Power Mobility Devices; Form Number: CMS-10421; OCN: 0938-New**

Dear Ms. Dooling:

The American Association for Homecare (AAHomecare) is submitting these comments in response to the Centers for Medicare and Medicaid Services' (CMS) request for approval under the Paperwork Reduction Act (PRA) of the above referenced information collection request (ICR). Specifically, CMS seeks approval from the Office of Management and Budget (OMB) for the information collection requirements of a proposed massive demonstration project on prior authorization for power mobility devices (PMD).

AAHomecare represents durable medical equipment (DME) providers, manufacturers, and others in the homecare community that serve the medical needs of millions of Americans who require wheelchairs, oxygen systems, medical supplies, inhalation drug therapy, and other medical equipment and services in their homes. Members operate more than 3,000 homecare locations in all 50 states. In light of our members' expertise and experience, AAHomecare is uniquely qualified to comment on the request for OMB approval of the ICR.

AAHomecare believes that CMS' request for approval of the information collection is premature given that the Agency has afforded the public only the broadest outline of the design and implementation plans for the demonstration. Based on the proposed collection of information published for comment, it is very nearly impossible to assess the paperwork burden the demonstration will impose on physicians and PMD providers. CMS states that the "submitter will submit to the DME MAC a request for prior authorization and all relevant documentation to support Medicare coverage of the PMD item" (emphasis added). The format for such a prior authorization

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request has not been provided, and the phrase “all relevant documentation” is too broad and subjective to allow for accurate estimate with regard to the burden. Consequently, AAHomecare recommends that OMB deny CMS’ request for approval until the Agency publishes the substantive and procedural standards physicians and DME providers will have to meet, including, most importantly, the specific documentation requirements. Until then, the paperwork burden cannot be accurately assessed.

By way of background, CMS intends to use prior authorization as way to address the high payment error rate for this benefit. There is no doubt that prior authorization will reduce the error rate because, simply stated, providers will not be paid and beneficiaries will not receive a PMD unless a claim meets contractors’ detailed, subjective, and inconsistently applied documentation requirements. We believe that the complexity and level of detail of current documentation requirements is what drives high error rates for PMDs in post payment audits. This is borne out by double-digit rates that remain firm despite many attempts at intervention by CMS and its contractors six years after the requirements were finalized (see chart in appendix for example of recent error rates). Prior approval would essentially reverse the current workflow by requiring providers to collect and produce up-front the level and quality of records now required to defend post payment audits. Because that bar is so high, we expect that many claims will be denied, at least once, but more likely more often than that.

Currently, when a physician prescribes a PMD and the PMD provider initiates service to a beneficiary, PMD providers collect only the documentation required by the national and local coverage determinations (NCD and LCD, respectively). In fact, physicians are instructed that they are required to furnish additional documentation to the PMD provider only when the PMD provider receives an additional documentation request from Medicare entities (DME MACs, RAC, CERT, etc.) These records establish a beneficiary’s current medical need for the PMD.

However, in response to the amount of detail that contractors require in a post payment audit, providers contact and collect “longitudinal” medical records from multiple facilities and/or practitioners in order to defend their claims. In fact, the Association has documented examples where submitted claims have been denied because the physician documentation is written on the wrong color paper or nurse reviewers do not see certain “buzzwords” they have been trained to look for when reviewing the claim. This an important point because CMS has not published the specific documentation requirements for the demonstration. Moving this prior authorization demonstration forward without an established clear process and appropriate education from CMS will place the paperwork burdens of prior authorization on the PMD providers. We are truly “putting the cart before the horse” without understanding what documentation standards will be used in the demonstration.

AAHomecare can, however, provide OMB with the burden estimates for responding to post pay PMD audits that were reported to us by our members. As you can see from the chart attached to these comments, the average time burden reported by our members substantially exceeds the estimates in CMS’ submission. The chart represents responses to our survey of our Complex Rehab and Mobility Council (CRMC) from AAHomecare member companies that furnish PMDs to Medicare beneficiaries. AAHomecare received seven responses with an average time burden of 82 minutes to

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review and package the paperwork for a standard power wheelchair and 92 minutes for a complex power wheelchair.

Moreover, it is crucial for CMS to include a clinical medical necessity documentation template for physicians to use in the prior approval process. Extensive legal research has been conducted by members of the Association that shows that a clinical medical necessity template can be completed by a physician and be considered part of the medical record. While CMS is developing an electronic clinical medical necessity template, CMS has stated that this tool is on a separate track from this demonstration and will not be used when the demonstration is initiated. Even more troubling, CMS stated that the use of the electronic template will be voluntary. AAHomecare firmly believes that if CMS wants: 1) to ensure beneficiary access to PMDs; 2) to reduce incidence of fraud; and, 3) significantly reduce the error rate, it must allow physicians to use a clinical medical necessity template when this demonstration begins.

The Association is also concerned about the size and scope of this demonstration. According to CMS, the demonstration will encompass seven states and more than 43 percent of all power mobility claims will be subject to the demonstration. We believe that this is unprecedented. Recall that the Medicare competitive bidding demonstration project was tested in two locations over a period of several years before the program was expanded to 9 test sites in 2009. Yet nearly half of all Medicare beneficiaries who require power mobility will be affected immediately by this demonstration. On this point, we urge that CMS reduce the size of the demonstration to ensure that it works properly without adversely impacting beneficiaries, physicians and PMD providers.

Finally, it is important to remember that beneficiaries also have a great deal at stake in the demonstration. Today beneficiaries receive their equipment up front and the provider gets paid but faces the prospect of a post payment audit. Because the prior authorization demonstration puts the audit burden on the front end, beneficiaries will not receive equipment if the claim is not pre-approved. Beneficiaries do not have appeal rights if the prior approval is denied, and they are left without recourse to challenge the validity of the contractor's decision. As we have recommended in previous comments, beneficiaries should be given the right to appeal a contractor's denial of prior approval.

In closing, for a demonstration testing such a new payment mechanism for a complex benefit, we believe that the program must: 1) be fully built in a transparent manner; 2) follow the prior authorization models currently in place by managed care and state Medicaid systems; 3) allot adequate time to educate and instruct all stakeholders of these significant changes; and, 4) allow the use of a clinical medical necessity template to reduce the burden on physicians and PMD providers. These actions would be the most efficient way to develop the demonstration with as minimal an impact on all stakeholders as possible. After these steps are taken, only then should CMS seek approval of collection of information from the public, PMD providers and the burden it places on them because to do so prior to taking these actions makes it impossible to determine the time necessary to comply with this request.

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Thank you for your time and attention to our concerns. We very much appreciate the opportunity to submit these comments. Please feel free to contact me if you have any questions or comments on the above.

Sincerely,

A handwritten signature in black ink, appearing to read "Walter J. Gorski". The signature is written in a cursive style with a large initial "W" and "G".

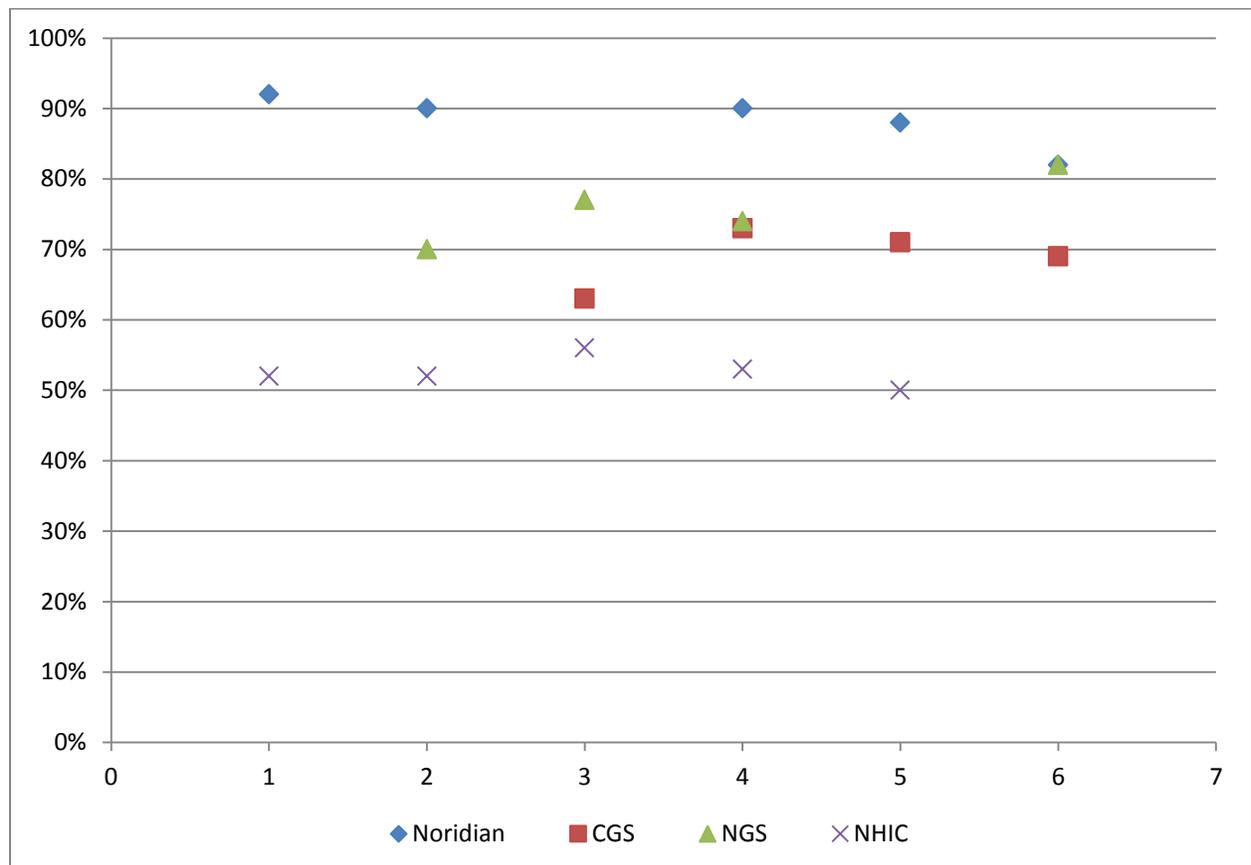
Walter J. Gorski

Vice President of Government Affairs

## Appendix

### DME MAC Error Rates: Standard Power Wheelchairs – K0823

Contractor	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1
Noridian	92%	90%		90%	88%	82%
CGS			63%	73%	71%	69%
NGS		70%	77%	74%		82%
NHIC	52%	52%	56%	53%	50%	



Note: Due to policy changes and other circumstances, the error rate for standard power wheelchairs (HCPCS code K0823) was not available from all contractors for every quarter.