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Micky Tripathi, Ph.D., M.P.P.
National Coordinator for Health Information Technology
The U.S. Department of Health and Human Services
Office of the National Coordinator for Health Information Technology
Mary E. Switzer Building, Mail Stop: 7033A
330 C Street SW
Washington, DC 20201
Document ID: HHS-ONC-2022-0001-0001

Re: Request for Information: Electronic Prior Authorization Standards, Implementation Specifications, and Certification Criteria

Dear Mr. Tripathi,

The American Association for Homecare (AAHomecare) is pleased to submit comments on the Department of Health and Human Services Office of the National Coordinator for Health Information Technology above captioned Request for Information. AAHomecare is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members provide medically necessary DMEPOS items and services to patients in their homes. AAHomecare supports maintaining and expanding the prior authorization (PA) program for certain DMEPOS items. PA has been successful in reducing provider burden and improving program integrity. AAHomecare is very supportive of a PA process that is efficient, electronic, and timely.

Prior authorization can be beneficial for certain DMEPOS product categories for all stakeholders, including patients, prescribers and DMEPOS suppliers.

Effective PA procedures improve the DMEPOS ordering process and reduces audit and appeal burden for suppliers and patients. An effective PA program should:

- Establish medical necessity for a DMEPOS item before the beneficiary receives the item.
- Include expedited procedures in case a referral source determines a beneficiary needs an item the same day.

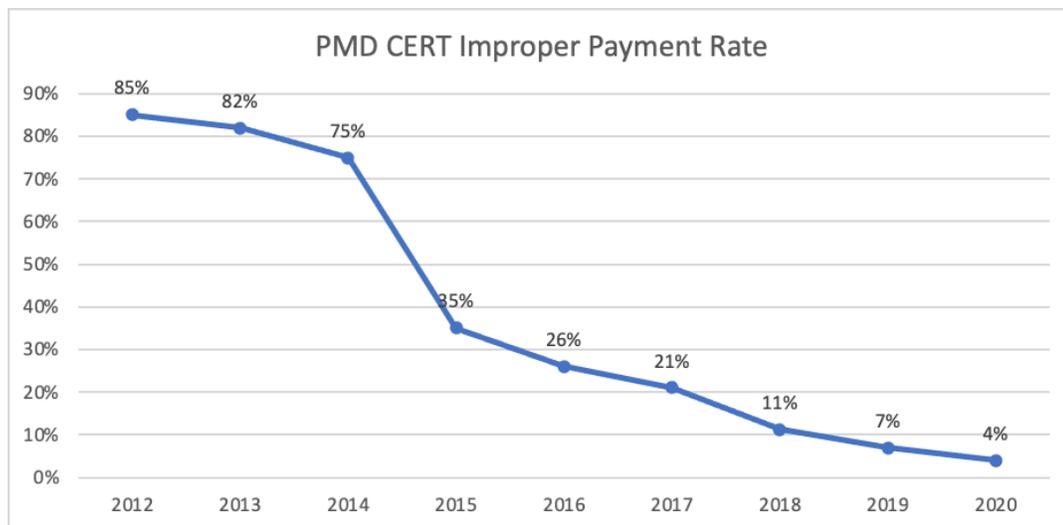
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- Rely on electronic communication that includes model documentation forms to facilitate the transmission of medical necessity information.
- Ensure beneficiaries have timely access to DMEPOS items subject to PA.
- Ensure that the ordering practitioner knows when he or she must submit records supporting a request or whether there are missing or deficient records he or she must supplement.
- Establish the beneficiary’s medical necessity for the DMEPOS item for as long as he or she needs the item even if the beneficiary moves or changes suppliers.
- Establish a beneficiary’s medical necessity for supplies, accessories and repairs of base DME with an affirmative prior approval for as long as the beneficiary needs the base equipment even if the beneficiary moves or changes suppliers.

Although AAHomecare is a strong supporter of PA for certain DME products, such as power mobility devices (PMDs), this program may not be beneficial for all product categories, such as urological, ostomy and surgical dressings. In addition, for products that need to be delivered immediately, a PA program could cause significant delays in needed care for patients. This tailored, individualized care means each beneficiary's care plan will differ based on their unique needs. The timing of the authorization process is a critical factor in determining which product categories should be considered. While a ten-day turnaround time may work for PMDs, it will not work for other product categories.

Prior authorization reduces provider burden and supports CMS program integrity.

AAHomecare is a strong supporter of program integrity measures. PA for certain DMEPOS items will improve program integrity efforts and reduces audit and appeals costs for both suppliers and the Medicare program. PA for PMD has proven to be successful for CMS by reducing improper payments, the evidence can be seen in CMS’ Comprehensive Error Rate Testing (CERT) reports.¹ In the 2012 Medicare Fee-for-Service Supplemental Improper Payment Data report (date of service: 07/01/2010-06/30/2011), CMS reported an 84.6% improper payment rate for PMDs.² The significant drop seen between the 2014 report and 2015 report coincides with the start of PMD PA Demonstration. The CERT improper payment rate steadily decreased since the implementation of the PMD PA Demonstration. This trend is illustrated in the graph below.



¹ Centers for Medicare and Medicaid Services, Comprehensive Error Rate Testing (CERT) Reports.

² Centers for Medicare and Medicaid Services, Appendices Medicare Fee-for-Service 2012 Improper Payments Report.

Prescriber needs to be the driver of prior authorization.

To implement an effective PA program, the PA request must be initiated and completed by the ordering prescriber. The issues with affirming prior approvals lie with the prescriber's records. Therefore, the prescriber should obtain the authorization prior to writing an order and sending it to a supplier. In other situations where a PA is required, the ordering physician seeks the authorization for procedures such as an MRI. CMS should avoid positioning suppliers in the middle and make it clear the ordering prescriber is responsible for completing the PA process.

CMS should track prior authorization by anticipated response.

The PA non-affirmation rate should not be a reflection of supplier activity or compliance. Frequently, suppliers submit a PA request anticipating a non-affirmation decision. Suppliers go through the process of submitting a request to demonstrate to the prescriber and/or the beneficiary that the order did not meet the coverage requirements. Some suppliers note on the request that they do not expect an affirmation of prior approval. AAHomecare recommends CMS include a field on the PA request where prescribers and/or suppliers can mark their expectation of a non-affirmation. In addition, AAHomecare recommends CMS track requests and report on affirmation/non-affirmation by product category based on the expected decision. Tracking submissions will provide CMS insightful information on needed provider education.

Prior authorization process should be uniform across all payers.

AAHomecare recommends uniformity in the PA process across all payers. Currently, there are different processes, formats, timeframes, and products that are required to be prior authorized. For example, some payers require PA for all rentals and purchases over \$500 while others have specific products that need to be prior authorized. Payers are also inconsistent with items that require PA. One payer requires PA for portable oxygen systems (HCPCS E1390 and E1392), but not on other portable systems (HCPCS E0434 and E0431), but not for stationary oxygen systems (HCPCS E1390). Some contractors have an Authorization Exclusion List based on diagnosis, which further complicates the requirements.

Being required to follow all of the different requirements is burdensome for suppliers and providers. Below are some additional examples of differing requirements from payers:

- Some payers only require PA for over established quantities for disposable supplies.
- Some payers require PA for E1392 & E0431 but not E1390.
- Most payers only authorize positive airway pressure devices (E0601) for 3 months and then requires PA to for the remaining rental months.
- For one national payer, PAP supplies need authorization for the initial order with the rental but not for future supply orders.
- Some payers have an Authorization Exclusion List based on diagnosis.

Prior authorized items should not be subject to audit for medical necessity.

The expansion of PA should exempt any claims for items that receive PA from subsequent routine audits, unless probable fraud and abuse is suspected. This would dramatically reduce the burden placed on the Medicare audit and appeals system by redirecting the focus of audits to criminal activities rather than lawful suppliers.

Conclusion

AAHomecare appreciates the opportunity to provide these comments. Please contact us with any questions, or if you would like additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberley S. Brummett". The signature is fluid and cursive, with the first name being the most prominent.

Kimberley S. Brummett
VP, Regulatory Affairs
American Association for Homecare