

Dear PMC Members:

On September 13, 2005, the Centers for Medicare and Medicaid Services (CMS) held a Special Open Door Forum (ODF) on the newly released interim final rule on power mobility devices (PMDs). Dr. Rich Lawlor, CMS' Director of Outreach, moderated the forum, stressing that the intent of the new rule was to: better serve beneficiaries; fight against inappropriate behavior; work to address refinement in the claims process so it would better reflect the new functional ambulation standard. Lawlor also announced a separate Special ODF on DME supplier standards to be held September 26th.

CMS' Overview of Interim Final Rule

Dr. Steve Phurrough, Director, Coverage and Analysis Group of CMS' Office of Clinical Standards and Quality (OCSQ) highlighted elements found in new rule and tried to provide some greater clarification. He noted that the rule affects only power wheelchairs (PWCs) and power operated vehicles (POVs). The rule, following Congressional intent, eliminates the restriction on the type of physician who can qualify a beneficiary for a PMD, thereby increasing access to POVs. The rule also eliminates the Certificate of Medical Necessity (CMN), instead requiring that physician provides suppliers with a prescription and supporting documentation. The rule defines what physicians need to put in prescription including name of beneficiary, date of the exam, item ordered, diagnosis, conditions for use, length of time the PMD will be needed and the date of the prescription. The new rule puts responsibility on the supplier to get the prescription and proper supporting documentation, physicians will be responsible for providing prescriptions and supporting documentation within 30 days of the exam (with a few exceptions, like if a hospitalization occurred within the 30 day timeframe).

John Warren, CMS' Director of Program Integrity discussed implementation of the rule at the contractor level. The DMERCs have yet to develop local coverage determinations for the new rule, although Warren did note that all LCDs will be consistent across all regions. This LCD will be available for a 45 day note and comment period prior to implementation. Warren expects the LCD to be released shortly with the initial comment period through the end of October at which time changes will be made and final policy will be in the beginning of December and final implementation by January 1st. In addition to providing guidance on the interim final rule, the LCD will also address the new HCPC codes, provide new coverage criteria for the new codes, as well as spelling out how the DMERCs intend to phase-out the CMN and the phase-in of the new rule requiring a prescription and supporting documentation. Warren explained that, in all likelihood, suppliers would just have to submit a valid prescription for a PMD claim, but must keep on file the mandated "pertinent documentation."

After the overview of the interim final rule, CMS took questions from participants. The questions and comments centered on a number of issues including:

30-Day Timeframe:

Many participants questioned the requirement in the interim final rule requiring suppliers to provide a PMD 30 days after receiving a physician's prescription. Concerns were raised that beneficiaries may need to see a therapist or other clinicians, or prescriptions may need to be modified and that could be extremely difficult in a 30-day timeframe. Suppliers also questioned whether they could get all supporting documentation from the physician in 30 days.

CMS seemed interested in hearing the concerns and felt greater clarification was necessary to clear up some confusion as to when the 30 days start to toll. CMS, however, felt committed to the 30 day timeframe and felt it provided adequate time for suppliers to get the required documentation and provide the PMD.

Documentation Specifications:

Several suppliers asked for greater specificity regarding the necessary documents needed to be on hand for suppliers to file a claim. CMS noted that great guidance and clarity will be provided in the LCD that the DMERCs will soon issue. Other suppliers, including PMC Members Dennis Kline of Source One Medical, and Phil Delernia of Cornell Health Care, questioned what documentation will be necessary to satisfy DMERCs in post-payment audits. This lack of specificity allows DMERCs to make determinations of medical judgment despite the fact that the physician has supplied a prescription and pertinent parts of the medical records. CMS responded that science is part objective facts and part subjective, and that CMS will not eliminate the subjective nature of their review process.

Physician Education and Supplier Liability:

Participants and CMS had a lengthy discussion concerning the difficulties in educating physicians and that fact that suppliers are on the hook if physicians fail to chart the patient's ambulation with the proper specificity required by the DMERCs. PMC member Doug Harrison of The SCOOTER Store asked CMS if the supplier was responsible for making medical decisions in determining whether the documentation provided by the physician supports the medical necessity for need of the PMD? CMS stated that they are undertaking an outreach effort to physicians to inform them of the new rule and coverage criteria. They also encouraged suppliers to work with the physicians in their community to help them with the new documentation requirement. CMS did state, however, that they will not hold physicians liable for payments made to suppliers if CMS determines that that physician failed to adequately document need.

Call for Delay:

Several participants, including PMC Member Dan Meuser of Pride Mobility Products, called on CMS to delay implementation of the new interim rule until such time as all the

changes to the PMD benefit are ready to be put in place. Meuser noted that the LCD has yet to be introduced, and by CMS' own admission, physicians need to be informed and educated about the new changes. Meuser also noted that CMS is issuing new HCPC codes and fee schedules. Moreover, Medicare software contractors indicated it will take several months from the release of the new rule before new systems for both contractors and suppliers can be developed and tested. CMS stated that it is "listening" to requests for a delay in implementation.

Current CMN:

Questions were posed to CMS about the current status of the CMN. CMS stated that, while the CMN no longer reflects current coverage criteria, suppliers must complete a partial CMN (Section C and some of Section B) until the interim final rule goes into effect October 25th. After October 25th, beneficiaries will be required to submit to a face-to-face examination and receive a prescription. The pending LCD will provide greater detail on the phase-out of the CMN and the phase-in of the prescription and pertinent documentation requirements.

Elimination of the CMN:

Several participants noted disappointment that CMS decided to eliminate the CMN. PMC Member Mike Johns of Electric Mobility Corp. stated that the CMN served as a concrete determination of medical necessity that all parties understood. CMS countered that they felt that the CMN serving as a "proxy" for the medical records was "less than sufficient." CMS "carefully considered" some form of a CMN, but determined "resoundingly" that there was no way to make a CMN that served as a bullet proof proxy for the medical information. As an alternative, they wrote the rule so that the supplier obtains the source documents that attest to medical necessity instead of a proxy for that information.

CMS concluded the ODF by stating that they will give all comment presented "due consideration and that many of the questions raised will be addressed in the impending LCD. Moreover, comment period on the interim final rule is open until November 25th (even though implementation of the rule is scheduled for October 25th). Finally, many participated in the ODF with 513 people on the phone in addition to nearly 50 who showed up in person.