

Talking Points for Comments to OMB

Dear PMC Members:

We appreciate your responses to the posting on audit activity. From our small sample, it seems that CMS DME MAC contractors are undertaking a widespread probe of power mobility device (PMD) providers.

In an effort to gain greater clarity, reduce administrative burdens and increase objectivity in the Medicare PMD claims process we are urging all PMD providers to submit comments to the Office of Management and Budget (OMB) regarding the current paperwork burden on PMD providers. Specifically, PMD providers should tell OMB that the current amorphous documentation requirement violates the principles of the Paperwork Reduction Act (PRA) by lacking any specificity and increasing the administrative burdens on both PMD providers and the physician's who prescribe them. The PRA was passed by Congress to reduce the paperwork burden on our citizens while improving the quality of information collected by the federal government.

While the PMC has weighed-in on this issue in the past with some success, our hope is the change in Administration will lead to a more positive outcome given President Obama's emphasis on health information technologies, increased efficiencies and e-prescribing.

The following are some detailed talking points that can be used in drafting comments to the OMB on how the current documentation requirement violates the PRA:

- Background about your business, number of beneficiaries served, geographical regions, types of diagnosis of patients, etc.;
- Number of denials, reasons for denials, number of denials overturned in the ALJ or upper appeal levels;
- Provide evidence demonstrating the lack of clarity in the PMD documentation process and lack of clarity in the claims review process; this would include the physicians familiarity with the regulations and how many times that physician prescribes a PMD;
- Provide evidence that CMS' burden estimate of 10 minutes for PMD providers to obtain, review and submit necessary documentation is extremely flawed. (Providers should give a detailed breakdown of their burden estimate and total time necessary to provide documentation to process a typical Medicare PMD claim); and
- Recommend that CMS adopt a solution that will result in more efficiency while guaranteeing that the health care needs are met for our nation's elderly and disabled. A good solution would be the development of a physician template/form that allows the physician to address the elements of the NCD for power wheelchairs as the needed documentation to file a PMD claim. Physicians routinely use clinical templates/guides as part of their medical practice.

Comments to OMB are due by June 1, 2009 and directions on how to file can be found at: <http://edocket.access.gpo.gov/2009/E9-9957.htm>. The PMC has attached a copy of comments on the PMD documentation requirement submitted to CMS for your review. Feel free to “cut and paste” sections as needed but remember that an original letter that outlines your experiences with the documentation requirement, the administrative burden on both physician and providers and the subsequent denials of PMD for eligible beneficiaries will carry much more weight and influence than a “form” letter.

As always, feel free to contact me if you have any questions or need additional information and again, many thanks for all your efforts.

Eric

April 14, 2009

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Centers for Medicare and Medicaid Services
Director, Regulations Development Group
Office of Strategic Operations and Regulatory Affairs
OMB Control Number 0938-0971
Attention: Document Identifier CMS-10116
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Via Electronic Submission

Dear Ms. Shortt:

On behalf of the Power Mobility Coalition (PMC), a nationwide association of manufacturers and providers of motorized wheelchairs and power operated vehicles (POVs), we are submitting comments concerning the data collection and paperwork burdens associated with the rule entitled, *Conditions of Payment of Power Mobility Devices, Including Power Wheelchairs and Power-Operated Vehicles* (CMS-3017-IFC).

Per the February 13, 2009 Federal Register (74 Fed. Reg. 7232), the Centers for Medicare and Medicaid Services (CMS) is seeking re-approval from the Office of Management and Budget (OMB) concerning the collection of information requirements associated with the final rule, CMS-3017-F (71 Fed. Reg. 17021), which was published on April 5, 2006, and became effective on June 5, 2006. In their notice to OMB dated June 12, 2008, CMS set forth the following "Terms of Clearance:"

This collection is approved for 1 year. Upon resubmission, CMS will provide industry guidance related to the provisions associated with this collection. CMS will consult with OMB prior to issuance of this guidance.

Contrary to the terms of clearance and sound public policy, CMS provided no data

demonstrating that the agency did in fact issue any revised “guidance” on the paperwork burden required of providers. The agency does not identify any study conducted, any data collected, nor does the agency address possible alternative collections of information that could reduce unnecessary burden and/or improve the utility of the information. Instead, CMS states in the Federal Register notice that “there have been no new requirements that have been necessitated changes to any burden.” 74 Fed. Reg. 7232. Yet, by accepting their original burden estimate without any reexamination, CMS is failing to engage in a meaningful analysis of the collection of information burden and utility.

The PMC is also concerned that the final power mobility device (PMD) rule provides a flawed estimate of the overall paperwork burdens and record keeping requirement imposed on physicians and PMD providers. The overall burdens and subjectivity associated with the final rule has resulted in a restriction in access to Medicare PMDs. In the *Federal Register* notice, CMS set appropriate access levels at 240,325 Medicare beneficiaries qualifying for a PMD. Yet, current projections estimate that only 180,000 – 200,000 Medicare beneficiaries will receive a PMD in 2009, leaving well over 40,000 medically qualified beneficiaries without access.

Not only did CMS fail to accurately gauge the paperwork burden under the rule, they failed to appreciate the scope of the rule. The agency focused its burden analysis on the elimination of the CMN and failed to consider the burdens established under the rule, including the development of a detailed product description (DPD). In addition, CMS’ Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) have revised the Local Coverage Determination (LCD) for Medicare PMD, LCD # L23613, Power Mobility Devices (issued 1/01/2009) by including even more vague elements to the face-to-face examination documentation requirement than were established under the initial rule. These additional steps will certainly increase the physician’s burden and should be reflected in any burden estimate.

To more accurately measure the paperwork burden on PMD providers under the rule, the PMC surveyed its members as to the actual time it takes to obtain, review and retain all the documentation required to file a PMD claim. In addition, providers surveyed included the time required for completion of the DPD which, while not even included in the original clearance of the final rule, is yet another component of the provider’s administrative burden.

The survey results demonstrate that suppliers take considerably longer in obtaining, reviewing and submitting PMD documentation than the ten minutes estimated by CMS in the final rule. One Western-based regional PMC provider breaks down their paperwork burden as follows:

- I. **Initial Interview – 75 minutes to 2 hours**
 - a. Call to beneficiary to collect necessary information – 30 minutes to 1 hour
 - b. Scheduling Face-to-Face examination - 5 minutes
 - c. Calling IVR ensure beneficiary eligibility – 5 to 10 minutes
 - d. Calling Medicare to check “same or similar” – 10 to 15 minutes
 - e. Calling secondary insurance to verify coverage – 10 to 20 minutes
 - f. Compiling client folder – 5 minutes
 - g. Scheduling with beneficiary for in-home assessment – 10 minutes
- II. **Initial Doctor’s Package – 10 minutes**
 - a. Compiling documentation and faxing to Physician’s office – 5 to 10 minutes
- III. **Follow-Up after Face-to-Face Examination – 5 minutes**
 - a. Most physician’s offices require multiple follow-ups – 5 minutes (per follow-up)
- IV. **Review Doctor’s Package – 18 to 23 minutes**
 - a. Review the prescription including checking the ICD-9 code, cross-checking the date of the FTF on the prescription with the date on the chart notes; ensuring the ICD-9 code will support a PMD claim – 3 minutes
 - b. Review chart notes to ensure medical necessity for PMDs has been established – 5 to 15 minutes
 - c. Ensuring the detailed product description has been dated and signed by the physician – 5 minutes (assuming no follow-up is needed)
- V. **Requests for Missing Information or Corrections – 30 to 40 minutes depending on number of follow-ups required**
 - a. Most beneficiaries require a minimum of three to four follow-

up faxes or requests for information – 5 to 10 minutes/follow-up

- b. As a result of the 45-day rule some beneficiaries must have another face-to-face examination since all documentation could not be compiled in the 45 day timeframe

VI. Delivery of PMD – **1.5 to 2 hours (not including travel time)**

- a. Re-verify insurance – 10 to 20 minutes
- b. Compile delivery package – 10 to 20 minutes
- c. Scheduling delivery – 10 minutes
- d. Delivery, including in-home assessment, measurements, equipment demonstration – 30 minutes to an hour
- e. Preparing home assessment paperwork – 15 minutes

The PMC hopes CMS will re-evaluate the data collection contained in the final PMD rule and seriously consider adopting a clear documentation requirement and objective standard that includes the eligibility criteria and algorithmic process established in the National Coverage Determination (NCD) for PMDs issued May 5, 2005. At a minimum, the PMC would recommend that CMS adopt documentation and objective standards that fulfill the following criteria:

- provide a degree of objectivity regarding the information necessary to supports the health care practitioner’s prescription for the most appropriate PMD;
- incorporate the algorithmic process established in the local coverage determination (LCD) to demonstrate PMD coverage criteria;
- ensure that the health care practitioner conducts a face-to-face examination;
- ensure that the health care practitioner chooses the most appropriate mobility device for the beneficiary;
- certify, under penalty of perjury, that the health care practitioner conducted the examination and that the beneficiary meets the medical necessity for PMD as stated in the rule.

It is the PMC’s belief that a template that encompasses the above-referenced criteria would

provide the documentation needed to satisfy to CMS that a health care practitioner examined the patient, evaluated the need consistent with national coverage criteria, while providing PMD beneficiaries and providers a reasonable assurance that their claim will not be denied. Such a template, moreover, will decrease the administrative burdens on both providers and physicians and ensure that beneficiaries have access to Medicare PMDs in a timely manner.

State physician groups have stepped up involvement in this issue and are developing solutions to help guide health care practitioners in evaluating Medicare beneficiaries for PMD coverage. By helping guide doctors through the elements of Medicare PMD eligibility, these physician-generated forms detail Medicare criteria and aid in assessing need for the most appropriate PMD devices (if any). Some states, including Colorado, Texas, Alabama, Virginia, Nevada and New York, are advocating use of these tools and other State physician groups are considering their adoption.

As you are aware, this is not the first comment period regarding data collection under the PMD rule. CMS has previously received many comments challenging their burden assumption, including a May 19, 2006 letter from Rep. Candace Miller (R-MI), then chair of the House Government Reform Subcommittee on Regulatory Affairs. In her letter, Chairman Miller stated that the Subcommittee is “greatly concerned” that CMS failed to “seriously evaluate the additional burden that the final rule imposes on suppliers of PMDs,” and that CMS did, in fact, increase administrative and documentation collection burdens on suppliers. By way of example, Chairman Miller included with her letter sample forms that would generate all the information required by the final rule, recognizing that these forms could, “relieve some of the new burden placed on suppliers of PMD” and urged CMS to consider “alternative collection methods” in addition to reconsidering the rule’s paperwork burden on PMD providers.

Further, in 2007, the PMC and the Texas Academy of Family Physicians held a joint meeting with OMB on documentation issues and the need for greater clarification and guidance from CMS to ensure fairness, efficiency and objectivity in the Medicare PMD claims process.

The Obama Administration has signaled that health information technology, e-prescribing and increasing health care efficiencies as major priorities and part of the solution in reforming our

Nation's health care system. Yet, contrary to these goals, CMS is requiring PMD providers to provide reams of documentation, physician chart notes and patient records in an effort to get claims paid. By requiring such voluminous and amorphous documentation, CMS is ensuring that the Medicare PMD benefit will be unable to take advantage of these new health information tools, e-prescribing and other efficiencies that will lower costs to beneficiaries, providers, physicians and Medicare.

The PMC urges adoption of alternative collection methods in addition to reconsideration of the paperwork burden imposed on PMD providers and physicians. As a result, the PMC proposes that OMB grant a provisional 3-month approval of the documentation collection, with a full three year approval contingent on CMS conducting a proper burden analysis for PMD providers and developing a standardize template as an alternative to the current documentation collection under the rule.

As always, the PMC thanks you for the opportunity to submit comments and looks forward to working with the OMB, CMS and all interested stakeholders on these important issues.

Sincerely,

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