American Association for Homecare Expects Medicare to Move Past its Deny-at-All-Costs Culture that Routinely Denies Claims for Power Wheelchairs

Homecare Providers Believe a Clinical Template Will Help Ensure that "Prior Authorization" Program Works for Power Mobility Patients

WASHINGTON, Sept. 19, 2012 /PRNewswire-USNewswire/ -- Stakeholders are hopeful that 11th-hour changes will smooth Medicare's new prior authorization process for beneficiaries who have prescriptions for power wheelchairs. But the stakeholders, including homecare providers, physicians, and advocates for Americans with disabilities, remain concerned about whether the Centers for Medicare and Medicaid Services (CMS) has done enough to ensure that patient care and services won't be jeopardized by the new program.

Just days before the September 1 start date for the massive prior authorization demonstration project, CMS agreed to a recommendation to allow use of clinical templates. This addressed one of the key factors for ensuring that the prior authorization program is successful.

Unfortunately, CMS didn't include more specifics or examples of acceptable clinical templates that will be permitted to be used by physicians to document their patients' medical need for power mobility devices. The focus now shifts to how CMS will direct its contractors to administer the program. It is critical that providers and physicians obtain clarity from CMS on acceptable clinical templates.

Under the three-year demonstration program, all power mobility claims from Medicare patients in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas must be submitted for prior authorization. Medicare beneficiaries in these states receive nearly 50 percent of all the power wheelchairs obtained through Medicare each year.

The controversy surrounding the prior authorization program had focused on the massive size of the project, the significantly flawed CMS process for approving power wheelchair claims, and the process for documenting a Medicare patient's medical need for mobility assistance. The program comes at a time when embattled home medical equipment providers are reeling from a barrage of CMS policies ranging from flawed competitive bidding process to reimbursement cuts, a 13-month rental policy, frequent claim denials, and excessive audits.

Now, the prior authorization demonstration will dramatically transform the provision of power wheelchairs, even though CMS adopted last-minute recommendations from stakeholders.

In the past, the numerous policy changes created havoc for providers, but often had limited impact on Medicare patients because their power wheelchairs were received ***before*** CMS reviewed documentation to further support the physician's prescription. But now, Medicare patients are at a far greater risk: power wheelchairs can't be delivered until after prior authorization is received, a change that may delay deliveries and some Medicare beneficiaries may never be approved for the devices.

Several consumer organizations, who advocate on behalf of people living with disabilities, have expressed grave concern for Medicare beneficiaries.

Mark Perriello, president and CEO of the American Association of People with Disabilities, wrote to CMS that, "From the users' standpoint, the consequences of inadequate documentation will be more serious in a system which requires prior authorization than they are in the current system in which prior authorization is not required, and users gain access to (power wheelchairs), subject to subsequent audit and review of the documentation."

The impact of requiring prior authorizations is underscored by the high error rates that CMS has cited for power wheelchair claims. Recently, a Comprehensive Error Rate Test (CERT) on power mobility devices in the jurisdiction covering 17 states, including California, found a 100 percent error rate – a score

supposedly signifying that NO power wheelchairs provided to Medicare beneficiaries in that region met the reimbursement and coverage criteria. The CERT results demonstrate that the guidelines for documenting medical need for mobility devices are so flawed and so subjective that virtually every reimbursement claim can be found to be in non-compliance. Other recent claim reviews have cited 87 percent error rates.

In fact, stakeholders say the CMS claim reviewers created "a deny-at-all-costs culture" that routinely denies Medicare beneficiaries' claims for power wheelchairs. Denials have occurred for matters as small as difficult-to-read dates on the documentation paperwork. Many of the denied claims have been paid after lengthy appeals by the providers. Providers and advocates for disabled Americans fear the prior authorization program could shift the high error rate to a high denial rate during the prior authorization process, leaving beneficiaries without timely access to physician-prescribed power mobility devices.

That's why a properly designed clinical template is so critical.

The template would standardize collection of a patient's medical information. A template would ask physicians for specific information rather than having to decipher confusing guidelines. CMS is developing a standardized, electronic template, but never targeted it for use with the prior authorization project. In the Operational Guide released just days before the project launched, CMS noted that it "does not prohibit" the use of a template to facilitate recordkeeping, but raised skepticism by adding, "CMS also does not endorse or approve of any particular templates."

Stakeholders would have preferred that CMS identify a specific template to use and guidelines on the specific information Medicare wants included by physicians using the template. Still, the CMS decision to allow a template is a step forward. And along with other late changes made in the prior authorization program, it appears to show that the agency is attempting to address the concerns of mobility stakeholders.

For instance, there was concern that when prior authorizations are declined due to missing or incomplete data, the beneficiary would have to return to the physician for another face-to-face exam. But CMS accepted recommendations from the American Association for Homecare, and a repeat exam won't be necessary in many cases. CMS is also working to allow the electronic submission of prior authorization documentation.

"We are pleased that CMS accepted many of our recommendations," said Tyler Wilson, president of the American Association for Homecare. "We will monitor the effectiveness of these changes, and look forward to working with CMS to ensure that Medicare beneficiaries, who are among our most vulnerable, receive the medical equipment and care that their doctors have prescribed."

The American Association for Homecare represents durable medical equipment providers and manufacturers who serve the medical needs of millions of Americans who require oxygen equipment and therapy, mobility devices, 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. Please visit www.aahomecare.org/athome.

CONTACT: Michael Reinemer, +1-202-372-0748, michaelr@aahomecare.org, or Michael K. Frisby, +1-202-625-4328