Eli's Rehab Report

Medical Supplies: Prior Authorization of DMEPOS Likely to Hit Your Bottom Line

Reimbursement for limb prosthetics just got a little trickier.

If some of your patients need orthotics, prosthetics, or durable medical supplies and you provide them with such items, don't imagine that you will be necessarily paid by Medicare for them.

On Dec. 29, 2015, the **Centers for Medicare & Medicaid Services** (CMS) published a long-awaited final rule that establishes a prior authorization program for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items frequently cited as subject to unnecessary utilization. The final rule's provisions are effective on Feb. 29, 2016.

Which DMEPOS Items are in CMS' Crosshairs?

"The impetus for the rule is CMS' determination that prior authorization will curb past issues with unnecessary utilization of DMEPOS, saving the government money and enhancing the care of Medicare beneficiaries," says attorney **Lee H. Little** of the Atlanta-based law firm **Hamil Little.**

Background: Under the Social Security Act, CMS can periodically revise its list of DMEPOS subjected to unnecessary utilization and develop a prior authorization process for such items, Little notes. CMS broadly considers "unnecessary utilization" to include furnishing items without complying with one or more of Medicare's coverage, coding, and payment rules.

"The final rule creates a 'Master List' of specific DMEPOS potentially subject to prior authorization," Little explains. But keep in mind that "an item's presence on the Master List does not automatically create a prior authorization requirement. CMS will implement a subset of items on the Master List, a 'Required Prior Authorization List,' which will be published in the Federal Register with 60 days' notice before implementation."

The initial Master List includes 135 items listed on the DMEPOS fee schedule with an average purchase fee of $1,000 or greater or an average rental fee schedule of $100 or greater, according to a Jan. 7 analysis by the law firm **McDermott Will & Emery** (MWE). These items also meet one of the following two criteria:

1. Identified as having a high rate of fraud or unnecessary utilization by an **HHS Office of Inspector General** (OIG) or **General Accountability Office** (GAO) report of national scope published in 2007 or later; or

2. Listed in the 2011 or later Comprehensive Error Rate Testing (CERT) program's Annual Medicare Fee-For-Service (FFS) Improper Payment Rate Report DME and/or DMEPOS Service Specific Report(s).

CMS will update the Master List every year and publish the updates in the Federal Register, MWE said. Items will "age off" the list after 10 years, unless a subsequent OIG or GAO report identifies the item as having a high rate of unnecessary utilization. CMS will also remove items from the Master List if they're discontinued, if Medicare no longer covers them, or if the purchase amount drops below the payment thresholds.

How the Process Works

If an item is on the Required Prior Authorization List, you will need to submit all relevant documentation for review before furnishing the item to the beneficiary and submitting your claim for processing. CMS or its contractors will review the request and provide either a "provisional affirmation" or "non-affirmation" decision within 10 business days. If you submit a claim with a provisional affirmation decision, Medicare will pay this claim as long as you meet all other requirements. But if you submit a claim with a non-affirmation decision or without a decision, Medicare will deny your claim.

Silver lining: CMS allows unlimited resubmissions of prior authorization requests. Medicare or its review contractor will provide a resubmission prior authorization determination within 20 business days. Keep in mind that "these are maximum timeframes and will be adjusted downward for items that require less time for making a determination," CMS said.

CMS is also providing an expedited process when the standard timeframes would jeopardize a beneficiary's life or health.

Downside: Rule Could Cause Unnecessary Delays

"CMS has determined that the final rule will save the government about $57 million over the next five years and about $212 million over 10 years," Little notes. In addition to cost savings, CMS believes that the final rule will also enhance care.

But not everyone is happy about the final rule's provisions. DMEPOS suppliers, for instance, could face claims denials.

Problem: "Although CMS will provide suppliers with 60 days' notice in the Federal Register before requiring prior authorization for new items, DMEPOS suppliers of Master List items should regularly take note whether items are included on the Required Prior Authorization List and update internal administrative and claims processes accordingly," MWE cautioned. "Failure to do so puts DMEPOS suppliers at risk for claims denials related to items subject to prior authorization."

Prosthetic and orthotic stakeholders are also worried about the new final rule, particularly because the rule could delay Medicare beneficiaries' access to needed devices. Most lower-limb prostheses may be subject to the prior authorization provisions, according to a Dec. 30, 2015 analysis by the **American Orthotic Prosthetic Association** (AOPA).

Link: CMS published the final rule on the Federal Register at www.federalregister.gov/articles/2015/12/30/2015-32506/medicare-program-prior-authorization-process-for-certain-durable-medical-equipment-prosthetics.