AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

July 24, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9941–P
P.O. Box 8010, Baltimore
MD 21244–8010

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, I write in response to the "Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items" proposed rule as published in the May 28, 2014, *Federal Register*. Notably this proposed rule would establish a prior authorization process for certain DMEPOS items that are frequently subject to unnecessary utilization and would add a contractor's decision regarding prior authorization of coverage of DMEPOS items to the list of actions that are not initial determinations and therefore not appealable.

Before we comment on the proposals, we first want to recognize that DMEPOS has an unfortunate history of being a haven for those wishing to commit Medicare fraud and abuse. Exemplifying this is the recent Comprehensive Error Rate Testing (CERT) data that showed, for the 2012 reporting period, that DMEPOS claims had an improper payment rate of 66 percent, accounting for approximately 20 percent of the overall Medicare fee-for-service improper payment rate. The AAFP supports strong and appropriate efforts to prevent this sort of fraud, waste and abuse.

While the AAFP believes physicians, their patients, and DMEPOS suppliers hope for a prior authorization process that helps determine appropriate care based on the patient's established coverage, it unfortunately appears that CMS increasingly utilizes prior authorizations for DMEPOS items as an enforcement mechanism.

Though improper payments should be avoided, the AAFP believes the CMS treats all improper payments immediately as fraud or abuse when inadvertent and honest billing mistakes or coding errors do occur with all medical practices. The AAFP is therefore concerned that the proposed prior authorization process mandates the existing Additional Development Request process for certain DMEPOS items without actually providing physicians with appeal rights until the item is furnished and the claim is submitted and denied.

1133 Connecticut Ave., N.W., Ste. 1100 • Washington, DC 20036-4305 • 888.794.7481 • 202.232.9033 • Fax: 202.232.9044 • capitol@aafp.org

The agency proposes to define 'unnecessary utilization' as the furnishing of items that do not comply with one or more of Medicare's coverage, coding, and payment rules, as applicable. Though, upon first glance, the definition seems understandable, the AAFP nevertheless would note that what is "unnecessary" from a Medicare perspective may be very "necessary" from a physician's and patient's perspectives. Medicare's coverage, coding, and payment rules increasingly address legislative and regulatory fiats rather than allow physicians to practice evidence-based medicine (EBM). The AAFP urges CMS to allow EBM to dictate the measure of "necessity" in medicine.

CMS proposes to create a "Master List" of items that, based on certain criteria, are frequently subject to unnecessary utilization. The AAFP reviewed the criteria and find them reasonable. The agency also proposes that items will remain on the Master List for 10 years from the date the item was added. The AAFP finds this somewhat concerning due to the agency's use of U.S. Government Accountability Office (GAO) and Office of Inspector General (OIG) reports that may already be up to 7 years old. If CMS wishes to use a 10-year time frame, the AAFP suggests CMS use the release date of the relevant GAO or OIG report rather than the date CMS added the relevant item to the Master list.

The AAFP appreciates that presence on the Master List does not automatically require prior authorization and that prior authorization will initially be limited to a subset of the Master List. We also appreciate that CMS proposes to provide the public with 60 days' notice with respect to items designated for prior authorization. In terms of frequency of updates to the Master List, the AAFP urges CMS to consider quarterly or annual updates, since it takes medical practices time to learn of and adapt to billing and coding changes.

The AAFP is concerned that CMS proposes that, "A provisional affirmation is a preliminary finding that a future claim meets Medicare's coverage, coding, and payment rules. Claims receiving a provisional affirmation may still be denied based on technical requirements that can only be evaluated after the claim has been submitted for formal processing." This proposal undermines the original intent of a prior authorization. What good is "prior authorization," if the supplier and beneficiary cannot depend upon it?

We are most alarmed at the discussion that "A prior authorization request that is non-affirmed under section 1834(a)(15) of the Act is not an initial determination on a claim for payment for items furnished, and therefore would not be appealable," and then later, "A requester who submits a claim for which there was a nonaffirmative decision or for which no prior authorization request was obtained is afforded appeal rights." By denying appeal rights for non-affirmation of a prior authorization request, CMS forces the supplier to submit a claim for denial, so that appeal rights can be attained. That means more work for the supplier and CMS and its contractors to get to the same end point: a first level appeal. Instead, the AAFP urges CMS simply to provide appeal rights for the prior authorization decisions.

In general, the AAFP finds the proposed timeline (i.e., ten calendar days for initial review of a prior authorization with an option for expedited review in two business days) and unlimited resubmissions as reasonable. However, we do not understand why 20 days to handle a resubmission is needed. It does not make sense for the CMS contractor to need more time to review a resubmission, since they already reviewed the situation before. Instead, the AAFP calls on CMS to handle resubmissions in no more than 10 calendar days.

CMS estimates it will take suppliers 30 minutes per prior authorization request. However, the AAFP notes no estimate was created describing the potential impact on physician prescribers. Though technically it will be suppliers who perform the prior authorization requests, they usually will contact the ordering physician for medical record documentation. That easily could generate another 30 minutes of work at the physician's office, which should be accounted for in CMS' impact analysis. Therefore, the AAFP considers the agency's initial estimates as drastically inaccurate.

It is for these reasons that the AAFP thoroughly disagrees with the CMS statement, "By addressing this process in advance of furnishing the item or service or submitting the claim, we believe there will be less [fewer] items and/or services paid improperly and unnecessarily utilized, **as well as less burden on providers**." (Emphasis added) We also disagree that this proposed rule "would offer an additional protection to a supplier's cash flow as the supplier would know in advance if the Medicare requirements are met." This contradicts CMS' previous statement, as noted earlier, that, "Claims receiving a provisional affirmation may still be denied based on technical requirements that can only be evaluated after the claim has been submitted for formal processing." Therefore, suppliers will not know in advance if the Medicare requirements are met, because the claim may still be denied after it is submitted, even if it receives provisional affirmation. The AAFP calls on CMS to address these discrepancies and accurately account for the burden on physicians as the agency develops a final rule.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Jeffrey J. Cain, MD, FAAFP
Board Chair