



Provider Inquiry Assistance

Medicare Parts A and B Coverage and Prior Authorization – JA0916

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Effective Date: N/A

Implementation Date: N/A

Key Words	SE0916, Coverage, Authorization
Contractors Affected	<ul style="list-style-type: none"> • Medicare Carriers • Part A/B Medicare Administrative Contractors (A/B MACs) • Fiscal Intermediaries (FIs) • Regional Home Health Intermediaries (RHHIs)
Provider Types Affected	Physicians, providers, and suppliers submitting claims to Medicare Carriers, A/B MACs, FIs, and/or RHHIs for therapy services provided to Medicare beneficiaries



The Centers for Medicare and Medicaid Services (CMS) is informing Medicare providers that Medicare does not grant prior-approval for any item or service that will receive payment under Part A or Part B *except for custom wheelchairs*.

Provider Needs to Know...	<ul style="list-style-type: none"> • Originally, the Social Security Act did not authorize any form of “prior authorization” for Medicare services. The law was subsequently changed to allow prior authorization of limited items of Durable Medical Equipment (DME) and physicians’ services. • In regard to prior authorization under Medicare fee-for-service, providers should be aware that Section 1834(a)(15)(c) of the Social Security Act allows for an Advance Determination of Medicare Coverage for certain items of DME. • The only items of DME currently subject to this provision are custom wheelchairs. • Also, Section 938 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173) required the Secretary to establish a “Prior Determination” process for a limited number of physicians’ services under Medicare. • Implementation of this provision is pending.
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- It should also be noted that Medicare Part C and Part D programs are authorized to have and may require prior authorizations for services billed to them.
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- When Medicare was established, Congress included certain provisions on broad categories of items or services that may be covered and not covered under the Medicare program as well as provisions on certain items or services that were to be excluded from coverage.
- Congress also included in Section 1862(a)(1)(A) of the Social Security Act the following provision, which has become known as the medically “reasonable and necessary” provision:

“Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,...”

- Therefore, Medicare coverage and payment for items or services is contingent upon a determination that an item or service:
 - Falls within a benefit category
 - Is not specifically excluded from coverage; AND
 - The item or service is medically “reasonable and necessary” unless specifically excluded from meeting this provision.

Background

- Also, as prescribed by law, CMS develops National Coverage Determinations (NCDs), which are national policy statements granting, limiting, or excluding Medicare coverage for a particular item or service.
 - NCDs may be found in the *Medicare National Coverage Determinations Manual* (Publication #100-03) at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS website.
 - For those items or services whose coverage is not determined in law, regulation, or NCD, the local Medicare contractors are authorized to develop local coverage determinations (LCDs) to further determine coverage of items or services covered by Medicare.
 - LCDs specify under what conditions an item or service is considered to be “reasonable and necessary”. Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, and public comments, including comments from the provider community. LCDs may be found on the CMS coverage website and the provider’s local contractor’s website.
 - If a provider believes that a Medicare NCD or LCD needs to be revised, they should request CMS or its contractors to reconsider the existing NCD or LCD.
 - What factors CMS considers when deciding to open or reopen an NCD can be found at https://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=6 on the CMS website. To request a new LCD or a LCD reconsideration, the provider should contact
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the local Medicare contractor.

Operational N/A
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Reference The related MLN Matters® article can be found at
Materials <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0916.pdf> on the CMS
website.
