CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1862	**Date: June 30, 2017**
	Change Request 10146

SUBJECT: Introductory Letters for Suppliers and Providers Related to the Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to serve as an alert to the Medicare Administrative Contractors (MACs) that stakeholder education, in the form of the attached Introductory Letters, shall be sent to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers and pertinent physicians/practitioners as outlined below.

EFFECTIVE DATE: July 31, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 31, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1862	Date: June 30, 2017	Change Request: 10146

SUBJECT: Introductory Letters for Suppliers and Providers Related to the Prior Authorization for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items

EFFECTIVE DATE: July 31, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 31, 2017

I. GENERAL INFORMATION

A. Background: As authorized under the Centers for Medicare & Medicaid Services (CMS) rule 6050-F, CMS has announced the selection of two items of durable medical equipment to be subject to required prior authorization:

- K0856- Power wheelchair, group 3 std., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0861- Power wheelchair, group 3 std., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

Beginning on March 20, 2017, prior authorization is a condition of payment when furnished to beneficiaries in the states of New York, Illinois, West Virginia, and Missouri. The CMS will implement the prior authorization of these two codes nationwide for those items furnished on or after July 17, 2017.

The CMS would like to educate suppliers and prescribing physicians about this program by sending the Introductory Letters attached to this CR, which describe the prior authorization program, related requirements, and resources to access additional information if needed.

Related CRs include 8475, 8562, 8800, 8956, 9017, 9202, 9407, 9943, and 10068. Common Working File (CWF) recognizes the application of such CRs to the current program, but has not identified an associated workload.

NOTE: This CR reiterates the previously provided DME MAC business requirements (outlined in CR 9407), with updated dates of implementation and new requirements related to education and tracking/reporting.

B. Policy: 42 CFR 405 and 414 (CMS-6050-F).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10146.1	The CMS shall provide the Introductory Letters for distribution, which are attached to this CR.									CMS
10146.2	Contractors shall prepare and mail the Introductory Letters to all applicable suppliers. The CMS has attached the applicable supplier letter to this CR.				X					
10146.2.1	Contractors shall generate lists of all active suppliers who have billed for Group II or Group III power mobility devices, or both, since January 1, 2016, to receive the appropriate Introductory Letter attached to this CR.				X					
10146.3	Contractors shall prepare and mail the Introductory Letters to all applicable physicians/practitioners as will be defined by CMS via an Excel spreadsheet through your COR. The CMS has attached the applicable physician/practioner letter to this CR.		X							
10146.3.1	The CMS shall generate a list of providers, nationwide, who have billed for Group II or Group III power mobility devices, or both, since January 1, 2016 to receive the appropriate Introductory Letter attached to this CR. The list will include provider National Provider Identifier (NPI) and NPI descriptions.									CMS
10146.3.2	The CMS shall provide volume information of pertinent providers (attached to this CR).									CMS
10146.3.3	Contractors shall determine which active physicians/practictioners from the list are applicable to its jurisdiction for receipt of the letter.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Dr. Scott H. Lawrence, 410-786-4313 or Scott.Lawrence1@cms.hhs.gov , Amy Cinquegrani, 410-786-86 or Amy.Cinquegrani@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 3

Attachment A
Introductory Physician Letter on the Following Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

Dear Physician/Practitioner:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has implemented **a prior authorization program for certain durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) items** furnished on or after March 20, 2017, in Illinois, Missouri, New York, and West Virginia**.,** and **on or after July 17, 2017, nationwide**.

The first two items that require prior authorization from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as a condition of payment include the Healthcare Common Procedure Coding System (HCPCS) codes:

- K0856: Power wheelchair, group 3 std., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0861: Power wheelchair, group 3 std., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

What You Need to Know
The prior authorization program does not change Medicare DMEPOS benefit or coverage requirements, nor does it create new documentation requirements. The documentation required to be included with a prior authorization request is information that physicians and suppliers are regularly required to maintain. The request must be submitted by the supplier (or by the Medicare patient), referred to as a "requester." Under the prior authorization process, the requester must submit the request with the required documentation before the claims payment process so that Medicare can make sure all relevant Medicare requirements are met.

In most cases, the DMEPOS supplier will submit a prior authorization request and all documentation to Medicare on behalf of the Medicare patient. Medicare patients can choose to submit the request themselves if they get the required documents from you and their DMEPOS supplier.
To make sure patients receive necessary items quickly, physicians and practitioners will need to provide the requester with relevant clinical documentation in a timely manner.

The prior authorization request must include all relevant documentation to support Medicare coverage of the DMEPOS item; in this case, certain power mobility devices (PMDs). This includes the following documents from you:

1. The seven-element written order for the PMD;
2. Documentation of the face-to-face examination where the physician/practitioner evaluated the patient's need for the PMD;
3. Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP);
4. The detailed product description; and
5. Other documentation in the medical record that may be required by the DME MAC to support medical need.

A review checklist with specific items physicians need to provide to suppliers is available on the CMS program website listed below.

After receipt of all relevant documentation from the requester, the respective DME MAC will review and communicate a decision to the requester within 10 business days on whether the prior authorization request meets all Medicare coverage requirements and is provisionally affirmed, or is non-affirmed. In emergency situations involving the Medicare patient's life or imminent safety, the requester may seek an expedited review of the prior authorization request. If the DME MAC substantiates the need for an expedited review, the DME MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of all relevant documentation. The DME MAC will send the decision letter regarding the prior authorization to the requester and, upon request, to the Medicare patient (if Medicare patient was not the requester).

As the prescribing physician/practitioner, you may also contact the DME MAC for a copy of the decision letter. The decision letter request may be included with the prior authorization request documentation, or may be made separately. The DME MAC will not automatically send you a copy of the decision letter.

If the prior authorization request is non-affirmed by the DME MAC, the requester may revise and resubmit the prior authorization request an unlimited number of times. The DME MAC will make every effort to conduct a review and communicate a decision within 20 business days on each resubmitted prior authorization request.

For detailed information about this program please refer to the following resources:
Power Mobility Devices Local Coverage Determination and Related Policy
Article: https://www.cms.gov/medicare-coverage-database
Individual MAC websites:
Jurisdiction A and D - https://med.noridianmedicare.com
Jurisdictions B and C - http://www.cgsmedicare.com
The CMS website for this program: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html.

Additional Resources
Physicians are vital partners in the Medicare program, and CMS is preparing a wide range of resources to give you the information you need. To facilitate open and ongoing dialogue with both patients and providers, and to support program transparency, CMS has established a dedicated website for DMEPOS Prior Authorization with comprehensive information for patients, suppliers, and physicians.

You may request an individual education session if you have concerns about the program. More information is available online. The CMS will post details of any upcoming educational sessions on its website (link noted above).

CMS Welcomes Feedback
CMS is committed to launching the DMEPOS Prior Authorization Program in an open and transparent manner that serves and protects patients and the health care providers that care for them. Your feedback will

be a critical part of the process. Physicians and Practitioners with questions or other feedback can contact CMS at DMEPOSPA@cms.hhs.gov.

Attachment B
Introductory Supplier Letter on the Following Page

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

Dear Medicare Supplier:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has implemented **a prior authorization program for certain durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) items** furnished on or after March 20, 2017, in Illinois, Missouri, New York, and West Virginia, and on or after **July 17, 2017, nationwide**.

The first two codes that require prior authorization from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as a condition of payment are:

- K0856: Power wheelchair, group 3 std., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0861: Power wheelchair, group 3 std., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

What You Need to Know
The prior authorization program does not change Medicare DMEPOS benefit and coverage requirements nor does it create new documentation requirements. The documentation required to be included with a prior authorization request is information that physicians and suppliers are regularly required to maintain. Under the prior authorization process, the requester must submit the request with the required documentation before the claims payment process so that Medicare can make sure all relevant Medicare requirements are met.

As a Medicare supplier, you (or the Medicare patient), referred to as a "requester," must submit the prior authorization request. The requester must submit the prior authorization request with accompanying relevant documentation to the appropriate DME MAC through fax or mail. Requests through Electronic Submission of Medical Documentation (esMD) will be available in late 2017.

You must include within the prior authorization request all relevant documentation to support Medicare coverage of the DMEPOS item; in this case, certain power mobility devices (PMDs). This includes the following documentation from the ordering Physician/Practitioner:

1. The seven-element written order for the PMD;
2. Documentation of the face-to-face examination where the physician/practitioner evaluated the patient's need for the PMD;
3. Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP);
4. The detailed product description; and
5. Other documentation in the medical record that may be required by the DME MAC to support medical need.

As a Medicare supplier, your request must also include the following documents:

6. Attestation Statement showing no financial relationship between the supplier and LCMP;
7. Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement;
8. Home Assessment/Visit, if available at the time of the request; and
9. Other documentation in the medical record that may be required by the DME MAC to support medical need.

A review checklist with specific items suppliers need to provide is available on the CMS program website below.

After receipt of all relevant documentation from the requester, the respective DME MAC will review and communicate a decision within 10 business days on whether the prior authorization request meets all Medicare coverage requirements and is provisionally affirmed, or is non-affirmed. In emergency situations, the requester may seek an expedited review of the prior authorization request. If the DME MAC substantiates the need for an expedited review, the DME MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of relevant documentation.

The DME MAC will send decision letters with the unique tracking number (UTN) to the requester and, upon request, to the Medicare patient (if they were not the requester) and the prescribing physician/practitioner. The UTN must be on all claims submitted for payment.

If the prior authorization request is non-affirmed by the DME MAC, the requester may revise and resubmit the prior authorization request an unlimited number of times. The DME MAC will make every effort to conduct a review and communicate a decision within 20 business days on each resubmitted prior authorization request. The DME MAC will deny claims submitted with a non-affirmative prior authorization decision or claims submitted without a prior authorization determination (i.e., no UTN listed on the claim). If a claim is denied, the Medicare patient or supplier may appeal the denial; however, a prior authorization request that is non-affirmed is not appealable.

Suppliers can refer to the operational guide for detailed instructions on the process for requesting and receiving a prior authorization decision, as well as the process for including such information on subsequent claim submissions. The operational guide and other relevant information is posted on the individual DME MAC websites and the CMS website at:

Power Mobility Devices Local Coverage Determination and Related Policy

Article: https://www.cms.gov/medicare-coverage-database

Individual MAC websites:

Jurisdiction A and D - https://med.noridianmedicare.com

Jurisdictions B and C - http://www.cgsmedicare.com

The CMS website for this program - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html.

Additional Resources

DMEPOS suppliers are vital partners in the Medicare program, and CMS is preparing a wide range of resources to give you the information you need. To facilitate open and ongoing dialogue with both patients and providers, and to support program transparency, CMS has established a dedicated website for DMEPOS Prior Authorization with comprehensive information for patients, suppliers, and physicians.

You may request an individual education session if you have concerns about the program. More information is available online. The CMS will post details of any upcoming educational sessions on its website (link noted above).

CMS Welcomes Feedback

CMS is committed to launching the DMEPOS Prior Authorization Program in an open and transparent manner that serves and protects patients and the health care providers that care for them. Your feedback will be a critical part of the process. Suppliers who have additional questions can call the appropriate DME MAC for individualized education. Suppliers can also provide feedback to CMS at DMEPOSPA@cms.hhs.gov.