# Power Mobility Device (PMD) Demonstration Operational Guide

## *8/8/2012*

*C. Licensed/Certified Medical Professional (LCMP) (PT/OT) Role in Face-to-Face Process*

*D. PMD Base Claim Line Process (if PA was sought)*

*E. PMD Base Claim Line Process (if PA was not sought)*

# Chapter 1: The PMD Benefit

For any item to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

The Local Coverage Determination (LCD) for each jurisdiction describes in further detail the circumstance under which a PMD will be covered by Medicare.

Medicare covers scooters and power wheelchairs (called PMDs) when:

- It is needed by the beneficiary to perform activities of daily living in the home
- Other devices (canes, walkers, manual wheelchairs) are not sufficient

Complete coverage and documentation requirements are outlined in the following policies:

- National Coverage Determination (NCD) for PMD
- LCDs for PMD
  - Jurisdiction A LCD (including NY)
  - Jurisdiction B LCD (including IL, MI)
  - Jurisdiction C LCD (including FL, NC, TX)
  - Jurisdiction D LCD (including CA)
  - CMS MLN Matters Article provides further guidance and clarification about documentation for physicians and treating practitioners when ordering PMDs

# Chapter 2: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to the Prior Authorization Demonstration

## A. PMD Base HCPCS Codes

The following PMD base HCPCS codes are subject to prior authorization under the demonstration:

- All power operated vehicles (K0800-K0805; K0809-K0812)
- All standard power wheelchairs (K0813-K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835-K0843)
- All group 3 complex rehabilitative power wheelchairs without power options (K0848-K0855)
- All pediatric power wheelchairs (K0890-K0891)
- Miscellaneous power wheelchairs (K0898)

Note: Group 3 complex rehabilitative power wheelchairs with power options (K0856 K0864) are excluded.

## *B. PMD Accessories*

*[Reserved for Future Use]*

# Chapter 3: Demonstration *Overview*

## A. Who

The physician/ treating practitioner *or suppliers may* submit the Prior Authorization request.

## B. Where

This 7 state demonstration is based on the beneficiary's state of residence as reported to the Social Security Administration. The 7 states are:

- California
- Florida
- Illinois
- Michigan
- New York
- North Carolina
- Texas

If a beneficiary needs to update the address on file at Social Security, the beneficiary can:

- Go online: https://secure.ssa.gov/apps6z/ICOA/coa001.jsp
- Call at 1-800-772-1213 (TTY 1-800-325-0778) between 7 a.m. to 7 p.m., Monday through Friday.
- Contact the local Social Security office
- What the beneficiary will need:
  - Complete new address, including zip code.
  - Provide a new phone number or a number to be contacted at.

## C. When:

The demonstration will start for PMDs *where the* order is signed on or after September 1, 2012.

The demonstration will end for PMDs *where the* order is signed on or after September 1, 2015.

# Chapter 4: Documentation Requirements

## A. The face-to-face examination documentation

### 1. *Content that should be included in the progress note documenting the face-to-face examination.*

See the MLN Checklist and LCD for PMDs for more details about what a provider needs to include in this documentation.

- Jurisdiction A LCD (including NY)
- Jurisdiction B LCD (including IL, MI)
- Jurisdiction C LCD (including FL, NC, TX)
- Jurisdiction D LCD (including CA)

### 2. *Tools/interfaces that assist physicians/practitioners in documenting a progress note.*

*See PIM Section ____ for definitions and guidelines about tools/interfaces that assist in documenting a progress note.*

*Physicians/practitioners may also wish to keep in mind that CMS is exploring the development of a Suggested Electronic Clinical Template that would allow electronic health record vendors to create prompts to assist physicians when documenting the Power Mobility Device (PMD) face-to-face encounter for Medicare purposes. The first draft is available in the Download section of go.cms.gov/eclinicaltemplate.*

### 3. *Late Entries in Medical Records.*

*See PIM 3.3.2.5[to be updated in August 2012]*

## B. 7 element order

1. Patient name
2. Description of item ordered
    a. "Power operated vehicle"
    b. "Power wheelchair"
    c. "Power mobility device"
    d. Or something more specific
3. Date of face-to-face examination
4. Diagnoses/conditions related to need for PMD
5. Length of need
6. Physician/practitioner signature
7. Date of physician/practitioner signature

**C. Detailed product description**

- Must be completed by the supplier, and reviewed and signed by the treating physician;
- Specific Healthcare Common Procedure Coding System (HCPCS) code for base and all options and accessories that will be separately billed;
- Narrative description of the items or manufacturer name and model name/number;
- Physician signature and date signed; and
- Date stamp to document receipt date.

**A. Other Relevant Documentation if necessary**

# Chapter 5: Submitting a Request

**A. *Include* the following data elements in a *Prior Authorization (*PA*)* request package:**

*Beneficiary Information*

- Beneficiary Name,
- *Beneficiary Medicare Number (also known as HICN)*, and
- *Beneficiary* Date of Birth
- *[TBD: Does Beneficiary Address need to be included??]*

*Physician/Practitioner Information*

- Physician*/Practitioner* Name,
- *Physician/Practitioner* National Provider Identifier (NPI), and
- *Physician/Practitioner* Address

*Supplier Information*

- Supplier *Name,*
- Supplier NPI, and
- *Supplier* Address

*Other Information*

- HCPCS Code
- Submission Date

**B. Include the following documentation *in a PA request package***

1. Face-to-face documentation
2. 7 element order
3. Detailed Product Description
4. *Any* other necessary clinical information

**C. Send *PA* request *package to***

- For beneficiaries residing in CA, *send requests to* DME MAC D *at*:
  - Fax Number: *701-277-7891*
  - Street Address: *NAS*
    *PO Box 6742*
    *Fargo, ND 58108-6742*
  - esMD[1]: (indicate document type "8")

- For beneficiaries residing in IL *send requests to* DME MAC B *at*:
  - Fax Number: *317-841-4414*
  - Street Address: *[TBD]*
  - esMD[1]: (indicate document type "8")

[1] *Submitters will be able to use the Electronic Submission of Medical Documentation (esMD) system to submit a PMD Prior Authorization request beginning on [__/__/2012].*

- For beneficiaries residing in MI *send requests to* DME MAC B *at*:
  - Fax Number: *317-841-4414*
  - Street Address: *Medical Review-PMD Prior Authorization Request*
    *P.O. Box 7018*
    *Indianapolis, IN 46207-7018*
  - esMD[1]: (indicate document type "8")

- For beneficiaries residing in NY *send requests to* DME MAC A *at*:
  - Fax Number: *781-383-4519*
  - Street Address: *NHIC*
    *75 Sgt. William B. Terry Drive*
    *Hingham, MA 02043*
  - esMD[1]: (indicate document type "8")

- For beneficiaries residing in FL *send requests to* DME MAC C *at*:
  - Fax Number: *615-664-5960*
  - Street Address: *CGS*
    *Two Vantage Way*
    *Nashville, TN 37228*
  - esMD[1]: (indicate document type "8")

- For beneficiaries residing in NC: DME MAC C:
  - Fax Number: 615-664-5960
  - Street Address: CGS
    Two Vantage Way
    Nashville, TN 37228
  - esMD[1] (indicate document type "8")

- For beneficiaries residing in TX: DME MAC C:
  - Fax Number: 615-664-5960
  - Street Address: CGS
    Two Vantage Way
    Nashville, TN 37228
  - esMD[1] (indicate document type "8")



[1] *Submitters will be able to use the Electronic Submission of Medical Documentation (esMD) system to submit a PMD Prior Authorization request beginning on [__/__/2012].*

## D. General Process

- The DME MAC will review the request and either:
    - Affirm the request (Chapter 5)
    - Non-affirm the request (Chapter 7)
    - Deem the request incomplete (Chapter 6)

- If a claim denial is necessary for secondary insurance payment for the PMD, the following process is to be followed:
    - The submitter is to submit the **prior authorization request** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the PMD, then a non affirmative prior authorization decision will be sent to the physician and treating practitioner, supplier and Medicare beneficiary advising them that Medicare will not pay for the item.
    - After receiving a non-affirmative decision for the prior authorization request, and a **claim** is submitted by the supplier to the DME MAC for payment it will be denied.
    - The submitter or Medicare beneficiary may forward the denied claim to his/her secondary insurance payee as appropriate to determine payment for the PMD.

- The DME MAC will postmark notification of the decision to the practitioner, supplier and beneficiary within 10 business days for an initial request. For resubmitted requests the DME MAC will postmark notification of the decision to the practitioner, supplier and beneficiary within 20 business days.

# Chapter 6: An Affirmative Request

**Supplier's Actions:**

- Ensure that home assessment is complete.
- Deliver the item to beneficiary.
- Document proof of delivery.
- Get patient authorization.
- Have all documentation available on request.
- Submit the claim with the tracking number on the claim.
    - The submission of the prior authorized PMD claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim, the unique tracking number is submitted in Item 23 of the 1500 Claim Form. For electronic claims the unique tracking number is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).
    - If all requirements are met the claim will be paid.
    - The prior authorization demonstration has specific parameters for pre-payment review; however other contractors (CERT, ZPICs, RACs, etc) may have parameters outside of the PA demonstration that will suspend the same claim for another type of review. If your claim is selected for review, guidance and directions will be provided on the Additional Documentation Request Letter from the requesting contractor.

# Chapter 7: An Incomplete Request

**When an incomplete request is submitted:**

- The DME MAC will provide notification of what is missing through a detailed decision letter postmarked within 10 business days for initial request and 20 business days for resubmitted request of the review to all parties affected.

- The submitter may resubmit another complete package with all documentation required as noted in the detailed decision letter. *If the PA was non-affirmed because a data element was missing from the progress note documenting the face-to-face evaluation, physicians should be mindful of CMS' guidance on Late Entries in Medical Records (see PIM §3.3.2.5)*

- If the claim is submitted by the supplier to the DME MAC for payment with a non-affirmative prior authorization decision, it will be denied.
    - All appeal rights are then engaged.
    - This claim could then be submitted to secondary insurance.

# Chapter 8: A Non-Affirmative Request

**Physicians/treating practitioner's actions:**

- Monitor the beneficiary for a future submission.
    - If the clinical condition of the beneficiary changes, complete and submit a new prior authorization request.

- Use the detailed decision letter to ensure that the request package complies with all requirements.
    - Resubmit a prior authorization request, if appropriate.

**Suppliers Action:**

- Use the detailed decision letter to ensure that the request package complies with all requirements.

    - Resubmit a prior authorization request, if appropriate.

- Submit the claim (with the tracking number) for a denial.
    - All appeal rights are then engaged.
    - This claim could then be submitted to secondary insurance.

# Chapter 9: Resubmitting a Prior Authorization Request

- The submitter should review the detailed decision letter that was provided.
- The submitter should make whatever modifications are needed to the prior authorization package and follow the submission procedures.
- The DME MAC will provide notification of the decision through a detailed decision letter postmarked within 20 business days of the review(s) to all parties affected.

# Chapter 10: Claim Submission

- The submission of the prior authorized PMD claim is to have the 14 byte unique tracking number that is located on the decision letter. For submission of a claim, the unique tracking number is submitted in Item 23 of the 1500 Claim Form. For electronic claims the unique tracking number is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).

- Series of claims:
  - Should be submitted with the prior authorization tracking number on the claim.
  - Should be submitted to the applicable DME MAC for adjudication.

- Follow the claim submission process based on the prior authorization decision determination.

# Chapter 11: The Payment Reduction

- If a claim is submitted without a prior authorization decision, it will be stopped for review.
    - An Additional Documentation Request (ADR) will be sent.
        - The supplier will have 45 days to respond to the ADR with all requested documentation.
        - The supplier can send the documentation via:
            - Fax
            - Mail
            - esMD (for more information see: www.cms.gov/esMD)
    - The DME MAC will review the claim.
        - If the claim is payable the DME MAC will determine if the supplier is a competitive bid supplier.
            - If yes, the claim (and the remainder of the series) will be paid at the single payment amount.
            - If no, the claim (and the rest of the series) will automatically be assessed a 25 percent reduction of the Medicare payment after co-insurance and deductible. *There will be a 3-month grace period before the payment reduction rule applies. Thus, the payment reduction begins for orders written on or after December 1, 2012.*
                - This payment reduction is not transferable to the beneficiary.
                - This payment reduction is not appealable.

# Chapter 12: The G-Code

- Physician/Practitioner can bill G9156 after he/she submits an initial Prior Authorization Request.
    - G-code is billed to the A/B MAC contractors with the Prior Authorization tracking number.
    - Only one G-code may be billed per beneficiary per PMD even if the physician/ practitioners must resubmit the request.
    - Code is not subject to co-insurance and deductible.
    - Physicians may not bill the G-code in instances where the supplier submits the Prior Authorization Request
    - Suppliers may not bill the G-code.

# Chapter 13: *Upgrades*

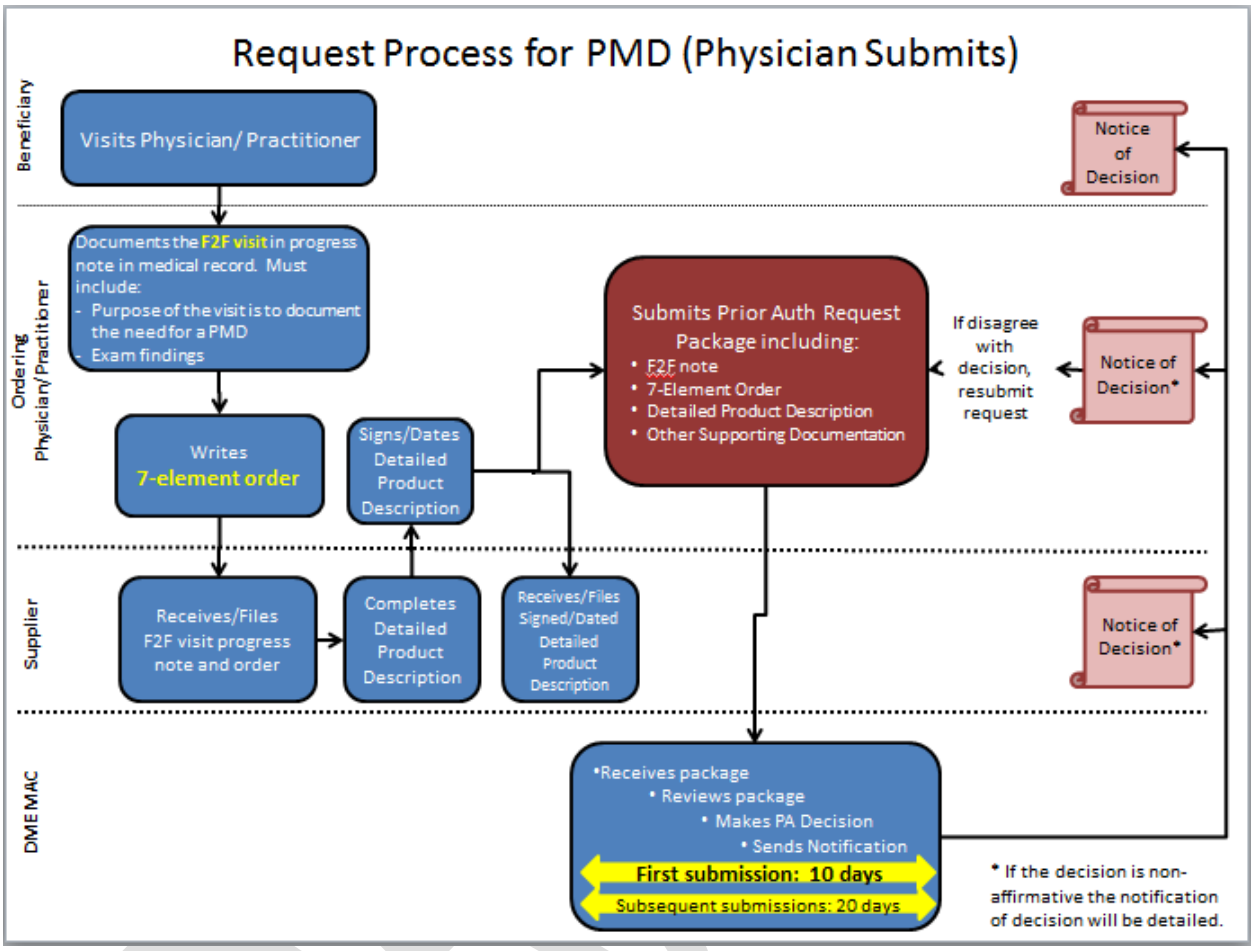
*[Reserved for Future Use]*

# Chapter 14: Claim Appeals

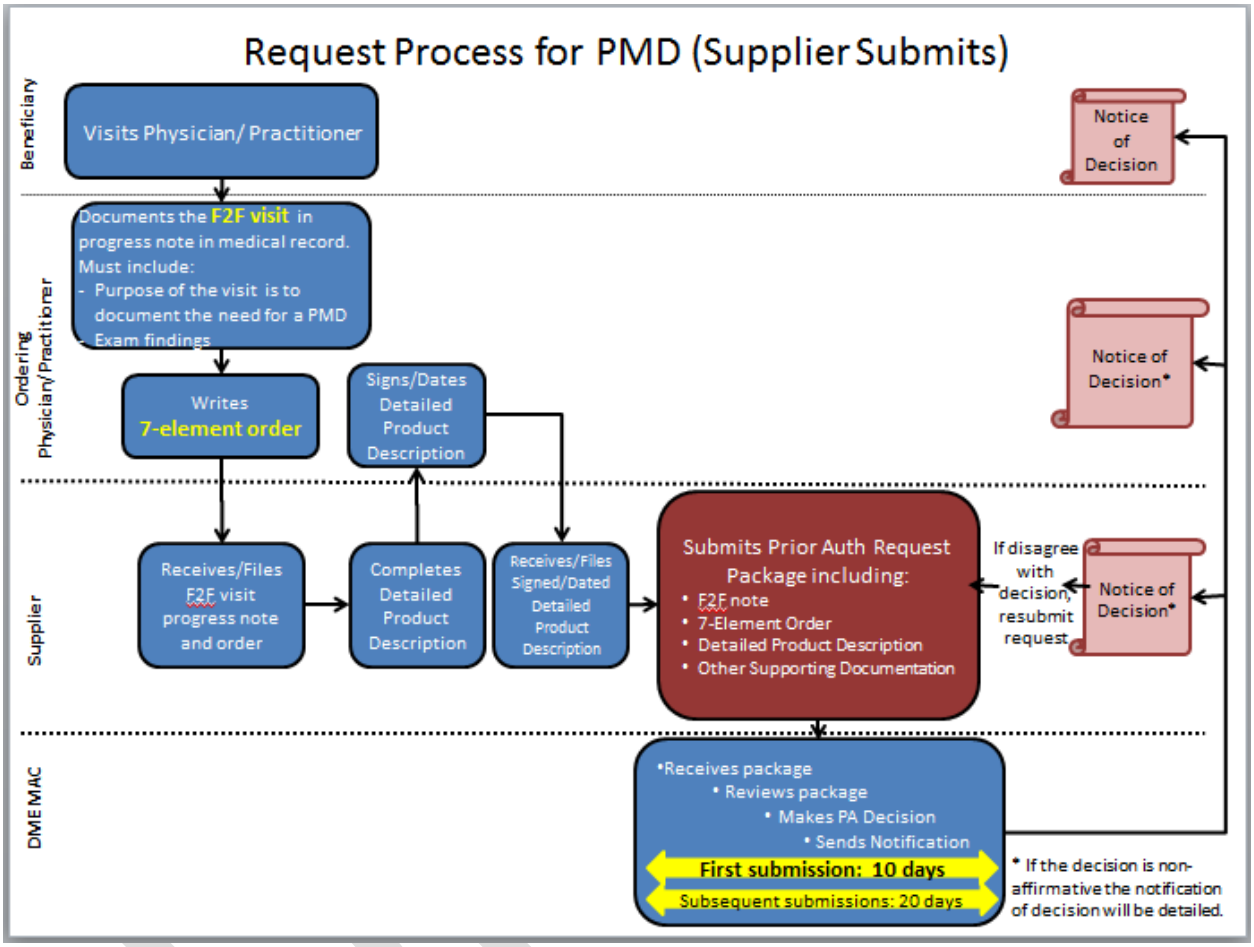
Appeals follow all current procedures. For further information consult the Medicare Claims Processing Manual publication 100-04, chapter 29 Appeals of Claims Decision.

This demonstration does not include a separate appeal process for a non-affirmative prior authorization request decision. However, a non-affirmative prior authorization request decision does not prevent the supplier from submitting a claim. Such a submission of a claim and resulting denial by the DME MAC would constitute an initial determination what would make the appeals process available for Medicare beneficiaries and suppliers disputes.

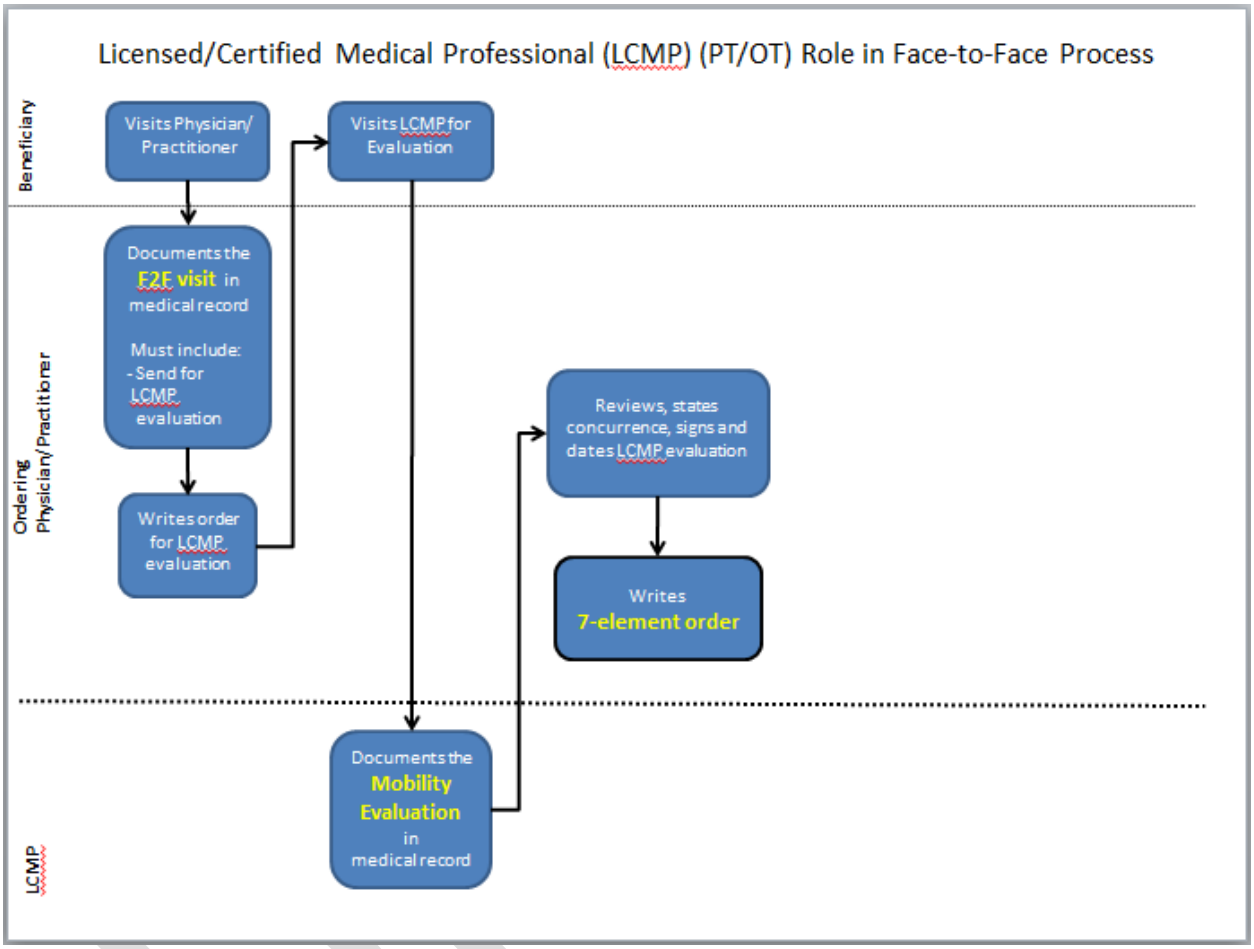
# *Appendix A: Request Process for PMD (Physician Submits)*



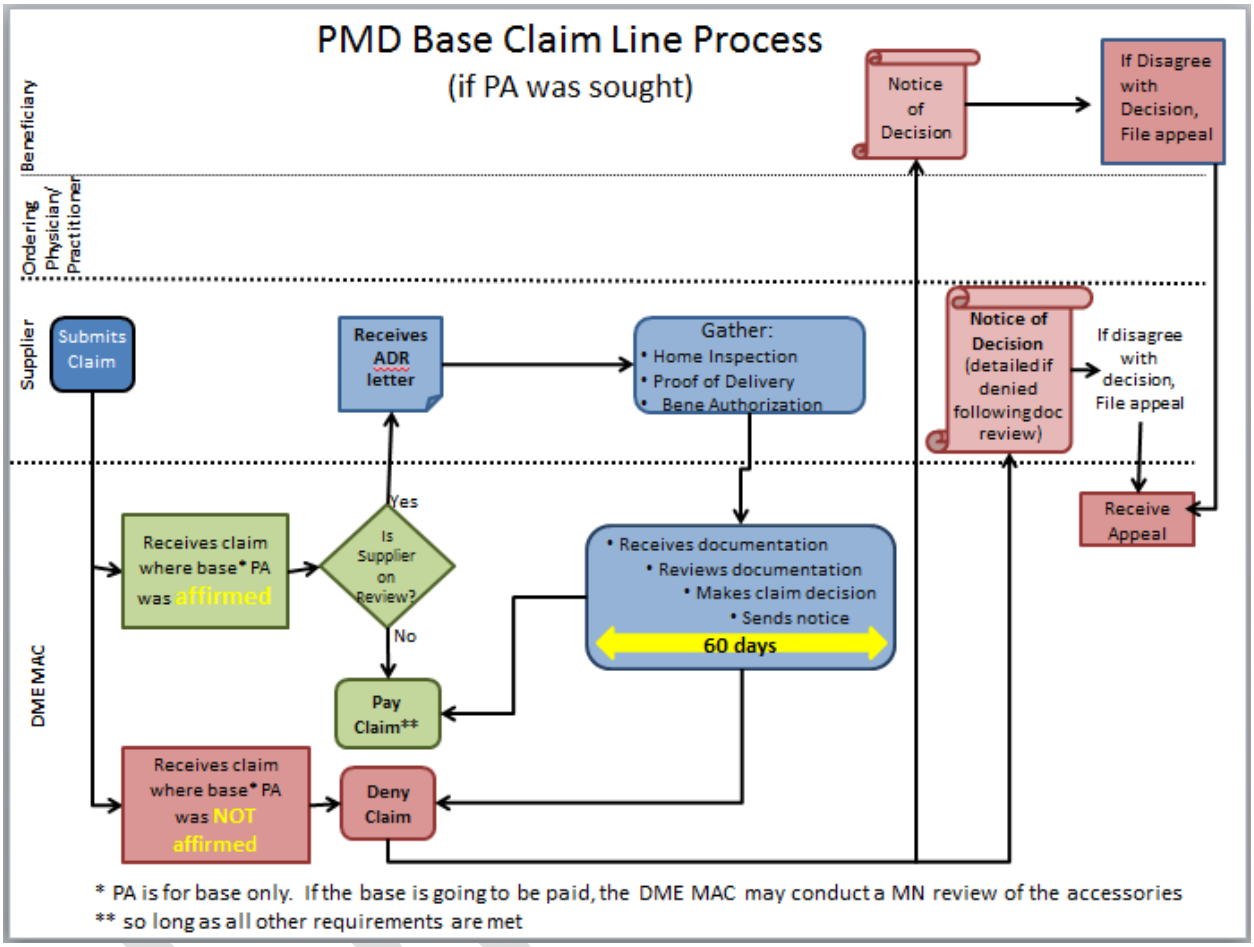
# *Appendix B: Request Process for PMD (Supplier Submits)*



# *Appendix C: Licensed/Certified Medical Professional (LCMP) (PT/OT) Role in Face-to-Face Process*



# *Appendix D: PMD Base Claim Line Process (if PA was sought)*



# *Appendix E: PMD Base Claim Line Process (if PA was not sought)*