Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items
Frequently Asked Questions

****New****

1. **Q: What is CMS announcing?**

   A: CMS announced in a Federal Register notice the selection of 31 additional items of durable medical equipment to be subject to required prior authorization nationwide on September 1, 2018. The Healthcare Common Procedure Coding System (HCPCS) codes being added to the Required Prior Authorization List are currently included in the Prior Authorization of Power Mobility Devices (PMDs) Demonstration.

2. **Q: Is the Prior Authorization of Power Mobility Devices (PMDs) Demonstration ending?**

   A: Yes, the demonstration is scheduled to end on August 31, 2018. DME MACs will cease accepting prior authorization requests on August 18, 2018 for items under the Power Mobility Device Demonstration that are not being added to the Required Prior Authorization List.

3. **Q: What codes are being added to the Required Prior Authorization List?**

   A: CMS is adding 31 additional codes to the Required Prior Authorization List as a condition of payment. The complete list of codes and descriptions can be located in the 'Downloads' section here.

4. **Q: Are all of the codes included in the PMD Demonstration being added to the Required Prior Authorization List?**

   A: No. 31 of the 38 items included in the PMD demonstration are being added to the Required Prior Authorization List. This includes all of the PMDs that are part of the PMD demonstration and are also included on the Master List of Items Frequently Subject to Unnecessary Utilization, as defined in § 414.234(b)(1).

5. **Q: How is the prior authorization process for items on the Required Authorization List different than the prior authorization process for the PMD Demonstration?**

   A: Although the PMD demonstration's prior authorization process is similar to the process used for those items on the Required Prior Authorization List, some differences

do exist. In particular, items on the Required Prior Authorization List require prior authorization as a condition of payment. As such, lack of a provisionally affirmed prior authorization request will result in a claim denial. Under the PMD demonstration, requesting prior authorization is optional, and claims submitted for payment without an associated prior authorization decision are subject to prepayment review and assessed a 25-percent reduction in Medicare payment if found payable.

Additionally, under the PMD demonstration, physicians/treating practitioners may submit prior authorization requests and are eligible to bill HCPCS code G9156 for an incentive payment. This process is not available for items on the Required Prior Authorization List.

6. **Q: What states are impacted by this announcement?**

   A: CMS will require prior authorization as a condition of payment in all US states and territories for all initial rental series claims on or after September 1, 2018.

7. **Q: When will prior authorization be required for these codes as a condition of payment?**

   A: Prior authorization will be required as a condition of payment for all new rental series claims for these PMDs for dates of delivery on or after September 1, 2018.

8. **Q: When can requestors begin submitting prior authorization requests for these 31 items?**

   A: In states not participating in the PMD Demonstration, requestors can begin submitting prior authorization requests for these items beginning August 18, 2018, for dates of delivery on or after September 1, 2018.

   In states participating in the PMD Demonstration, requestors can continue submitting prior authorization requests without interruption. DME MACs will honor provisionally affirmative decisions on PMD Demonstration prior authorization requests, which may be applied to the rental series for claims with a delivery date on or after September 1, 2018.

9. **Q: Are the documentation requirements for the codes being added to the Required Prior Authorization List the same as the documentation requirements under the PMD Demonstration?**

   A: Yes, the documentation requirements for these codes are the same as under the PMD Demonstration. The Required Prior Authorization List does not create new

documentation requirements. The process simply requires that all documentation regularly required to be maintained be submitted earlier in the course of claims payment.

10. Q: Are the timeframes for receiving a prior authorization decision for these items the same as under the PMD Demonstration?

A: Yes, the timeframes are the same. The DME MACs will complete their review of an initial prior authorization request and send a detailed decision letter postmarked or faxed by the 10th business day following the DME MAC's receipt of the prior authorization request. For prior authorization requests that are resubmitted after the initial prior authorization request was non-affirmed (i.e., resubmissions that correct curable errors or add previously missing documentation), the DME MAC will complete their review and send a detailed decision letter postmarked or faxed by the 20th business day of receipt of the prior authorization request.

11. Q: What if a beneficiary needs a PMD subject to required prior authorization sooner than the review timeframes noted?

A: If delays in receipt of a prior authorization decision could jeopardize the life or health of the beneficiary, then the requester should request that the DME MAC process the prior authorization request under an "expedited" timeframe. For expedited reviews, CMS or its review contractors would expect the submitted documentation to include evidence that applying the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary. If it is determined that a request requires expedited review and response, then under this prior authorization process, the DME MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of the prior authorization request.

12. Q: Where can I find additional information?

A: Additional information is available on the DMEPOS Prior Authorization webpage here.

Previous FAQs

1. **Q. What is prior authorization?**

   A: Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a DMEPOS item is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps ensure that applicable coverage, payment, and coding rules are met before items are delivered.

2. **Q. How does prior authorization help patients with Medicare?**

   A: Patients with Medicare are able to receive the items and services they need quickly and efficiently. They also appreciate the reduced stress of knowing that the appropriate items should be covered by Medicare.

3. **Q. How does prior authorization help Medicare suppliers, physicians, and other practitioners?**

   A: Suppliers, physicians, and other Medicare practitioners can be confident that the items and services that their patients need will be covered and paid for without time delays, subsequent paperwork, or the need to file an appeal for a claim that was later deemed not payable. In addition, paid claims for which there is an associated affirmed prior authorization decision will be afforded some protection from future audits.

4. **Q. What items will be subject to review under the Prior Authorization Process for Certain DMEPOS Items?**

   A: CMS is narrowly implementing the Prior Authorization for Certain DMEPOS items. The first two items requiring prior authorization will be:

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

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

5. **Q: When will this prior authorization process begin?**

   A: The program will begin on March 20, 2017, in Illinois, Missouri, New York, and West Virginia. The Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) began accepting prior authorization requests (PAR) on March 6, 2017 for dates of service of March 20, 2017 and beyond.

6. **Q: When will this program be expanded nationwide?**

   A: CMS intends to expand the prior authorization process for these two HCPCS codes nationwide in July 2017.

7. **Q: Does the prior authorization process for K0856 and K0861 create new documentation requirements?**

   A: The prior authorization process developed for K0856 and K0861 does not create new documentation requirements. The process simply requires that all documentation regularly required to be maintained be submitted earlier in the course of claims payment.

8. **Q: Will accessories to the two power wheelchair codes be subject to prior authorization?**

   A: Accessories for these two power wheelchair codes are not separately subject to prior authorization.

   When the specialty evaluation supports the need for specific options/accessories that are needed to address a Medicare patient's particular limitations, these options/accessories will be considered as part of the PAR.

   Accessory codes required to make a coverage decision on the base for K0856 and K0861 include, but are not limited to, items such as power seating system combination tilt and recline (E1007), head control interface (E2327, E2328, E2329, E2330), sip-n-puff interface (E2325), joystick other than a standard proportional joystick (E2312, E2321, E2373), multi-switch hand control interface (E2322), and seat cushions.

   Accessory codes not required to make a coverage decision for the overall review include, but are not limited to, headrests (E0955), lateral hip/trunk supports (E0956), swing away hardware (E1028), electronics (E2310, E2311), leg rests (K0195, K0108, E1012), and batteries.

   Suppliers and Providers should consult the applicable MAC LCD for specific information.

9. **Q: What are the review timelines for a prior authorization request for K0856 and K0861?**

   A: The DME MACs will complete their review of an initial PAR and send a detailed decision letter postmarked or faxed by the 10th business day following the DME MAC's receipt of the PAR. For PARs that are resubmitted after the initial PAR was non-affirmed (i.e., resubmissions that correct curable errors or add previously missing documentation), the DME MAC will complete their review and send a detailed decision letter postmarked or faxed by the 20th business day of receipt of the PAR.

10. Q: What if a beneficiary needs the DMEPOS item sooner than the review timelines for K0856 and K0861?

A: If delays in receipt of a prior authorization decision could jeopardize the life or health of the beneficiary, then the requester should request that the DME MAC process the PAR under an "expedited" timeframe. For expedited reviews, CMS or its review contractors would expect the submitted documentation to include evidence that applying the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary. If it is determined that a request requires expedited review and response, then under this prior authorization process, the DME MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of the PAR.

11. Q: What should be included in the PAR?

A: The PAR must include evidence that the item complies with all applicable Medicare coverage, coding, and payment rules. Consistent with § 414.234(d), such evidence must include the order, relevant information from the beneficiary's medical record, and relevant supplier-produced documentation. The PAR must include necessary documentation from the medical record to support the medical necessity of the DMEPOS item(s) and any other relevant documents as deemed necessary by the DME MAC. This information can be found through your local DME MAC website in the relevant local coverage determinations, national coverage determinations, and the in the Operational Guide. It is important to note that the relevant documentation from the medical record only pertains to documentation that occurs prior to the delivery of the DMEPOS item(s).

12. Q: What are the different decisions that a PAR can obtain and how will this decision be communicated?

A: The DME MACs can either render a provisional affirmative or a non-affirmative decision.

A **provisional affirmative decision** is a preliminary finding that a future claim submitted to Medicare for the DMEPOS item likely meets Medicare's coverage, coding, and payment requirements.

A **non-affirmative decision** is a preliminary finding that if a future claim is submitted for the DMEPOS item, it does not meet Medicare's coverage, coding, and payment requirements.

DME MACs will send the requester of the PAR (i.e., the entity who will submit the claim for payment) a letter providing their PA decision (i.e., affirmative or non-affirmative), and if applicable, giving the detailed reasons for the non-affirmation. The DME MAC will also share such information with beneficiaries upon request.

13. Q: How will the DME MACs know my claim has undergone prior authorization?

A: After the DME MAC reviews the PAR, they will render a unique tracking number (UTN). Each UTN is specific to a prior authorization request and provisional affirmation or non-affirmation decision. Requesters must ensure they place the UTN on the claim to notify the contractor that they adhered to the prior authorization process, as a condition of payment. If a UTN is not included on the claim for payment or is related to a non-affirmation decision, the DME MAC will deny the claim for failing to meet the prior authorization requirements as a condition of payment.

14. Q: Since prior authorization is a condition of payment for certain DMEPOS items identified on the Required Prior Authorization List, what happens if a claim is submitted for payment without any indication that prior authorization occurred?

A: Claims billed without first submitting a PAR and receiving a provisional affirmation decision will be denied payment. Requesters are reminded that claims for payment must include the UTN that was received in response to their PAR, to indicate that a prior authorization decision was made, whether it is a provisional affirmative or non-affirmative decision. If a UTN is not included on the claim for payment or is related to a non-affirmation decision, the DME MAC will deny the claim for failing to meet the prior authorization requirements as a condition of payment.

15. Q: Does this prior authorization process protect beneficiary access to care?

A: CMS believes this prior authorization program will both help protect the Medicare Trust Funds from improper payments and make sure beneficiaries are not hindered from accessing necessary DMEPOS items when they need them. Prior authorization allows CMS to make sure items frequently subject to unnecessary utilization are furnished in compliance with applicable Medicare coverage, coding, and payment rules before they are furnished, and it allows the beneficiary to be notified if the item would be covered by Medicare and any potential financial implications earlier in the payment process. Access is preserved by having set timeframes for contractors to complete any PAR decisions, and an expedited process in cases where delays jeopardize the life or health of beneficiaries.

16. Q: How does the prior authorization process help dual eligible beneficiaries?

A: Prior authorization of DME process has the potential to improve access to these specific items DME for dual eligible beneficiaries who need them. In many cases, Medicaid may cover DME that Medicare does not, but first requires suppliers to provide evidence that Medicare will not cover it. If a supplier submits a PAR and receives a non-affirmative decision, the supplier can then submit that to the state so that the state is assured it has met its obligation to pursue other coverage before considering Medicaid coverage. For additional information, please see the January 13, 2017 CMCS Informational Bulletin (here).

17. Q: Is there more information on the prior authorization process available?

A: Yes, information is available on the DMEPOS Prior Authorization webpage. In the 'Downloads' section, there is a public, published Operational Guide that provides additional details on the prior authorization process for the two HCPCS codes, K0856 and K0861. CMS and the DME MACs collaborated to create the published operational guide. Additional information regarding the prior authorization process and review checklists are also available.

18. **Q: Why is Medicare implementing prior authorization for these two power wheelchair codes?**

A: These two power wheelchair codes have historically been among those subject to overutilization. The two HCPCS codes selected for prior authorization represent national vulnerabilities to the Medicare Trust Funds, and were selected based on factors including, but not limited to, claims data, systems capabilities, and operational impacts (i.e. supplier educational needs, DME MAC workload).

19. **Q: How can a supplier receive education for the prior authorization program?**

A: Suppliers should contact their DME MAC for education and more information about DMEPOS Prior Authorization. The DME MACs are:

For beneficiaries residing in **Jurisdiction A** (Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont):
Noridian Healthcare Solutions
https://med.noridianmedicare.com/web/jadme
866-419-9458

For beneficiaries residing in **Jurisdiction B** (Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio and Wisconsin):
CGS
http://www.cgsmedicare.com/jb/index.html
866-590-6727

For beneficiaries residing in **Jurisdiction C** (Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia and West Virginia):
CGS
http://www.cgsmedicare.com/jc/index.html
866-270-4909

For beneficiaries residing in **Jurisdiction D** (Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington and Wyoming):
Noridian Healthcare Solutions

https://med.noridianmedicare.com/web/jddme/
877-320-0390

20. Q: How are claims handled for patients who have a representative payee?

A: Claims from patients who have a representative (rep) payee are exempted from required prior authorization during the initial four-state implementation. Suppliers may continue to use the Advanced Determination of Medical Coverage (ADMC) process for these claims. Before submitting a prior authorization request, suppliers should verify if the patient has a rep payee on file.

21. Q: Does the MAC review for same or similar items as part of the Prior Authorization Request (PAR)?

A: Yes, the MAC will check if the patient has previously received the same or similar piece of equipment and the item has not yet reached its reasonable useful lifetime period as part of the PAR.

Same or similar denials occur when the patient's Certificate of Medical Necessity (CMN) history indicates a piece of equipment is the same or similar to the equipment being billed. To determine whether same or similar items have previously been provided, suppliers must obtain all possible information from a patient, which may include the following:

- Patient's correct Health Insurance Claim number;
- Whether the patient has employer insurance or is enrolled in a Health Maintenance Organization;
- If the patient currently has or had an identical or similar item in the past;
- When the patient received the items and whether or not the items have been returned;
- Where the item will be used; and
- CMN or DIF information, if required.

The supplier should also make sure the patient understands that items such as wheelchairs and power-operated vehicles are considered similar equipment and that Medicare usually will not cover both items at the same time.

22. Q: What is the timeframe for delivery of a power wheelchair under this prior authorization process?

A: To mirror the previous ADMC process for these items, the time frame for delivery of these prior authorized items has been changed from 120 days to six months. The DME MACs are revising their LCDs to reflect this change.