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

Frequently Asked Questions (FAQs)

Updated 8/30/2024

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Background

1. **What is prior authorization?**

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

   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. **Does this prior authorization process protect beneficiary access to care?**

   CMS believes that 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.

4. **How does the prior authorization process help dual eligible beneficiaries?**

   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.

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

   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.

6. **What should be included in the Prior Authorization Request (PAR)?**

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 (here). 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).

7. **What are the different decisions that a PAR can obtain and how will this decision be communicated?**

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.

8. **How will the DME MACs know my claim has undergone prior authorization?**

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.

9. **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?**

   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.

10. **How does CMS choose the codes for required prior authorization?**

    CMS selects codes that historically have been among those subject to overutilization. The HCPCS codes selected for prior authorization represent vulnerabilities to the Medicare Trust Funds, and are selected based on factors including, but not limited to, claims data, systems capabilities, and operational impacts (i.e., supplier educational needs, DME MAC workload).

11. **How can a supplier receive education for the prior authorization program?**

    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/cert-reviews/mr/pre-claim/required-programs
    866-419-9458

    For beneficiaries residing in **Jurisdiction B** (Illinois, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin):

    CGS
    https://www.cgsmedicare.com/jb/pa/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
https://www.cgsmedicare.com/jc/pa/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, South Dakota, Utah, Washington, and Wyoming):

Noridian Healthcare Solutions
https://med.noridianmedicare.com/web/jddme/cert-reviews/mr/pre-claim/required-programs
877-320-0390

12. How are claims handled for patients who have a representative payee?

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, if available. Before submitting a prior authorization request, suppliers should verify if the Patient has a rep payee on file.

13. Does the MAC review for same or similar items as part of the PAR?

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 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 Medicare Beneficiary Identifier (MBI);
- 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

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.

14. Where can I find additional information?

Additional information is available on the DMEPOS Prior Authorization webpage (here).

15. Is there more information on the prior authorization process available?

Yes, information is available on the DMEPOS Prior Authorization webpage (here). In the 'Downloads' section, there is a public, published Operational Guide that provides additional details on the prior authorization process for items on the Required Prior Authorization List. Additional information regarding the prior authorization process and review checklists are also available.

Power Mobility Devices (PMDs)

1. What Power Mobility Device (PMD) codes require prior authorization?

CMS requires prior authorization as a condition of payment on 46 Power Mobility Device (PMD) codes. The complete list of codes and descriptions can be located in the 'Downloads' section (here).

2. When did required prior authorization of these codes begin?

Required prior authorization for codes K0856 and K0861 started in Illinois, Missouri, New York, and West Virginia on March 20, 2017, and expanded nationwide on July 17, 2017. The Federal Register Notice is available (here).

- Following the conclusion of the Power Mobility Device Demonstration, CMS added 31 PMD codes to the required prior authorization list, which began nationwide on September 1, 2018. The Federal Register Notice is available (here).

- CMS added seven additional PMD codes to the required prior authorization list, which began nationwide on July 22, 2019. The Federal Register Notice is available (here).

- CMS added six additional PMD codes to the required prior authorization list, which begins nationwide on April 13, 2022. The Federal Register Notice is available (here).

3. **What are the timeframes for receiving a prior authorization decision for these items?**

   The DME MACs complete their review of initial and resubmitted prior authorization requests and send a detailed decision letter postmarked, faxed, or delivered electronically by the 10th business day following the DME MAC's receipt of the initial or resubmission prior authorization request.

4. **What if a beneficiary needs a PMD subject to required prior authorization sooner than the review timeframes noted?**

   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.

5. **What is the validation period for PMD prior authorization decisions?**

   Prior authorization decisions for PMD codes will remain valid for six months following the affirmed review decision. For example: If the PAR is affirmed on October 15th, the supplier has until April 15th, 11:59 pm, to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time-period.

6. **Do PMD replacements require prior authorization?**

   Yes, prior authorization is still required for PMD replacements for items that are lost, stolen, or damaged provided the items are still within the reasonable useful lifetime. [1]When submitting a PAR for PMD replacements, supporting documentation must be submitted that includes an explanation of the circumstances leading to the need for replacement (for example, detailed reports of loss, theft, or damage). The submitter should also request an expedited review for the PMD replacement items and note on the cover sheet that the request is for a replacement. Expedited reviews are completed within two business days.

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[1] *Medicare covers a replacement PMD when a manufacturer exits the wheelchair business resulting in the wheelchair ceasing to exist on the market, and there is no availability of aftermarket repair or replacement parts to make the manufacturer's equipment operable the power or manual wheelchair may be designated as lost.*

Voluntary Prior Authorization of Power Mobility Device (PMD) Accessories:

1. **Why is CMS implementing voluntary prior authorization of Power Mobility Device (PMD) accessories?**

   Policies finalized in the 2019 ESRD and DMEPOS final rule (84 Fed. Reg. 60648 (Nov. 8, 2019)) permit suppliers to voluntarily request prior authorization for certain Durable Medical Equipment, Prosthetics, Orthoses Supplies (DMEPOS) accessories on the same prior authorization request (PAR) as the DMEPOS items on the Required Prior Authorization List. Pursuant to this rule, CMS is implementing voluntary prior authorization for select accessories for PMDs. The goal is to increase operational simplicity by allowing suppliers to request Prior Authorization for a DMEPOS PMD accessory item(s) that may not appear on the Master List. Subsequently, a prior authorization decision will be rendered for both the PMD (the base item), which requires prior authorization, and a PMD accessory that does not require prior authorization.

2. **Is prior authorization of PMD accessories required as a condition of payment?**

   No, prior authorization of accessories is not required and is not a condition of payment. The supplier is not required to submit a PAR for the accessories and may submit a claim for the accessories as was previously done prior to the implementation of this program. However, if the accessory receives a provisional affirmative decision, that means that a future claim submitted to Medicare for the item(s) likely meets Medicare's coverage, coding, and payment requirements.

3. **Which accessories may be submitted for voluntary prior authorization?**

   CMS has selected 53 PMD accessories that are eligible for voluntary prior authorization, provided that the PAR includes a corresponding PMD base. The PAR for the accessory must be included on the PAR for the required PMD base; otherwise, the PAR will be rejected. The complete list of eligible accessories and their descriptions is located in the 'Downloads' section (here).

4. **What happens when the PMD base is provisionally affirmed without a PAR for accessories?**

   This is a voluntary program, and a PAR for accessories is not required. The claim for the PMD base item would be allowed in accordance with existing procedures. The claim for an accessory would go through the normal claims review process.

5. **What happens when the PMD base is provisionally affirmed, and the accessory is provisionally affirmed?**

   The claim for the base item would be allowed in accordance with existing procedures. The claim for the accessory would be allowed as well.

6. **What happens when the PMD base is provisionally affirmed, and some accessories are provisionally affirmed, and some accessories are non-affirmed?**

   The claim for the base would be allowed in accordance with existing procedures. The claim for the provisionally affirmed accessories would be allowed, and the claim for the non-affirmed accessories would be denied.

7. **What happens when a PMD base is non-affirmed, and there are no PMD accessory item(s)?**

   The claim for a non-affirmed base would be denied unless the PAR is resubmitted and subsequently provisionally affirmed. The PAR may be resubmitted an unlimited number of times until it is provisionally affirmed.

8. **What happens when the PMD base is non-affirmed, and the accessory is provisionally affirmed?**

   Accessories cannot be provisionally affirmed if the base is non-affirmed; therefore, this scenario would not occur. The claim for the PMD base and the accessory would be denied. Accessories cannot be billed without a covered base.

9. **What happens when the PMD base is non-affirmed, and the accessory item(s) is non-affirmed?**

   The claim for the PMD base and the accessory would be denied. Accessories cannot be billed without a covered base.

10. **What happens when the PMD base is non-affirmed, some accessories are provisionally affirmed, and some are non-affirmed?**

    Accessories cannot be provisionally affirmed if the base is non-affirmed; therefore, this scenario would not occur. The claim for the PMD base and the accessories would be denied. Accessories cannot be billed without a covered base.

11. **What happens when a claim for a PMD base is submitted without prior authorization?**

    As a condition of payment, PMDs on the Required Prior Authorization List must receive a provisional affirmed decision; otherwise, the claim would be denied.

12. **What are the timeframes for receiving a voluntary prior authorization decision for these accessories?**

    The timeframe for receiving a voluntary prior authorization decision for an accessory is the same for receiving a decision for the PMD base, since the PAR for the voluntary

accessories must be included with the PAR for the required base. The DME MACs complete their review of initial and resubmitted PARs and send a detailed decision letter postmarked, faxed, or delivered electronically by the 10th business day following the receipt of the PAR.

13. What if the beneficiary needs the required PMD and its related accessories sooner than the review timeframes noted?

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 for the PMD and its related accessories under an "expedited" timeframe. The prior authorization request will include both items; consequently, the same review timeframe applies. For expedited reviews, CMS or its review contractors would expect the submitted documentation to include evidence that applying the standard decision timeframe could seriously jeopardize the life or health of the beneficiary. If it is determined that the request requires expedited review and response, then the DME MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of the prior authorization request.

14. What is the validation period for prior authorization decisions of accessories?

PAR decisions for accessories remain valid for six months following the provisionally affirmed review decision. The PAR must include both the PMD base and the accessory so both items are reviewed at the same time, yielding the same validation period. For example: if the PAR for the PMD base and accessories is provisionally affirmed on October 15, the supplier has until April 15, 11:59 pm to furnish the base and the accessories. Otherwise, a new PAR will need to be submitted to restart the valid six-month time-period.

Pressure Reducing Support Surfaces (PRSS)

1. What Pressure Reducing Support Surfaces (PRSS) codes require prior authorization?

CMS announced in a Federal Register notice (here) the selection of E0193, E0277, E0371, E0372, and E0373 to be subject to required prior authorization. The complete list of codes and descriptions can be located in the 'Downloads' section (here).

2. When did required prior authorization of these codes begin?

Required prior authorization for codes E0193, E0277, E0371, E0372, and E0373 started in California, Indiana, New Jersey, and North Carolina on July 22, 2019, and expanded nationwide on October 21, 2019.

3. **What are the timeframes for receiving a prior authorization decision for these items?**

   The DME MACs complete their review of initial and resubmitted prior authorization requests and send a detailed decision letter postmarked, faxed, or delivered electronically by the 5th business day following the DME MAC's receipt of the initial or resubmission prior authorization request.

4. **What if a beneficiary needs a PRSS subject to required prior authorization sooner than the review timeframe noted?**

   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.

5. **What is the validation period for PRSS prior authorization decisions?**

   Prior authorization decisions for PRSS codes will remain valid for one month following the "affirmed" review decision. For example: If the PAR is affirmed on October 15th, the supplier has until November 15th, 11:59pm to furnish the PRSS. Otherwise, a new PAR will need to be submitted to restart the valid one-month time period.

Lower Limb Prosthetics

1. **What Lower Limb Prosthetic (LLP) codes require prior authorization?**

   CMS announced in a Federal Register notice (here) the selection of L5856, L5857, L5858, L5973, L5980, and L5987 to be subject to required prior authorization. The complete list of codes and descriptions can be located in the 'Downloads' section (here).

2. **When did prior authorization of these codes begin, and when can requestors begin submitting prior authorization requests?**

   Prior authorization for L5856, L5857, L5858, L5973, L5980, and L5987 was initially scheduled to begin in California, Michigan, Pennsylvania and Texas on May 11, 2020, and the remaining states and territories on October 8, 2020. Implementation was delayed due to the COVID-19 public health emergency. Required prior authorization for these six LLP codes started in California,

Michigan, Pennsylvania, and Texas on September 1, 2020, and expanded nationwide on December 1, 2020.

Requestors began submitting prior authorization requests for Phase one states for dates of delivery on or after September 1, 2020, on August 18, 2020.

- Requestors can begin submitting prior authorization requests for Phase two states for dates of delivery on or after December 1, 2020, starting on November 17, 2020.

3. **What are the timeframes for receiving a prior authorization decision for these items?**

   The DME MACs complete their review of initial and resubmitted prior authorization requests and send a detailed decision letters postmarked, faxed, or delivered electronically by the 10th business day following the DME MAC's receipt of the prior authorization request.

4. **What if a beneficiary needs an LLP subject to required prior authorization sooner than the review timeframes noted?**

   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.

5. **What is the validation period for LLP prior authorization decisions?**

   Prior authorization decisions for LLP codes will remain valid for one hundred and twenty (120) calendar days following the provisional affirmation review decision. For example: If the PAR is affirmed on October 15th, the supplier has until February 12th, 11:59pm to furnish the PRSS. Otherwise, a new PAR will need to be submitted to restart the valid 120-day time-period.

Orthoses

1. **What orthoses codes require prior authorization?**

   CMS announced in a Federal Register notice (here) the selection of L0648, L0650, L1832, L1833, and L1851 to be subject to required prior authorization.

On May 13, 2024, CMS announced in a Federal Register notice (here) the selection of L0631, L0637, L0639, L1843, L1845, and L1951 to be subject to required prior authorization. L1833 will no longer require prior authorization beginning on August 12, 2024. The complete list of codes and descriptions can be located in the "Downloads" section of our website here.

2. When did prior authorization of these codes begin, and when can requestors begin submitting prior authorization requests?

Prior authorization for L0648, L0650, L1832, L1833, and L1851 will occur in three phases:

- Phase one begins April 13, 2022, in New York, Illinois, Florida, and California.
  - Requestors can begin submitting prior authorization requests for Phase one states for dates of delivery on or after April 13, 2022, on March 30, 2022.

- Phase two begins July 12, 2022, in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington.

  - Requestors can begin submitting prior authorization requests for Phase two states for dates of delivery on or after July 12, 2022, on June 28, 2022.

- Phase three begins on October 10, 2022, in all remaining US states and territories not included in phases one and/or two.

  - Requestors can begin submitting prior authorization requests for Phase three states for dates of delivery on or after October 10, 2022, on September 26, 2022.

- Prior authorization for L0631, L0637, L0639, L1843, L1845, and L1951 will occur nationwide on August 12, 2024.

  - Requestors can begin submitting prior authorization requests nationwide for dates of delivery on or after August 12, 2024, on July 29, 2024.

3. Why is orthosis code L1833 no longer on the Required Prior Authorization List?

Effective August 12, 2024, L1833 (Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf) is being removed from the Required Prior Authorization List as the item no longer meets the criteria to be maintained on the Master List and is no longer eligible for inclusion on the Required Prior Authorization list.

4. What are the timeframes for receiving a prior authorization decision for these

items?

The DME MACs complete their review of initial and resubmitted prior authorization requests and send a detailed decision letters postmarked, faxed, or delivered electronically by the 5th business day (not to exceed 7 calendar days) following the DME MAC's receipt of the prior authorization request.

5. What if a beneficiary needs an item sooner than the 2-day expedited timeframe?

Due to the need for certain patients to receive an orthoses item that may otherwise be subject to prior authorization when the 2-day expedited review would delay care and risk the health or life of the beneficiary, we are suspending prior authorization requirements under these limited circumstances:

- Claims for HCPCS codes L0648, L0650, L1832, L1851, L0631, L0637, L0639, L1843, L1845, and L1951 that are billed using modifier ST, indicating that the item was furnished urgently. Claims billed using the ST modifier will be subject to 100% prepayment review for dates of service prior to January 1, 2024. Claims billed with these HCPCS codes, using the ST modifier will be subject to 50% prepayment review for dates of service on or after January 1, 2024.

6. Are orthoses that are included in the Competitive Bidding Program (CBP) subject to prior authorization?

Yes, Claims for HCPCS codes L0648, L0650, and L1851 billed with modifiers KV, J5, or J4, by suppliers furnishing these items under a competitive bidding program exception (as described in 42 CFR 414.404(b)), to convey that the DMEPOS item is needed immediately either because it is being furnished during a physician office visit where the physician determines that the brace is needed immediately due to medical necessity or because it is being furnished by an occupational therapist or physical therapist who determines that the brace needs to be furnished as part of a therapy session(s). Additionally, 10% of claims submitted using the KV, J5, or J4 modifiers for HCPCS L0648, L0650, L1833, and L1851 will be subject to prepayment review.

- Effective January 1, 2024, there will be a temporary gap period in the DMEPOS Competitive Bidding Program (CBP) for off-the-shelf back and knee braces. As such, prior authorization requirements for HCPCS codes L0648, L0650, and L1851 billed with the competitive bid modifiers KV, J4, or J5 will no longer be suspended, as there will be no need for a CBP exception. Treating practitioners, Physical Therapists, Occupational Therapists, and hospital-based suppliers in previously designated CBP areas utilizing the KV, J5, and/or J4 modifiers have the option to undergo the regular prior authorization process with the standard timeframe of review, request expedited review, or utilize the ST modifier indicating acute/emergent need. Claims for these codes using the ST modifier with dates of service on or after January 1, 2024, will be subject to 50% prepayment review.

7. **How long will prior authorization be suspended for these items?**

   There is no suspension end date for HCPCS codes L0631, L0637, L0639, L0648, L0650, L1832, L1843, L1845, L1851, and L1951 that are billed using modifier ST, indicating that the item was furnished urgently. Effective January 1, 2024, prior authorization requirements for HCPCS codes L0648, L0650, L1833, and L1851 billed with the competitive bid modifiers KV, J4, or J5 will no longer be suspended, as there will be a temporary gap period in the DMEPOS Competitive Bidding Program (CBP) for off-the-shelf back and knee braces. As such, there will be no need for a CBP exception.

8. **Will prior authorization continue for orthoses items not covered in this update?**

   Yes. Prior authorization will continue for these orthoses items when furnished under circumstances not covered in this update, as well as all other items on the Required Prior Authorization List (PDF).

9. **What is the validation period for orthoses prior authorization decisions?**

   Prior authorization decisions for orthoses codes will remain valid for sixty (60) calendar days following the provisional affirmation review decision. For example: If the PAR is affirmed on April 13th, the supplier has until June 12th, 11:59 pm to furnish the orthoses. Otherwise, a new PAR will need to be submitted to restart the valid 60-day time-period.

Osteogenesis Stimulators

1. **What osteogenesis stimulator HCPCS codes are being removed from the Required Prior Authorization List?**

   CMS is suspending prior authorization for HCPCS codes E0747, E0748, and E0760, and is removing these codes from the Required Prior Authorization List.

2. **Why is CMS suspending prior authorization for these osteogenesis stimulator HCPCS codes and when will this be effective?**

   Due to continued confusion over some noninvasive osteogenesis stimulators and whether they comply with the DME three-year expected life requirement at 42 CFR 414.202, CMS is suspending prior authorization requirements for HCPCS codes E0747, E0748, and E0760 effective August 28, 2024. CMS plans to provide additional direction regarding the three-year expected life requirement at 42 CFR 414.202 in future notice and comment rulemaking.