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

Background:

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. 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.

4. 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.

5. 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.

6. Q. What should be included in the Prior Authorization Request (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 (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. 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.

8. 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.

9. 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.

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

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

13. Q. Does the MAC review for same or similar items as part of the 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:

    o Patient's correct Medicare Beneficiary Identifier (MBI);

    o Whether the patient has employer insurance or is enrolled in a Health Maintenance Organization;

    o If the patient currently has or had an identical or similar item in the past;

    o When the patient received the items and whether or not the items have been returned;

    o Where the item will be used; and

    o 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.

14. Q. Where can I find additional information?
    A. Additional information is available on the DMEPOS Prior Authorization webpage (here).

15. Q. Is there more information on the prior authorization process available?
    A. 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. Q. What Power Mobility Device (PMD) codes require prior authorization?
   A. 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. Q. When did required prior authorization of these codes begin?
   A. 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. Q. What are the timeframes for receiving a prior authorization decision for these items?
   A. 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 initial or resubmission prior authorization request.

4. 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.

5. Q. What is the validation period for PMD prior authorization decisions?
   A. 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, 11:59pm to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time period.

Pressure Reducing Support Surfaces (PRSS):

1. Q. What Pressure Reducing Support Surfaces (PRSS) codes require prior authorization?
   A. 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. Q. When did required prior authorization of these codes begin?
   A. 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. Q. What are the timeframes for receiving a prior authorization decision for these items?
   A. 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. Q. What if a beneficiary needs a PRSS 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.

5. Q. What is the validation period for PRSS prior authorization decisions?
   A. 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 (LLPs):

1. Q. What Lower Limb Prosthetic (LLP) codes require prior authorization?
   A. 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. Q. When did prior authorization of these codes begin?
   A. 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 will expanded nationwide on December 1, 2020.

3. Q. When can requestors begin submitting prior authorization requests for these LLP codes?
   A. 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.

4. Q. What are the timeframes for receiving a prior authorization decision for these items?
   A. 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.

5. Q. What if a beneficiary needs a LLP 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.

6. Q. What is the validation period for LLP prior authorization decisions?
   A. 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. Q. What orthoses codes require prior authorization?
   A. CMS announced in a Federal Register notice (here) the selection of L0648, L0650, L1832, L1833, and L1851 to be subject to required prior authorization. The complete list of codes and descriptions can be located in the 'Downloads' section (here).

2. Q. When did prior authorization of these codes begin?
   A. 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.

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

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

3. Q. When can requestors begin submitting prior authorization requests for these orthoses codes?
   A. 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.

      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.

      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.

4. Q. What are the timeframes for receiving a prior authorization decision for these items?
   A. 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 following the DME MAC's receipt of the prior authorization request.

5. Q. What if a beneficiary needs an item sooner than the 2-day expedited timeframe?
   A. 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, L1833, and L1851 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.
- Claims for HCPCS codes L0648, L0650, L1833, 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.

6. Q. Are orthoses that are included in the Competitive Bidding Program (CBP) subject to prior authorization?
   A. Yes, Claims for HCPCS codes L0648, L0650, L1833, 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.

7. Q. How long will prior authorization be suspended for these items?
   A. There is no current end date.

8. Q. Will prior authorization continue for orthoses items not covered in this update?
   A. Yes. Prior authorization will continue for these orthoses items (HCPCS L0648, L0650, L1832, L1833, and L1851) when furnished under circumstances not covered in this update, as well as all other items on the Required Prior Authorization List (PDF).

9. Q. What is the validation period for orthoses prior authorization decisions?
   A. Prior authorization decisions for orthoses codes will remain valid for (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, 11:59pm to furnish the orthoses. Otherwise, a new PAR will need to be submitted to restart the valid 60-day time-period.