

Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies



***Amy Cinquegrani
Dr. Scott H. Lawrence***

***Provider Compliance
Group***

CMS Goals

Welcoming Feedback to Support Program Transparency while Empowering Patients and Providers

- CMS is committed to launching the narrowly tailored DMEPOS Prior Authorization Program in an open and transparent manner that serves and protects patients and the health care providers that care for them.
- CMS has the opportunity to learn from patient and provider experience and welcomes feedback as a critical part of this process. We look forward to an ongoing dialogue to help us gather feedback and learn how the program can best meet patients' needs.
- To enhance this dialogue with both patients and providers, and to support program transparency, CMS will be improving our DMEPOS Prior Authorization website, and posting helpful tools for patients, suppliers, and physicians. These resources aim to improve transparency; protect access to care; and support direct engagement with patients, suppliers, and physicians.

Purpose

- To provide an overview of the prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as outlined in Section 1834(a)(15) of Title 18 of the Social Security Act and Centers for Medicare & Medicaid Services (CMS) regulation 6050, codified at 42 C.F.R. 405.926 and 414.234.
- To provide the sub-regulatory guidance for the first two Healthcare Common Procedure Coding System (HCPCS) codes on the Required Prior Authorization List.

Prior Authorization Process for Certain DMEPOS Items

- Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item is rendered to a Medicare patient and before a claim is submitted for payment.
- Prior authorization helps make sure that applicable Medicare coverage, payment, and coding rules are met before item(s) are rendered.
- 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.

Prior Authorization Process for Certain DMEPOS Items

- CMS announced, through recent regulation, its creation of a list of items frequently subject to unnecessary utilization and potential candidates for prior authorization (i.e., “Master List”).
- CMS may select items from the Master list, to be subject to mandatory prior authorization at its discretion (i.e., Required Prior Authorization List).
- Federal Register Notice announcing the 2 HCPCS codes added to the Required Prior Authorization List was published December 21, 2016.
- Prior authorization of items on the Required Prior Authorization List is a condition of payment.

Who and What

Who

- Suppliers and Medicare patients
 - Claims from patients who have a representative (rep) payee are included in the national expansion. Note: these claims were exempt during the initial four state rollout.

What

- **K0856**: Power wheelchair, group 3 std., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- **K0861**: Power wheelchair, group 3 std., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

Where and When

Where

- Nationwide
- States are assigned based upon the beneficiary's permanent address (per CMS IOM 100-04 , Ch.1, § 10.1.5.1).

When

All new rental series claims for K0856 & K0861 with a date of service on or after July 17, 2017

*Phase 1 was effective in IL, MO, NY, and WV for dates of service beginning March 20, 2017

Why

Prior Authorization

- Allows the supplier to know earlier in the process whether Medicare will likely pay for the DMEPOS item(s).
- Allows the Medicare patient to know, prior to receipt of the item(s), whether Medicare will likely pay for the item(s).
- Allows DME MACs to assess medical information, prior to making a claim determination, to provide provisional feedback on the item(s) to be rendered.

Why Not - Accessories

Why aren't wheelchair accessories included in the prior authorization process?

- All codes subject to required prior authorization must be identified on the Master List (CMS 6050). For inclusion on the master list, an item must meet certain criteria:
 - Have a DMEPOS Fee Schedule average purchase fee of \$1,000 or greater, or an average rental fee schedule of \$100 or greater, (adjusted annually for inflation) and be the subject of HHS Office of the Inspector General (OIG) or U.S. Government Accountability Office (GAO) reports that are national in scope and published since 2007, or Medicare Fee-for-Service Improper Payment Rate Reports and/or the Supplementary Appendices for the Medicare Fee-for-Service Improper Payment Rate Reports since 2011.
- Wheelchair accessories do not meet these criteria, and thus, aren't separately eligible for prior authorization under this program.

Why Not – Accessories (cont'd)

When the specialty evaluation supports the need for specific options/accessories and 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 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.
- Consult the MAC LCDs for more information.

Status Quo

- Medicare coverage policies and documentation requirements are unchanged.
- DME MACs will continue to conduct the reviews.
- Advance Beneficiary Notice (ABN) policies and claim appeal rights are unchanged.

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.

Prior Authorization Request Content

- Request needs to identify:
 - The beneficiary's name, Medicare number, date of birth, address
 - The supplier's name, NSC number, NPI number, address, and phone number
 - The requester's name, telephone number, NPI (if applicable), and address
 - Submission date
 - HCPCS code
 - Indicate if the request is an initial or resubmission review
 - Indicate if the request is expedited and the reason why

Prior Authorization Request Content (2)

Request needs to include:

- Any other relevant document as deemed necessary by the contractor to process the prior authorization, such as:
 - Detailed Product Description
 - Attestation Statement showing no financial relationship between the supplier and LCMP
 - Evidence of Rehabilitation Engineering & Assistive Technology of America (RESNA) Assistive Technology Practitioner (ATP) Certification and involvement
 - Home assessment/visit, if available at the time of the PAR

Prior Authorization Request Content (3)

Request also needs to include (from the provider):

- Documentation from the medical record to support the medical necessity, such as:
 - Seven-Element Order
 - Face-to-Face Examination
 - Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP)

Prior Authorization Request Submission

- The supplier or the Medicare patient may submit the prior authorization request.
- The request can be:
 - Mailed
 - Faxed
 - Submitted through the Electronic Submission of Medical Documentation (esMD) system*
 - Submitted through the MAC's provider portal, when available

* More info about Electronic Submission of Medical Documentation (esMD) can be found at www.cms.gov/esMD.

Review Timeframes

- **Initial Requests**

- The DME MAC makes every effort to review request and postmark decision letters within **10 business days**.

- **Resubmitted Requests**

- The request submitted with additional documentation after the initial prior authorization request was non-affirmed.
- The DME MAC makes every effort to review request and postmark decision letters within **20 business days**.

- **Expedited Circumstances**

- The request submitted when the standard timeframe could jeopardize the life or health of the Medicare patient.
- The DME MAC will make reasonable efforts to communicate a decision within **2 business days**.

Detailed Decision Letter

- DME MACs will send the requester of the prior authorization (i.e., the entity who will submit the claim for payment) a letter providing their prior authorization decision (i.e., affirmative or non-affirmative).
- Medicare patients can receive a copy, upon request. MACs may also send these letters voluntarily.
- Prescribing physicians can receive a copy of the decision letter upon request.
- If the request is non-affirmed, the letter will provide a detailed explanation for the decision.
- Decisions on individual accessory codes are not included in the decision letters.

Unique Tracking Number

- Decision Letters for both affirmed and non-affirmed decisions will contain a Unique Tracking Number (UTN).
- Claims submitted must include the UTN to receive payment.

When a Prior Authorization Request is Submitted and Affirmed

- Claims for which there is an associated provisional affirmative prior authorization decision will be paid in full, so long as all of the appropriate documentation and all relevant Medicare coverage and clinical documentation requirements are met and the claim was billed and submitted correctly.
- Generally, claims that have an affirmative prior authorization decision will not be subject to additional review; however, CMS contractors, including Zone Program Integrity Contractors and Unified Program Integrity Contractors, may conduct targeted pre- and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process. In addition, the Comprehensive Error Rate Testing contractor may select these claims for review as part of its random sample.

When a Prior Authorization Request is Submitted but Non-Affirmed

- A requester can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request.
 - Unlimited resubmissions are allowed; however, a non-affirmative prior authorization request decision is not appealable.

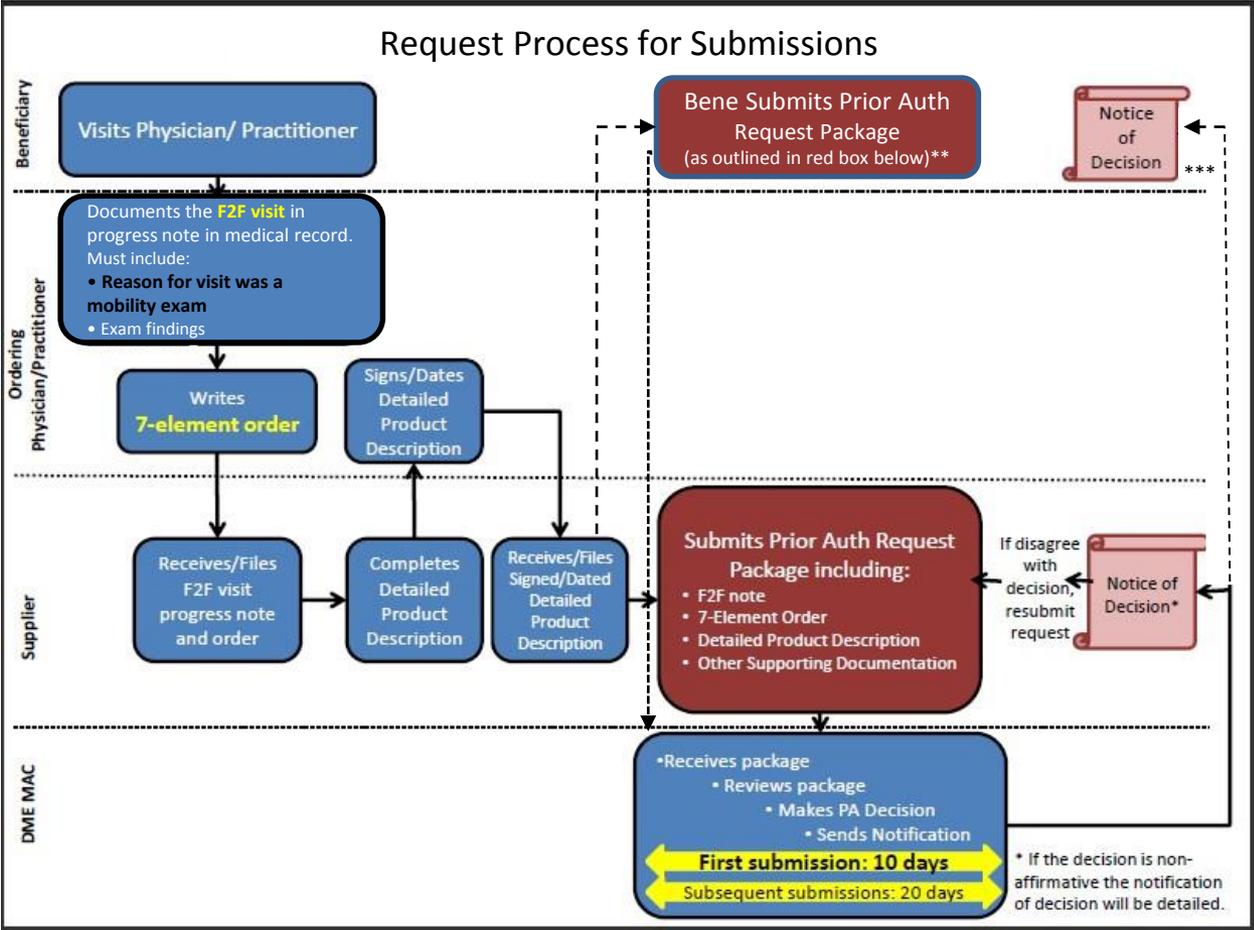
or

- A requester can forego the resubmission process, provide the DMEPOS item(s), and submit the claim for payment.
 - The claim will be denied.
 - All appeal rights are available.

When a Prior Authorization Request is Not Submitted

- As described in 42 C.F.R. §§ 405 and 414, if an item is selected for required prior authorization under the program, then submitting a prior authorization request is a condition of payment.
- Claims for items subject to required prior authorization submitted without a prior authorization determination and a corresponding UTN will be automatically denied.

Prior Authorization Process



** CMS notes that beneficiaries may submit prior authorization requests under the national program; however, CMS expects that this option will be seldom used. Whenever possible, beneficiaries are encouraged to work with their supplier, who have the expertise in the process.

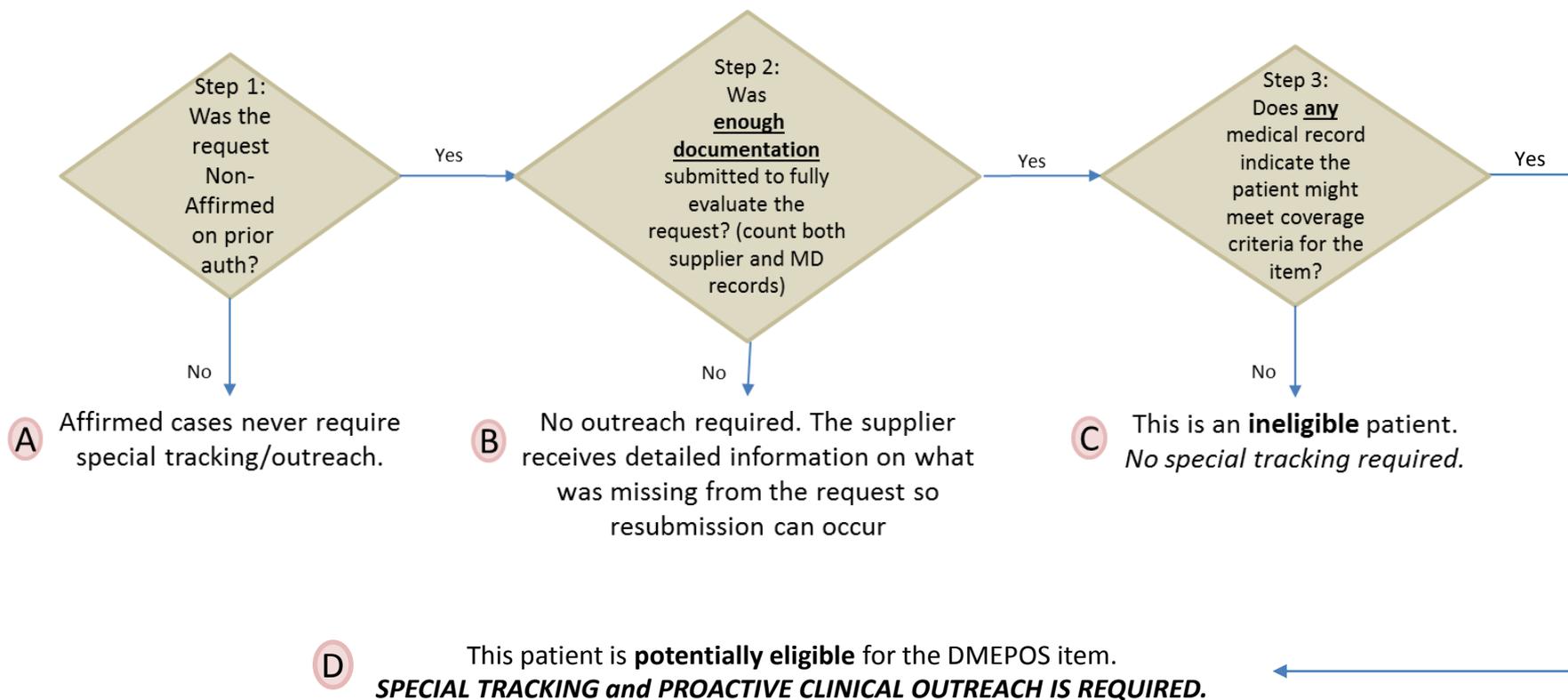
*** Notice of Decision is available to the Beneficiary upon request, although the DME MAC may send the notice voluntarily, as a courtesy to the beneficiary.

Educational Outreach for Non-Affirmed Requests

- DME MACs have special tracking for requests that are not approved due to documentation errors, where the patient may otherwise meet Medicare's coverage criteria.
- Suppliers with these documentation errors receive individualized education and are encouraged to resubmit their request to ensure their patients receive the necessary item for which they are covered.

Educational Outreach for Non-Affirmed Requests

DMEPOS Prior Authorization Special Tracking Decision Tool



Scenarios

	Prior authorization request is:	The DME MAC decision is:	The supplier or beneficiary chooses to:	The DME MAC will:
1	Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met)
2	Submitted	Non- Affirmative	a. Submit a claim	a. Deny the claim
			b. Fix and resubmit the request	b. Review the resubmission and render a decision
3	Not submitted	N/A	Submit a claim	Deny the claim

Medicare Patient Impact

- The benefit is not changing.
- Medicare patients will know earlier in the payment process if an item will likely meet Medicare's coverage requirements.
- Medicare patients may receive their prior authorization decision, upon request.
- Dual eligible coverage is not changing.
- Private insurance coverage is not changing.

CMS Oversight

- CMS will contract with an independent evaluator to analyze the impacts of prior authorization, including impacts to patient care, access to service, and overall expenditures and savings.
- CMS will conduct regular reviews of DME MAC prior authorization decisions.
- CMS will discuss its findings with and seek feedback from the DME MACs during regularly scheduled meetings.

DME MAC Information

- Jurisdictions A and D: Noridian
 - <https://med.noridianmedicare.com/>
- Jurisdictions B and C: CGS
 - <http://www.cgsmedicare.com/>

CMS Resources

- Local Coverage Decision and Policy Article for Power Mobility Devices, available at: <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33789&ver=14&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=power+mobility&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAAACAAAAAAAAAA%3d%3d&>
- Prior Authorization Web Site: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html>
- Feedback: DMEPOSPA@cms.hhs.gov

Summary

	Phase I	Phase II
Codes:	K0856, K0861	K0856, K0861
Where:	IL, MO, NY, WV	Nationwide
PAR submissions begin:	March 6, 2017	July 3, 2017
Impacted Dates of Service:	March 20, 2017	July 17, 2017
Submitted by:	Supplier or beneficiary	Supplier or beneficiary



Questions?