DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

7500 Security Boulevard,

Baltimore, Maryland 21244-1850

Dear Medicare Supplier:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has implemented **a prior authorization program for certain durable medical equipment, prosthetic, orthotics, and supplies (DMEPOS) items** as a condition of payment.

The following items will require prior authorization from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) as a condition of payment, when furnished on or after **September 1, 2018, nationwide**:

- Group 1 power operated wheelchairs: (K0813-K0816)
- Group 2 standard power operated wheelchairs: (K0820-K0829)
- All Group 2 complex rehabilitative power wheelchairs: (K035-K043)
- Group 3 complex rehabilitative wheelchairs without power options: (K0848-K0855)

CMS will continue to require prior authorization as a condition of payment for K0856 and K0861, both group 3 power wheelchairs.

What You Need to Know

The prior authorization program does not change Medicare DMEPOS benefit and coverage requirements nor does it create new documentation requirements. The documentation required to be included with a prior authorization request is information that physicians and suppliers are regularly required to maintain. Under the prior authorization process, the requester must submit the request with the required documentation before the claims payment process so that Medicare can make sure all relevant Medicare requirements are met.

As a Medicare supplier, you (or the Medicare patient), referred to as a "requester," must submit the prior authorization request. The requester must submit the prior authorization request with accompanying relevant documentation to the appropriate DME MAC through fax or mail. Requests through Electronic Submission of Medical Documentation (esMD) will be available in late 2018.

You must include in the prior authorization request all relevant documentation to support Medicare coverage of the DMEPOS item; in this case, certain power mobility devices (PMDs). This includes the following documentation from the ordering Physician/Practitioner:

1. The seven-element written order for the PMD;
2. Documentation of the face-to-face examination where the physician/practitioner evaluated the patient's need for the PMD;
3. Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP);
4. The detailed product description; and
5. Other documentation in the medical record that may be required by the DME MAC to support medical need.

As a Medicare supplier, your request must also include the following documents:

6. Attestation Statement showing no financial relationship between the supplier and LCMP;
7. Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement;
8. Home Assessment/Visit, if available at the time of the request; and
9. Other documentation in the medical record that may be required by the DME MAC to support medical need.

A review checklist with specific items suppliers need to provide is available here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/PMDDocumentationRequirementsNationwide.html

After receipt of all relevant documentation from the requester, the DME MAC will review and communicate a decision within 10 business days on whether the prior authorization request meets all Medicare coverage requirements and is provisionally affirmed, or is non-affirmed. In emergency situations, the requester may seek an expedited review of the prior authorization request. If the DME MAC substantiates the need for an expedited review, the DME MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of relevant documentation.

The DME MAC will send decision letters with the unique tracking number (UTN) to the requester and, upon request, to the Medicare patient (if they were not the requester) and the prescribing physician/practitioner. The UTN must be on all claims submitted for payment.

If the prior authorization request is non-affirmed by the DME MAC, the requester may revise and resubmit the prior authorization request an unlimited number of times. The DME MAC will make every effort to conduct a review and communicate a decision within 20 business days on each resubmitted prior authorization request. The DME MAC will deny claims submitted with a non-affirmative prior authorization decision or claims submitted without a prior authorization determination (i.e., no UTN listed on the claim). If a claim is denied, the Medicare patient or supplier may appeal the denial; however, a prior authorization request that is non-affirmed is not appealable.

Suppliers can refer to the operational guide for detailed instructions on the process for requesting and receiving a prior authorization decision, as well as the process for including such information on subsequent claim submissions. The operational guide and other relevant information is posted on the individual DME MAC websites and the CMS website below.

The CMS website for this prior authorization program - 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.

Power Mobility Devices Local Coverage Determination and Related Policy Article:
Search *L33789* at https://www.cms.gov/medicare-coverage-database

DME MAC Jurisdictions A and D website: https://med.noridianmedicare.com

DME MAC Jurisdictions B and C website: http://www.cgsmedicare.com

Additional Resources

DMEPOS suppliers are vital partners in the Medicare program, and CMS has a wide range of resources to give you the information you need. To facilitate open and ongoing dialogue with both patients and providers, and to support program transparency, CMS has established a dedicated website for DMEPOS Prior Authorization with comprehensive information for patients, suppliers, and physicians.

You may request an individual education session if you have concerns about the program. More information is available online. CMS will post details of any upcoming educational sessions on its website (link noted above).

CMS Welcomes Feedback

CMS is committed to launching the DMEPOS Prior Authorization Program in an open and transparent manner that serves and protects patients and the health care providers that care for them. Your feedback will be a critical part of the process. Suppliers who have additional questions can call the appropriate DME MAC for individualized education. Suppliers can also provide feedback to CMS at DMEPOSPA@cms.hhs.gov.