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

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Purpose

The purpose of this Operational Guide is to interpret and clarify the prior authorization (PA) program authorized by the Social Security Act (The Act) at §1834(a)(15) and implemented by the Centers for Medicare & Medicaid Services (CMS) 6050- Prior Authorization Process for Certain DMEOPOS Items final rule. The final rule was codified at 42 Code of Federal Regulations (C.F.R.) §§405 and 414.

The intended audience for this operational guide is Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) and Medicare participating DME suppliers that provide (and beneficiaries whom receive) durable medical equipment, prosthetics, orthotics, and supplies that are frequently subject to unnecessary utilization, as described in 42 C.F.R. §405. These guidelines aim to provide operational guidance and do not alter the requirements described in 42 C.F.R. §§405 and 414. In addition, these guidelines do not alter or conflict with any Medicare coverage, coding, and pricing policies.

This Operational Guide was developed based on input from the CMS review contractors. This is a working document and is subject to change at any given time.

1 - DMEPOS Benefit

For any service or item to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

The payment rules for Medicare coverage of DMEPOS are located in Title XVIII of the Social Security Act, §1834(a), including the Secretary's authority to prior authorize items frequently subject to unnecessary utilization.

The scope and condition for payment of DMEPOS items is codified in the C.F.R. at 42 C.F.R. §410.38. The ability to prior authorize DMEPOS items subject to frequent unnecessary utilization is further codified in regulation, at 42 C.F.R. §§405 and 414.

The CMS provides additional guidance through Internet-Only Manuals, including the Medicare Benefit Policy Manual 100-02, Ch. 15 and Medicare Program Integrity Manual 100-08, Ch. 5.

The CMS posts updates regarding DMEPOS items on its public website, on the Durable Medical Equipment (DME) Center webpage, and updates regarding this PA program on its PA webpage, Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, Supplies Items.

The CMS websites are provided as a resource, and is not meant to provide an all-inclusive list of applicable statutory, regulatory, or sub-regulatory requirements.

2 - Program Overview

This section gives an overview of the requirements described in 42 C.F.R. §§405 and 414. The program requirements described in these sections are applicable to the Prior Authorization of Certain DMEPOS created by final rule.

The final rule can be found at https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-30273.pdf.

DMEPOS not meeting the criteria described in the rule are not subject to the requirements of the rule and 42 C.F.R. §§405 and 414.

As described in 42 C.F.R. §§405 and 414, CMS will maintain a "Master List" of DMEPOS items that fit the prescribed criteria and *may* be selected for PA, and "The Required Prior Authorization List" comprised of a smaller subset of DMEPOS items which CMS has selected for PA. As described in 42 C.F.R. §§405 and 414, if an item is selected for prior authorization under the program, then submitting a PAR is a condition of payment. It is important to note that CMS will be selecting such DMEPOS item(s) based on a number of factors including, but not limited to administrative burden and systems capabilities. CMS publishes in the Federal Register and posts on the CMS PA Website the Required PA List. As noted earlier, items appearing on The Required PA List require PA as a condition of payment.

2.1 – Master List

A. Creation of the Master List

The final rule created an initial Master List that includes certain DMEPOS items potentially subject to PA, which meet the following criteria:

1. Appear on the DMEPOS Fee Schedule list;

2. Have an average purchase fee of $1,000 or greater (adjusted annually for inflation) or an average rental fee schedule of $100 or greater (adjusted annually for inflation). (These dollar amounts are referred to as the payment threshold); and

3. Meet either of the following:

    a. Were identified in a General Accountability Office (GAO) or Department of Health and Human Services Office of Inspector General (OIG) report that is national in scope and published in 2007 or later as having a high rate of fraud or unnecessary utilization; or

    b. Were listed in the 2011 or later Comprehensive Error Rate Testing (CERT) program's Annual Medicare Fee For Service (FFS) Improper Payment Rate Report Durable Medical Equipment (DME) Report's Service Specific Overpayment Rate Appendix.

B. Maintenance of the Master List

We notify the public annually of any additions and deletions from the Master List by posting the notification in the Federal Register and on the CMS PA website.

- The Master List is self-updating annually. That is, items on the DMEPOS Fee Schedule that meet the payment threshold are added to the list when the item is listed in a future OIG or GAO report of a national scope or a future CERT DME and/or DMEPOS Service Specific Report(s).

- Items that are discontinued or are no longer covered by Medicare are removed from the Master List.

- Items remain on the Master List for 10 years from the date the item was added to the Master List.

- Items are updated on the Master List when the Healthcare Common Procedure Coding System (HCPCS) codes representing an item have been discontinued and cross walked to an equivalent item.

- Items are removed from the list sooner than 10 years if the purchase amount drops below the payment threshold (currently an average purchase fee of $1,018 or greater or an average monthly rental fee schedule of $102 or greater).

- Items that age off the Master List because they have been on the list for 10 years can remain on or be added back to the Master List if a subsequent GAO/OIG, or CERT DME and/or DMEPOS Service Specific Report(s) identifies the item to be frequently subject to unnecessary utilization.

- Items on the Master List identified by a GAO/OIG, or CERT DME and/or DMEPOS Service Specific Report(s) while on the Master List will remain on the list for 10 years from the publication date of the new report(s).

2.2 – The Required Prior Authorization List

Presence on the Master List will not automatically require PA. In order to balance the need to minimize provider and supplier burden with our need to protect the Medicare Trust Funds, the PA program will be limited to a subset of items from the Master List, which CMS has selected based on a variety of factors to be placed on the "Required Prior Authorization List". For such CMS identified items, prior authorization is a condition of payment.

CMS will publish The Required Prior Authorization List in the Federal Register and on the CMS PA website.

3 – Prior Authorization Request (PAR)

3.1 – General PAR Documentation

Submitters are encouraged to include the following data elements in all PARs to avoid potential delays in processing:

Beneficiary Information (as written on their Medicare card):

- Beneficiary Name,
- Beneficiary Medicare Number (also known as the HICN or MBI), and
- Beneficiary Date of Birth
- Beneficiary Address
- Place of Service
- Diagnosis Code

Supplier Information:

- Supplier Name,
- Supplier National Supplier Clearinghouse (NSC) Number,
- Supplier National Provider Identification, and
- Supplier Address
- Supplier Phone Number

Requestor Information:

- Requestor Name
- Requestor Phone Number
- NPI (if applicable)
- Requestor Address

Other Information:

- HCPCS Code,
- Submission Date, and
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why

Indicate if the request includes an upgrade.

Submitters should note that the **beneficiary and supplier** addresses listed in the PAR **will not** be used by the DME MACs when sending review decision letters. The decision letters for suppliers and beneficiaries will be mailed to the supplier address on file with the NSC and the beneficiary address on file with the Social Security Administration.

Additional Required Documentation

- Documentation from the medical record to support the medical necessity of the items, and
- Any other relevant documents as deemed necessary by the DME MAC to process the PAR.

3.1.1 – Methods for sending a PAR

Submitters have the following options for submitting PARs to the DME MACs:

1) mail,
2) fax,
3) electronic submission of medical documentation (esMD), or
4) Internet based provider portals (DME MAC specific, if available).

For more information about esMD, see www.cms.gov/esMD or contact your DME MAC.

MAC Contact Information:

For beneficiaries residing in **Jurisdiction A** states send requests to:

- Fax Number: 701-277-7891
- Street Address: Noridian Healthcare Solutions
  Jurisdiction A Medical Review - PAR
  900 42nd Street S
  P.O Box 6742
  Fargo, ND 58108-6742
- esMD: (indicate document/content type "8.4")

For beneficiaries residing in **Jurisdiction B** states send requests to:

- Fax Number: 615-660-5992
- Street Address: CGS-DME Medical Review-Prior Authorization
  P.O Box 23110
  Nashville, TN 37202-4890
- esMD: (indicate document/content type "8.4")

For beneficiaries residing in **Jurisdiction C** states send requests to:

- Fax Number: 615-664-5960
- Street Address: CGS-DME Medical Review-Prior Authorization
  P.O. Box 24890
  Nashville, TN 37202-4890
- esMD: (indicate document/content type "8.4")

For beneficiaries residing in **Jurisdiction D** states send requests to:

- Fax Number: 701-277-7891
- Street Address: Noridian Healthcare Solutions
  Jurisdiction D Medical Review - PAR
  PO Box 6742
  Fargo, ND 58108-6742
- esMD: (indicate document/content type "8.4")

4 - Timeframe for Decisions

The timeframes for conducting PA of certain DMEPOS items will be dependent upon the item(s) selected for PA (see specifics for each program in §5). There are 3 types of prior authorization submissions, which will have corresponding review timeframes for each specific item selected for review:

- **Initial Submission**—the first prior authorization request sent to the contractor for review and decision.

- **Resubmission**—any subsequent resubmissions to correct an error or omission identified during a previous prior authorization decisions. (Typically the review timeframe for resubmissions will be elongated from the initial review decision).

- **Expedited**—a prior authorization decision that is expedited based on the MAC determination that delays in review and response could jeopardize the life or health of the beneficiary.

4.1 – Expedited Review Process

If delays in receipt of a PA decision could jeopardize the life or health of the beneficiary, then the DME MAC should process the PAR under an "expedited" timeframe.

Upon identification of a PAR which requires an expedited review, the DME MAC shall implement the following for purposes of expediency:

- Render an affirmative or non-affirmative decision within the CMS-prescribed expedited review timeframe (specified for the code being prior authorized) and provide the decision to the supplier and/or beneficiary (if specifically requested by the beneficiary) via telephone, fax, or other "real-time" communication, within the requisite timeframe.

- The issuance of the decision should make it explicit that although the decision has been reached, the supplier shall (to prevent the claim from denying upon submission) ***hold their claim and not submit it*** until such time as the unique tracking number (UTN) is provided. DME MACs shall follow the normal process to obtain a UTN from CMS shared systems.

- Suppliers shall be notified that if the claim is submitted prior to receipt of the UTN, there will be no mechanism to identify it to prevent an auto-denial. Suppliers shall be notified that any claims prematurely submitted will require a formal reopening request to process for payment.

- Suppliers shall be given a point of contact to follow-up on the UTN status, and DME MACs shall check the same on a daily basis.

5 – Program Specifics

5.1—Program Specifics for Codes K0856 and K0861

5.1.1—Implementation of Prior Authorization

The first 2 codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- K0861- 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.

The prior authorization process for these 2 codes will be implemented in phases. Phase 1 limits the initial roll out to 4 states (1 per DME MAC jurisdiction). Phase 2 expands the program nationally.

Phase 1

- DME MACs will begin accepting prior authorization requests for K0856 & K0861 on **March 6, 2017,** for New York, Illinois, Missouri, and West Virginia**,** for dates of delivery on or after March 20, 2017.
    - Note- States are assigned based upon the beneficiary's permanent address (per CMS IOM 100-04 , Ch.1, § 10.1.5.1)

- **All new rental series** claims, within the specified states, for K0856 & K0861 with a date of service (DOS) on or after **March 20, 2017** must have a prior authorization request on file as a condition of payment.

Phase 2

- DME MACs will begin accepting prior authorization requests for K0856 & K0861 on July 3, 2017, for all remaining states/territories, for dates of delivery on or after July 17, 2017.

- **All new rental series claims nationwide,** for K0856 & K0861 with a DOS on or after **July 17, 2017,** must have a prior authorization request on file.

5.1.2—Required Documentation

Documentation from the medical record to support the medical necessity of K0856 and K0861 would include but not limited to:

- Seven Element Order
- Detailed Product Description
- Face-to-Face Examination

- Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP)
- Attestation Statement showing no financial relationship between the supplier and LCMP
- Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) and the Local Coverage Determination (LCD): Power Mobility Devices (L33789)

5.1.3—Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will complete its complex medical review and send an initial decision letter that is either postmarked or faxed within **10 business days** following the DME MAC's receipt of the initial request.

- **Resubmission:** A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The DME MAC will postmark or fax notification of the decision of these resubmitted requests to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within **20 business days** of receipt of the resubmission.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request.

For those beneficiaries that are excluded from the K0856 and K0861 PA program (see § 12.2), an Advanced Determination of Medical Coverage should be offered, if applicable.

5.2—Program Specifics for Codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, and K0855

5.2.1—Implementation of Prior Authorization

The additional codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- K0813- Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds

- K0814- Power wheelchair, group 1 standard, portable, captains chair, patient weight

capacity up to and including 300 pounds

- K0815- Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
- K0816- Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0820- Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0821- Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
- K0822- Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0823- Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0824- Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0825- Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds
- K0826- Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0827- Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
- K0828- Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0829- Power wheelchair, group 2 extra heavy duty, captains chair, patient weight 601 pounds or more
- K0835- Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0836- Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
- K0837- Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0838- Power wheelchair, group 2 heavy duty, single power option, captains chair,

patient weight capacity 301 to 450 pounds

- K0839- Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0840- Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0841- Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0842- Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds
- K0843- Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0848- Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0849- Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0850- Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds
- K0851- Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds
- K0852- Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds
- K0853- Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds
- K0854- Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more
- K0855- Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on **August 18, 2018,** for dates of delivery on or after September 1, 2018.

All new rental series claims nationwide with a DOS on or after **September 1, 2018,** must have a prior authorization request on file.

5.2.2—Required Documentation

Documentation from the medical record to support the medical necessity would include but not limited to:

- Seven Element Order
- Detailed Product Description
- Face-to-Face Examination
- Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP), if applicable
- Attestation Statement showing no financial relationship between the supplier and LCMP, if applicable
- Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement, if applicable
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) and the Local Coverage Determination (LCD): Power Mobility Devices (L33789)

5.2.3—Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will complete its complex medical review and send an initial decision letter that is either postmarked or faxed within **10 business days** following the DME MAC's receipt of the initial request.

- **Resubmission:** A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The DME MAC will postmark or fax notification of the decision of these resubmitted requests to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within **20 business days** of receipt of the resubmission.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request.

5.3—Program Specifics for Codes K0857, K0858, K0859, K0860, K0862, K0863, and K0864

5.3.1—Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- K0857 - Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds.

- K0858 - Power wheelchair, group 3 heavy duty, single power option, sling/solid set/back, patient weight 301 to 450 pounds.

- K0859 - Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds.

- K0860 - Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds.

- K0862 - Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds.

- K0863 - Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds.

- K0864 - Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more.

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on **July 8, 2019,** for dates of delivery on or after **July 22, 2019**.

All new rental series claims nationwide with a DOS on or after **July 22, 2019,** must have a prior authorization request on file.

5.3.2—Required Documentation

Documentation from the medical record to support the medical necessity of K0857, K0858, K0859, K0860, K0862, K0863, and K0864 would include but not limited to:

- Seven Element Order
- Detailed Product Description
- Face-to-Face Examination
- Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP)
- Attestation Statement showing no financial relationship between the supplier and LCMP
- Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the NCD for Mobility Assistive Equipment (MAE): 280.3 and the LCD for Power Mobility Devices: L33789.

5.3.3-Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will complete its complex medical review and

send an initial decision letter that is either postmarked or faxed within **10 business days** following the DME MAC's receipt of the initial request.

- **Resubmission:** A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The DME MAC will postmark or fax notification of the decision of these resubmitted requests to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within **20 business days** of receipt of the resubmission.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request.

5.4 —Program Specifics for Codes E0193, E0277, E0371, E0372, and E0373

5.4.1—Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- E0193 –Powered Air Flotation Bed (Low Air Loss Therapy)

- E0277 –Powered Pressure- Reducing Air Mattress

- E0371 – Non-powered Advanced Pressure Reducing Overlay for Mattress, Standard Mattress Length and Width

- E0372 – Powered Air Overlay for Mattress, Standard Mattress Length and Width

- E0373 –Non-powered Advanced Pressure Reducing Mattress

The prior authorization process for these codes will be implemented in two phases. Phase 1 limits the prior authorization requirement to 4 states (one per DME MAC jurisdiction). Phase 2 expands the program nationally.

Phase 1

- DME MACs will begin accepting prior authorization requests for E0193, E0277, E0371, E0372, and E0373 on July 8, 2019**,** for California, Indiana, New Jersey, and North Carolina, for dates of delivery on or after July 22, 2019.
    - Note- States are assigned based upon the beneficiary's permanent address (per CMS IOM 100-04, Ch.1, § 10.1.5.1)

- **All new rental series** claims, within the specified states, for E0193, E0277, E0371, E0372, and E0373 with a date of service (DOS) on or after **July 22, 2019** must have a prior authorization request on file as a condition of payment.

Phase 2

- DME MACs will begin accepting prior authorization requests for E0193, E0277, E0371, E0372, and E0373 on **October 7, 2019** for all remaining states/territories**,** for dates of delivery on or after **October 21, 2019**.

- **All new rental series claims nationwide,** for E0193, E0277, E0371, E0372, and E0373 with a DOS on or after **October 21, 2019,** must have a prior authorization request on file.

5.4.2 - Required Documentation

Documentation from the medical record to support the medical necessity of E0193, E0277, E0371, E0372, and E0373 would include but not limited to:

- A Detailed Written Order (DWO)
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the LCD for Pressure Reducing Support Surfaces – Group 2 (L33642) and the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Considerations.

5.4.3—Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will complete its complex medical review and ensure that the written decision is faxed, postmarked, or delivered electronically by the 5th business day following the DME MAC's receipt of the initial request.

- **Resubmission:** A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The DME MAC will ensure that the written decision is faxed, postmarked, or delivered electronically by the 5th business day of these resubmitted requests to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within **5 business days** of receipt of the resubmission.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

  Note: One of the coverage criteria in LCD L33642 for Pressure Reducing Support Surfaces – Group 2 requires that the beneficiary has diagnosis of a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days, and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. Patients with the above conditions may meet the criteria for an expedited review. Suppliers shall ensure that the PAR clearly notes an expedited request and is completed accurately to ensure expeditious processing.

6 – Secondary Insurance

This section pertains to the instances where the beneficiary has more than one insurance. In these instances, Medicare must be either the first or the secondary insurance company.

6.1 – Medicare is Primary Insurance

In cases where Medicare is primary and another insurance company is secondary:

The contractors shall suspend claims to request documentation and conduct a review of the Advanced Beneficiary Notice (ABN) when there is no prior authorization request and the claim is submitted with the GA modifier appended.

The Contractor shall determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).

If a supplier chooses to use the PA for a denial then the following process is to be followed:

- The submitter may submit the **PAR** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the DMEPOS item, then a non-affirmative PA decision will be sent to the entity requesting the PA (i.e., the supplier or the beneficiary if requested), advising that Medicare will not pay for the item.

- After receiving a non-affirmative decision for the PAR, if the associated **claim** is submitted by the supplier to the DME MAC for payment, it will be denied.

- The submitter or beneficiary may forward the denied claim to his/her secondary insurance payer as appropriate to determine payment for the DMEPOS item(s).

In cases where a beneficiary is dually eligible for Medicaid and Medicare, a non-affirmed prior authorization decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage. The supplier does not need to submit the claim to Medicare first and obtain a denial before submitting the claim to Medicaid for payment[1].

Beneficiaries with retroactive Medicare eligibility status must have a Medicare PA request submitted on their behalf to the DME MAC for payment reimbursement from Medicare. When submitting a PAR, the supplier should indicate that the item has already been delivered, that Medicare coverage is retroactive and submit all necessary PAR documentation to support the medical necessity of the item. Claims submitted without first going through the PA process will be denied.

6.2 – Another Insurance Company is Primary

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf

Cases where another insurance company is primary and Medicare is secondary:

- The submitter submits the PAR with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the item(s), then a provisional affirmative PA decision will be sent to the supplier and to the beneficiary, if specifically requested by the beneficiary, advising them that Medicare **will** pay for DMEPOS item.

- The supplier submits a claim to the other insurance company.

- If the other insurance company denies the claim, the supplier or beneficiary can submit a claim to the DME MAC for payment (listing the unique tracking number on the claim).

7 - Supplier Telephone Inquiries

Suppliers, or beneficiaries who submit PARs and who have questions about the PA should call the appropriate DME MAC. The numbers for Customer Service Representatives at the DME MACs are as follows:

- For beneficiaries residing in Jurisdiction A states call 1-866-419-9458; TTY/TDD 1-888-897-7539.

- For beneficiaries residing in Jurisdiction B states call 1-866-590-6727; TTY/TDD 1-888-897-7534.

- For beneficiaries residing in Jurisdiction C states call 1- 866-270-4909; TTY/TDD 1-888-204-3771.

- For beneficiaries residing in Jurisdiction D states call 1-877-320-0390; TTY/TDD 1-866-879-2704.

8 - Decision Letter(s)

The DME MAC will send decision letters with the unique tracking number (UTN) to the submitter via fax, mail, or the DME MAC provider portal (when available) postmarked within the timeframes described in Section 5 as it pertains to each individual DMEPOS item(s).

Decision letters sent via electronic submission of medical documentation (esMD) are not available at this time. A copy of the decision letter may also be mailed to the beneficiary, upon request. The DME MAC may also sent the letter to the beneficiary voluntarily.

(**Note:** Providers/physicians requesting decision letters must be able to demonstrate a legitimate, specific need for the information requested and contractors shall ensure that the information provided is sufficiently tailored to comply with Health Insurance Portability and Accountability Act's minimum necessary standards and other applicable laws or regulations. Prescribing physicians/practitioners may contact the DME MAC for a copy of the prior authorization decision letter. The request for the decision letter may be included with the documentation sent to the supplier as part of the prior authorization request, or may be made separately. CMS has provided a sample letter on its website here.)

9 - Provisional Affirmative PA Decision

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

9.1 - Supplier's Actions

- Before furnishing the DMEPOS item and before submitting the claim for payment, the supplier obtains a PA decision.

- Render the DMEPOS item to the beneficiary after receiving a PA decision,

- Submit the claim with the UTN on the claim.

- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the UTN is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the UTN is submitted in either the 2300 - Claim Information loop or 2400 - Service Line loop in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.

Note: If all Medicare coverage, coding and payment requirements are met the claim will likely be paid.

- Claims receiving a provisional affirmation may be denied based on either of the following:

- Technical requirements that can only be evaluated after the claim has been submitted for formal processing; or

- Information not available at the time of a PAR.

- We note claims for which there is a provisional affirmation PA decision will be afforded some protection from future audits, both pre- and post-payment; however, review contractors may audit claims if potential fraud, inappropriate utilization or changes in billing patterns are identified.

- Submitters are reminded to bill their claims in sequential order to avoid any delays in claim payment.

10 - Non-Affirmative PA Decision

A non-affirmative PA decision is a preliminary finding that if a future claim is submitted to Medicare for the DMEPOS item(s) it does not likely meet Medicare's coverage, coding, and payment requirements. We consider this an incomplete PAR.

The DME MAC will provide the PAR submitter notification of what is missing via fax, mail, or the DME MAC provider portal (when available). The decision letter for an incomplete PAR will be detailed and postmarked within the applicable timeframes described in Section 4.4.

The submitter may resubmit another complete PAR with all documentation required as noted in the detailed decision letter. See Section 8.2.1 for instructions on resubmitting a PAR. Unlimited submissions are permitted.

10.1 - Suppliers Action

Use the detailed decision letter to ensure that resubmitted PARs comply with all requirements.

Resubmit a PAR, if appropriate.

10.1.1 - Resubmitting a PAR

The submitter should review the detailed decision letter that was provided.

The submitter should make whatever modifications are needed to the PAR and follow the submission procedures.

11 - Claim Submission

11.1 – Affirmed PA Decision on File

Cases where a PAR was submitted and a provisional affirmation PA decision was granted.

- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the UTN is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the UTN must be submitted in the 2300 Claim Information loop in the PA reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop.

- Series of claims:

- Should be submitted with the UTN on each claim in the series.

- Should be submitted to the applicable DME MAC for adjudication.

11.2 – Non-Affirmed PA Decision on File

Cases where a PAR was submitted and a non-affirmed PA decision was granted.

- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the UTN is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the UTN must be submitted in the 2300 Claim Information loop in the PA reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop.

- Series of claims:

- Should be submitted with the UTN on each claim.

- Should be submitted to the applicable DME MAC for adjudication.

- If the claim is submitted to the DME MAC for payment with a non-affirmative PA decision, it will be denied.

- All appeal rights are then engaged.

- This claim could then be submitted to secondary insurance, if applicable.

11.3—Claims Submitted without a PA Decision on File

Cases where a PAR was never received/ decision granted for an item(s) on the Required Prior Authorization List.

- As described in 42 C.F.R. §414.234, 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 HCPCS code subject to required prior authorization submitted without a prior authorization determination and a corresponding UTN will be automatically denied.

12 – Special Claim Considerations

12.1 – Advanced Beneficiary Notice (ABN)

If an applicable claim is submitted without a PA decision and is flagged as having an ABN, it will be stoppedfor additional documentation to be requested and a review of the ABN shall be performed (to determine the validity of the ABN) following standard claim review guidelines and timelines.

The supplier should submit the claim with the GA modifier appended to it. The Contractor shall determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).

12.2 – Exclusions

The following claim types are excluded from any PA program described in this operational guide, unless otherwise specified:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage
- Part A and Part B Demonstrations

Note: Claims from Representative Payees will only be excluded for PA programs that are not implemented on a national level. Before submitting a PAR, suppliers should verify if the beneficiary has a rep payee on file. Once the PA program becomes national, this exclusion will not apply.

12.3 –Beneficiary Moves During Rental Series

The table is only applicable for PA programs that are not implemented on a national level.

The table below describes the process for suppliers and/or beneficiaries to receive claims payment subsequent to beneficiary changes in rendering/billing supplier and/or geographic location. The table accounts for the following assumptions:

1. The circumstances when an item is first furnished and subsequently billed for payment (i.e., the initial date of service) shall be used to determine whether a claim is subject to prior authorization as a condition of payment under the national program.

2. When applicable, the prior authorization decision and corresponding claim information may remain with the beneficiary (i.e., the prior authorization decision identified via a Unique Tracking Number, or UTN, may transfer between suppliers). CMS assumes such transfers would be made in accordance with applicable privacy laws.

	PA state to PA state	**PA state to Non-PA state**	**Non-PA state to PA state**
Same Supplier **Same Jurisdiction**	UTN CWF HUPA record on file BITS and VDME screens and CWF HUPA records will remain active on the files with no action needed Supplier continues to bill	UTN CWF HUPA record on file PA editing does not apply to the Non PA state BITS and VDME screens and CWF HUPA record will remain on the files in an active status but will	No UTN No CWF HUPA record on file No BITS/VDME screens on file Same Supplier continues to bill subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim is after the start date of the PA

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Supplier **Same Jurisdiction**	subsequent rentals using same UTN System changes: No	not apply to services in the Non-PA state Supplier discontinues using UTN on the subsequent rental claims in the Non-PA state If supplier submits claim with the UTN then VMS will reject claim with action code 27 and MACs will return claim to supplier. Supplier resubmits claim without UTN System changes: No	program Subsequent rental claims billed in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Supplier **Change Jurisdiction**	UTN CWF HUPA record on file BITS and VDME screens and CWF HUPA records set up in jurisdiction 1 will remain active on the files with no action needed Supplier continues to bill subsequent rentals with UTN from jurisdiction 1 Per MAC/VMS/CWF conversations no editing is done to validate the prefix digits of the UTN that identifies the jurisdiction. The claim will continue to process. System changes: No.	UTN CWF HUPA record on file PA editing does not apply to Non PA state BITS and VDME screens and CWF HUPA records set up in jurisdiction 1 will remain in an active status on the files but will not apply to services in the Non-PA state. A new VDME screen will automatically populate in the jurisdiction 2—MAC manual manipulations will be limited to situations in which the initial claim date needs to be corrected or to otherwise overcome an edit. Supplier discontinues using UTN on subsequent rental claims in the	No UTN No CWF HUPA record on file No BITS/VDME screens on file Same Supplier continues to bill subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim is after the start date of the PA program Subsequent rental claims billed in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) MACS will check HIMR and revise the CMN initial claim date to reflect the first claim billed in the Non-PA state, if the initial date

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Supplier **Change Jurisdiction**		Non-PA state If supplier submits claim with the UTN then VMS will reject claim with action code 27 and MACs will return claim to supplier. Supplier resubmits claim without UTN System changes: No	of service preceded the program start date. If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No
Change Supplier	UTN CWF HUPA record on file	UTN CWF HUPA record on file	No UTN No CWF HUPA record on file

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Jurisdiction **Change Supplier**	PA decision transfers to supplier 2 UTN transfers to supplier 2 BITS and VDME screens and CWF HUPA records set up for supplier 1 will remain active on the files with no action needed Supplier 1 discontinues billing and using UTN Supplier 2 should use Supplier 1's UTN to submit subsequent rental claims for the same beneficiary/item. If Supplier 2 submits without a UTN on the claim it will reject on CWF edit 5467 (no UTN on claim, Program ID present, matches aux file) and MACS will return claim to	PA decision does not transfer PA editing will not apply to Non PA state BITS and VDME screens and CWF HUPA records set up for supplier 1 will remain in an active status on the files but will not apply to services in the Non-PA state Supplier 1 discontinues billing and using UTN Supplier 2 bills subsequent rentals in Non-PA state which will not be subjected to PA. System changes: No	No BITS/VDME screens on file Supplier 2 bills subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim billed by Supplier 1 is after the start date of the PA program Subsequent rental claims billed by Supplier 2 in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Jurisdiction	supplier. Supplier resubmits claim with Supplier 1's UTN. System changes: No		System changes: No.
Change Supplier **Change Jurisdiction**	UTN CWF HUPA record on file PA decision transfers UTN transfers to supplier 2 BITS and VDME screens and CWF HUPA records set up for supplier 1 in jurisdiction 1 will remain active on the files with no action needed Supplier 1 discontinues billing and using UTN	UTN CWF HUPA record on file PA decision does not transfer PA editing does not apply to Non PA state BITS and VDME screens and CWF HUPA records set up for supplier 1 in jurisdiction 1 will remain in an active status on the files but will not apply to services in the Non-PA state. A new VDME screen will automatically	No UTN No CWF HUPA record on file No BITS/VDME screens on file Supplier 2 bills subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim billed by Supplier 1 is after the start date of the PA program Subsequent rental claims billed by Supplier 2 in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Change Supplier **Change Jurisdiction**	Supplier 2 should use Supplier 1's UTN from Jurisdiction 1 to submit subsequent rental claims for the same beneficiary/item. Per MAC/VMS/CWF conversations no editing is done to validate the prefix digits of the UTN that identifies the jurisdiction. The claim will continue to process. If Supplier 2 submits without a UTN on the claim it will reject on CWF edit 5467 (no UTN on claim, Program ID present, matches aux file) and MACs will return claim to supplier 2. Supplier 2 resubmits claim with Supplier 1's UTN	populate in the jurisdiction 2—MAC manual manipulations will be limited to situations in which the initial claim date needs to be corrected or to otherwise overcome an edit. Supplier 1 discontinues billing and using UTN. Supplier 2 bills subsequent rentals in Non-PA state which will not be subjected to PA. System changes: No	reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) MACS will check HIMR and revise the CMN initial claim date to reflect the first claim billed by Supplier 1 in the Non-PA state, if the initial date of service preceded the program start date. If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No.

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
	System changes: No.		

13.0 - Claim Appeals

Claims subject to the PA requirements that were denied payment follow all current appeals procedures. For further information consult the Medicare Claims Processing Manual publication 100-04, chapter 29 Appeals of Claims Decision.

A DME MAC PA decision of coverage (i.e. PA affirmation) is not a payment determination and thus not appealable. (See 42 C.F.R. §405.926). As noted earlier, a submitter receiving a non-affirmation PA decision is permitted to resubmit PARs an unlimited number of times.

A non-affirmative PA decision does not prevent the supplier from submitting a claim. Submission of such a claim and resulting denial by the DME MAC would constitute an initial payment determination and makes the appeal rights available.