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

Operational Guide

Updated April 12, 2022

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1 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) Prior Authorization Process for Certain DMEPOS Items final rule. The final rules, 6050-F and 1713-F, were codified at 42 Code of Federal Regulations (CFR) §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 CFR§405. These guidelines aim to provide operational guidance and do not alter the requirements described in 42 CFR §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.

2 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 at 42 CFR §410.38. The ability to prior authorize DMEPOS items subject to frequent unnecessary utilization is further codified in regulation, at 42 CFR §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 are not meant to provide an all-inclusive list of applicable statutory, regulatory, or sub-regulatory requirements.

3 Program Overview

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

The final rules can be found at:

- 6050-F: https://www.federalregister.gov/documents/2016/12/21/2016-30273/medicare-program- implementation-of-prior-authorization-process-for-certain-durable-medical-equipment

- 1713-F: https://www.federalregister.gov/documents/2019/11/08/2019-24063/medicare-program- end-stage-renal-disease-prospective-payment-system-payment-for-renal-dialysis

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

As described in 42 CFR §405 and §414, CMS will maintain a "Master List of Items Potentially Subject to a Face-To-Face Encounter, Written Orders Prior to Delivery Requirements, and/or Prior Authorization" 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 CFR §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.

3.1 Master List of DMEPOS Items Potentially Subject to Face-to Face Encounter, Written Orders Prior to Delivery Requirements and/or Prior Authorization

3.1.1 Creation of the Master List of DMEPOS Items Potentially Subject to a Face-To-Face Encounter, Written Orders Prior to Delivery Requirements and/or Prior Authorization

The final rules 6050-F and 1713-F both created and streamlined a 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 $500 or greater (adjusted annually for inflation) or an average rental fee schedule of $50 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 2015 or later as having a high rate of fraud or unnecessary utilization; or

    b. Were listed in the 2018 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.

3.1.2 Maintenance of the Master List of DMEPOS Items Potentially Subject to a Face-To-Face Encounter, Written Orders Prior to Delivery Requirements and/or Prior Authorization

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 will be updated as needed and more frequently than annually (for example, to address emerging billing trends).
- 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 $500 or greater or an average monthly rental fee schedule of $50 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).

3.2 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.

4 Prior Authorization Request (PAR)

4.1 General PAR Documentation

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

A. Beneficiary Information (as written on their Medicare card):

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

B. Supplier Information:

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

C. Requestor Information:

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

D. 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.

4.1.1 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")

5 Timeline 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 previous prior authorization decisions.
- **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.

5.1 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.

6 Program Specifics

6.1 Program Specifics for Codes K0856 and K0861

6.1.1 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.

6.1.2 *Required Documentation*

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

- Written Order Prior to Delivery (WOPD)
- 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)

6.1.3 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 **10 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.

6.1.4 *Validation Period for Prior Authorization for Power Mobility Devices*

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

6.2 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

6.2.1 *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.

6.2.2 *Required Documentation*

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

- WOPD
- 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)

6.2.3 *Timeframe 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 **10 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.

6.2.4 *Validation Period for Prior Authorization Decisions for Power Mobility Devices*

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

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

6.3.1 *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.

6.3.2 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:

- WOPD

- 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.

6.3.3 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 **10 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.

6.3.4 Validation Period for Prior Authorization Decisions for Power Mobility Devices

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

6.4 Program Specifics for Codes K0800, K0801, K0802, K0806, K0807, and K0808

6.4.1 *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:

- K0800 - Power Operated Vehicle, Group 1 Standard, Patient Weight Capacity up to and including 300 pounds

- K0801 - Power Operated Vehicle, Group 1 Heavy Duty, Patient Weight Capacity, 301 To 450 Pounds

- K0802 - Power Operated Vehicle, Group 1 Very Heavy Duty, Patient Weight Capacity 451 To 600 Pound

- K0806 - Power Operated Vehicle, Group 2 Standard, Patient Weight Capacity Up to And Including 300 Pounds

- K0807 - Power Operated Vehicle, Group 2 Heavy Duty, Patient Weight Capacity 301 To 450 Pounds

- K0808 - Power Operated Vehicle, Group 2 Very Heavy Duty, Patient Weight Capacity 451 To 600 Pound

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on **March 30, 2022,** for dates of delivery on or after **April 13, 2022**.

All new rental series claims nationwide with a DOS on or after **April 13, 2022,** must have a prior authorization request on file.

6.4.2 *Required Documentation*

Documentation required for the prior authorization request package for K0800, K0801, K0802, K0806, K0807, and K0808 shall include:

- WOPD
- Face-to-Face Examination
- 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 and the Power Mobility Devices - Policy Article: A52498.

K0806, K0807, and K0808 are currently not covered as reasonable and necessary and will not be affirmed on prior authorization

6.4.3 *Timeframes for Review Decisions*

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within **10 business days** (excluding federal holidays and weekends) of receipt of documentation for the initial PA request.
- **Resubmission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within **10 business days** (excluding federal holidays and weekends) of receipt of documentation for the resubmission of the PA request.
- **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 PA request.

6.4.4 *Validation Period for Prior Authorization Decisions for Power Operated Vehicles*

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

6.5 Program Specifics for Codes E0193, E0277, E0371, E0372, and E0373

6.5.1 *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 E1093, E0277, E0371, E0372, 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.

6.5.2 *Required Documentation*

Documentation required for the prior authorization request package for E0193, E0277, E0371, E0372, and E0373 shall include:

- Standard Written Order (SWO)
- 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 (PRSS) – Group 2 (L33642) and the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Considerations.

6.5.3 *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 within **5 business days** (excluding federal holidays and weekends) of 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.

6.5.4 *Validation Period for Prior Authorization Decisions for Pressure Reducing Support Surfaces*

PAR decisions for these 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, 11:59 pm to furnish the PRSS. Otherwise, a new PAR will need to be submitted to restart the valid month time period.

6.6 Program Specifics for Codes L5856, L5857, L5858, L5973, L5980, and L5987

6.6.1 *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:

- L5856 - Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type

- L5857 - Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type

- L5858 - Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type

- L5973 - Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source

- L5980 - All lower extremity prostheses, flex foot system

- L5987 - All lower extremity prosthesis, shank foot system with vertical loading pylon

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 to accept prior authorization requests for codes L5856, L5857, L5858, L5973, L5980, and L5987 in California, Michigan, Pennsylvania, and Texas, one state from each DME MAC Jurisdiction, on August 18, 2020 for items furnished on or after September 1, 2020. [1]

Phase 2

- DME MACs will begin to accept prior authorization requests for codes L5856, L5857, L5858, L5973, L5980 and L5987 in all of the remaining states and territories in all four DME MAC jurisdictions on November 17, 2020 for items furnished on or after December 1, 2020.

6.6.2 *Required Documentation*

Documentation required for the prior authorization request package for L5856, L5857, L5858, L5973, L5980 and L5987 shall include:

- SWO

- Documentation from the medical record to support the medical necessity

Note: Suppliers are reminded that Section 1834(h)(5) of the Act states that for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's medical record to support documentation created by eligible professionals as described in section 1848(k)(3)(B) of the Act.

[1] The implementation of the prior authorization requirement for lower limb prosthetic codes L5856, L5857, L5858, L5973, L5980, and L5987 initially scheduled for the first four states for May 11, 2020 and the remaining states and territories initially scheduled for October 8, 200 were delayed due to the Covid-19 pandemic and public health emergency.

Documentation from a face-to-face encounter conducted by a treating practitioner, as well as documentation created by an orthotist or prosthetist becomes part of the medical records and if the orthotist or prosthetist notes support the documentation created by eligible professionals described in section 1848(k)(3)(B), they can be used together to support medical necessity of an ordered DMEPOS item. In the event the orthotist or prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

Further information regarding documentation requirements can be located within the LCD for Lower Limb Prostheses (LLP) (L33787) and the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Considerations.

6.6.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within **10 business days** (excluding federal holidays and weekends) of receipt of documentation for the initial PA requests.

- **Resubmission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within **10 business days** (excluding federal holidays and weekends) of receipt of documentation for the resubmission of the PA request.

- **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 PA request.

6.6.4 Validation Period for Prior Authorization Decisions for Lower Limb Prosthetics

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

6.7 Program Specifics for Codes L0648, L0650, L1832, L1833, and L1851

6.7.1 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:

- L0648 - Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

- L0650 - Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

- L1832 - Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L1833 - Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf

- L1851 - Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf

The prior authorization process for these codes will be implemented in three phases. Phase 1 limits the prior authorization requirement to 4 states (one state per DME MAC jurisdiction). Phase 2 expands the prior authorization requirement to twelve additional states (three states per DME jurisdiction). Phase 3 expands it to all remaining states.

Phase 1

- DME MACs will begin accepting prior authorization requests in New York, Illinois, Florida, and California on **March 30, 2022,** for items furnished on or after **April 13, 2022.**

Phase 2

- DME MACs will begin accepting prior authorization requests in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, Washington, on **June 28, 2022,** for items furnished on or after **July 12, 2022.**

Phase 3

- DME MACs will begin accepting prior authorization requests for all remaining States and territories on **September 26, 2022, f**or items furnished on or after **October 10, 2022.**

6.7.2 Required Documentation

Documentation required for the prior authorization request package for L0648, L0650, L1832, L1833, and L1851

- WOPD
- Face to Face Examination
- Documentation from the medical record to support the medical necessity

Note: Suppliers are reminded that Section 1834(h)(5) of the Act states that for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's medical record to support documentation created by eligible professionals as described in section 1848(k)(3)(B) of the Act.

Documentation from a face-to-face encounter conducted by a treating practitioner, as well as documentation created by an orthotist or prosthetist becomes part of the medical records and if the orthotist or prosthetist notes support the documentation created by eligible professionals described in section 1848(k)(3)(B), they can be used together to support medical necessity of an ordered DMEPOS item. In the event the orthotist or prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

Note: Further information regarding documentation requirements can be located within the LCD for Knee Orthoses (L33318) and the Knee Orthosis Policy Article (A52465); within the LCD for Spinal Orthoses: TLSO and LSO (L33790) and the Spinal Orthosis: TLSO and LSO Policy Article (A5200); and the Program Integrity Manual Program Integrity Manual (PIM 5.2) –

Items and Services Having Special DME Review Considerations.

6.7.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within **5 business days** (excluding federal holidays and weekends) of receipt of documentation for the initial PA request.

- **Resubmission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within 5 business days (excluding federal holidays and weekends) of receipt of documentation for the resubmission of the PA request.

- **Expedited**: Prior Authorization requests are processed in an expedited manner when the beneficiary's health/life is in jeopardy without the use of the orthotic device within the regular review timeframe; e.g., when a beneficiary suffers an acute injury to the knee or spine. 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 PA request. Suppliers shall ensure that the PAR clearly notes an expedited request and is completed accurately to ensure expeditious processing.

Note: Acute Situations: Due to the need for certain patients to receive an orthoses item that may otherwise be subject to prior authorization when the two-day expedited review would delay care and risk the health or life of the beneficiary, we are suspending prior authorization requirements for HCPCS codes L0648, L0650, L1832, L1833, and L1851 furnished under these circumstances:

- Claims for these HCPCS codes which meet the above description are to be billed using modifier ST and will not undergo prior authorization. These claims will instead be subject to 100% prepayment review.

- For suppliers furnishing these items under a competitive bidding program exception (as described in 42 CFR 414.404(b)), claims billed using modifiers KV, J5, or J4 would also convey that the DMEPOS item is needed immediately and therefore these modifiers will be

accepted in addition to the ST modifier. Ten percent of claims submitted using the KV, J5, or J4 modifiers for HCPCS L0648, L0650, L1833, and L1851 will be subject to prepayment review.

6.7.4 Validation Period for Prior Authorization Decision for Orthoses Codes

PAR decisions for these codes will remain valid for 60 days following the "affirmed" review decision. For example: if the PAR is affirmed on April 30th, the supplier has until June 28th to furnish the orthoses. Otherwise, a new PAR will need to be submitted to restart the valid 60-day period.

6.7.5 Special Considerations for Orthoses Subject to Competitive Bidding

For suppliers furnishing these items under a competitive bidding program exception (as described in 42 CFR 414.404(b)), claims billed with modifiers KV, J5, or J4 would convey that the DMEPOS item is needed immediately and therefore these modifiers will be accepted in addition to the ST modifier. Ten percent of claims submitted using the KV, J5, or J4 modifiers for HCPCS L0648, L0650, L1833, and L1851 will be subject to prepayment review.

7 Secondary Insurance

7.1 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[2].

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.

7.2 Another Insurance Company is Primary

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 the 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).

8 Supplier Telephone Inquiries

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

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

- 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.

9 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 send 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.)

10 Provisional Affirmative Prior Authorization 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.

10.1 Suppliers Action

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

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

- Furnish 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.
- 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.

11 Non-Affirmative Prior Authorization 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 required documentation 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 5 as it pertains to each DMEPOS item(s).

The submitter may resubmit another complete PAR with all documentation required as noted in the detailed decision letter. See Section 8 for instructions on resubmitting a PAR. Unlimited resubmissions are permitted.

11.1 Suppliers Action

Use the detailed decision letter to ensure that resubmitted PARs comply with all requirements. Resubmit a PAR, if appropriate.

11.1.1 *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.

12 Claim Submission

12.1 Affirmed Prior Authorization 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.

12.2 Non-Affirmed Prior Authorization 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 available.
- This claim could then be submitted to secondary insurance, if applicable.

12.3 Claims Submitted Without a Prior Authorization 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 CFR §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.
- Claims for L0648, L0650, L1833, and L1851 billed with modifier KV, J5, or J4 to indicate a CBP exception will not be subject to prior authorization requirements. See section 6.7.5 for more information.
- Claims for L0648, L0650, L1833, and L1851 billed with modifier ST to indicate an acute injury will not be subject to prior authorization requirements; however, will be subject to prepayment medical record review by the MAC as outlined in Internet Only Manual (IOM) 100-08 Ch.3. See section 6.7.3 for more information.

13 Special Claim Considerations

13.1 Advanced Beneficiary Notice

If an applicable claim is submitted without a PA decision and is flagged as having an ABN, it will be stopped for 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, § 40).

13.2 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.

13.3 Beneficiary Moves During Rental Series

	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 subsequent rentals using same UTN. System changes: No	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 not apply to services in the Non- PA state. Supplier discontinues using UTN on the subsequent rental claims in the Non-PA state.	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.

		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	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
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 Non-PA state.	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

		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	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
Change Supplier	UTN CWF HUPA record on file	UTN CWF HUPA record on file	No UTN No CWF HUPA record on file
Change Supplier **Same Jurisdiction**	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 supplier.	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.
Same Jurisdiction	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. 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.	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 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	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 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.

	System changes: No.		All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing. System changes: No.

14 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 CFR §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.