DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Supplier:

On September 1, 2012, the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare Prior Authorization of Power Mobility Devices (PMDs) Demonstration in selected states with high populations of fraud-and error-prone providers (California, Florida, Illinois, Michigan, New York, North Carolina, and Texas). Since the start of the demonstration expenditures and improper payments for PMDs have decreased. Due to the initial success of the demonstration, CMS is expanding it to 12 additional states: Pennsylvania, Ohio, Louisiana, Missouri, Maryland, New Jersey, Indiana, Kentucky, Georgia, Tennessee, Washington, and Arizona. The demonstration will end on August 31, 2015 for all states.

The purpose of this letter is to inform you that on October 1, 2014, the Medicare Fee-For-Service (FFS) Program will implement the expansion of the demonstration. In addition, we want to tell you about the new prior authorization process and inform you how to get more information.

The prior authorization process is for 7-element orders for PMDs written on or after October 1, 2014, and applies to beneficiaries who permanently reside in one of the states selected for the demonstration. The prior authorization process is available for the following Healthcare Common Procedure Coding System (HCPCS) codes for Medicare FFS payment:

- Group 1 Power Operated Vehicles (K0800 - K0802 and K0812)
- All standard power wheelchairs (K0813 - K0829)
- All Group 2 complex rehabilitative power wheelchairs (K0835 - K0843)
- All Group 3 complex rehabilitative power wheelchairs without power options (K0848 - K0855)
- Pediatric power wheelchairs (K0890 - K0891)
- Miscellaneous power wheelchairs (K0898)

Note: Group 3 complex rehabilitative power wheelchairs with power options (K0856 thru K0864) are excluded.

The goal of this program is to develop and demonstrate improved methods for the investigation and prosecution of fraud in the provision of PMDs. The CMS will test this process and compare the results to traditional pre-payment review to evaluate whether, and to what extent, the two processes are effective in investigating and prosecuting fraud.

What You Need to Know

It is important to keep in mind that the prior authorization demonstration does not create new documentation requirements for physicians/practitioners and suppliers - it simply requires them to provide the information earlier in the claims process. The prior authorization request can be submitted by either the physician/practitioner or the supplier (referred to as a "submitter"). The submitter will fax, mail, or submit through esMD (Electronic Submission of Medical Documentation) via the contractor's online web portal the prior authorization request with accompanying documentation to the appropriate Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) based on the state where the beneficiary resides.

- For beneficiaries residing in MD, NJ or PA; submit to NHIC, Corp. http://www.medicarenhic.com/dme/default.aspx
- For beneficiaries residing in IN, KY or OH; submit to National Government Services http://www.ngsmedicare.com
- For beneficiaries residing in GA, LA or TN; submit to CGS Administrators, LLC http://www.cgsmedicare.com/jc/index.html
- For beneficiaries residing in AZ, MO or WA; submit to Noridian Administrative Services, LLC http://www.noridianmedicare.com/dme/

More information about relevant fax numbers and addresses are available at the respective websites and in the Demonstration Operational Guide at http://go.cms.gov/PADemo.

The submitter of a prior authorization request must include **all relevant documentation to support Medicare coverage of the PMD item.** This includes:

1. the 7-element written order for the PMD;
2. documentation of the face-to-face examination where the physician/practitioner evaluated the patient's need for the PMD;
3. the detailed product description; and
4. other relevant documentation if necessary.

Regardless of which entity is functioning as the submitter, the Local Coverage Determination (LCD) requires physicians/practitioners to originate the 7- element order, face-to-face encounter documentation, and any other clinical documentation such as progress notes that are necessary to support the medical necessity of the item. In addition, the supplier is required to complete the detailed product description.

After receipt of all relevant documentation from the submitter, the respective DME MAC will review and communicate within 10 business days a decision on whether the PMD meets all Medicare coverage requirements. In emergency situations the physician/practitioner may seek an expedited review of the prior authorization request. If approved, the DME MAC will review and communicate a decision on the prior authorization request within 2 business days.

The DME MAC will send the decision letter regarding prior authorization (affirmative or non-affirmative) to the physician/practitioner, the supplier, and the Medicare beneficiary. The decision letter will also contain information about why the prior authorization request is non-affirmative. In addition, a prior authorization unique tracking number (UTN) will be provided when a decision is made. This number should be submitted on the claim for the PMD. When submitting a claim, the UTN is entered in Item 23 of the 1500 Claim Form. For electronic claims the UTN is submitted at either loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1).

If the prior authorization request is non-affirmed by the DME MAC, the submitter may revise and resubmit the prior authorization request. The DME MAC will make every effort to conduct a review and communicate a decision within 20 business days on each subsequent prior authorization request. If a claim, with a non-affirmative decision, is still submitted by the supplier to the DME MAC for payment, it will be denied. The supplier and/or beneficiary can use the claim appeal process for a claim denial but not a non-affirmative decision from the DME MAC.

Starting on January 1, 2015, CMS will assess a 25 percent payment reduction on a supplier's payable claim when the first claim was not preceded by a prior authorization request.
To avoid the payment reduction, the supplier must include the prior authorization tracking number on the claim. This 25 percent reduction in the Medicare payment is for each covered claim not preceded by a prior authorization request, with one important exception: if a competitive bidding contract supplier submits a payable claim for a beneficiary with a permanent residence in a competitive bidding area, the competitive bid supplier will receive the contractual single payment amount under their contract. These suppliers must continue to adhere to all other requirements of the demonstration.

Additional information about the demonstration is available at:

PMD Prior Authorization Demonstration Website
http://go.cms.gov/PADemo

Power Mobility Device (PMD) Demonstration Operational Guide
http://go.cms.gov/PMD_Guide

Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements
http://go.cms.gov/PMD-CompReq

Local Coverage Determination for PMDs
http://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html

If you have specific questions that are not addressed on these CMS websites please contact pademo@cms.hhs.gov