DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF COMMUNICATIONS

# FACT SHEET

**FOR IMMEDIATE RELEASE**
December 19, 2016
Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

## CMS Announces First Two Items of Durable Medical Equipment Subject to Prior Authorization under the National Program

### OVERVIEW

In December 2015, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that established a national prior authorization process as a condition of payment for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization. Prior authorization helps make sure that all relevant coverage, coding, and clinical documentation requirements are met before the item is furnished to the beneficiary and before the claim is submitted for payment. Prior authorization requires the same information necessary to support Medicare payment today, just earlier in the process. Prior authorization is an effective way to reduce or prevent questionable billing practices and improper payments for DMEPOS items.

This fact sheet provides an overview of the national prior authorization program for certain DMEPOS items, announces the initial items under the Required Prior Authorization List, and identifies the impacted geographic locations.

### THE MASTER LIST

The Master List is the set of 135 DMEPOS items identified as being frequently subject to unnecessary utilization. Items that meet the following criteria are included on the Master List, and thus potentially subject to prior authorization: items on the DMEPOS Fee Schedule with an average purchase fee of $1,000 or greater, or an average rental fee schedule of $100 or greater, (adjusted annually for inflation) and the subject of:

- HHS Office of the Inspector General (OIG) or U.S. Government Accountability Office (GAO) reports that are national in scope and published since 2007, or
- Comprehensive Error Rate Testing program's Annual Medicare Fee-for-Service Improper Payment Rate Reports and/or the Supplementary Appendices for the Medicare Fee-for-Service Improper Payment Rate Report since 2011.

### REQUIRED PRIOR AUTHORIZATION LIST

Presence on the Master List does not automatically create a prior authorization requirement for that item. Rather, CMS selects items from the Master List to be subject to mandatory prior authorization as a condition for payment ("Required Prior Authorization List"). CMS selects items based on several factors, including, but not limited to: the frequency with which the item(s) is billed for payment, systems capabilities, and operational impacts (i.e., supplier educational needs, DME MAC workload). In making these selections, CMS balances provider and supplier burden with protecting the Medicare Trust Funds and beneficiary access. As announced in the Federal Register (here), published on December 19, 2016, CMS released the initial Required Prior Authorization List of DMEPOS items that require prior authorization as a condition of payment. Two Healthcare Common Procedure Coding System (HCPCS) codes for power wheelchairs are included on this list for initial implementation in four select states (one per DME Medicare Administrative Contractor (MAC) jurisdiction) beginning March 20, 2017:

**Codes:**

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

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

**States:**

- New York –Jurisdiction A
- Illinois –Jurisdiction B
- West Virginia –Jurisdiction C
- Missouri –Jurisdiction D

CMS notes that the prior authorization process for these two HCPCS codes will be expanded nationwide in July 2017.

**PRIOR AUTHORIZATION PROCESS**

As of March 6, 2017, suppliers and beneficiaries may begin to submit prior authorization requests to their DME MACs for items K0856 or K0861 in the 4 selected states. Beginning March 20, 2017, claims submitted for payment that include one of the above codes (as identified on the "Required Prior Authorization List") must have been subject to prior authorization and received a decision. Prior authorization is a condition of payment for these items. Suppliers (or beneficiaries) must ensure that all relevant documentation is submitted for review prior to the item being furnished and the claim being submitted for processing. CMS or its contractors will review the prior authorization request and provide a provisional affirmation or non-affirmation decision. A claim submitted with a provisional affirmation decision will be paid so long as all other requirements are met. A claim submitted with a non-affirmation decision or without a decision will be denied. Unlimited resubmissions of prior authorization requests are allowed.

Medicare or its review contractor will make a reasonable effort to render an initial prior authorization decision within 10 business days and will make a reasonable effort to render a resubmission prior authorization decision within 20 business days. An expedited review process of 2 business days will be available to address circumstances where applying the standard timeframe for making a prior authorization decision could seriously jeopardize the life or health of the beneficiary. The request for an expedited review must provide rationale supporting the request.

Detailed information regarding the national prior authorization program for certain DMEPOS items, including links to both the Master and Required Prior Authorization Lists, is located on the CMS website. Suppliers or beneficiaries may refer to the operational guide for detailed instructions on the process for requesting and receiving a prior authorization decision, as well as the process for including the relevant information on subsequent claim submissions. Support materials will be posted on the individual DME MAC websites, and also posted on the CMS website, available here.

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