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Inclusion of Power Mobility Device Codes in the Prior Authorization Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items

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PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for providers and suppliers prescribing, ordering, or billing Medicare Administrative Contractors (MACs) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

This Special Edition alerts suppliers to the inclusion of power mobility device codes in the DMEPOS prior authorization program. Please be sure your billing staffs are aware of these updates.

BACKGROUND

The goal of prior authorization for select DMEPOS items is to reduce unnecessary usage and aberrant billing for these devices. Medicare pays for DMEPOS items only if the beneficiary's medical record contains sufficient documentation of the beneficiary's medical condition to support the need for the type and quantity of items ordered. In addition, all required documentation elements outlined in Medicare policies must be present for the claim to be paid. Improper payments are made for claims that do not comply with one or more Medicare coding, billing or coverage requirements. This prior authorization process will ensure that Medicare coverage and documentation requirements are likely met before the item or service is rendered and a claim is submitted.

Prior authorization has the added benefit of providing a supplier some assurance of payment for items receiving a provisional affirmation decision. Beneficiaries benefit by knowing that they will not incur financial liability for non-covered items and/or will have information regarding coverage prior to receiving the item. Prior authorization enhances the coordination and collaboration of care between the provider and the supplier to deliver the most appropriate DMEPOS item to meet the needs of the beneficiary.

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CMS implemented the Prior Authorization of Power Mobility Devices (PMDs) Demonstration on September 1, 2012, in California, Illinois, Michigan, New York, North Carolina, Florida and Texas. On October 1, 2014, the demonstration was expanded to include Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri, Washington and Arizona. The demonstration was extended for 3 years and will end on August 31, 2018.

Under the Centers for Medicare & Medicaid Services (CMS) final rule 6050-F, *Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies; Final Rule*, CMS can select items that are frequently subject to unnecessary utilization from a Master List to be subject to prior authorization.

CMS selected two group 3 power wheelchair codes (K0856 and K0861) to be subject to required prior authorization as a condition of payment beginning March 20, 2017, in Illinois, Missouri, New York and West Virginia. Required prior authorization was expanded to the remaining states beginning July 17, 2017.

At the conclusion of the Power Mobility Device Demonstration, CMS will require prior authorization for applicable demonstration codes under the prior authorization process for certain DMEPOS items as listed in the below table. Prior authorization of these items is a condition of payment when furnished to beneficiaries in all states and US territories on or after September 1, 2018.

HCPCs Codes for Prior Authorization

HCPCS CODES	Long Description
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, captain's 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, captain's 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, captain's chair, patient weight capacity up to and including 300 pounds

HCPCS CODES	Long Description
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, captain's 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, captain's 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, captain's 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, captain's 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, captain's 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, captain's 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, captain's chair, patient weight capacity up to and including 300 pounds

HCPCS CODES	Long Description
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, captain's 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, captain's 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, captain's 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, captain's chair, patient weight capacity 601 pounds or more

Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) Codes

1. When **no prior authorization request was submitted** and the **GA modifier (indicating a signed Advance Beneficiary Notice (ABN)) is appended** and the ABN is valid, you will receive the following codes on your Electronic Remittance Advice (835) and the Standard Paper Remit:

- CARC 197: Precertification/authorization/notification absent.
- RARC N210: Alert: You may appeal this decision
- Group Code PR

Note: MACs will suspend claims to request documentation and conduct a review of the ABN when there is no prior authorization request and the claim is submitted with the GA modifier.

2. If the claim is denied when **no prior authorization request** was submitted and **no valid GA** modifier is appended you will receive the following codes on your Electronic Remittance Advice (835) and the Standard Paper Remit:

- CARC 197: Precertification/authorization/notification absent
- RARC N210: Alert: You may appeal this decision
- Group Code CO

3. **If the claim is denied as a result of a non-affirmed decision**, you will receive the following codes on your Electronic Remittance Advice (835) and the Standard Paper Remit:

- CARC 39: Services denied at the time authorization/pre-certification was requested
- RARC N210: Alert: You may appeal this decision
- Group Code CO

Note: If a GY modifier (beneficiary liable) or EY modifier (no physician or other licensed health care provider order for this item or service) is present, the claim will be process according to the modifier, taking precedence over the non-affirmative prior authorization request processing.

Important Notes and Dates

- In states that are not currently participating in the PMD Demonstration, DME MACs will begin accepting prior authorization requests for these PMDs on August 18, 2018.
- In states currently participating in the PMD Demonstration, DME MACs will continue accepting prior authorization requests for these PMDs without interruption. DME MACs will cease accepting prior authorization requests for items under the PMD Demonstration that are not being added to the Required Prior Authorization List on August 18, 2018.
- MACs will honor all valid requests for prior authorization under the Power Mobility Device Demonstration up to and including August 17, 2018.
- MACs will honor prior authorization affirmation decisions on HCPCS codes in the Power Mobility Device Demonstration, which may be applied to the rental series for claims with a delivery date on or after September 1, 2018.
- Your MAC will educate stakeholders on the requisite information and timeframes for prior authorization submissions, and the vehicle(s) for submitting such information to your MAC for assessment. Your MAC will make sure requesters/submitters are aware of the timeframes for contractors to render prior authorization decisions, dependent upon the type of submission.
- MACs will accept the prior authorization requests by fax, mail, electronic submission of medical documentation (esMD) or CMS approved electronic portal from the supplier or beneficiary.

- MACs will send written decisions to prescribing physicians, upon request, when the physician includes their return address and the MAC has verified through the medical documentation that the physician has the authority to receive the letter.
- MACs will allow an unlimited number of resubmissions for each prior authorization request. Resubmissions are subsequent prior authorization requests submitted after the initial prior authorization request was submitted, reviewed, and a non-affirmed decision was made. Resubmissions may include additional documentation.
- MACs will consider an expedited prior authorization request if the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary.

ADDITIONAL INFORMATION

You can review more information on the prior authorization process for certain DMEPOS at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html. For more information on prior authorization, you may want to review MM9940 (*The Process of Prior Authorization).*

If you have questions, your MAC may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
August 7, 2018	Initial article released.