

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



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- [“The Basics of Internet-based PECOS for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\) Suppliers Fact Sheet,”](#) ICN 904283, Downloadable only.

MLN Matters® Number: SE1231 **Revised**

Related Change Request (CR) #: N/A

Related CR Release Date: N/A

Effective Date: N/A

Related CR Transmittal #: N/A

Implementation Date: N/A

### **Medicare Demonstration Allows for Prior Authorization for Certain Power Mobility Devices (PMDs)**

**Note:** This article was revised on August 7, 2014, to add information regarding the addition of 12 states (Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington) to the demonstration.

#### **Provider Types Affected**

This MLN Matters® Special Edition Article is intended for Medicare Fee-For-Service (FFS) suppliers who submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Power Mobility Devices (PMDs) in the demonstration states (Arizona, California, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, and Washington). Physicians and other practitioners who prescribe these devices for Medicare beneficiaries who reside in the demonstration states may also benefit from this article.

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## What You Need to Know

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PMDs includes power wheelchairs and Power-Operated Vehicles (POVs) that a beneficiary uses in their home (42 CFR 410.38(c)). Power wheelchairs are four-wheeled motorized vehicles that are steered by operating an electronic device or joystick to control direction and turning. POVs are three- or four-wheeled motorized scooters that are operated by a tiller. PMDs are classified as items of Durable Medical Equipment (DME) for Medicare coverage purposes.

**Power Operated Vehicles (POVs or scooters):** Under the Mobility Assistive Equipment (MAE) National Coverage Determination (NCD), POVs may be medically necessary for beneficiaries who cannot effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home using a cane, walker, or manually operated wheelchair.

In addition, the beneficiary must demonstrate sufficient strength and postural stability to safely and effectively operate the POV in the home environment. These vehicles are appropriately used in the home environment to improve the ability of chronically-disabled persons to cope with normal domestic, vocational, and social activities.

**Power (Motorized) Wheelchairs:** Under the MAE NCD, power wheelchairs may be medically necessary for beneficiaries who cannot effectively perform MRADLs in the home using a cane, walker, manually operated wheelchair, or a POV/scooter. In addition, the beneficiary must demonstrate the ability to safely and effectively operate the power wheelchair. Most beneficiaries who require power wheelchairs are non-ambulatory and have severe weakness of the upper extremities due to a neurological or muscular condition.

This article provides guidance on upcoming changes to billing requirements for PMDs. Please make sure your medical and billing staff is aware of these changes.

## Background

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The Centers for Medicare & Medicaid Services (CMS) is committed to reducing waste, fraud, and abuse in the Medicare Fee-For-Service Program. CMS is conducting a 3-year demonstration to ensure that Medicare only pays for PMDs that are medically necessary under existing coverage guidelines for orders written on or after September 1, 2012. The demonstration was initially implemented in seven States with high rates of Medicare fraud: California, Texas, Florida, Michigan, Illinois, North Carolina, and New York. **Due to the demonstration's early success, the demonstration will be expanded to 12 additional states: Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington.** These 19 States accounted for 71 percent of the total Medicare PMD expenditures in 2011. The expanded demonstration will be effective for orders written on or after October 1, 2014. This

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demonstration targets a claim type known to be susceptible to fraud and that has had high rates of improper payments.

The demonstration implements a prior authorization request process for PMDs for Medicare beneficiaries residing in the demonstration States. The prior authorization request can be completed by the ordering physician/ practitioner or the DME supplier. The physician/practitioner or supplier who submits the request is referred to as the “submitter.” The DME MAC will review the prior authorization request.

The following HCPCS codes are subject to prior authorization process in the demonstration States:

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

**Note:** Group 3 complex rehabilitative power wheelchairs with power options (K0856 through 0864) are excluded.

The prior authorization process allows submitters to send a prior authorization request for a PMD before the supplier delivers the device to the beneficiary’s home. All relevant documentation to support Medicare coverage of the PMD should be submitted to the appropriate DME MAC for an initial decision. The request package should include the face-to-face encounter documentation, the 7 element order, the detailed product description, and whatever additional documentation is necessary to show that coverage requirements have been met.

Physicians/ practitioners can bill G9156 after he/she submits an initial prior authorization request to partially compensate physicians for the additional time spent in submitting the prior authorization request.

Please note, that the prior authorization demonstration does not create new documentation requirements for physician/practitioners or suppliers. It simply allows them to provide the information earlier in the claims process.

After receiving the prior authorization request, the DME MAC will conduct a medical review and communicate the coverage decision to the beneficiary, physician/practitioner and supplier within 10 business days of receiving the request. Under rare, emergency circumstances, Medicare will complete this process within 2 business days. Claims with affirmative prior authorization requests will be paid so long as all other Medicare

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coverage and documentation requirements are met. Claims with a non-affirmative prior authorization decision will not be paid by Medicare.

If a second prior authorization request is resubmitted after a non-affirmative decision on an initial prior authorization request, the DME MAC will conduct a medical review within 20 business days and communicate a coverage decision to the beneficiary, physician/practitioner, and supplier. Tricare programs and private insurance use similar time frames for prior authorization of non-emergent services.

Suppliers may choose to submit claims without a prior authorization decision. However, the claim will be subject to prepayment review. CMS currently assesses a payment reduction for orders written on or after December 1, 2012, in the initial demonstration states. CMS will begin to assess a payment reduction for noncompliance with the prior authorization process for any orders written on or after January 1, 2015, in the 12 additional states. If the claim satisfies Medicare's coverage and documentation requirements, it will be paid with a 25 percent reduction in Medicare reimbursement. The 25 percent reduction will not be applied if the claim is submitted by a contract supplier under the Medicare DMEPOS Competitive Bidding Program and the claim is for a PMD provided to a Medicare beneficiary residing in a competitive bidding area.

Extensive education and outreach to physicians, treating practitioners, suppliers, and Medicare beneficiaries on the requirements of the prior authorization process has been initiated by CMS and will continue after the implementation of the demonstration.

Additional information and updates on the demonstration will be posted at <http://go.cms.gov/PADemo> on the CMS website.

Utilizing the prior authorization request process will help CMS improve methods for identifying and prosecuting fraud and prevent improper payments. This will help ensure that Medicare only pays for PMD claims that are medically necessary under existing coverage guidelines. It will also provide valuable data for tackling the continued challenges the Medicare program faces.

## Key Points

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CMS initially conducted this three year demonstration in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas based on the beneficiary's address as reported to the Social Security Administration and recorded in Medicare's Common Working File (CWF). This demonstration will expand to Arizona, Maryland, Georgia, Indiana, New Jersey, Kentucky, Louisiana, Missouri, Ohio, Pennsylvania, Tennessee, and Washington for orders written on or after October 1, 2014. This demonstration involves all four DME MACs.

Competitive bidding would not affect participation in this demonstration. However, if a contract supplier submits a payable claim for a beneficiary with a permanent residence, according to the CWF, in a competitive bidding area, that supplier would receive the single payment amount under the competitive bid contract. In other words, the single

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payment amount rules for contract suppliers outlined in 42 CFR 414.408 are not affected by this demonstration.

This demonstration will help ensure that no Medicare payments are made for PMDs unless a beneficiary's medical condition warrants the equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's right to receive quality products from accredited suppliers. It will also help protect beneficiaries from unexpected financial liability.

## Additional Information

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The Prior Authorization of Power Mobility Device Section of the CMS web page is at <http://go.cms.gov/PADemo> on the CMS website.

MLN Matters® Special Edition Article SE1112, "Power Mobility Device Face-to-Face Examination Checklist," is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1112.pdf> on the CMS website.

The Medicare Learning Network® (MLN) fact sheet, "Power Mobility Devices (PMDs): Complying with Documentation & Coverage Requirements," is available at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD\\_DocCvg\\_FactSheet\\_ICN905063.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/PMD_DocCvg_FactSheet_ICN905063.pdf) on the CMS website.

Please visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> for the latest MLN educational products designed to help Medicare FFS Providers understand – and avoid – common billing errors and other improper activities.

You may want to review MLN Matters® article MM8056, which is available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8056.pdf> on the CMS website. The article clarifies that only one G9156 code (for preauthorization incentive payment) may be billed, per beneficiary, per PMD even if the physician or treating practitioner must resubmit the prior authorization request.

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