Good afternoon and welcome to the Jurisdiction B Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Ask-the-Contractor Teleconference (ACT) call. This call is being hosted by the DME Provider Outreach and Education (POE) team for Jurisdiction B. My name is Ashley DeCoteau and I am a Provider Outreach & Education Sr. Analyst with Jurisdiction B. Our topic for today’s ACT call is the Condition of Payment Prior Authorization Program and we ask that you keep your questions strictly to this topic.

On the next slide you will see a disclaimer and all it says is that we have put our best effort in to ensuring that we have provided the most current and up to date information available. Please note all questions must be asked verbally, we will not be accepting questions through the questions tab as the call is being recorded and a transcript will be posted within 30 days.

Once you are connected to the audio portion of our webinar today, be sure that you enter the pin number that displays on your screen into your telephone keypad. In order to un-mute your line so you can ask a question during the Q&A portion, you will need to have entered your pin number.

The purpose of this presentation is to provide an overview of the required prior authorization process for 33 Power Mobility Device (PMD) codes. The PMD Demonstration has ended. Advanced Determination of Medicare Coverage (ADMC) is no longer available for codes K0835-K0843, and K0848-K0855. The ADMC program reviewed the base code and all accessories; however, the condition of payment prior authorization does NOT review all accessories, rather, ONLY those accessories on which the base is contingent.

First, I will provide some background information on the program and recent expansion. CMS published a regulation, in December of 2015, which created a list of 135 items frequently subject to unnecessary utilization and potential candidates for prior authorization, which is referred to as the Master List (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/FINAL-RULE-MASTER-LIST-of-DMEPOS-Subject-to-Frequent-Unnecessary-Utilization-2018-03-30.pdf). CMS may select items from the Master List to be subject to required prior authorization as the condition of payment. The existence of an item on the Master List alone does not mean that the item is subject to required prior authorization.

The rule also requires that CMS announce through a Federal Register Notice the items which will be subject to the required prior authorization process, which was issued on December 21, 2016 for the first two items that are subject to prior authorization. Initially two power wheelchair codes K0856 - Group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds power wheelchair and the K0861 - Group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds power wheelchair were subject to the prior authorization as a condition of payment when it implemented nationally in July of 2017.

For dates of service on or after September 01, 2018, thirty one additional PMD codes have been added to the required prior authorization process as a condition of payment. There is a list of codes in the CMS Special Edition article 18010 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18010.pdf), and you can also confirm the specific codes in our new Condition of Payment Look-Up Tool (https://www.cmsmedicare.com/medicare_dynamic/jb/cppa.asp), which is available on our Condition of Payment page under Medical Review.

The condition of payment prior authorization program does not change the coverage policies or the documentation requirements. It just requires this information earlier in the process and prior to the item being delivered.

There are certain claim types that are excluded from any PA program as described in the CMS operational guide. This includes Veterans Affairs, Indian Health Services, Medicare Advantage, and Part A and Part B Demonstrations. Rep payee claims are not excluded.

Now we will review the information that is required when submitting a Prior Authorization Request (PAR). Submitters are encouraged to include the following data elements in all PARs to avoid potential delays in processing:

- Beneficiary Information (as written on their Medicare card)
  - Beneficiary Name
  - Medicare number
  - Date of birth
  - Address
  - Date of service, and
  - Diagnosis code
Ask the Contractor Teleconferences (ACT)

September 19, 2018

- Supplier Information
  - Supplier name
  - National Supplier Clearinghouse (NSC) number
  - National Provider Identification (NPI)
  - Supplier address, and
  - Phone number
- Additional Information
  - HCPCS code
  - Submission date
  - Indication if it is an initial or subsequent submission, and
  - If the request is expedited and the reason why

The PAR must also include documentation from the medical record to support the medical necessity of the PMD including but is not limited to: The Seven Element Order, Detailed Product Description (DPD), Face-to-Face examination, the specialty evaluation performed by Licensed/Certified Medical Professional (LCMP), attestation statement showing no financial relationship between the supplier and the LCMP, evidence of RESNA Assistive Technology Practitioner (ATP) certification and involvement, the home assessment/visit, if available at the time of the PAR, and documentation from the medical record to support the medical necessity additional information regarding documentation requirements can be located within the Local Coverage Determination (LCD) for Power Mobility Devices (L33789), and the standard documentation requirements.

The request can be submitted by either the supplier or the beneficiary, and it can be mailed, faxed, or submitted through Electronic Submission of Medical Documentation System (ESMD) indicate document/content type “8.4”.

Next, let’s talk about timeframes. Initial requests should have a postmark for a decision within 10 business days, whereas the resubmitted request, those that have been previously requested, a non-affirmed decision was sent, and then they are resubmitted. These should have a new decision within 20 days. Expedited requests are also available for situations that could jeopardize the life or health of the Medicare beneficiary, and these decisions will be communicated within two days.

CGS will send the requester of the prior authorization a letter providing their decision either affirmative or non-affirmative. Medicare beneficiary can receive a copy upon request if the request is non-affirmed, the letter will provide a detailed explanation for the decision. The decisions on individual accessories will not be included in the decision letter.

The letter will be sent to the correspondence address on file with the NSC for the supplier or the address on file with the Social Security Administration for the beneficiary.

This brings us to the Unique Tracking Number (UTN). When decision letters, either affirmed or non-affirmed, are sent to the supplier, they will contain an UTN. All claims submitted must include the UTN in order for payment to be received. Claims for which there is an associated provisional affirmation prior authorization decision will be paid in full so long as all the appropriate documentation and all the relevant Medicare coverage and clinical documentation requirements are met, and the claim was billed and submitted correctly.

A requester can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request. There are an unlimited number of resubmissions that are allowed; however, a non-affirmative prior authorization request decision is not appealable. So, to reiterate, the request can be resubmitted an unlimited number of times until the problems are resolved. Detailed decisions for the non-affirmation will be provided in the letter so that it should help you have as few resubmissions as possible. A requester can, however, forego the resubmission process, provide the DMEPOS item and submit the claim for payment, but that claim will be denied, although appeal rights are available in that situation. Claims for items subject to the required prior authorization submitted without a prior authorization determination and their corresponding UTN will be automatically denied as prior authorization for these items are a condition of payment.


CGS is also working on a self-service tool for codes that fall under the Condition of Payment Prior Authorization to help suppliers with choosing equipment based on the patient’s weight. We anticipate the self-service tool will be ready later this fall so look for a listserv announcement.

Before we open the phone lines for your questions, I want to make sure everyone is aware of the new Medicare cards that began distribution in April 2018. A new, randomly generated Medicare Beneficiary Identifier, or MBI, will replace the SSN-based Health Insurance Claim Number. The new MBIs will be noticeably different than the HICN and RRB numbers; they will be 11 characters in length and made up of only numbers and uppercase letters with no special characters. For new enrollees in fee-for-service Medicare, they will only receive the new MBI cards. For current Medicare beneficiaries, CMS is mailing new cards to them over the next few months.
There will be a transition period that will allow claims to be submitted with either the HICN or the MBI. This transition period is scheduled from April 1, 2018, through December 31, 2019. Beginning January 1, 2020, suppliers must use the MBI on all claims submitted to the DME MACs. If you would like more information about these new Medicare cards, Provider Outreach will offer a monthly webinar through the end of 2018. There is also a link from the Jurisdiction B home page to the New Medicare Card Web page (https://www.cms.gov/Medicare/New-Medicare-Card/index.html) on the CMS website.

As I prepare to queue your questions, please note that we will only take questions over the telephone as this call is being recorded for transcription purposes. To raise your hand, simply click on the icon of the hand. I will announce you and unmute your individual line so that you can ask a question. Also remember that no specific claim information or Medicare beneficiary’s private health information should be verbalized. I will now give you just a moment to prepare your questions and raise your hands.

While we are waiting for questions, I did want to announce that we will continue to do education on the Condition of Payment Prior Authorization. We do have another webinar coming up on September 27. That webinar will go into a little more detail about the program. If you or anyone else in your company did not get to attend today’s event, you can find information to register in the Education (https://www.cgsmedicare.com/jb/education/webinars.html) section of our website.

We still do not have any questions from our attendees so I will review some questions that Jurisdiction C had from their Condition of Payment ACT call they recently hosted.

- We did have some requests for the ACT call presentation. The presentation for this is not available but the resources that I mentioned in this presentation will be included in the transcript. We will have a full transcript of this call and I will include links that are in this presentation.

- Are accessories included in Condition of Payment Prior Authorization? The only time accessories would be reviewed is if the base is contingent on that accessory. For example, if it is tilt or recline. All of the accessories must be included on the DPD but they will not be reviewed as part of the Condition of Payment Prior Authorization.

We still do not have any questions from our attendees so I will bring this call to an end. Thank you to everyone for joining us and have a good day.