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MEDICARE PRIOR AUTHORIZATION CONDITION OF PAYMENT FOR CERTAIN POWER MOBILITY DEVICES
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Dear Physician,

Effective for power wheelchairs with dates of delivery on or after July 22, 2019, claims to Medicare must be associated with a prior authorization request as a condition of payment. Lack of a provisionally affirmed prior authorization request will result in the supplier of the wheelchair receiving a claim denial. Prior authorization has been in effect for codes K0856 and K0861 since July 17, 2017, and Group 1, Group 2 and Group 3 power wheelchair categories (K0813-K0829, K0835-K0843, K0848-K0855) since September 1, 2018. This program change impacts additional products in the Group 3 power wheelchair product category (K0857, K0858, K0859, K0860, K0862, K0863, and K0864). Complete descriptions of the power wheelchairs impacted may be found in the Power Mobility Devices (PMD) Local Coverage Determination (LCD) (L33789, https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33789) and related Policy Article (A52498, https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=52498) on the Medicare Coverage Database.

When these items are ordered, the DME supplier must submit a prior authorization request which includes all required documentation prior to providing the item to the Medicare beneficiary.

In order for Medicare to provide a provisionally affirmed prior authorization request and reimbursement for the PMD, there are several requirements that must be met:

1. There must be a face-to-face encounter with a physician (as defined in section 1861(r)(1), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) addressing the beneficiary's mobility needs.

2. There must be a history and physical examination by the physician or other medical professional focusing on an assessment of the beneficiary's mobility limitation and needs. The results of this evaluation must be recorded in the beneficiary's medical record.

3. The physician who conducts the face-to-face encounter, must also write the Standard Written Order (SWO) for the PMD base item. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed.

4. The SWO for the PMD base item must be completed within 6 months of the face-to-face encounter and provided to the supplier prior to delivery of the PMD.

You may write the SWO for the PMD base item only after the visit and examination are complete. This SWO must contain the following elements:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
    - The description can be either a general description (such as wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
    - For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (list each separately).
- Quantity to be dispensed, if applicable
- Treating practitioner name or NPI
- Treating practitioner's signature

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You must forward a copy of the face-to-face evaluation and SWO to the supplier. You should also include copies of previous notes, consultations with other physicians, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to document the severity of your patient's ambulatory problems.

After the supplier receives your SWO, they may also prepare a second SWO that describes additional options and accessories to be added to the power mobility base device. You must review it, and if you agree with what is being provided, sign and return it to the supplier. If you do not agree with any part of the SWO, you should contact the supplier to clarify what you want the beneficiary to receive.

This information is not intended to serve as a substitute for the complete DME MAC Power Mobility Devices LCD and related policy articles. It is only a synopsis detailing the highlights of documentation. Please refer to the complete LCD and related policy article in the Medicare Coverage Database (http://www.cms.gov/medicare-coverage-database).

Suppliers may ask you to provide the documentation from your medical records to assure that Medicare will pay for these mobility devices and that your patient will not be held financially liable. Providing this documentation is in compliance with the Health Insurance Portability and Accountability Act Privacy Rule. No specific authorization is required from your patient. Also note that you may not charge the supplier or the beneficiary to provide this information. Please cooperate with the supplier so that they can provide the mobility devices that are needed by your patient.

Your participation in this process and cooperation with the supplier will allow your patient to receive the most appropriate type of mobility equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

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