



Prior Authorization Process for Pressure Reducing Support Services



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Purpose

- To provide an overview of the prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as outlined in section 1834(a)(15) of Title 18 of the Social Security Act and Centers for Medicare & Medicaid Services (CMS) regulation 6050, codified at 42 C.F.R. 405.926 and 414.234.
- To provide specific operational guidance related to the prior authorization process for Pressure Reducing Support Surfaces (PRSS).

Prior Authorization Process for Certain DMEPOS Items

- Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item is provided to a Medicare patient and before a claim is submitted for payment.
- Prior authorization helps to ensure that all applicable Medicare coverage, payment, and coding rules are met before an item is provided.
- A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the DMEPOS item likely meets Medicare's coverage, coding, and payment requirements.

Who and What

Who

- Suppliers and Medicare patients

What – Group 2 PRSS

- E0193: Powered air flotation bed (low air loss therapy)
- E0277: Powered pressure-reducing air mattress
- E0371: Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
- E0372: Powered air overlay for mattress, standard mattress length and width
- E0373: Non-powered advanced pressure reducing mattress

Where and When

Phase 1

- Effective in California, Indiana, North Carolina, and New Jersey
States are assigned based upon the beneficiary's permanent address (per CMS Internet Only Manuals (IOM) 100-04 , Ch.1, § 10.1.5.1).
- All new support services claims for E0193, E0277, E0371, E0372, and E0373 with a date of service or delivery on or after July 22, 2019

Phase 2

- Effective nationally for dates of service or delivery beginning October 21, 2019

Note: Prior authorization of these items for patients with a representative (rep) payee are exempt during the initial four-state rollout. Once the prior authorization program becomes national, this exclusion will not apply.

Why

Prior Authorization

- Suppliers will know earlier in the process whether Medicare will likely pay for the DMEPOS item.
- Medicare patients will know, prior to receipt of the item, whether Medicare will likely pay for the item.
- Durable Medical Equipment (DME) Medicare Administrative Contractor (MACs) can assess medical information, prior to making a claim determination, to provide provisional feedback on the item to be furnished.

Status Quo

- Medicare coverage policies and documentation requirements are unchanged.
- DME MACs will continue to conduct the reviews.
- Advance Beneficiary Notice (ABN) policies and claim appeal rights are unchanged.

The prior authorization process developed for E0193, E0277, E0371, E0372, and E0373 does not create new documentation requirements.

Regularly required documentation must be submitted earlier in the process.

Prior Authorization Request Content

Request needs to identify:

- The beneficiary's name, Medicare Beneficiary Identifier (MBI), date of birth, address
- The supplier's name, NSC number, NPI number, address, and phone number
- The requester's name, telephone number, NPI (if applicable), and address
- Submission date
- Healthcare Common Procedure Coding System (HCPCS) code
- Indicate if the request is an initial or resubmission review
- Indicate if the request is expedited and the reason why

Prior Authorization Request Content (continued)

- Requests also need to include (from the provider):
 - A Detailed Written Order (DWO)
 - Documentation from the medical record to support the medical necessity of the item
- A Prior Authorization Request (PAR) Coversheet is available on the DME MAC websites

Prior Authorization Request Submission

- The supplier or the Medicare patient may submit the prior authorization request.
- The request can be:
 - Mailed
 - Faxed*
 - Submitted through the Electronic Submission of Medical Documentation (esMD) system**
 - Submitted through the MAC's provider portal (Note: when available)

* Must adhere to Acceptable Risk Safeguards ([ARS](#))

** More info about Electronic Submission of Medical Documentation (esMD) can be found at www.cms.gov/esMD.

Review Timeframes

- **Initial Requests**

- The DME MAC will ensure the written determination is faxed, postmarked, or delivered electronically by within **5 business days**.

- **Resubmitted Requests**

- The request submitted with additional documentation after the initial prior authorization request was non-affirmed.
- The DME MAC will ensure the written determination is faxed, postmarked, or delivered electronically within **5 business days**.

Expedited Review Requests

- **Expedited Circumstances**

- If it is determined that delays in receipt of a Prior Authorization decision could jeopardize the life or health of the beneficiary, then the DME MAC will process the PAR under an “expedited” timeframe.
- The DME MAC will communicate a determination within **2 business days** of receipt of the expedited request.
- Suppliers are encouraged to use fax, esMD, or the MAC Portal to avoid delays with mailing.

Detailed Decision Letter

- DME MACs will send the requester of the prior authorization (i.e., the entity who will submit the claim for payment) a letter providing their prior authorization decision (i.e., affirmative or non-affirmative).
- Medicare patients can receive a copy, upon request. DME MACs may also send these letters voluntarily.
- Prescribing physicians can receive a copy of the decision letter upon request.
- If the request is non-affirmed, the letter will provide a detailed explanation for the decision.

Unique Tracking Number

- Decision letters for both affirmed and non-affirmed decisions will contain a Unique Tracking Number (UTN).
- Claims submitted must include the UTN to receive payment.

When a Prior Authorization Request is Submitted and Affirmed

- Claims for which there is an associated provisional affirmative prior authorization decision will be paid in full, so long as all of the appropriate documentation and all relevant Medicare coverage and clinical documentation requirements are met and the claim was billed and submitted correctly.
- Generally, claims that have an affirmative prior authorization decision will not be subject to additional review.
 - Claims may be chosen as part of the CERT sample (random) or by the UPIC (if there are concerns of fraud or gaming).

When a Prior Authorization Request is Submitted but Non-Affirmed

- A requester can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request.
 - Unlimited resubmissions are allowed; however, a non-affirmative prior authorization request decision is not appealable.

or

- A requester can forego the resubmission process, provide the DMEPOS item(s), and submit the claim for payment.
 - The claim will be denied.
 - All appeal rights are available.

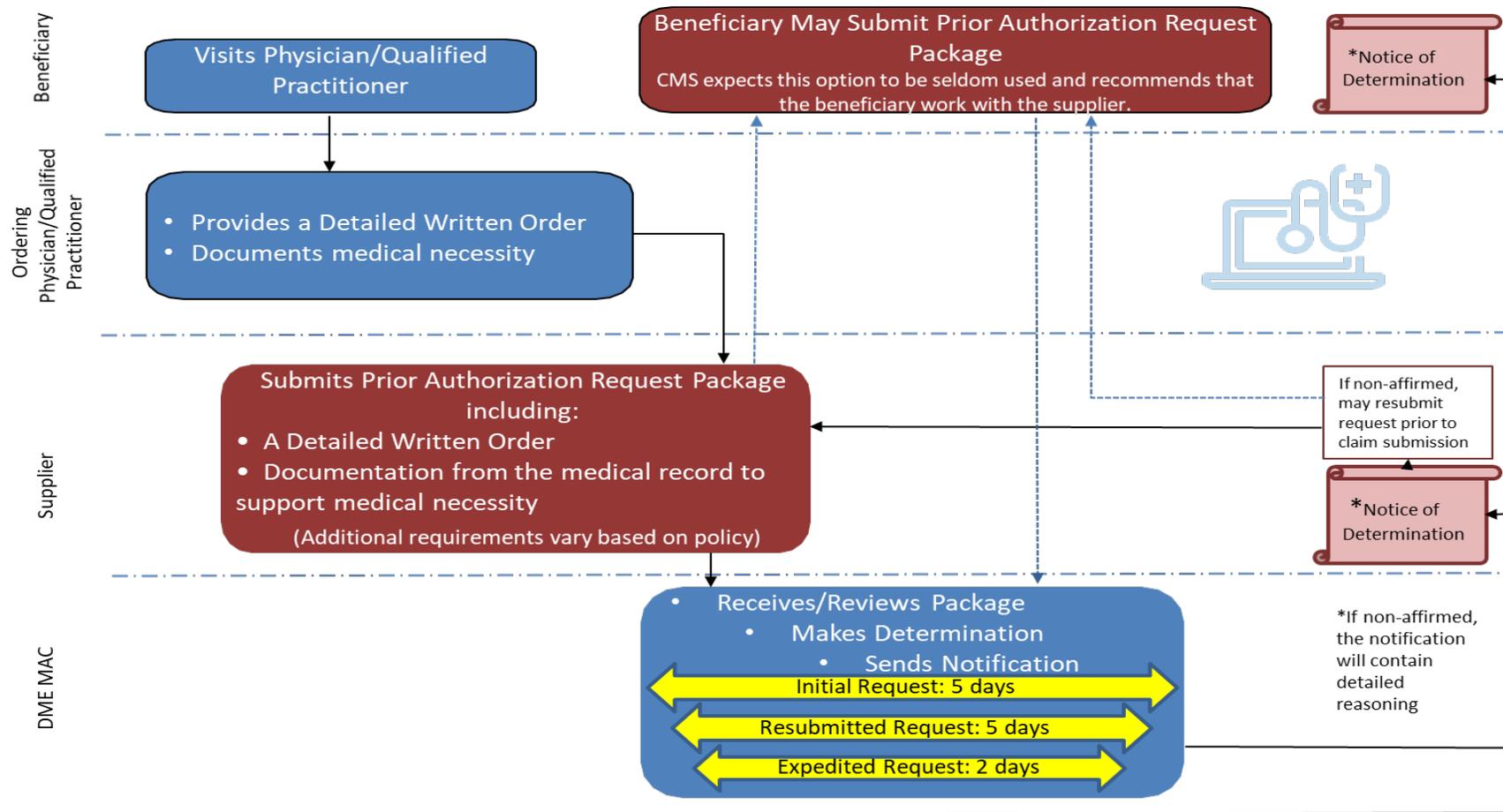
When a Prior Authorization Request is Not Submitted

- As described in 42 C.F.R. §§ 405 and 414, if an item is selected for required prior authorization under the program, then submitting a prior authorization request is a condition of payment.
- Claims for items subject to required prior authorization submitted without a prior authorization determination and a corresponding UTN will be automatically denied.

Educational Outreach for Non-Affirmed Requests

- DME MACs have special tracking for requests that are not approved due to documentation errors, where the patient may otherwise meet Medicare's coverage criteria.
- Suppliers with these documentation errors receive individualized education and are encouraged to resubmit their request to ensure their patients receive the necessary item for which they are covered.

Prior Authorization Process for Certain DMEPOS Items – Flow Chart

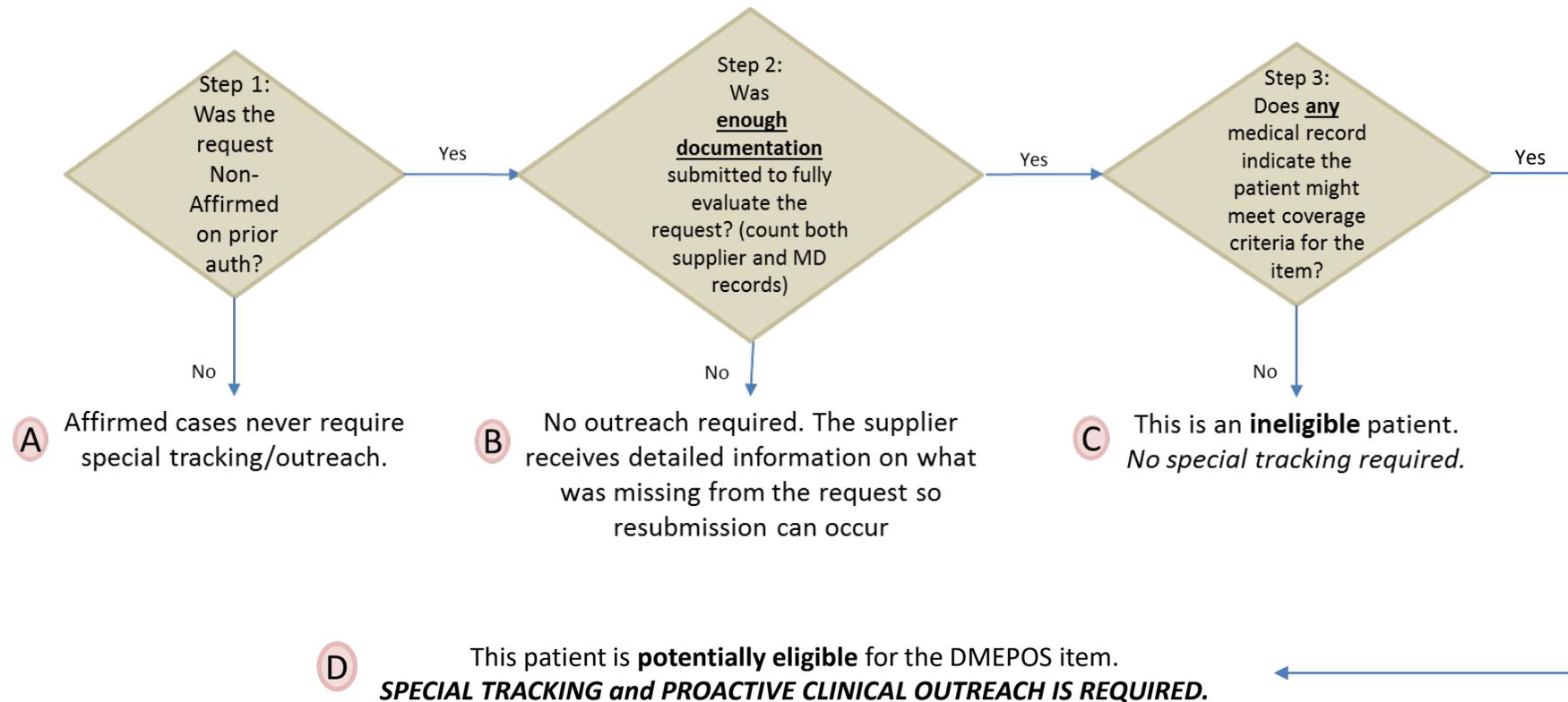


❖ The information on this chart is applicable to the following healthcare common procedure coding system (HCPCS) codes: E0193, E0277, E0371, E0372 and E0373.
 ❖ The Practitioner and/or Beneficiary may request a copy of the Notice of Determination. As a courtesy, the DME MAC may send the notice to the beneficiary voluntarily.



Prior Authorization Process for Certain DMEPOS Items – Decision Tracking Tool

DMEPOS Prior Authorization Special Tracking Decision Tool



Scenarios

	Prior authorization request is:	The DME MAC decision is:	The supplier (or beneficiary) chooses to:	The DME MAC will:
1	Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met)
2	Submitted	Non- Affirmative	a. Submit a claim	a. Deny the claim
			b. Fix and resubmit the request	b. Review the resubmission and render a decision
3	Not submitted	N/A	Submit a claim	Deny the claim

Medicare Patient Impact

- The benefit is not changing.
- Medicare patients will know earlier in the payment process if an item will likely meet Medicare's coverage requirements.
- Medicare patients may receive a copy of their prior authorization decision, upon request.
- Dual eligible coverage is not changing. A non-affirmed prior authorization decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage.
- Private insurance coverage is not changing.

CMS Oversight

- CMS will contract with an independent evaluator to analyze the impacts of prior authorization, including impacts to patient care, access to service, and overall expenditures and savings.
- CMS will conduct regular reviews of DME MAC prior authorization decisions.
- CMS will discuss its findings with and seek feedback from the DME MACs during regularly scheduled meetings.

DME MAC Perspective

- DME MAC Medical Directors will discuss coverage criteria and clinical feedback on these Group 2 PRSS codes
- Local Coverage Decision (LCD) L33643 and Policy Article for Pressure Reducing Support Surfaces - Group 2: [LCD 33642](#)

DME MAC Information

- Jurisdictions A and D: Noridian
 - <https://med.noridianmedicare.com/>
- Jurisdictions B and C: CGS
 - <http://www.cgsmedicare.com/>

Summary

	Phase I	Phase II
Codes:	E0193, E0277, E0371, E0372, E0373	E0193, E0277, E0371, E0372, E0373
Where:	CA, IN, NJ, NC	Nationwide
PAR submissions begin:	July 8, 2019	October 7, 2019
Impacted Dates of Service:	July 22, 2019	October 21, 2019
Submitted by:	Supplier or beneficiary	Supplier or beneficiary

Additional Information

- CMS is also adding seven HCPCS codes for Power Mobility Devices (PMDs) to the Required Prior Authorization List: K0857, K0858, K0859, K0860, K0862, K0863, and K0864.
 - Implemented nationwide beginning July 22, 2019.
 - Review timeframes for PMDs will remain the same (10 business days for initial requests, 20 business days for resubmitted requests, and 2 business days for expedited requests).
- All HCPCS codes previously added to the Required Prior Authorization List will continue to be subject to the requirements of PA
 - Required Prior Authorization List: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf

CMS Resources

- Local Coverage Decision (LCD) and Policy Article for Pressure Reducing Support Surfaces - Group 2, available at: [LCD 33642](#)
- Prior Authorization Web Site: go.cms.gov/DMEPOSPA
- Feedback: DMEPOSPA@cms.hhs.gov



Questions?