MEDICARE PRIOR AUTHORIZATION FOR CERTAIN POWER MOBILITY DEVICES AND ACCESSORIES

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Dear Clinician,

CMS requires that claims submitted to Medicare for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) HCPCS codes be associated with a prior authorization request (PAR) as a condition of payment. Lack of a provisionally affirmed PAR will result in the supplier of the item receiving a claim denial. This process applies to certain Power Mobility Devices (PMDs). For additional information on prior authorization requirements, see the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) webpage dedicated to prior authorization (Required Prior Authorization Programs - JA DME - Noridian (noridianmedicare.com) and Required Prior Authorization Programs - JD DME - Noridian (noridianmedicare.com)).

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

In order for Medicare to provide a provisionally affirmed prior authorization request and reimbursement, there are specific requirements that must be met.

Required Prior Authorization and Required Face-to-Face Encounter and Written Order Prior to Delivery List

Prior authorization is required for power wheelchair (PWC) HCPCS codes K0813-K0816, K0820-K0829, K0835-K0843 and K0848-K0864 and power operated vehicle (POV) HCPCS codes K0800-K0802 and K0806-K0808. (Note: HCPCS codes K0806, K0807 and K0808 have added capabilities not needed for use in the home. A prior authorization request for these codes will be provisionally non-affirmed as not reasonable and necessary.)

For Medicare to provide reimbursement for the above power mobility device (PMD) codes, the following requirements must be met:

1. A face-to-face (F2F) encounter - a history and physical examination by the treating practitioner addressing the patient's mobility limitations and needs - has been conducted via an in-person or Medicare-approved telehealth visit. The face-to-face encounter must be provided to the supplier prior to delivery of the PMD.

2. A written order prior to delivery (WOPD) has been completed. The WOPD must be completed by the same treating practitioner who completed the F2F encounter. Additionally, the WOPD may only be written after the completion of the face-t0-face encounter and the date of the WOPD must be within 6 months following the face-to-face encounter date. The WOPD must be provided to the supplier prior to delivery of the PMD.

3. Documentation from the medical records support the medical necessity of the PMD.

In addition to the above requirements, the following must also be met for PWC codes that are Group 2 single and multiple power option bases and Group 3 bases (Note: For some PWC bases, the coverage criteria for certain options/accessories must be met in order to meet coverage criteria for the base. Therefore, the appropriate supporting documentation, as outlined in the local coverage determinations (LCDs) and LCD-related Policy Articles, for the PWC base should be submitted as part of the prior authorization request.):

1. A standard written order (SWO) for related options/accessories, signed by you. (If you do not agree with any part of the SWO, you should contact the supplier to clarify what the beneficiary is to receive.)

2. A specialty (mobility) evaluation performed by a licensed/certified medical professional (LCMP), such as a physical therapist (PT) or occupational therapist (OT).

   - You, as the treating practitioner, must co-sign, date, and document agreement with the LCMP's specialty evaluation.
   - Often performed simultaneously, the LCMP's specialty evaluation and your F2F encounter with the patient are commonly referred to collectively as "the F2F." The requirement for the WOPD to be completed within 6 months after the F2F encounter is based on the date the patient is seen by you for the F2F encounter. It is not based on the date the patient is referred to the LCMP for a specialty evaluation, or the date you co-signed, dated, and indicated agreement with the LCMP's specialty evaluation.

3. An attestation of "no financial involvement" from the LCMP, if the specialty evaluation is to be considered part of the F2F encounter. (Exception: If the supplier is owned by a hospital, the PT or OT working in the inpatient or outpatient hospital setting may perform the specialty evaluation as part of the F2F encounter.)

4. A RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs has direct, in-person involvement in the wheelchair selection.

You must provide a copy of the F2F encounter, WOPD and SWO, if applicable, to the supplier. You should also include copies of previous notes, consultations with other physicians and therapists, 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.

Voluntary Prior Authorization

As of March 20, 2023, Medicare began accepting voluntary prior authorization requests for certain PMD accessories, when submitted with the related PMD base code that requires prior authorization, for dates of service on or after April 6, 2023. Voluntary prior authorization requests for accessories do not create a condition of payment and are not mandatory. PMD accessory HCPCS codes E0950, E0955, E1002-E1010, E1012, E1029, E1030, E2310-E2313, E2321-E2330, E2351, E2373, E2377, E2601-E2608, E2611-E2616, E2620-E2625, K0020, and K0195 are those for which a voluntary prior authorization may be submitted.

In addition to providing records in support of the PMD base, the order for the accessories and medical records supporting the need for the accessories must be submitted with the voluntary prior authorization request.

Medical Necessity Documentation

The F2F encounter must include a complete physical examination, documentation of your patient's medical condition(s) and past medical history relevant to their limitations in accomplishing mobility-related activities of daily living (MRADLs). **The medical record documentation should paint a picture of your patient's functional abilities and limitations in their home on a typical day, and should contain as much objective data as possible.** The physical examination should be focused on the body systems that are responsible for the patient's ambulatory difficulty or impact on the patient's ambulatory ability. Vague terms such as "difficulty walking" or "upper extremity weakness" are insufficient since they do not objectively address the mobility limitation or provide a clear picture of the patient's mobility deficits when participating in MRADLs. A power mobility device is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs their ability to perform their MRADLs **within the home**. Thus, in your documentation, you must clearly distinguish your patient's mobility needs within the home from their needs outside the home.

Please record the F2F encounter (and the LCMP's specialty evaluation, if applicable) in your usual medical record-keeping format. Many suppliers may provide forms for you to complete. Some suppliers try to create the impression that these forms are a sufficient record of the F2F encounter and the LCMP's specialty evaluation; however, based upon our auditing experience, most of them are not.

The information in this letter is not intended to serve as a substitute for the LCDs and LCD-related Policy Articles. It is only a synopsis detailing the highlights of documentation. Please refer to the Power Mobility Devices LCD (L33789) and LCD-related Policy Article (A52498), the Wheelchair Options/Accessories LCD (L33792) and LCD-related Policy Article (A52504), and the Wheelchair Seating LCD (L33312) and LCD-related Policy Article (A52505), which are located in the 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 device your patient needs.

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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