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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS-6080-N2]

Medicare Program; Update to the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items That Require Prior Authorization as a Condition of Payment

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Update to list.

SUMMARY: This document announces the addition of 12 Healthcare Common Procedure Coding System (HCPCS) codes to the Required Prior Authorization List of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items that require prior authorization as a condition of payment.

DATES: Phase one of implementation is effective on [Insert date 90 days after the date of publication in the **Federal Register**]. Phase two of implementation is effective on [Insert date 180 days after the date of publication in the **Federal Register**].

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:

I. Background

Sections 1832, 1834, and 1861 of the Social Security Act (the Act) establish that the provision of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are covered benefits under Part B of the Medicare program.

Section 1834(a)(15) of the Act authorizes the Secretary to develop and periodically update a list of DMEPOS items that the Secretary determines, on the basis of prior payment experience, are frequently subject to unnecessary utilization and to develop a prior authorization process for these items.

In the December 30, 2015 final rule (80 FR 81674) titled "Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," we implemented section 1834(a)(15) of the Act by establishing an initial Master List (called the Master List of Items Frequently Subject to Unnecessary Utilization) of certain DMEPOS that the Secretary determined, on the basis of prior payment experience, are frequently subject to unnecessary utilization and by establishing a prior authorization process for these items. In the same final rule, we also stated that we would inform the public of those DMEPOS items on the Required Prior Authorization List in the **Federal Register** with 60-day notice before implementation. The Required Prior Authorization List specified in § 414.234(c)(1) is selected from the Master List of Items Frequently Subject to Unnecessary Utilization (as described in § 414.234(b)(1)), and items on the Required Prior Authorization List require prior authorization as a condition of payment.

In addition to the prior authorization process for certain DMEPOS items that we established under section 1834(a)(15) of the Act, on September 1, 2012, we implemented the Medicare Prior Authorization for Power Mobility Devices (PMDs) Demonstration that would operate for a period of 3 years (September 1, 2012 through August 31, 2015). This demonstration was established under section 402(a)(1)(J) of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1(a)(1)(J)), which authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program. The demonstration was initially implemented in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas. These states were selected for the demonstration based upon their history of having high levels of improper payments and incidents of fraud related to PMDs. On October 1, 2014, we expanded the demonstration to 12 additional states (Pennsylvania, Ohio, Louisiana, Missouri, Washington, New Jersey, Maryland, Indiana, Kentucky, Georgia, Tennessee, and Arizona) that had a history of high expenditures and improper payments for PMDs based on 2012 billing data. On July 15, 2015, we announced we were extending the demonstration for 3 years, through August 31, 2018. The demonstration ended as scheduled on August 31, 2018.

In a June 5, 2018 **Federal Register** document, we announced that, effective September 1, 2018, we would add 31 HCPCS codes that were a part of the PMD demonstration to the Required Prior Authorization List (83 FR 25947).

II. Provisions of the Document

The purpose of this document is to inform the public that we are updating the Required Prior Authorization List of DMEPOS items that require prior authorization as a condition of payment to include seven additional power mobility devices and five pressure reducing support surfaces. These 12 items are on the Master List of Items Frequently Subject to Unnecessary Utilization. To assist stakeholders in preparing for implementation of the prior authorization program, we are providing 90 days' notice.

The following seven HCPCS codes for PMDs are being added to the Required Prior Authorization List:

HCPCS Code	Description
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid set/back, patient weight 301 to 450 pounds
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds
K0860	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds
K0863	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more

In phase one of implementation, which begins as specified in the DATES section of this document, we will implement a prior authorization program for these seven HCPCS codes for PMDs nationwide. The nationwide prior authorization program for these seven HCPCS code will continue during phase 2. We believe prior authorization of these seven additional HCPCS codes for PMDs will help further our program integrity goals of reducing fraud, waste, and abuse, while protecting access to care.

The following five HCPCS codes for Support Surfaces are also being added to the Required Prior Authorization List:

HCPCS Code	Description
E0193	Powered Air Flotation Bed (Low Air Loss Therapy)
E0277	Powered pressure-reducing air mattress
E0371	Nonpowered advance pressure reducing overlay for mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
E0373	Nonpowered advanced pressure reducing mattress

The CMS' Comprehensive Error Rate Testing (CERT) program continues to estimate high rates of improper payments for support surface codes. Since 2015, the estimated improper payment rate for these codes is over 59 percent, with an estimated improper payment rate of 75.2 percent, or over $18 million in projected improper payments for fiscal year 2018.

We will implement a prior authorization program for these five HCPCS codes for Support Surfaces in two phases. This phased-in approach will allow us to identity and resolve any unforeseen issues by using a smaller claim volume in phase one before nationwide implementation occurs in phase two. In phase one of implementation, which begins as specified in the DATES section of this document, we will limit the prior authorization requirement to one state in each of the four DME Medicare Administrative Contractors (MAC) geographic jurisdictions, as follows: California, Indiana, New Jersey, and North Carolina. In phase two, which begins as specified in the DATES section of this document, we will expand the program to the remaining states.

We believe prior authorization of these five HCPCS codes for Support Surfaces will help further our program integrity goals of reducing fraud, waste, and abuse, while protecting access to care.

These additional 12 HCPCS codes will be subject to the requirements of the prior authorization program for certain DMEPOS items as outlined in § 414.234. All 33 HCPCS codes currently on the Required Prior Authorization List (81 FR 93636 and 83 FR 25947) will continue to be subject to the requirements of prior authorization as well.

Prior to furnishing the item to the beneficiary and prior to submitting the claim for processing, a requester must submit a prior authorization request that includes evidence that the item complies with all applicable Medicare coverage, coding, and payment rules. Consistent with § 414.234(d), such evidence must include the order, relevant information from the beneficiary's medical record, and relevant supplier-produced documentation. After receipt of all applicable required Medicare documentation, CMS or one of its review contractors will conduct a medical review and communicate a decision that provisionally affirms or non-affirms the request.

We will issue specific prior authorization guidance in subregulatory communications, including final timelines, which are customized for the DMEPOS items subject to prior authorization, for communicating a provisionally affirmed or non-affirmed decision to the requester. In the December 30, 2015 final rule (80 FR 81694), to allow us to safeguard beneficiary access to care, we stated that this approach to final timelines provides the flexibility to develop a process that involves fewer days, as may be appropriate. If at any time we become aware that the prior authorization process is creating barriers to care, we can suspend the program.

The updated Required Prior Authorization list is available in the download section of the following CMS website: https://www.cms.gov/Research-Statistics-Data-and-

Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html. We will post additional educational resources to the website.

III. Collection of Information Requirements

This document announces the addition of DMEPOS items on the Required Prior Authorization List and does not impose any new information collection burden under the Paperwork Reduction Act of 1995. However, there is an information collection burden associated with this program that is currently approved under OMB control number 0938–1293 which expires on March 31, 2022.

Dated: March 19, 2019.

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Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

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