



**MEDICARE PRIOR AUTHORIZATION CONDITION
OF PAYMENT FOR CERTAIN POWER MOBILITY DEVICES**

Revised July 2019

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 statutory requirements that must be met:

1. There must be an in-person visit with a physician specifically addressing the patient's mobility needs.
2. There must be a history and physical examination by the physician or other medical professional (see below) focusing on an assessment of the patient's mobility limitation and needs. The results of this evaluation must be recorded in the patient's medical record.
3. A prescription must be written AFTER the in-person visit has occurred and the medical evaluation is completed. This prescription has seven (7) required elements (see below).
4. The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.

You may write a prescription for a power mobility device ONLY after the visit and examination are complete. This prescription must contain the following seven elements:

1. Beneficiary's name
2. Description of the item that is ordered. This may be general - e.g., "power operated vehicle," "power wheelchair," or "power mobility device" - or may be more specific.
3. Date of **completion** of the face-to-face examination
4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
5. Length of need
6. Physician's signature
7. The date the prescription was written

You must forward a copy of the face-to-face evaluation and your seven-element prescription to the supplier within 45 days from the completion of the face-to-face mobility exam. 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 order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. You should review it and, if you agree with what is being provided, sign, date and return it to the supplier. If you do not agree with any part of the detailed product description, 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 (<https://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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