Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items Operational Guide

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1. Purpose

The purpose of this Operational Guide is to interpret and clarify the prior authorization (PA) program authorized by the Social Security Act (The Act) at §1834(a)(15) and implemented by the Centers for Medicare & Medicaid Services (CMS) Prior Authorization Process for Certain DMEPOS Items final rule. The final rules, CMS-650-F and CMS-1713-F were codified at 42 Code of Federal Regulations (CFR) §405 and §414.

The intended audience for this operational guide is Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) and Medicare participating DME suppliers that provide (and beneficiaries who receive) durable medical equipment, prosthetics, orthotics, and supplies that are frequently subject to unnecessary utilization, as described in 42 CFR§405. These guidelines aim to provide operational guidance and do not alter the requirements described in 42 CFR §405 and §414. In addition, these guidelines do not alter or conflict with any Medicare coverage, coding, and pricing policies.

This Operational Guide was developed based on input from the CMS review contractors. This is a working document and is subject to change at any given time.

2. DMEPOS Benefit

For any service or item to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

The payment rules for Medicare coverage of DMEPOS are located in Title XVIII of the Social Security Act, §1834(a), including the Secretary's authority to prior authorize items frequently subject to unnecessary utilization.

The scope and conditions for payment of DMEPOS items is codified at 42 CFR §410.38. The ability to prior authorize DMEPOS items subject to frequent unnecessary utilization is further codified in regulation, at 42 CFR §405 and §414.

The CMS provides additional guidance through Internet-Only Manuals, including the Medicare Benefit Policy Manual 100-02, Ch. 15 and Medicare Program Integrity Manual 100-08, Ch. 5.

The CMS posts updates regarding DMEPOS items on its public website, on the Durable Medical Equipment (DME) Center webpage, and updates regarding this PA program on its PA webpage, Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, Supplies Items.

The CMS websites are provided as a resource and are not meant to provide an all-

inclusive list of applicable statutory, regulatory, or sub-regulatory requirements.

3. Program Overview

This section gives an overview of the requirements described in 42 CFR §405 and §414. The program requirements described in these sections are applicable to the Prior Authorization of Certain DMEPOS created by final rules.

The final rules can be found at:

- CMS-650-F:https://www.federalregister.gov/documents/2016/12/21/2016-30273/medicare-program- implementation-of-prior-authorization-process-for-certain-durable-medical- equipment

- CMS-1713-F:https://www.federalregister.gov/documents/2019/11/08/2019-24063/medicare-program-end-stage-renal-disease-prospective-payment-system-payment-for-renal-dialysis

As described in 42 CFR §405 and §414, CMS will maintain a "Master List of Items Potentially Subject to a Face-To-Face Encounter, Written Orders Prior to Delivery Requirements, and/or Prior Authorization" that fit the prescribed criteria and *may* be selected for PA, and "The Required Prior Authorization List" comprised of a smaller subset of DMEPOS items which CMS has selected for PA. As described in 42 CFR §405 and §414, if an item is selected for prior authorization under the program, then submitting a PAR is a condition of payment. It is important to note that CMS will be selecting such DMEPOS item(s) based on a number of factors, including, but not limited to, administrative burden and systems capabilities. CMS publishes in the Federal Register and posts on the CMS PA Website the Required PA List. As noted earlier, items appearing on the Required PA List require PA as a condition of payment.

3.1. Master List of DMEPOS Items Potentially Subject to Face-to-Face Encounter, Written Orders Prior to Delivery Requirements and/or Prior Authorization

3.1.1. Creation of the Master List of DMEPOS Items Potentially Subject to a Face-To-Face Encounter, Written Orders Prior to Delivery Requirements and/or Prior Authorization

The final rules CMS-650-F and CMS-1713-F both created and streamlined a Master List that includes certain DMEPOS items potentially subject to PA, which meet the following criteria:

1. Appear on the DMEPOS Fee Schedule list.

2. Have an average purchase fee of $500 or greater (adjusted annually for inflation) or an average rental fee schedule of $50 or greater (adjusted annually for inflation). (These dollar amounts

are referred to as the payment threshold); and

3. Meet either of the following:

    a. Were identified in a General Accountability Office (GAO) or Department of Health and Human Services Office of Inspector General (OIG) report that is national in scope and published in 2015 or later as having a high rate of fraud or unnecessary utilization; or

    b. Were listed in the 2018 or later Comprehensive Error Rate Testing (CERT) program's Annual Medicare Fee for Service (FFS) Improper Payment Rate Report Durable Medical Equipment (DME) Report's Service Specific Overpayment Rate Appendix.

3.1.2 Maintenance of the Master List of DMEPOS Items Potentially Subject to a Face-To- Face Encounter, Written Orders Prior to Delivery Requirements and/or Prior Authorization

We notify the public annually of any additions and deletions from the Master List by posting the notification in the Federal Register and on the CMS PA website.

- The Master List will be updated as needed and more frequently than annually (for example, to address emerging billing trends).

- Items that are discontinued or are no longer covered by Medicare are removed from the Master List.

- Items remain on the Master List for 10 years from the date the item was added to the Master List.

- Items are updated on the Master List when the Healthcare Common Procedure Coding System (HCPCS) codes representing an item have been discontinued and cross walked to an equivalent item.

- Items are removed from the list sooner than 10 years if the purchase amount drops below the payment threshold (currently an average purchase fee of $500 or greater or an average monthly rental fee schedule of $50 or greater).

- Items that age off the Master List because they have been

on the list for 10 years can remain on or be added back to the Master List if a subsequent GAO/OIG, or CERT DME and/or DMEPOS Service Specific Report(s) identifies the item to be frequently subject to unnecessary utilization.

- Items on the Master List identified by a GAO/OIG, or CERT DME, and/or DMEPOS Service Specific Report(s) while on the Master List will remain on the list for 10 years from the publication date of the new report(s).

3.2 The Required Prior Authorization List

Presence on the Master List will not automatically require PA. In order to balance the need to minimize provider and supplier burden with our need to protect the Medicare Trust Funds, the PA program will be limited to a subset of items from the Master List, which CMS has selected based on a variety of factors to be placed on the "Required Prior Authorization List". For such CMS identified items, prior authorization is a condition of payment.

CMS will publish The Required Prior Authorization List in the Federal Register and on the CMS PA website.

4 Prior Authorization Request (PAR)

4.1 General PAR Documentation

Submitters are encouraged to include the following data elements in all PARs to avoid potential delays in processing:

A. Beneficiary Information (as written on their Medicare card):
- Beneficiary Name
- Beneficiary Medicare Number (also known as the MBI)
- Beneficiary Date of Birth
- Beneficiary Address
- Place of Service
- Diagnosis Code

B. Supplier Information:
- Supplier Name
- Supplier National Provider Enrollment (NPE) Number
- Supplier National Provider Identification
- Supplier Address
- Supplier Phone Number

C. Requestor Information:
- Requestor Name

- Requestor Phone Number
- NPI (if applicable)
- Requestor Address

D. Other Information:
- HCPCS Code,
- Submission Date, and
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why
- Indicate if the request includes an upgrade

Submitters should note that the **beneficiary and supplier** addresses listed in the PAR **will not** be used by the DME MACs when sending review decision letters. The decision letters for suppliers will be made electronically available or mailed to the supplier address on file with the NSC and mailed to the beneficiary address on file with the Social Security Administration.

Additional Required Documentation

- Documentation from the medical record to support the medical necessity of the items, and
- Any other relevant documents as deemed necessary by the DME MAC to process the PAR.

4.1.2 Methods for Sending a PAR

Submitters have the following options for submitting PARs to the DME MACs:
- mail,
- fax,
- electronic submission of medical documentation (esMD), or
- Internet based provider portals (DME MAC specific).

For more information about esMD, see www.cms.gov/esMD or contact your DME MAC.

MAC Contact Information:

For beneficiaries residing in **Jurisdiction A** states send requests to:

Fax Number: 701-277-7891
Street Address: Noridian Healthcare Solutions Jurisdiction A Medical Review -PAR
900 42nd Street S
P.O Box 6742
Fargo, ND 58108-6742
esMD: (indicate document/content type "8.4")

For beneficiaries residing in **Jurisdiction B** states send requests to:

Fax Number: 615-660-5992
Street Address: CGS-DME Medical Review Prior Authorization
P.O Box 23110
Nashville, TN 37202-4890
esMD: (indicate document/content type "8.4")

For beneficiaries residing in **Jurisdiction C** states send requests to:

Fax Number: 615-664-5960
Street Address: CGS-DME Medical Review Prior Authorization
P.O. Box 24890 Nashville, TN 37202-4890
esMD: (indicate document/content type "8.4")

For beneficiaries residing in **Jurisdiction D** states send requests to:

Fax Number: 701-277-7891
Street Address: Noridian Healthcare Solutions Jurisdiction D Medical Review - PAR
PO Box 6742
Fargo, ND 58108-6742
esMD: (indicate document/content type "8.4")

5 Timeline for Decisions

The timeframes for conducting PA of certain DMEPOS items will be dependent upon the item(s) selected for PA (see specifics for each program in §5). There are 3 types of prior authorization submissions, which will have corresponding review timeframes for each specific item selected for review:

- **Initial Submission -** the first prior authorization request sent to the contractor for review and decision.
- **Resubmission -** any subsequent resubmissions to correct an error or omission identified during previous prior authorization decisions.
- **Expedited** - a prior authorization decision that is expedited based on the MAC determination that delays in review and response could jeopardize the life or health of the beneficiary.

5.1 Expedited Review Process

If delays in receipt of a PA decision could jeopardize the life or health of the

beneficiary, then the DME MAC should process the PAR under an "expedited" timeframe.

Upon identification of a PAR which requires an expedited review, the DME MAC shall implement the following for purposes of expediency:

- Render an affirmative or non-affirmative decision within the CMS-prescribed expedited review timeframe (specified for the code being prior authorized) and provide the decision to the supplier and/or beneficiary (if specifically requested by the beneficiary) via telephone, fax, electronic transmission, or other "real-time" communication, within the requisite timeframe.

- The issuance of the decision should make it explicit that although the decision has been reached, the supplier shall (to prevent the claim from denying upon submission) ***hold their claim and not submit it*** until such time as the unique tracking number (UTN) is provided. DME MACs shall follow the normal process to obtain a UTN from CMS shared systems.

- Suppliers shall be notified that if the claim is submitted prior to receipt of the UTN, there will be no mechanism to identify it to prevent an auto-denial. Suppliers shall be notified that any claims prematurely submitted will require a formal reopening request to process for payment.

- Suppliers shall be given a point of contact to follow-up on the UTN status, and DME MACs shall check the same on a daily basis.

6 Program Specifics

6.1 Program Specifics for Codes K0856 and K0861

6.1.1 Implementation of Prior Authorization

The first 2 codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- K0856- Power wheelchair, group 3 std., single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds.

- K0861- Power wheelchair, group 3 std., multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds.

The prior authorization process for these 2 codes will be implemented in phases. Phase 1 limits the initial roll out to 4 states (1 per DME MAC jurisdiction). Phase 2 expands the program nationally.

Phase 1

- DME MACs will begin accepting prior authorization requests for K0856 & K0861 on **March 6, 2017,** for New York, Illinois, Missouri, and West Virginia**,** for dates of delivery on or after March 20, 2017.
    - Note - States are assigned based upon the beneficiary's permanent address (per CMS IOM 100-04, Ch.1, § 10.1.5.1)
- **All new rental series** claims, within the specified states, for K0856 & K0861 with a date of service (DOS) on or after **March 20, 2017,** must have a prior authorization request on file as a condition of payment.

Phase 2

- DME MACs will begin accepting prior authorization requests for K0856 & K0861 on July 3, 2017, for all remaining states/territories, for dates of delivery on or after July 17, 2017.
- **All new rental series claims nationwide,** for K0856 & K0861 with a DOS on or after **July 17, 2017,** must have a prior authorization request on file.

6.1.2 Required Documentation

Documentation from the medical record to support the medical necessity of K0856 and K0861 would include but not limited to:

- Written Order Prior to Delivery (WOPD)
- Face-to-Face Examination
- Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP)
- Attestation Statement showing no financial relationship between the supplier and LCMP
- Evidence of RESNA Assistive Technology Practitioner (ATP)

Certification and involvement

- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) and the Local Coverage Determination (LCD): Power Mobility Devices (L33789)

6.1.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will complete its complex medical review and send an initial decision letter that is either postmarked, faxed, or delivered electronically within **5 business days (not to exceed 7 calendar days)** following the DME MAC's receipt of the initial request.

- **Resubmission:** A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The DME MAC will postmark, fax, or deliver electronically notification of the decision of these resubmitted requests to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within **5 business days (not to exceed 7 calendar days)** of receipt of the resubmission.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

6.1.4 Validation Period for Prior Authorization for Power Mobility Devices

PAR decisions for these codes will remain valid for six months following the "affirmed" review decision. For example: if the PAR is affirmed on October 15th, the supplier has until April 15th, 11:59 pm to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time period.

6.1.5 Prior Authorization for Power Mobility Device Replacements

Medicare covers a replacement PMD only if an item is lost, stolen, or irreparably damaged within the 5-year reasonable lifetime. Replacement of a PMD item due to these circumstances requires the submission of a

PAR prior to furnishing the replacement.*

As part of the PA process, a WOPD from the treating practitioner is needed to reaffirm the medical necessity of the PMD along with supporting documentation explaining the need for the replacement, such as detailed reports of loss, theft, or damage. The submitter should request an expedited review for a PMD replacement and indicate that the request is for a PMD replacement on the PAR coversheet. Expedited reviews are completed within two business days.

6.2 Program Specifics for Codes K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, and K0855

6.2.1 Implementation of Prior Authorization

The additional codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- K0813- Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds
- K0814- Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds
- K0815- Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds
- K0816- Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds
- K0820- Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds
- K0821- Power wheelchair, group 2 standard, portable, captain's chair, patient weight capacity up to and including 300 pounds

* *Medicare covers a replacement PMD when a manufacturer exits the wheelchair business resulting in the wheelchair ceasing to exist on the market, and there is no availability of aftermarket repair or replacement parts to make the manufacturer's equipment operable the power or manual wheelchair may be designated as lost.*

- K0822- Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0823- Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds

- K0824- Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds

- K0825- Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds

- K0826- Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds

- K0827- Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds

- K0828- Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or moreK0829- Power wheelchair, group 2 extra heavy duty, captain's chair, patient weight 601 pounds or more

- K0835- Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0836- Power wheelchair, group 2 standard, single power option, captain's chair, patient weight capacity up to and including 300 pounds

- K0837- Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds

- K0838- Power wheelchair, group 2 heavy duty, single power option, captain's chair, patient weight capacity 301 to 450 pounds

- K0839- Power wheelchair, group 2 very heavy duty, single power option sling/solid seat/back, patient weight capacity 451 to 600 pounds

- K0840- Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more

- K0841- Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0842- Power wheelchair, group 2 standard, multiple power option, captain's chair, patient weight capacity up to and including 300 pounds

- K0843- Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds

- K0848- Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds

- K0849- Power wheelchair, group 3 standard, captain's chair, patient weight capacity up to and including 300 pounds

- K0850- Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds

- K0851- Power wheelchair, group 3 heavy duty, captain's chair, patient weight capacity 301 to 450 pounds

- K0852- Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds

- K0853- Power wheelchair, group 3 very heavy duty, captain's chair, patient weight capacity 451 to 600 pounds
- K0854- Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more

- K0855- Power wheelchair, group 3 extra heavy duty, captain's chair, patient weight capacity 601 pounds or more

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on **August 18, 2018**, for dates of delivery on or after September 1, 2018.

All new rental series claims nationwide with a DOS on or after **September 1, 2018**, must have a prior authorization request on file.

6.2.2 Required Documentation

Documentation from the medical record to support the medical necessity would include but not limited to:

- WOPD
- Face-to-Face Examination
- Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP), if applicable
- Attestation Statement showing no financial relationship between the supplier and LCMP, if applicable
- Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement, if applicable
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3) and the Local Coverage Determination (LCD): Power Mobility Devices (L33789).

6.2.3 Timeframe for Review Decisions

- **Initial Submission:** The DME MAC will complete its complex medical review and send an initial decision letter that is either postmarked, faxed, or delivered electronically within **5 business days (not to exceed 7 calendar days)** following the DME MAC's receipt of the initial request.
- **Resubmission:** A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The DME MAC will postmark, fax, or deliver electronically notification of the decision of these resubmitted requests to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within **5 business days (not to exceed 7 calendar days)** of receipt of the resubmission.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

6.2.4 Validation Period for Prior Authorization Decisions for Power Mobility Devices

PAR decisions for these codes will remain valid for six months following the "affirmed" review decision. For example: if the PAR is affirmed on October 15th, the supplier has until April 15th, 11:59 pm to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time period.

6.3 Program Specifics for Codes K0857, K0858, K0859, K0860, K0862, K0863, and K0864

6.3.1 Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- K0857 - Power wheelchair, group 3 standard, single power option, captain's 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, captain's 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

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on **July 8, 2019,** for dates of delivery on or after **July 22, 2019**.

All new rental series claims nationwide with a DOS on or after **July 22, 2019,** must have a prior authorization request on file.

6.3.2 Required Documentation

Documentation from the medical record to support the medical necessity of K0857, K0858, K0859, K0860, K0862, K0863, and K0864 would include but not limited to:

- WOPD
- Face-to-Face Examination
- Specialty Evaluation performed by Licensed/Certified Medical Professional (LCMP)
- Attestation Statement showing no financial relationship between the supplier and LCMP
- Evidence of RESNA Assistive Technology Practitioner (ATP) Certification and involvement
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the NCD for Mobility Assistive Equipment (MAE): 280.3 and the LCD for Power Mobility Devices: L33789.

6.3.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a written decision to the requester/submitter within **5 business days (not to exceed 7 calendar days** of receipt of documentation for the initial PA request.
- **Resubmission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter

within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the resubmission of the PA request.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

6.3.4 Validation Period for Prior Authorization Decisions for Power Mobility Devices

PAR decisions for these codes will remain valid for six months following the "affirmed" review decision. For example: if the PAR is affirmed on October 15th, the supplier has until April 15th, 11:59 pm to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time period.

6.4 Program Specifics for Codes K0800, K0801, K0802, K0806, K0807, and K0808

6.4.1 Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment are:

- K0800 - Power Operated Vehicle, Group 1 Standard, Patient Weight Capacity up to and including 300 pounds
- K0801 - Power Operated Vehicle, Group 1 Heavy Duty, Patient Weight Capacity, 301 To 450 Pounds
- K0802 - Power Operated Vehicle, Group 1 Very Heavy Duty, Patient Weight Capacity 451 To 600 Pound
- K0806 - Power Operated Vehicle, Group 2 Standard, Patient Weight Capacity Up to And Including 300 Pounds
- K0807 - Power Operated Vehicle, Group 2 Heavy Duty, Patient Weight Capacity 301 To 450 Pounds
- K0808 - Power Operated Vehicle, Group 2 Very Heavy Duty, Patient Weight Capacity 451 To 600 Pound

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on

March 30, 2022, for dates of delivery on or after **April 13, 2022**.

All new rental series claims nationwide with a DOS on or after **April 13, 2022,** must have a prior authorization request on file.

6.4.2 Required Documentation

Documentation required for the prior authorization request package for K0800, K0801, K0802, K0806, K0807, and K0808 shall include:

- WOPD
- Face-to-Face Examination
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the NCD for Mobility Assistive Equipment (MAE): 280.3 and the LCD for Power Mobility Devices: L33789 and the Power Mobility Devices - Policy Article: A52498.

K0806, K0807, and K0808 are currently not covered as reasonable and necessary and will not be affirmed on prior authorization.

6.4.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the initial PA request.
- **Resubmission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the resubmission of the PA request.
- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited PA request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

6.4.4 Validation Period for Prior Authorization Decisions for Power Operated Vehicles

PAR decisions for these codes will remain valid for six months following the "affirmed" review decision. For example: if the PAR is affirmed on October 15th, the supplier has until April 15th, 11:59 pm, to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time period.

6.5 Program Specifics for Voluntary PMD Accessory Codes E0950, E0955, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1012, E1029, E1030, E2310, E2311, E2312, E2313, E2321, E2322, E2323, E2324, E2325, E2326, E2327, E2328, E2329, E2330, E2351, E2373, E2377, E2601, E2602, E2603, E2604, E2605, E2606, E2607, E2608, E2611, E2612, E2613, E2614, E2615, E2616, E2620, E2621, E2622, E2623, E2624, E2625, K0020, and K0195

6.5.1 Implementation of Voluntary Prior Authorization for PMD Accessories

Policies finalized in the 2019 ESRD and DMEPOS final rule* (84 Fed. Reg. 60648 (Nov. 8, 2019)) permit suppliers to voluntarily request prior authorization for certain Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) accessories on the same prior authorization request (PAR) as the DMEPOS item(s) on the Required Prior Authorization List. Pursuant to this rule, CMS is implementing voluntary prior authorization for select accessories for PMDs. The goal of this process is to increase operational simplicity by allowing suppliers to request prior authorization for a PMD accessory. Subsequently, a prior authorization decision will be rendered for both the PMD (the base item), which requires prior authorization and a PMD accessory that does not require prior authorization.

Submitting a voluntary PAR for a PMD accessory is not mandatory and does not create a condition of payment. PARs submitted for a PMD accessory must include the related PMD base item. If the PAR does not include a required PMD base, the PAR will be rejected. If the base item on the PAR is non-affirmed, the accessory will also be non- affirmed.

The full descriptions of the PMD accessories eligible for voluntary prior authorization are listed in the Appendix.

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* *Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule Amounts, DMEPOS Competitive Bidding Program (CBP) Amendments, Standard Elements for a DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Order Prior to Delivery and/or Prior Authorization Requirements* (CMS-1713-F*) was published on November 8, 2019.*

DME MACs will begin accepting PARs for PMDs with related accessories on March 20, 2023, for dates of delivery on or after April 6, 2023.

Below is a table with examples of decision outcomes for PARs with a provisionally affirmed or non-affirmed base and PARs with a provisionally affirmed or non-affirmed accessory and their related claim outcomes.

Outcomes of Voluntary PARs for PMD Accessories

Prior Authorization Request Decision		**Related Claim Outcome**	
BASE	ACCESSORY	BASE	ACCESSORY
Provisionally Affirmed	Not Submitted	Allowed	N/A
Provisionally Affirmed	Provisionally Affirmed	Allowed	Allowed
Provisionally Affirmed	Non-affirmed*	Allowed	Denied
Provisionally Affirmed	Some Provisionally Affirmed Some Non-affirmed*	Allowed	Provisionally Affirmed Allowed Non-affirmed - Denied
Non-affirmed	Not Submitted	Denied	N/A
Non-affirmed	Non-affirmed**	Denied	Denied
Not Submitted	Rejected***	N/A	N/A

* Requests for accessories may NOT be resubmitted in this scenario because the base has already been provisionally affirmed.

** Requests for accessories MAY be resubmitted in this scenario because the base has not yet been provisionally affirmed.

*** Requests for accessories must be submitted on the same PAR as a required base.

6.5.2 Required Documentation

Documentation required for the voluntary PAR package for PMD accessories includes:

- The same documentation required for the prior authorization of PMDs
- Documentation from the medical record to support medical necessity

Note: Further information regarding documentation requirements can be located within the NCD for Mobility Assistive Equipment (MAE): 280.3 and the LCD for Power Mobility Devices: L33789 and the Power Mobility Devices - Policy Article: A52498.

See Section 6.1.2 for Required documentation for PMDs.

6.5.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the initial PA request

- **Resubmission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the resubmission of the PA request

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited PA request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing

6.5.4 Validation Period for Voluntary Prior Authorization Decisions for PMD Accessories

PAR decisions for these codes will remain valid for six months following the provisionally affirmed review decision. For example: if the PAR is provisionally affirmed on October 15, the supplier has until April 15, 11:59 pm to furnish the PMD. Otherwise, a new PAR will need to be submitted to restart the valid six-month time period.

6.6 Program Specifics for Codes E0193, E0277, E0371, E0372, and E0373

6.6.1 Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- 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

The prior authorization process for these codes will be implemented in two phases. Phase 1 limits the prior authorization requirement to 4 states (one per DME MAC jurisdiction). Phase 2 expands the program nationally.

Phase 1

- DME MACs will begin accepting prior authorization requests for E1093, E0277, E0371, E0372, E0373 on July 8, 2019, for California, Indiana, New Jersey, and North Carolina, for dates of delivery on or after July 22, 2019.
    - Note: States are assigned based upon the beneficiary's permanent address (per CMS IOM 100-04, Ch.1, §10.1.5.1)
- **All new rental series** claims, within the specified states, for E0193, E0277, E0371, E0372, and E0373 with a date of service (DOS) on or after **July 22, 2019,** must have a prior authorization request on file as a condition of payment.

Phase 2

- DME MACs will begin accepting prior authorization requests for E0193, E0277, E0371, E0372, and E0373 on **October 7, 2019,** for all remaining states/territories**,** for dates of delivery on or after **October 21, 2019**.
- **All new rental series claims nationwide,** for E0193, E0277, E0371, E0372, and E0373 with a DOS on or after **October 21, 2019,** must have a prior authorization request on file.

6.6.2 Required Documentation

Documentation required for the prior authorization request package for E0193, E0277, E0371, E0372, and E0373 shall include:

- Standard Written Order (SWO)
- Documentation from the medical record to support the medical necessity

Note: Further information regarding documentation requirements can be located within the LCD for Pressure Reducing Support Surfaces (PRSS) – Group 2 (L33642) and the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Considerations.

6.6.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a decision to the

requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the resubmission of the PA request.

- **Resubmission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the resubmission of the PA request.

- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

Note: One of the coverage criteria in LCD L33642 for Pressure Reducing Support Surfaces – Group 2 requires that the beneficiary has a diagnosis of a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the past 60 days and has been on a group 2 or 3 support surface immediately prior to discharge from a hospital or nursing facility within the past 30 days. Patients with the above conditions may meet the criteria for an expedited review. Suppliers shall ensure that the PAR clearly notes an expedited request and is completed accurately to ensure expeditious processing.

6.6.4 Validation Period for Prior Authorization Decisions for Pressure Reducing Support Surfaces

PAR decisions for these codes will remain valid for one month following the "affirmed" review decision. For example: if the PAR is affirmed on October 15th, the supplier has until November 15th, 11:59 pm to furnish the PRSS. Otherwise, a new PAR will need to be submitted to restart the valid month time period.

6.7 Program Specifics for Codes L5856, L5857, L5858, L5973, L5980, and L5987

6.7.1 Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment are:

- L5856 - Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic

sensor(s), any type

- L5857 - Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type

- L5858 - Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type

- L5973 - Endoskeletal ankle foot system, microprocessor-controlled feature, dorsiflexion and/or plantar flexion control, includes power source

- L5980 - All lower extremity prostheses, flex foot system

- L5987 - All lower extremity prosthesis, shank foot system with vertical loading pylon

The prior authorization process for these codes will be implemented in two phases. Phase 1 limits the prior authorization requirement to 4 states (one per DME MAC jurisdiction). Phase 2 expands the program nationally.

Phase 1

- DME MACs will begin to accept prior authorization requests for codes L5856, L5857, L5858, L5973, L5980, and L5987 in California, Michigan, Pennsylvania, and Texas, one state from each DME MAC Jurisdiction, on August 18, 2020, for items furnished on or after September 1, 2020. [*]

Phase 2

- DME MACs will begin to accept prior authorization requests for codes L5856, L5857, L5858, L5973, L5980 and L5987 in all of the remaining states and territories in all four DME MAC jurisdictions on November 17, 2020, for items furnished on or after December 1, 2020.

6.7.2 Required Documentation

[*] *The implementation of the prior authorization requirement for lower limb prosthetic codes L5856, L5857, L5858, L5973, L5980, and L5987 initially scheduled for the first four states for May 11, 2020, and the remaining states and territories initially scheduled for October 8, 2020, were delayed due to the Covid-19 pandemic and public health emergency*

Documentation required for the prior authorization request package for L5856, L5857, L5858, L5973, L5980 and L5987 shall include:

- SWO
- Documentation from the medical record to support the medical necessity

Note: Suppliers are reminded that Section 1834(h)(5) of the Act states that for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's medical record to support documentation created by eligible professionals as described in section 1848(k)(3)(B) of the Act.

Documentation created by an orthotist or prosthetist becomes part of the medical records and if the orthotist or prosthetist notes support the documentation created by eligible professionals described in section 1848(k)(3)(B), they can be used together to support medical necessity of an ordered DMEPOS item. In the event the orthotist or prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

Further information regarding documentation requirements can be located within the LCD for Lower Limb Prostheses (LLP) (L33787) and the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Considerations.

6.7.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the initial PA requests.
- **Resubmission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days (not to exceed 7 calendar days)** of receipt of documentation for the resubmission of the PA request.
- **Expedited:** If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited PA request. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal

to avoid delays with mailing.

6.7.4 Validation Period for Prior Authorization Decisions for Lower Limb Prosthetics

PAR decisions for these codes will remain valid for one hundred twenty (120) calendar days following the provisional affirmation review decision. The supplier has up to 120 days to furnish the LLP. For example, if the PAR is affirmed on October 15th, the supplier has until February 12th, 11:59 p.m., to furnish the LLP. Otherwise, a new PAR will need to be submitted to restart the 120-day time period.

6.8 Program Specifics for Codes L0648, L0650, L1832, L1833, and L1851

6.8.1 Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- L0648 - Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

- L0650 - Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf

- L1832 - Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L1833 - Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the-shelf. (Effective August 12, 2024, L1833 will be removed from the Required Prior Authorization List, as the item no longer meets the criteria to be maintained on the Master List.)

- L1851 - Knee orthosis (ko), single upright, thigh, and calf, with

adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf.

The prior authorization process for these codes will be implemented in three phases. Phase 1 limits the prior authorization requirement to 4 states (one state per DME MAC jurisdiction). Phase 2 expands the prior authorization requirement to twelve additional states (three states per DME jurisdiction). Phase 3 expands it to all remaining states.

Phase 1

- DME MACs will begin accepting prior authorization requests in New York, Illinois, Florida, and California on **March 30, 2022,** for items furnished on or after **April 13, 2022.**

Phase 2

- DME MACs will begin accepting prior authorization requests in Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, Washington, on **June 28, 2022,** for items furnished on or after **July 12, 2022.**

Phase 3

- DME MACs will begin accepting prior authorization requests for all remaining States and territories on **September 26, 2022, f**or items furnished on or after **October 10, 2022.**

6.8.2 Required Documentation

Documentation required for the prior authorization request package for L0648, L0650, L1832, L1833*, and L1851.

- WOPD
- Face to Face Examination
- Documentation from the medical record to support the medical necessity

Note: Suppliers are reminded that Section 1834(h)(5) of the Act states that for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's

**Effective August 12, 2024, L1833 will be removed from the Required Prior Authorization List, as the item no longer meets the criteria to be maintained on the Master List.*

medical record to support documentation created by eligible professionals as described in section 1848(k)(3)(B) of the Act.

Documentation from a face-to-face encounter conducted by a treating practitioner, as well as documentation created by an orthotist or prosthetist becomes part of the medical records and if the orthotist or prosthetist notes support the documentation created by eligible professionals described in section 1848(k)(3)(B), they can be used together to support medical necessity of an ordered DMEPOS item. In the event the orthotist or prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

Further information regarding documentation requirements can be located within the LCD for Knee Orthoses (L33318) and the Knee Orthosis Policy Article (A52465); within the LCD for Spinal Orthoses: TLSO and LSO (L33790) and the Spinal Orthosis: TLSO and LSO Policy Article (A5200); and the Program Integrity Manual Program Integrity Manual (PIM 5.2). Items and Services Having Special DME Review Considerations.

6.8.3 Timeframes for Review Decisions

- **Initial Submission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days, not to exceed 7 calendar days** of receipt of documentation for the initial PA request.

- **Resubmission:** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days, not to exceed 7 calendar days** of receipt of documentation for the resubmission of the PA request.

- **Expedited**: Prior Authorization requests are processed in an expedited manner when the beneficiary's health/life is in jeopardy without the use of the orthotic device within the regular review timeframe, e.g., when a beneficiary suffers an acute injury to the knee or spine. If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited PA request. Suppliers shall ensure that the PAR clearly notes an expedited request and is completed accurately to ensure expeditious processing. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid

delays with mailing.

Note: Acute Situations: Due to the need for certain patients to receive an orthoses item that may otherwise be subject to prior authorization when the 2- day expedited review would delay care and risk the health or life of the beneficiary, we are suspending prior authorization requirements under these limited circumstances:

- Claims for HCPCS codes L0648, L0650, L1832, L1833*, and L1851 that are billed using modifier ST, indicating that the item was furnished urgently. Claims billed using the ST modifier will be subject to 50% prepayment review, for dates of service on or after January 1, 2024.

6.8.4 Validation Period for Prior Authorization Decision for Orthoses Codes

PAR decisions for these codes will remain valid for 60 days following the "affirmed" review decision. For example: if the PAR is affirmed on April 30th, the supplier has until June 28th to furnish the orthoses. Otherwise, a new PAR will need to be submitted to restart the valid 60-day period.

6.8.5 Special Considerations for Orthoses Subject to Competitive Bidding

Due to the need for certain patients to receive an orthoses item that may otherwise be subject to prior authorization when the 2-day expedited review would delay care and risk the health or life of the beneficiary, we are suspending prior authorization requirements for claims for HCPCS codes L0648, L0650, L1833*, and L1851 billed with modifiers KV, J5, or J4, by suppliers furnishing these items under a competitive bidding program exception (as described in 42 CFR 414.404(b)) to convey that the DMEPOS item is needed immediately either because it is being furnished during a physician office visit where the physician determines that the brace is needed immediately due to medical necessity or because it is being furnished by an occupational therapist or physical therapist who determines that the brace needs to be furnished as part of a therapy session(s). Prior authorization will continue for these orthoses' items (HCPCS L0648, L0650, L1832, L1833*, and L1851) when furnished under circumstances not covered in this update, as well as all other items on the Required Prior Authorization List. Additionally, 10% of claims submitted using the KV, J5, or J4 modifiers for HCPCS L0648, L0650, L1833*, and L1851 will be subject to prepayment review.

Effective January 1, 2024, there will be a temporary gap period in the

**Effective August 12, 2024, L1833 will be removed from the Required Prior Authorization List, as the item no longer meets the criteria to be maintained on the Master List.*

DMEPOS Competitive Bidding Program (CBP) for off-the-shelf back and knee braces. As such, prior authorization requirements for HCPCS codes L0648, L0650, L1833*, and L1851 billed with the competitive bid modifiers KV, J4, or J5 will no longer be suspended, as there will be no need for a CBP exception. Treating practitioners have the option to undergo the regular prior authorization process with the standard timeframe of review, request an expedited review, or utilize the ST modifier indicating acute/emergent need.

6.9 Program Specifics for Codes L0631, L0637, L0639, L1843, L1845, L1951

6.9.1 Implementation of Prior Authorization

The codes placed on the Required Prior Authorization List, to be subject to prior authorization as a condition of payment, are:

- L0631 - Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L0637 - Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L0639 - Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L1843 - Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L1845 – Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

- L1951- Ankle foot orthosis (AFO), spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment

The prior authorization process for these codes will be implemented nationally. DME MACs will begin accepting PARs for these codes on **July 29, 2024,** for dates of delivery on or after **August 12, 2024.**

6.9.2 Required Documentation

Documentation required for the prior authorization request package for L0631, L0637, L0639, L1843, L1845, and L1951.

- WOPD

- Face to Face Examination Required

- Documentation from the medical record to support the medical necessity.

Note: Suppliers are reminded that Section 1834(h)(5) of the Act states that for purposes of determining the reasonableness and medical necessity of orthotics and prosthetics, documentation created by orthotists and prosthetists shall be considered part of the individual's medical record to support documentation created by eligible professionals as described in section 1848(k)(3)(B) of the Act.

Documentation from a face-to-face encounter conducted by a treating practitioner, as well as documentation created by an orthotist or prosthetist, becomes part of the medical records and if the orthotist or prosthetist notes support the documentation created by eligible professionals described in section 1848(k)(3)(B), they can be used together to support the medical necessity of an ordered DMEPOS item. In the event the orthotist or

prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

Further information regarding documentation requirements can be located within the LCD for Knee Orthoses (L33318) and the Knee Orthoses Policy Article (A52465); within the LCD for Spinal Orthoses: TLSO and LSO (L33790) and the Spinal Orthoses: TLSO and LSO Policy Article (A52500); within the LCD for Ankle-Foot/Knee-Ankle-Foot (L33686) and Ankle-Foot/Knee-Ankle-Foot Policy Article (A52457) and the Program Integrity Manual (PIM 5.2) – Items and Services Having Special DME Review Consideration.

6.9.3 Timeframes for Review Decisions

- **Initial Submission-** The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days**, **not to exceed 7 calendar days** of receipt of documentation for the initial PA request.

- **Resubmission-**The DME MAC will conduct a medical record review and communicate a decision to the requester/submitter within **5 business days**, **not to exceed 7 calendar days** of receipt of documentation for the resubmission of the PA request.

- **Expedited:** Prior Authorization requests are processed in an expedited manner when the beneficiary's health/life is in jeopardy without the use of the orthotic device within the regular review timeframe, e.g., when a beneficiary suffers an acute injury to the knee or spine. If the DME MAC substantiates the need for an expedited decision, the DME MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited PA request. Suppliers shall ensure that the PAR clearly notes an expedited request and is completed accurately to ensure expeditious processing. For expedited review requests, suppliers should use fax, esMD, or the MAC Portal to avoid delays with mailing.

Acute Situations: Due to the need for certain patients to receive an orthoses item that may otherwise be subject to prior authorization when the 2- day expedited review would delay care and risk the health or life of the beneficiary, we are suspending prior authorization requirements under these limited circumstances: Claims for HCPCS codes L0631, L0637, L0639, L1843, L1845, and L1951 that are billed using modifier ST, indicating that the item was furnished urgently. Claims

billed using the ST modifier will be subject to 50% prepayment review, for dates of service on or after **August 12, 2024.**

6.9.4 Validation Period for Prior Authorization Decision for Orthoses Codes

PAR decisions for these codes will remain valid for 60 days following the "affirmed" review decision. For example: if the PAR is affirmed on April 30th, the supplier has until June 28th to furnish the orthoses. Otherwise, a new PAR will need to be submitted to restart the valid 60-day period.

6.10 Program Specifics for Codes E0747, L0748, E0760

6.10.1 Implementation of Prior Authorization

Due to continued confusion over some noninvasive osteogenesis stimulators and whether they comply with the DME three-year expected life requirement at 42 CFR 414.202, CMS is suspending prior authorization requirements for HCPCS codes E0747, E0748, E0760.

7 Secondary Insurance

7.1 Medicare is Primary Insurance

In cases where Medicare is primary, and another insurance company is secondary:

The contractors shall suspend claims to request documentation and conduct a review of the Advanced Beneficiary Notice (ABN) when there is no PA request, and the claim is submitted with the GA modifier appended to the claim.

The Contractor shall determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).

- If a supplier chooses to use the PA for a denial, then the following process is to be followed:
    - The submitter may submit the **PAR** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the DMEPOS item, then a non-affirmative PA decision will be sent to the entity requesting the PA (i.e., the supplier or the beneficiary if requested), advising that Medicare will not pay for the item.

- After receiving a non-affirmative decision for the PAR, if the associated **claim** is submitted by the supplier to the DME MAC for payment, it will be denied.

- The submitter or beneficiary may forward the denied claim to his/her secondary insurance payer as appropriate to determine payment for the DMEPOS item(s).

In cases where a beneficiary is dually eligible for Medicaid and Medicare, a non-affirmed prior authorization decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage. The supplier does not need to submit the claim to Medicare first and obtain a denial before submitting the claim to Medicaid for payment[3].

Beneficiaries with retroactive Medicare eligibility status must have a Medicare PA request submitted on their behalf to the DME MAC for payment reimbursement from Medicare. When submitting a PAR, the supplier should indicate that the item has already been delivered, that Medicare coverage is retroactive and submit all necessary PAR documentation to support the medical necessity of the item. Claims submitted without first going through the PA process will be denied.

7.2 Another Insurance Company is Primary

Cases where another insurance company is primary, and Medicare is secondary:

- The submitter submits the PAR with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the item(s), then a provisional affirmative PA decision will be sent to the supplier and to the beneficiary, if specifically requested by the beneficiary, advising them that Medicare **will** pay for the DMEPOS item.

- The supplier submits a claim to the other insurance company.

- If the other insurance company denies the claim, the supplier or beneficiary can submit a claim to the DME MAC for payment (listing the unique tracking number on the claim).

8 Supplier Telephone Inquiries

Suppliers, or beneficiaries who submit PARs and who have questions should call the appropriate DME MAC. The numbers for Customer Service Representatives at the DME MACs are as follows:

- For beneficiaries residing in Jurisdiction A states call 1-866-419-9458; TTY/TDD 1-888-897-7539.

- For beneficiaries residing in Jurisdiction B states call 1-866-590-6727; TTY/TDD 1-888-897-7534.

- For beneficiaries residing in Jurisdiction C states call 1- 866-270-4909; TTY/TDD 1- 888-204-3771.

- For beneficiaries residing in Jurisdiction D states call 1-877-320-0390; TTY/TDD 1- 866-879-2704.

9 Decision Letter(s)

The DME MAC will send decision letters with the unique tracking number (UTN) to the submitter via fax, mail, esMD or the DME MAC provider portal and postmarked within the timeframes described in Section 5 as it pertains to each individual DMEPOS item(s).

A copy of the decision letter may also be mailed to the beneficiary, upon request. The DME MAC may also send the letter to the beneficiary voluntarily. (Note: Providers/physicians requesting decision letters must be able to demonstrate a legitimate, specific need for the information requested and contractors shall ensure that the information provided is sufficiently tailored to comply with Health Insurance Portability and Accountability Act's minimum necessary standards and other applicable laws or regulations. Prescribing physicians/practitioners may contact the DME MAC for a copy of the prior authorization decision letter. The request for the decision letter may be included with the documentation sent to the supplier as part of the prior authorization request or may be made separately. CMS has provided a sample letter on its website here.)

10 Provisional Affirmative Prior Authorization Decision

A provisional affirmative PA decision is a preliminary finding that a future claim submitted to Medicare for the DMEPOS item(s) likely meets Medicare's coverage, coding, and payment requirements.

10.1 Suppliers Action

Note: If all Medicare coverage, coding, and payment requirements are met the claim will likely be paid.

- Before furnishing the DMEPOS item and before submitting the claim for payment, the supplier obtains a PA decision.
- Furnish the DMEPOS item to the beneficiary after receiving a PA decision,
- Submit the claim with the UTN on the claim.
- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the UTN is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the UTN is submitted in either the 2300 Claim Information loop or 2400 - Service Line loop in the Prior Authorization

reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.

- Claims receiving a provisional affirmation may be denied based on either of the following:
    - Technical requirements that can only be evaluated after the claim has been submitted for formal processing; or
    - Information not available at the time of a PAR.
- Claims for which there is a provisional affirmation PA decision will be afforded some protection from future audits. However, CMS contractors, including Unified Program Integrity Contractors (UPICs) may conduct targeted prepayment and post payment reviews if the provider shows evidence of potential fraud, gaming, inappropriate utilization, or changes in billing patterns. In addition, the Comprehensive Error Rate Testing (CERT) contractor must review a random sample of claims for post payment review for purposes of estimating the Medicare improper payment rate.
- Submitters are reminded to bill their claims in sequential order to avoid any delays in claim payment.

11 Non-Affirmative Prior Authorization Decision

A non-affirmative PA decision is a preliminary finding that if a future claim is submitted to Medicare for the DMEPOS item(s) it does not likely meet Medicare's coverage, coding, and payment requirements. We consider this an incomplete PAR.

The DME MAC will provide the PAR submitter notification of what required documentation is missing via fax, mail, esMD, or the DME MAC provider portal. The decision letter for an incomplete PAR will be detailed and postmarked within the applicable timeframes described in Section 5 as it pertains to each DMEPOS item(s).

The submitter may resubmit another complete PAR with all documentation required as noted in the detailed decision letter. See Section 8 for instructions on resubmitting PAR. Unlimited resubmissions are permitted.

11.1 Suppliers Action

Use the detailed decision letter to ensure that resubmitted PARs comply with all requirements. Resubmit a PAR, if appropriate.

11.1.1 Resubmitting a PAR

- The submitter should review the detailed decision letter that was provided.
- The submitter should make whatever modifications are

needed to the PAR and follow the submission procedures.

12 Claim Submission

12.1 Affirmed Prior Authorization Decision on File

Cases where a PAR was submitted, and a provisional affirmation PA decision was granted.

- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the UTN is submitted in the first 14 positions in item 23. All other data submitted in item 23 must begin in position 15. For submission of electronic claims, the UTN must be submitted in the 2300 Claim Information loop in the PA reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop.

- Series of claims:

    - Should be submitted with the UTN on each claim in the series.

    - Should be submitted to the applicable DME MAC for adjudication.

12.2 Non-Affirmed Prior Authorization Decision on File

Cases where a PAR was submitted, and a non-affirmed PA decision was granted:

- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of a claim on a 1500 Claim Form, the UTN is submitted in the first 14 positions in item 23. All other data submitted in item

  23 must begin in position 15. For submission of electronic claims, the UTN must be submitted in the 2300 Claim Information loop in the PA reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN. A UTN submitted in this loop applies to the entire claim unless it is overridden in the REF segment in the 2400 Service Line loop.

- Series of claims:

- Should be submitted with the UTN on each claim.

- Should be submitted to the applicable DME MAC for adjudication.

- If the claim is submitted to the DME MAC for payment with a non-affirmative PA decision, it will be denied.

- All appeal rights are then available.

- This claim could then be submitted to secondary insurance, if applicable.

12.3 Claims Submitted Without a Prior Authorization Decision on File

Cases where a PAR was never received/decision granted for an item(s) on the Required Prior Authorization List:

- As described in 42 CFR §414.234, 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 HCPCS codes subject to required prior authorization submitted without a prior authorization determination and a corresponding UTN will be automatically denied.

- Claims for L0648, L0650, L1833*, and L1851 billed with modifier KV, J5, or J4 to indicate a CBP exception will not be subject to prior authorization requirements. See section 6.7.5 for more information.

- Claims for L0648, L0650, L1833*, L1851, L0631, L0637, L0639, L1843, L1845, and L1951 billed with modifier ST to indicate an acute injury will not be subject to prior authorization requirements; however, will be subject to prepayment medical record review by the MAC as outlined in Internet Only Manual (IOM) 100-08 Ch.3. See sections 6.7.3 and 6.9.3 for more information.

13 Special Claim Considerations

13.1 Advanced Beneficiary Notice

If an applicable claim is submitted without a PA decision and is flagged as having an ABN, it will be stopped for additional documentation to be requested and a review of the ABN shall be performed (to determine the validity of the ABN) following standard claim review guidelines and timelines.

The supplier should submit the claim with the GA modifier appended to it. The Contractor shall determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100- 04, Chapter 30, § 40).

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* *Effective August 12, 2024, L1833 will be removed from the Required Prior Authorization List, as the item no longer meets the criteria to be maintained on the Master List.*

13.2 Exclusions

The following claim types are excluded from any PA program described in this operational guide, unless otherwise specified:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage Part A and Part B Demonstrations

Note: Claims from Representative Payees will only be excluded for PA programs that are not implemented on a national level. Before submitting a PAR, suppliers should verify if the beneficiary has a rep payee on file. Once the PA program becomes national, this exclusion will not apply.

13.3 Beneficiary Moves During Rental Series

The table below describes the process for suppliers and/or beneficiaries to receive claims payment subsequent to beneficiary changes in rendering/billing supplier and/or geographic location. The table accounts for the following assumptions:

1. The circumstances when an item is first furnished and subsequently billed for payment (i.e., the initial date of service) shall be used to determine whether a claim is subject to prior authorization as a condition of payment under the national program.

2. When applicable, the prior authorization decision and corresponding claim information may remain with the beneficiary (i.e., the prior authorization decision identified via a Unique Tracking Number, or UTN, may transfer between suppliers). CMS assumes such transfers would be made in accordance with applicable privacy laws.

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Supplier **Same Jurisdiction**	UTN CWF HUPA record on file BITS and VDME screens and CWF HUPA records will remain active on the files with no action needed Supplier continues to bill subsequent rentals using same UTN	UTN CWF HUPA record on file; PA editing does not apply to the Non-PA state BITS and VDME screens and CWF HUPA record will remain on the files in an active status but will not apply to services in the Non-PA state	No UTN No CWF HUPA record on file No BITS/VDME screens on file Same Supplier continues to bill subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim is after the start date of the PA program

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Supplier **Same Jurisdiction**	System changes: No	Supplier discontinues using UTN on the subsequent rental claims in the Non-PA state If Supplier submits claim with the UTN then VMS will reject claim with action code 27 and MACs will return claim to Supplier. Supplier resubmits claim without UTN System changes: No	Subsequent rental claims billed in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Same Supplier **Change Jurisdiction**	BITS and VDME screens and CWF HUPA records set up in jurisdiction 1 will remain active on the files with no action needed Supplier continues to bill subsequent rentals with UTN from jurisdiction 1 Per MAC/VMS/CWF conversations no editing is done to validate the prefix digits of the UTN that identifies the jurisdiction. The claim will continue to process.	UTN CWF HUPA record on file; PA editing does not apply to Non-PA state BITS and VDME screens and CWF HUPA records set up in jurisdiction 1 will remain in an active status on the files but will not apply to services in the Non- PA state. A new VDME screen will automatically populate in the jurisdiction 2— MAC manual manipulations will be limited to situations in which the initial claim date needs to be corrected or to otherwise overcome an edit. Supplier discontinues using UTN on subsequent rental claims in the Non-PA state If Supplier submits claim with the UTN then VMS will reject the claim	No UTN No CWF HUPA record on file No BITS/VDME screens on file Same Supplier continues to bill subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim is after the start date of the PA program. Subsequent rental claims billed in PA state will edit due to no UTN on claim. Subsequent rental claims without UTN will reject on CWF edit 5470 (program ID present on claim, no UTN, no CWF HUPA record on file). MACS will check HIMR and revise the CMN initial claim date to reflect the first claim billed in the Non-PA state, if the initial date of service preceded the program start date. If the initial date of service was on or after the program start date, the MACs will override
Same Supplier	System changes: No		

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Change Jurisdiction		With action code 27 and MACs will return claim to Supplier. Supplier resubmits claim without UTN System changes: No	CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No
Change Supplier **Same Jurisdiction**	UTN CWF HUPA record on file PA decision transfers to Supplier 2 UTN transfers to Supplier 2	UTN CWF HUPA record on file PA decision does not transfer PA editing will not apply to Non-PA state	No UTN No CWF HUPA record on file No BITS/VDME screens on file Supplier 2 bills subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Change Supplier **Same Jurisdiction**	BITS and VDME screens and CWF HUPA records set up for Supplier 1 will remain active on the files with no action needed Supplier 1 discontinues billing and using UTN Supplier 2 should use Supplier 1's UTN to submit subsequent rental claims for the same beneficiary/item. If Supplier 2 submits without a UTN on the claim it will reject on CWF edit 5467 (no UTN on claim, Program ID present, matches aux file) and MACS will return claim to Supplier. Supplier resubmits claim with Supplier 1's UTN. System changes: No	BITS and VDME screens and CWF HUPA records set up for Supplier 1 will remain in an active status on the files but will not apply to services in the Non-PA state Supplier 1 discontinues billing and using UTN Supplier 2 bills subsequent rentals in Non-PA state which will not be subjected to PA. System changes: No	Billed by Supplier 1 is after the start date of the PA program Subsequent rental claims billed by Supplier 2 in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No.

	PA state to PA state	PA state to Non-PA state	Non-PA state to PA state
Change Supplier **Change Jurisdiction**	UTN CWF HUPA record on file PA decision transfers UTN transfers to Supplier 2 BITS and VDME screens and CWF HUPA records set up for Supplier 1 in jurisdiction 1 will remain active on the files with no action needed Supplier 1 discontinues billing using UTN Supplier 2 should use Supplier 1's UTN from Jurisdiction 1 to submit subsequent rental claims for the same beneficiary/item.	UTN CWF HUPA record on file PA decision does not transfer PA editing does not apply to Non-PA state BITS and VDME screens and CWF HUPA records set up for supplier 1 in jurisdiction 1 will remain in an active status on the files but will not apply to services in the Non-PA state. A new VDME screen will automatically populate in the jurisdiction 2— MAC manual manipulations will be limited to situations in which the initial claim date needs to be corrected or to otherwise overcome an edit.	No UTN No CWF HUPA record on file No BITS/VDME screens on file Supplier 2 bills subsequent rentals in the PA state that were started in the Non-PA state. The date of delivery on the initial claim billed by Supplier 1 is after the start date of the PA program Subsequent rental claims billed by Supplier 2 in PA state will edit due to no UTN on claim Subsequent rental claims without UTN will reject on CWF edit 5470 (program id present on claim, no UTN, no CWF HUPA record on file) MACS will check HIMR and revise the CMN initial claim date to reflect the first claim billed by Supplier 1 in the Non-PA state, if

	PA State to PA State	PA State to Non-PA State	Non-PA State to PA State
Change Supplier **Change Jurisdiction**	Per MAC/VMS/CWF conversations no editing is done to validate the prefix digits of the UTN that identifies the jurisdiction. The claim will continue to process. If Supplier 2 submits without a UTN on the claim it will reject on CWF edit 5467 (no UTN on claim, Program ID present, matches aux file) and MACs will return claim to Supplier 2. Supplier 2 resubmits claim with Supplier 1's UTN System changes: No.	Supplier 1 discontinues billing and using UTN. Supplier 2 bills subsequent rentals in Non-PA state which will not be subjected to PA. System changes: No	The initial date of service preceded the program start date. If the initial date of service was on or after the program start date, the MACs will override CWF edit 5470 and allow the subsequent rental claims to process All subsequent rental claims will be overridden and allowed to process without any further PA editing or processing System changes: No.

14 Claim Appeals

Claims subject to the PA requirements that were denied payment follow all current appeals procedures. For further information, consult the Medicare Claims Processing Manual publication 100-04, chapter 29 - Appeals of Claims Decision.

A DME MAC PA decision of coverage (i.e. PA affirmation) is not a payment determination and thus not appealable. (See 42 CFR §405.926). As noted earlier, a submitter receiving a non- affirmation PA decision is permitted to resubmit PARs an unlimited number of times.

A non-affirmative PA decision does not prevent the supplier from submitting a claim. Submission of such a claim and resulting denial by the DME MAC would constitute an initial payment determination and makes the appeal rights available.

Appendix: List of PMD Accessories for Voluntary Prior Authorization

HCPCS	Description	Effective Date
E0950	Tray	Nationwide: 4/06/2023
E0955	Wheelchair accessory, headrest, cushioned, any type, includes fixed mounting hardware	Nationwide: 4/06/2023
E1002	Wheelchair accessory, power seating system, tilt only	Nationwide: 4/06/2023
E1003	Wheelchair accessory, power seating system, recline only, without shear reduction	Nationwide: 4/06/2023
E1004	Wheelchair accessory, power seating system, recline only, with mechanical shear reduction	Nationwide: 4/06/2023
E1005	Wheelchair accessory, power seating system, recline only, with power shear reduction	Nationwide: 4/06/2023
E1006	Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction	Nationwide: 4/06/2023
E1007	Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	Nationwide: 4/06/2023
E1008	Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction	Nationwide: 4/06/2023
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each	Nationwide: 4/06/2023
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	Nationwide: 4/06/2023
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	Nationwide: 4/06/2023
E1029	Ventilator tray, fixed	Nationwide: 4/06/2023
E1030	Ventilator tray, gimbaled	Nationwide: 4/06/2023
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Nationwide: 4/06/2023
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature,	Nationwide: 4/06/2023

	mechanical function selection switch, and fixed mounting hardware	
E2312	Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware	Nationwide: 4/06/2023
E2313	Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each	Nationwide: 4/06/2023
E2321	Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Nationwide: 4/06/2023
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Nationwide: 4/06/2023
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	Nationwide: 4/06/2023
E2324	Power wheelchair accessory, chin cup for chin control interface	Nationwide: 4/06/2023
E2325	Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware	Nationwide: 4/06/2023
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	Nationwide: 4/06/2023
E2327	Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	Nationwide: 4/06/2023
E2328	Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware	Nationwide: 4/06/2023
E2329	Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	Nationwide: 4/06/2023
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware	Nationwide: 4/06/2023
E2351	An electronic interface for speech generating device	Nationwide: 4/06/2023

E2373	Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware	Nationwide: 4/06/2023
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	Nationwide: 4/06/2023
E2601	General Use Wheelchair Seat Cushion width less than 22 inches	Nationwide: 4/06/2023
E2602	General Use Wheelchair Seat Cushion width 22 inches or greater	Nationwide: 4/06/2023
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	Nationwide: 4/06/2023
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	Nationwide: 4/06/2023
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth	Nationwide: 4/06/2023
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any dept	Nationwide: 4/06/2023
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	Nationwide: 4/06/2023
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	Nationwide: 4/06/2023
E2611	General Use wheelchair back cushion width less than 22 inches, any height includes mounting hardware	Nationwide: 4/06/2023
E2612	General use wheelchair back cushion width 22 inches or greater, any height, includes mounting hardware	Nationwide: 4/06/2023
E2613	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	Nationwide: 4/06/2023
E2614	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	Nationwide: 4/06/2023
E2615	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	Nationwide: 4/06/2023
E2616	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	Nationwide: 4/06/2023

E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware	Nationwide: 4/06/2023
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware	Nationwide: 4/06/2023
E2622	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Nationwide: 4/06/2023
E2623	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Nationwide: 4/06/2023
E2624	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Nationwide: 4/06/2023
E2625	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Nationwide: 4/06/2023
K0020	Fixed, adjustable height armrest, pair	Nationwide: 4/06/2023
K0195	Elevating leg rests, pair with capped rental wheelchair base	Nationwide: 4/06/2023