DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 414

[CMS–6087–N]

Medicare Program; Suspension of Required Prior Authorization for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items Under Certain Circumstances

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, (HHS).

ACTION: Suspension of prior authorization requirements for specified orthoses prescribed and furnished urgently or under special circumstances.

SUMMARY: This document announces the suspension of prior authorization for specified orthoses items on the Required Prior Authorization List that require prior authorization as a condition of payment under certain circumstances when reported with certain modifiers. Items subject to face-to-face encounter and written order prior to delivery requirements are not impacted by this document.

DATES: The suspension of the prior authorization requirement discussed in this document took effect on April 13, 2022, when CMS published an announcement on its website.

FOR FURTHER INFORMATION CONTACT: Emily Calvert, (410) 786–4277.

SUPPLEMENTARY INFORMATION:

I. Background

In the December 30, 2015, final rule (80 FR 81674) titled, ''Medicare Program; Prior Authorization Process for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies,'' we implemented section 1834(a)(15) of the Act by establishing an initial Master List (called the Master List of Items Frequently Subject to Unnecessary Utilization) of certain DMEPOS that the Secretary determined, on the basis of prior payment experience, are frequently subject to unnecessary utilization and by establishing a prior authorization process for these items.

In the November 8, 2019, **Federal Register** (84 FR 60648), we published a final rule titled, ''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.'' Through this November 2019 final rule, we harmonized the lists of DMEPOS items created by former rules and established one ''Master List of DMEPOS Items Potentially Subject to Face-To-Face Encounter and Written Orders Prior to Delivery and/or Prior Authorization Requirements'' (the ''Master List''). The November 2019 final rule was effective January 1, 2020.

In January 13, 2022, **Federal Register** (87 FR 2051), we published a document, titled, ''Medicare Program; Updates to Lists Related to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Conditions of Payment.'' Through the January 2022 **Federal Register** document, we updated the Master List and selected certain lower limb orthoses, lumbar sacral orthoses, and power mobility devices to be subject to required prior authorization. The January 2022 **Federal Register** document was effective April 13, 2022.

II. Provisions of the Document

In accordance with 42 CFR 414.234(f), CMS may suspend DMEPOS prior authorization requirement generally or for a particular item or items at any time and without undertaking rulemaking. 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 indefinitely, 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 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 by a physician or treating practitioner during an office visit where the physician or treating practitioner 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, available at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf.*

The Administrator of the Centers for Medicare & Medicaid Services (CMS), Chiquita Brooks-LaSure, having reviewed and approved this document, authorizes Lynette Wilson, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Dated: August 5, 2022.

Lynette Wilson,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2022–17187 Filed 8–9–22; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 414

[CMS–5537–N]

Medicare Program; Alternative Payment Model (APM) Incentive Payment Advisory for Clinicians—Request for Current Billing Information for Qualifying APM Participants

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

ACTION: Payment advisory.

SUMMARY: This advisory is to alert certain clinicians who are Qualifying APM participants (QPs) and eligible to receive an Alternative Payment Model (APM) Incentive Payment that CMS does not have the current billing information needed to disburse the payment. This advisory provides information to these clinicians on how to update their billing information to receive this payment.