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Prior Authorization Process and Exemption

Prior Authorization Hospital Outpatient Department

8/13/2024

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Meaningful | Informative | Simplified

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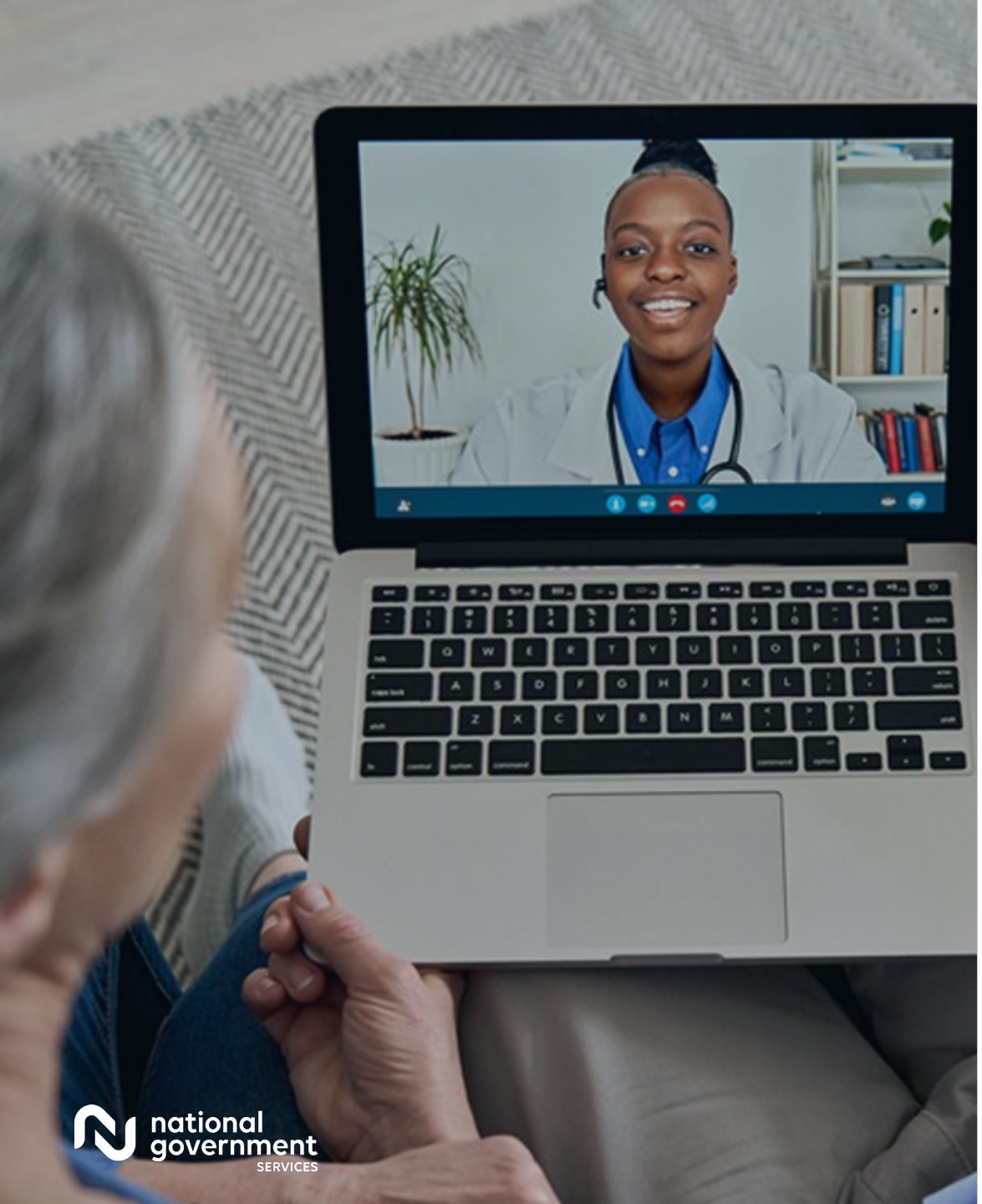

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Today's Presenters

- Hospital Outpatient Department (HOPD) Prior Authorization Clinical Review Nurse Leadership Team
  - Macy Smith RN, BSN
  - Sydney Sabo RN, BSN
  - Stefanie Boucher RN, BSN
  - Bailey Lindsay RN, BSN
  - Michelle Vannatter-Johnson RN, BSN

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Agenda

- Objectives
- Medicare Prior Authorization Program Overview
- How to Successfully Submit Requests
- Exemption
- Common Errors and Mitigation Strategies
- Resources

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Objectives

- Refresh key points and criteria for the Medicare Prior Authorization Program
- Review the steps on how to successfully submit requests and utilize NGS resources
- Tips and tricks for a streamlined process
- Recognizing and understanding next steps and mitigating errors

Medicare Prior Authorization Program Overview

Reminder

- CMS OPD PA program does not change Medicare benefits or coverage requirements, nor does it create new documentation requirements.
- Medicare Coverage: For any item or service to be covered, it must be:
  - Eligible for a defined Medicare benefit category
  - Reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member, and
  - Meet all other applicable statutory and regulatory requirements

Medicare Prior Authorization Program Overview

- Nationwide program that includes Medicare Fee-for-Service (FFS) enrolled Hospital Outpatient Departments (HOPDs) that provide certain HOPD services
- Condition of Payment: Providers must submit Prior Authorization requests (PARs) to their Medicare Administrative Contractor (MAC) for any service on the list of OPD services that require PA
- Designed to ensure all relevant coverage, coding, payment rules and medical record requirements are met before the service is rendered to the beneficiary and the claim is submitted for payment
- Beneficiary must have Medicare as primary or secondary insurance

Medicare Prior Authorization Program Overview (2)2

- HOPD is responsible for obtaining PA
- Requester: person/entity submitting the PAR
- Unique tracking number (UTN) will be assigned to each PAR that receives a clinical decision
- PAR decisions are not appealable
- UTN Decisions
  - Provisional Affirmation UTN is the preliminary finding that the future claim will likely meet Medicare coverage, coding, and payment requirements.
  - Non-Affirmation UTN is the preliminary finding that the future claim submitted will NOT likely meet Medicare requirements, resulting in claim denial. Appeal rights then become available.
- Prior Authorization - NGSMEDICARE

Medicare Prior Authorization Program Overview (3)2

- Claim types excluded from PA requirements
  - Veteran Affairs
  - Indian Health Services
  - Medicare Advantage
  - Medicare Advantage sub-category Indirect Medical Education only claims
  - Part A/B rebilling
  - All Part A and Part B demonstrations
  - Claims for emergency department services when the claim is submitted with an ET modifier or 045x revenue code

HOPD Services that Require PA

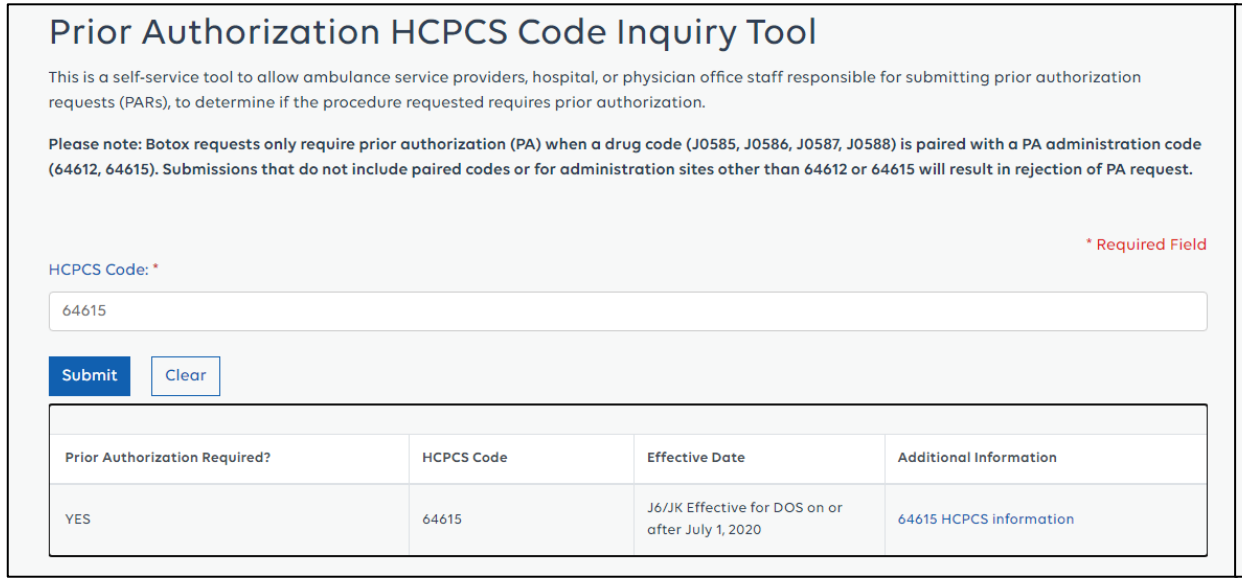
Dates of service on/after 7/1/2020	Dates of service on/after 7/1/2021	Dates of service on/after 7/1/2023
Blepharoplasty	Cervical Fusion with Disc Removal	Facet Joint Interventions
Botulinum Toxin Injections	Implanted Spinal Neurostimulators	
Panniculectomy		
Rhinoplasty		
Vein Ablation		

How to Successfully Submit Requests

How to Successfully Submit Requests 1

[Prior Authorization - NGSMEDICARE]

[Prior Authorization HCPCS Code Inquiry Tool - NGSMEDICARE]



Prior Authorization HCPCS Code Inquiry Tool

This is a self-service tool to allow ambulance service providers, hospital, or physician office staff responsible for submitting prior authorization requests (PARs), to determine if the procedure requested requires prior authorization.

Please note: Botox requests only require prior authorization (PA) when a drug code (J0585, J0586, J0587, J0588) is paired with a PA administration code (64612, 64615). Submissions that do not include paired codes or for administration sites other than 64612 or 64615 will result in rejection of PA request.

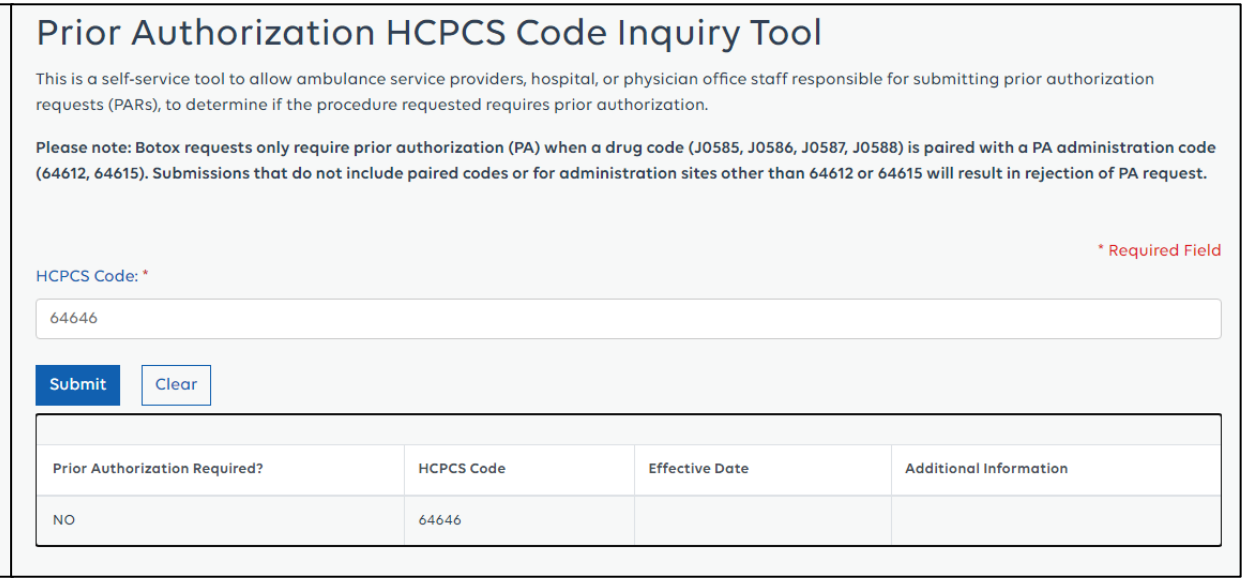
* Required Field

HCPCS Code: *

64615

Submit | Clear

Prior Authorization Required?	HCPCS Code	Effective Date	Additional Information
YES	64615	J6/JK Effective for DOS on or after July 1, 2020	64615 HCPCS information



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* Required Field

HCPCS Code: *

64646

Submit | Clear

Prior Authorization Required?	HCPCS Code	Effective Date	Additional Information
NO	64646		

How to Successfully Submit Requests(2)2

Submission Methods

- NGSConnex
  - Part A: NGSConnex User Guide
  - Part B: NGSConnex User Guide
- esMD
  - Content type 8.5
- Fax
  - JK: 317-841-4530
  - J6: 317-841-4528
- Mail
  - National Government Services, Inc.
    Attention: Medical Review Prior Authorization Request
    P.O. Box 7108
    Indianapolis, IN 46207-7108

Questions Pertaining to Prior Authorization

- Provider Contact Center
  - JK: 888-855-4356
    - NH, VT, CT, RI, NY, MA, ME
  - J6: 877-702-0990
    - WI, MN, IL

How to Successfully Submit Requests (3)2

- The standard timeframe to review and communicate a decision for all initial and resubmitted requests is 10-business days from the date of receipt
- Provisionally affirmed UTNs have a validation period of 120 days
  - The decision date is counted as the first day of the 120-day validation period
- Outpatient Department Guide (cms.gov)

How to Successfully Submit Requests (4)2

- **Expedited Requests**
  - The requestor may submit for an expedited review of the PAR if it is determined that a delay could seriously jeopardize the beneficiary's life, health or ability to regain maximum function.
  - If the PA OPD team substantiates the need for an expedite decision, a decision will be communicated within 2-business days of receipt of the expedited request. If medical documentation does not support an expedited process, the request will be subject to the standard review timeframe.

How to Successfully Submit Requests (5)2

- **Documentation Requirements**
  - You can find all documentation requirements on the NGS Medicare site:
    - ✓ Prior Authorization – NGSMEDICARE
  - There are more detailed requirements for services with local or national policies
    - ✓ Vein Ablation
    - ✓ Facet Joint Interventions
    - ✓ Botulinum Toxin Injections
    - ✓ Implanted Spinal Neurostimulators
    - ✓ Cervical Fusion

How to Successfully Submit Requests(6)

- **Documentation requirements for each service type**
  - Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair
  - Botulinum Toxin Injections
  - Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue
  - Rhinoplasty and Related Services
  - Vein Ablation and Related Services
  - Cervical Fusion with Disc Removal
  - Implanted Spinal Neurostimulators
  - Facet Joint Interventions

How to Successfully Submit Requests(7)

- **PAR coversheet**
  - Any field marked REQUIRED on the PAR coversheet is necessary for UTN creation
    - ✓ If incorrect/invalid information is provided, NGS will contact the requester listed for the correct information
    - ✓ NGS cannot assume these data elements. Please consult with hospital billing prior to each submission to ensure all elements provided are related to Part A
- **Resubmissions**
  - Read the decision letter carefully. Contact NGS PA with any questions.
  - Must include all original and additional medical records
- **Valid procedures**
  - PA HCPC Inquiry tool (slide 14)
  - Botox pairs

How to Successfully Submit Requests (8)2

- **Resubmissions**
  - PA Submission Types: Initial or Resubmission
    - ✓ Reminder: there is an unlimited number of resubmission attempts for PA
    - ✓ PA decisions do not have appeal rights
    - ✓ PA does not conduct peer-to-peer reviews
      - NGS will provide outreach calls as necessary to obtain anything that can ultimately support an affirmed decision
    - ✓ Standard process is to resubmit
      - Resubmission of rejected cases should include the newly verified required elements
      - Resubmission of non-affirmed cases should include initial and additional documentation to support the reason(s) for non-affirmation
  - In addition to the required PAR documentation in the Initial Submission section, the resubmission of the PAR should contain an exact match of the beneficiary's first name, last name, and date of birth to the previous submission

How to Successfully Submit Requests (9)2

- **Clinical Decision Letters**
  - The HOPD (provider), physician, and beneficiary receive a decision letter from the MAC
  - Each Non-Affirmation and Provisional Partial Affirmation decision letter includes a reason code, description, and clarifying statement:
    - ✓ HP703: Insufficient documentation to support that pain was present for a minimum of 3 months with documented failure of noninvasive conservative management. Refer to Social Security Act (SSA) Title XVIII, Section 1862(a)(1)(A), Title XVIII, Section 1833 (e) of the Act. Refer to the Medicare Administrative Contractor (MAC) Local Coverage Determination (LCD) and/or Local Coverage Article (LCA) if applicable. The submitted documentation does not support that pain was present for a minimum of 3 months with documented failure to respond to noninvasive conservative management. In addition, the lack of radicular symptoms must be documented. The submitted documentation included only imaging and the order form.

Common Errors and Mitigation Strategies

Required Information for Each Submission

Hospital OPD Information

- Name of facility
- PTAN/CCN
- Facility Address
- Facility NPI
- Type of Bill (TOB) Code

Reasons for PAR rejection

- Missing or invalid HOPD billing information
- Facility/provider types, such as physician's offices, critical access hospitals, or ambulatory surgery centers that submit claims other than type of bill (TOB) 13X, are not required to submit PARs

Required Information for Each Submission(2)

Physician/Practitioner Information

- Physician/Practitioner's Name
- Physician/Practitioner's NPI
- Physician/Practitioner PTAN
- Physician/Practitioner's Address

Reasons for PAR rejection

- NPI does not belong to the physician listed
- Physician name provided is the same as the requester's

Required Information for Each Submission(3)

Other Information

- HCPCS code(s)
- Type of Bill (TOB)
- Indicate if the request is expedited and the reason why
  - Must be substantiated
  - Non-substantiated expedites convert to 10-business day reviews
  - No need to resubmit the case if expedited review is rejected

Reasons for PAR rejection

- Missing or invalid TOB
- Missing HCPCS code(s)
- HCPCS code(s) is not part of the program

Mitigating Errors 2

- **Botulinum Toxin**
  - Botox requests only require PA when a drug code (J0585, J0586, J0587, J0588) is paired with a PA administration code (64612, 64615). Submissions that do not include paired codes or for administration sites other than 64612 or 64615 will result in rejection of the PA request
- **Primary Codes**
  - A primary code must be present on all submissions. Add on codes cannot be billed alone; therefore, NGS rejects these cases to prevent billing errors from occurring
    - ✓ Vein Ablation
    - ✓ Cervical Fusion with Disc Removal
    - ✓ Facet Joint Interventions
    - ✓ Panniculectomy

Mitigating Errors(2)

- **Implanted Spinal Neurostimulators**
  - Permanent placement requests
    - ✓ If PA was obtained for the trial request, AND
    - ✓ The facility and physician information for the permanent request has not changed, and validation period for the trial has not expired, then
      - NO PA required for permanent placement. CMS has instructed to use the trial UTN for the permanent placement claim

Mitigating Errors(3) 4

Vein Ablation

36475: first vein treated
36476: subsequent vein(s) treated in a single extremity

Cervical Fusion with Disc Removal

22551: cervical below C2
22552: each additional interspace

Facet Joint Interventions

64490: single level
64491: second level
64492: third and any additional level(s)
64633: single facet joint
64634: each additional facet joint

Panniculectomy

15830: Excision, excessive skin and subcutaneous tissue
15847: includes umbilical transposition and fascial plication

Exemption

Exemption

- HOPDs who demonstrate compliance with Medicare coverage, coding, and payment rules related to PA may be eligible for exemption
- This exemption remains in effect for a twelve-month period or until CMS elects to withdraw the exemption
- Each exemption cycle starts **January 1** of each year
- Exempt HOPDs should ***not*** submit PARs during the exemption period.
  - If you are a requester submitting on behalf of the HOPD and are unaware of the HOPD's exemption status, please contact the HOPD and request a copy of the exemption notification letter, or utilize the self-service Exemption Inquiry Tool
  - Connex providers will not be able to initiate PARs and will be directed to the exemption notice displayed in the portal

Exemption (2)2

Prior Authorization Exemption Status Inquiry Tool

This is a self-service tool to allow both hospital or physician office staff responsible for submitting prior authorization requests (PARs), to **check the exempt status of the HOPD**. This tool will only recognize the hospital **6-10 digit PTAN (CCN) number**. If the PTAN entered is not recognized, it is an indication that a PAR is required.

Please note: Physician, Ambulatory Surgical Center and Critical Access Hospital PTAN entries will not return results; however a PAR is not required for these facility types. Only hospital outpatient departments billing with a Type of Bill (TOB) code 13x require prior authorization.

Updates to this tool are completed annually. Please check back on or after December 10 each year for the most up-to-date OPD exemption status.

Reviewed 6/12/2024

PTAN *

55A290

Search | Reset

Search Results	Notes
No results returned for this PTAN	Please check back on 12/10/2024 for updates on provider Exemption status.

Exemption(3)2

- **Current exemption timeline**
  - ADRs
    - ✓ 10 post pay ADRs have been issued to those facilities who qualified
      - Due within **45 days** of issue date- please reference the due date provided on the ADR
    - ✓ Pre-ADR withdrawals have been issued
      - Providers still exempt through **December 31**
    - ✓ Claim review results will be sent via US mail or displayed in NGSCONNEX by **November 2**
    - ✓ Exemption tool will be updated by **December 10**
    - ✓ Withdrawn providers will be able to submit starting **December 18**
  - PARs
    - ✓ New exempt providers for 2025 will be notified by **November 2**

Resources

CMS Resources

- CMS website: Prior Authorization for Certain Hospital Outpatient Department (OPD) Services
  - Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services Operational Guide

NGS Resources

NGS website: Prior Authorization – NGSMEDICARE

- PA Rejections Alert – NGSMEDICARE
- Tools & Calculators – NGSMEDICARE

- NGSConnex – NGSMEDICARE
  - NGSConnex User Guide - NGSMEDICARE

NGS YouTube Videos

- Prior Authorization - Program Overview
- Prior Authorization - The Exemption Process
- Prior Authorization - Vein Ablation and Related Services
- Prior Authorization - Panniculectomy and Related Services
- Prior Authorization - Rhinoplasty and Related Services

Additional HOPD PA Resources

NGS Local Coverage Determinations and Local Coverage Articles

- A52837 Blepharoplasty – Medical Policy Article
- L33646 Botulinum Toxins
- A52848 Billing and Coding: Botulinum Toxins
- L33575 Treatment of Varicose Veins of the Lower Extremity
- A52870 Billing and Coding: Treatment of Varicose Veins of the Lower Extremity
- L35936 Facet Joint Interventions for Pain Management
- A57826 Billing and Coding: Facet Joint Interventions for Pain Management
- L39770 Cervical Fusion
- A59632 Billing and Coding: Cervical Fusion

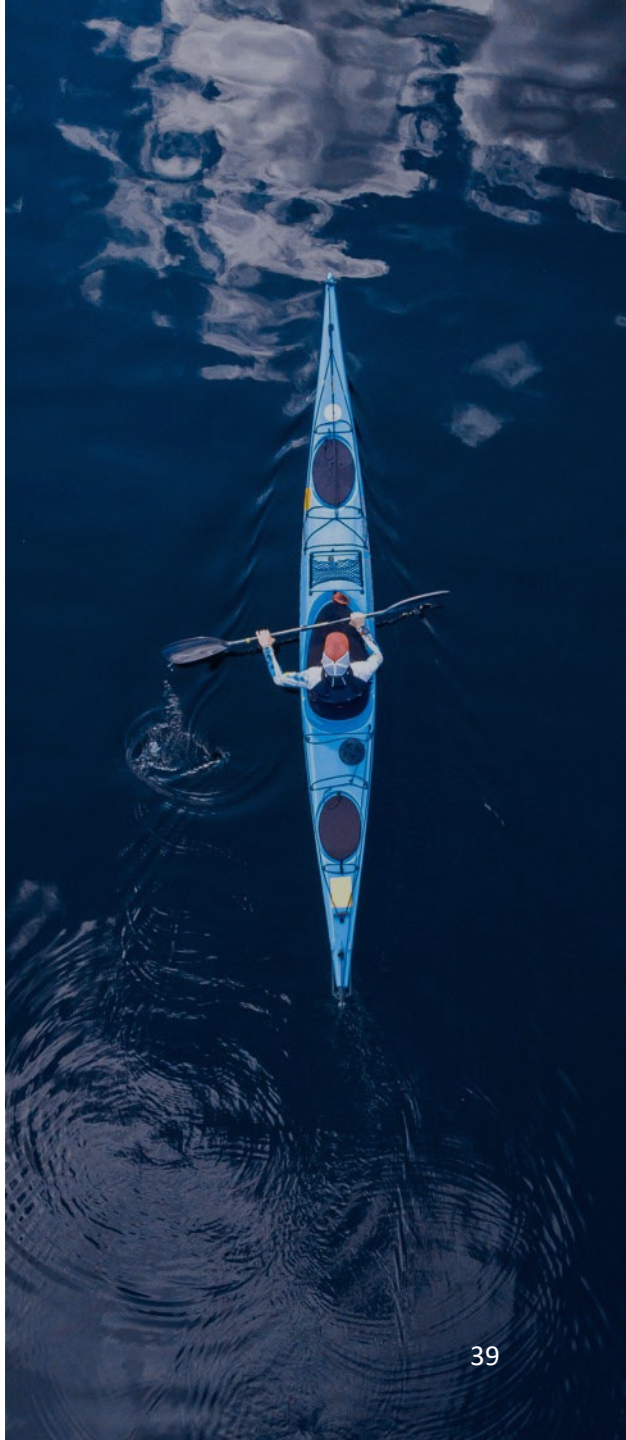
NCD for Spinal Neurostimulators 160.7

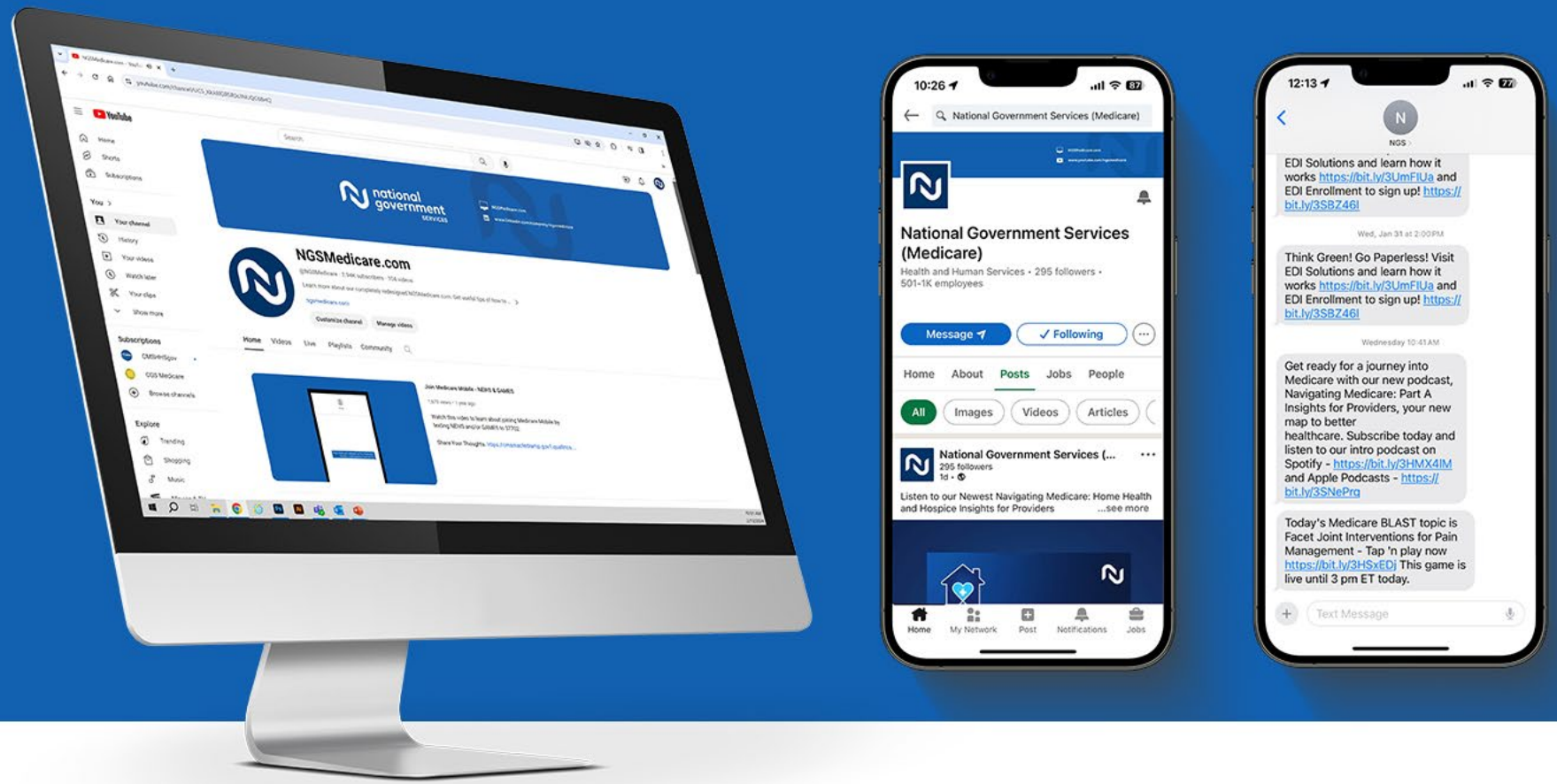
Questions?

You can check the Events Calendar on NGSMedicare.com to find out more information and register for upcoming educational sessions.

Thank you for taking the time to join us today

We hope the information provided will be helpful in the HOPD Prior Authorization Submission and Exemption processes





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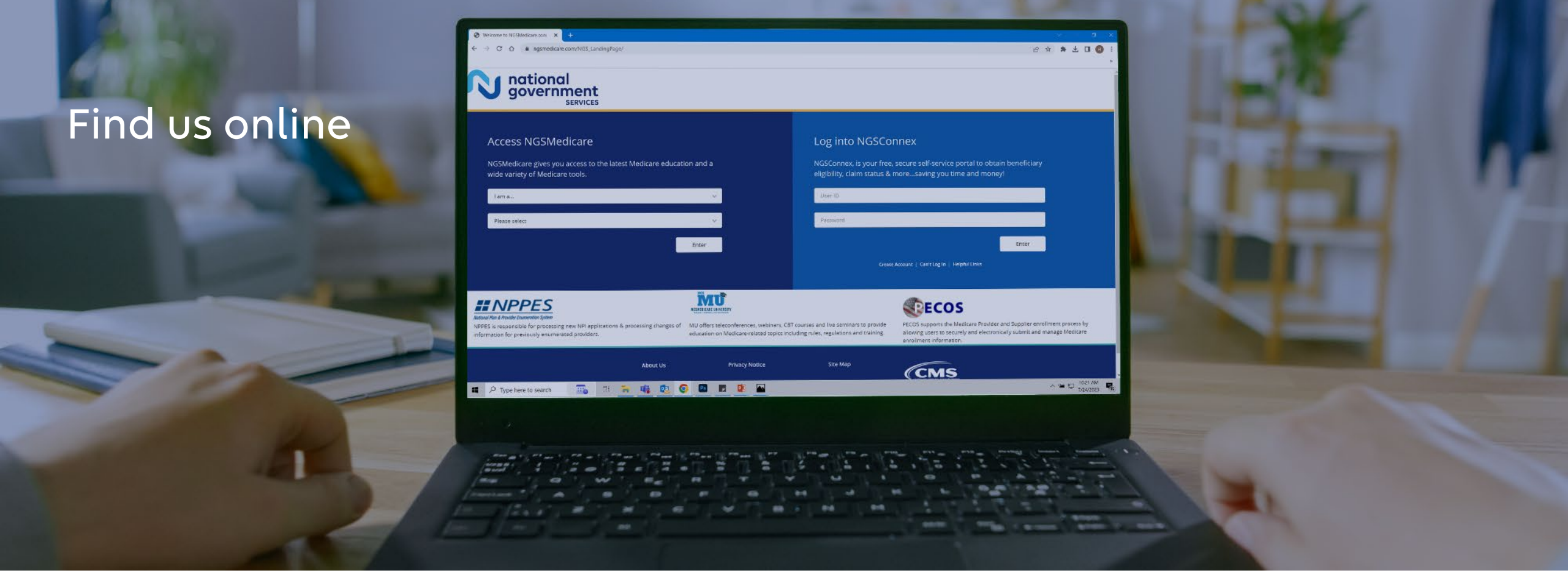

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Online resources, event calendar, LCD/NCD, and tools

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