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Prior Authorization for Facet Joint Interventions in HOPD Effective DOS on/after 7/1/2023

Note: PARs accepted on/after 6/15/2023 for DOS on/after 7/1/2023

7/12/2023

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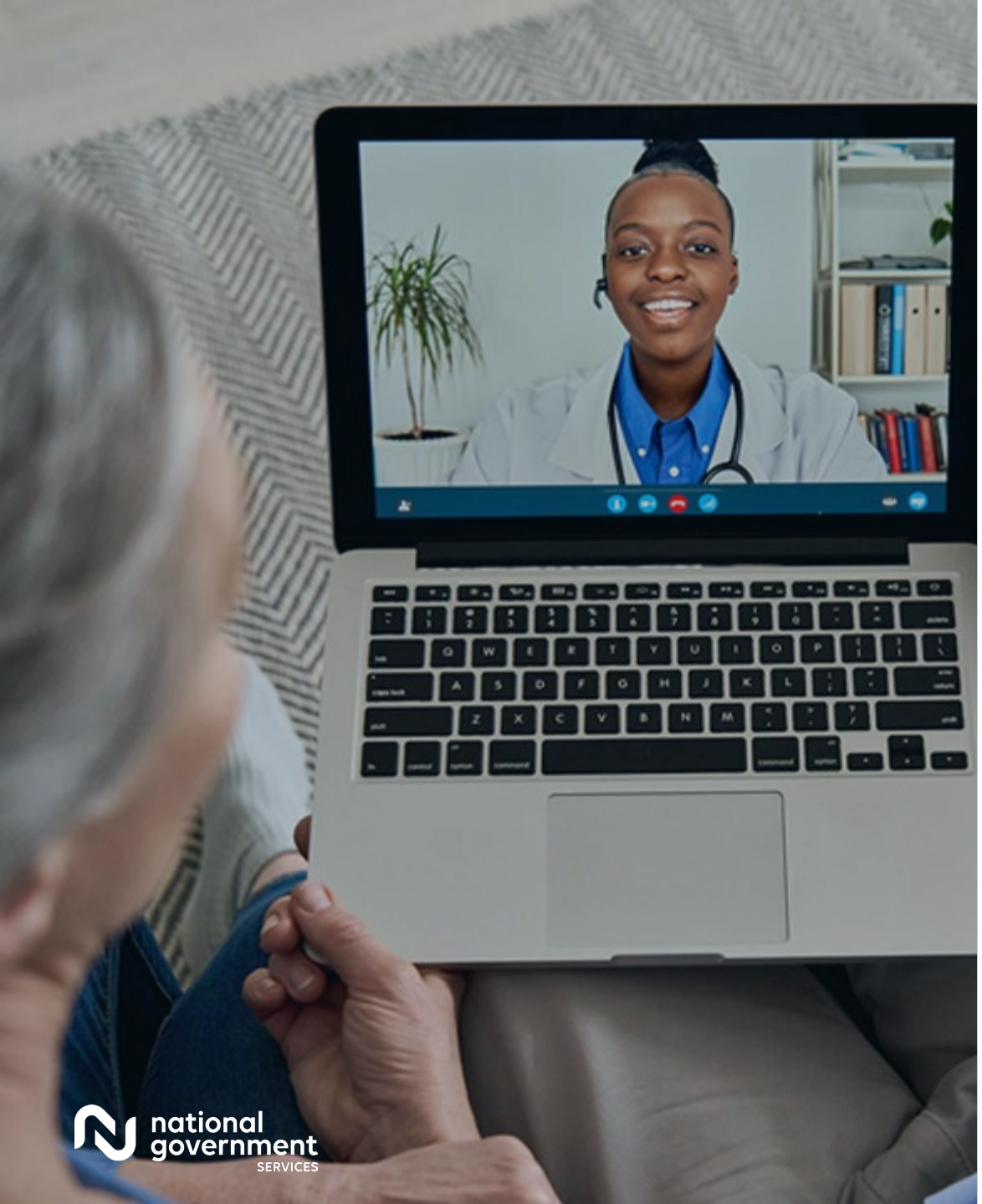

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Objective

Understand the prior authorization requirement, including when prior authorization is required for facet joint interventions and how to request prior authorization

Today's Presenters

- Provider Outreach and Education Consultants
  - Jean Roberts, RN, BSN, CPC
  - Jen DeStefano

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AGENDA

- Overview of the Medicare Prior Authorization Program
- New Requirement: Prior Authorization for Facet Joint Interventions
- Required Documentation to Submit with PAR for Facet Joint Intervention
- OPD Prior Authorization Process
- Scenarios to Consider
- Resources

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Overview of the Medicare Prior Authorization Program

Reminder

- CMS Outpatient Department 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

PA Program Overview

- CY 2020 OPPS/ASC Final Rule (CMS -1717-FC)
- Authority as per SSA section 1833(t)(2)(F)
  - Note: National Program for all applicable providers and physicians
  - Condition of Medicare payment: Provider must submit PA request to MAC for any service on the list of OPD services requiring PA
  - Medicare beneficiary must have Medicare as primary or secondary
  - For specified services rendered on/after 7/1/2020
    - ✓ Medical necessity documentation requirements remain unchanged

Purpose and Goal

- Purpose
  - Ensure Medicare beneficiaries receive medically necessary care
  - Protect the Medicare Trust Fund from improper payment
- Goal
  - Control unnecessary increases in the volume of certain hospital OPD services covered under Part B of the Medicare Fee-for-Service program
    - ✓ Hospital outpatient services covered under Part B are billed on the 1450 claim form

PA Program Overview

- Nationwide program that includes Medicare FFS enrolled hospital outpatient departments that provide certain hospital outpatient department services
  - Requestor – person/entity submitting prior authorization request, documentation, and/or claims
  - Requestor submits PAR to their Medicare FFS contractor, NGS, on behalf of the outpatient department
  - NGS will review the PAR and issue a decision

PA Program Overview

- Effective for DOS on/after 7/1/2020 providers must request PA for the following five categories/groups of HOPD services and related services and must obtain affirmation UTN before the services are rendered
  - Blepharoplasty
  - Botulinum toxin injections
  - Panniculectomy
  - Rhinoplasty
  - Vein ablation

PA Program Overview

- Effective for DOS on/after 7/1/2021 providers must request PA for the following two categories/groups of HOPD services and related services and must obtain affirmation UTN before the services are rendered
  - Cervical Fusion with Disc Removal
  - Implanted Spinal Neurostimulators

PA Program Overview

- NGS will begin accepting PARs for one new service on 6/15/2023, for the following service provided beginning DOS on/after 7/1/2023
  - Facet Joint Interventions
    - ✓ Must obtain affirmation UTN before the services are rendered

Future Updates to Prior Authorization

- List of hospital OPD services requiring prior authorization will be updated through formal notice-and-comment rulemaking
- Technical updates to the list of services, such as changes to the name of the service or the HCPCS code, will be published on the CMS website
- **Note:** CMS may suspend the outpatient department services prior authorization process requirements generally or for a particular service(s) at any time by issuing notification on the CMS website

Exclusions from PA Program

- Claims with eligible item(s)/service(s) for a PA program when submitted by
  - 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
    - ✓ **Note:** This does not exclude these claims from regular medical review

New Requirement: Prior Authorization for Facet Joint Interventions

Prior Authorization: Facet Joint Intervention

- Facet joint interventions added to prior authorization process for hospital outpatient department services
  - Per CY2023 Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule (CMS-1772-FC)

Prior Authorization: Facet Joint Intervention

- NGS will begin accepting PARs on 6/15/2023 for DOS on/after 7/1/2023 for facet joint interventions in hospital outpatient department setting
  - Applies to TOB 13X (hospital outpatient)
  - The facility is responsible for submitting claims for PA on a 1450 claim
    - ✓ Physician services relevant to the PA services are billed on a 1500 using one of the following place of service codes
      - 19 – Off Campus Outpatient Hospital
      - 22 – On campus – Outpatient Hospital

Diagnostic and Therapeutic Facet Joint Intervention Codes

CPT Codes	Description
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), **cervical or thoracic**; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), **cervical or thoracic**; second level
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), **cervical or thoracic**; third and any additional level(s)

Diagnostic and Therapeutic Facet Joint Intervention Codes

CPT Codes	Description
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), **lumbar or sacral**; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), **lumbar or sacral**; second level
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), **lumbar or sacral**; third and any additional level(s)

RFA Facet Joint Intervention Codes

CPT Code	Description
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); **cervical or thoracic**, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); **cervical or thoracic,** each additional facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); **lumbar or sacral**, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); **lumbar or sacral**, each additional facet joint

Required Documentation to Submit with PAR for Facet Joint Intervention

Reminder: Local Coverage Determination

- Refer to NGS LCD and LCA for detailed documentation requirements
  - NGS LCD: L35936: Facet Joint Interventions for Pain Management
  - Associated NGS LCA: A57826: Billing and Coding: Facet Joint Interventions for Pain Management
- The beneficiary's medical record must contain documentation fully supporting medical necessity for facet joint intervention services

General Documentation Requirements

- Intraarticular Facet Joint Injections, Medial Branch Blocks, and Radiofrequency Ablations:
  - Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale, and
  - Presence of pain for minimum of three months with documented failure to respond to conservative management, and
  - Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst), and
  - Non-facet pathology must be ruled out based on clinical evaluation or radiology studies

General Documentation Requirements

- Scales used to assess the measurement of pain and/or disability must be obtained at baseline and documented in the medical record for each assessment (refer to your MAC's LCD/LCA)
  - ✓ **Note:** Same scale used for initial baseline assessment should be used for every subsequent procedure to measure injection effectiveness
    - Applies to all diagnostic, therapeutic and RFA subsequent injections

Documentation: Diagnostic Facet Joint Procedures (IA or MBB)

- Indicate if this request is for an initial or second diagnostic procedure
- Diagnostic procedures should be performed with the intent that if successful, RFA would be considered the primary treatment goal at the diagnosed level(s)
- First diagnostic facet joint procedure (IA or MBB)
  - Documentation must support the criteria outlined in general documentation requirements for facet joint interventions
- Second diagnostic facet joint procedure(s) (IA or MBB), documentation must support the following:
  - Documentation must support the requirements for the first diagnostic procedure at the same level, and

Documentation: Diagnostic Facet Joint Procedures (IA or MBB)

- After the first diagnostic procedure, there must be at least 80% of pain relief, **and**
- The second diagnostic procedure may only be performed a minimum of two weeks after the initial diagnostic procedure. Exception to the two-weeks duration may be considered on an individual basis and must be clearly documented in the medical record
- **Note:** Same pain/disability scale should be used to confirm the second procedure's effectiveness of at least 80% pain relief

Documentation: Therapeutic Facet Joint Procedures (IA)

- Indicate if this request is for an initial or subsequent therapeutic procedure
- Documentation of two diagnostic facet joint procedures with each providing at least 80% of pain relief, **and**
- Subsequent therapeutic facet joint procedures at the same anatomic site with at least 50% pain relief for at least three months from the prior therapeutic procedure or at least 50% improvement in the ability to perform previously painful movements and ADLs, compared to baseline measurement using the same scale, **and**
- Documentation of why the beneficiary is not a candidate for RFA

Documentation: Facet Joint Denervation (RFA)

- Indicate if this request is for an initial or subsequent facet joint denervation procedure
- Documentation must support at least two diagnostic MBBs with each one providing at least 80% of pain relief, **and**
- Subsequent thermal facet joint RFA at the same anatomic site with at least 50% of pain improvement for at least six months or at least 50% improvement in the ability to perform previously painful movements and ADLs, compared to baseline measurement using the same scale

Frequency Limitations

- Diagnostic procedures
  - For each covered spinal region no more than four diagnostic joint sessions will be considered medically reasonable and necessary per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure
- Therapeutic procedures
  - For each covered spinal region no more than four therapeutic facet joint injection (IA) sessions will be reimbursed per rolling 12 months
- Denervation procedures
  - For each covered spinal region no more than two radiofrequency sessions will be reimbursed per rolling 12 months

OPD Prior Authorization Process

Prior Authorization Request Types

- Three PAR submission types
  - Initial
  - Expedited
  - Resubmission

Initial PAR must include all of the following

- Beneficiary information
  - Name (first and last), MBI, DOB
- Hospital OPD information
  - Facility: Name, PTAN/CCN, address, NPI
- Physician/practitioner information
  - Physician/practitioner: Name, NPI, PTAN/CCN, practitioner's address, phone number, fax number
- Requestor information
  - Requestor: name, address, phone number, fax number, email address
- If required elements do not match the information on file with Medicare we will contact listed requester to verify

Initial PAR must include all of the following

- Other information
  - HCPCS/CPT code(s), TOB
    - ✓ Include paired codes for Botulinum Toxin Injections
- Indicate initial or resubmission request
  - Initial means there is not a decision letter for a prior request
  - If provider received a non affirm decision letter for a DOS, it is a resubmission
- Indicate if request is expedited and the reason why it is expedited

Expedited PA Request

- In emergency situations, requestor may submit request for expedited PAR when requestor determines delay in receiving PAR approval may seriously jeopardize the Medicare beneficiary's life or imminent safety
- Must include all information as per an initial PAR request
- PAR request must indicate request is expedited and provide reason
- If MAC agrees that expedited PA is necessary, decision is completed on accelerated timeframe
- Expediting PAR to meet anticipated DOS is not acceptable reason to qualify for expedited review

Resubmission of PAR

- After reviewing detailed decision letter
  - Resubmission of PAR is allowed after a non-affirmation decision made on PAR
  - Include all elements required for initial PAR submission
    - ✓ Must state this is a subsequent request and include UTN associated with previous submission
  - Ensure an exact match of the following that was submitted with the initial request
    - ✓ Must include the medical records, as well as beneficiary first name, last name, DOB
- Submitter may resubmit PAR request unlimited number of times

Requestor Options for submitting PAR to NGS

- MAC secure provider portal: NGSConnex
  - NGS YouTube Video: How to Submit PAR
  - NGSConnex User Guide: NGSMedicare.com > Provider Resources tab > NGSConnex
- Mail
- Fax
- esMD – electronic submission of medical documentation
  - Content type 8.5
  - **Note**: Submission via esMD began on/after 7/6/2020
    - For more information: Electronic Submission of Medical Documentation (esMD)

NGS MAC Contact Information

J6 – National Government Services

- NGSConnex (preferred)
- Mailing Address

  National Government Services

  PO BOX 7108

  Indianapolis, IN 46207-7108
- Fax: 317-841-4528
- NGS Website
- esMD: Indicate document/content type 8.5

JK – National Government Services

- NGSConnex (preferred)
- Mailing Address

  National Government Services

  PO BOX 7108

  Indianapolis, IN 46207-7108
- Fax: 317-841-4530
- NGS Website
- esMD: Indicate document/content type 8.5

NGS Review Decision

- NGS will review all information submitted and issue decision to PAR requestor
  - Send initial decision letter within 10 business days
- Provisional affirmation: NGS will issue a UTN for PA decisions
  - Provisional affirmation means: Future claim submitted to Medicare per the PAR likely meets applicable Medicare coverage, coding, and payment rules
    - ✓ Validation period of 120 days begins with decision date

NGS Review Decision

- Non-affirmation PA Decision: preliminary finding that if a claim is submitted to Medicare, based on the PAR, the services would likely not meet applicable Medicare coverage, coding, and payment rules
  - NGS will provide detailed information to PAR requestor and will be returned by the method it was submitted
- PAR requestor retains option to resubmit PAR
  - Must be complete PAR with all requested documentation and any modifications that may be necessary as per the detailed decision letter
    - ✓ Include original non-affirmed UTN with resubmission

NGS Review Decision

- NGS will review expedited PAR to determine whether to expedite or convert request to standard PA review process
  - Requester is notified within two days of NGS decision as to acceptance or non-acceptance of expedited review; non-accepted expedited review denial is converted to standard PA review process
    - ✓ Valid affirmation of expedited review: Provider notified via telephone, fax, electronic portal, or other “real-time” communication, within two business days
    - ✓ Non-affirmative decision: Provider will be notified within two business days
  - Request for an expedited review is appropriate when delays in receipt of a PA decision could jeopardize beneficiary life, health, or ability to regain maximum function

FAQ

- How long does PAR approval and associated UTN remain valid?
- PAR decisions and UTNs for these services are valid for 120 days.
  - Example
    - ✓ 5/31/2023: PAR is affirmed
    - ✓ PAR is valid for DOS through 9/27/2023
      - Provider must submit new PAR to continue beyond 9/27/2023

Decision Letter

- Sent to requestor, physician and beneficiary
- Includes the UTN
  - Unless letter is notification of non-accepted expedited request or PAR was missing required elements
- NGS sends the decision letter via the same method that the PAR was received
  - However, NGS may send a copy of decision letter via fax when a valid fax number is provided
    - ✓ May send via fax when PAR was received via mail
    - ✓ If fax is not verified, letter is mailed
  - Rejection letters do not include a UTN

Reminder

- Decision letter includes the UTN for affirm, non-affirm, partial affirm
- **Important:** Do not submit claim(s) without a UTN
  - Otherwise the claim will deny
- Please confirm the UTN validation dates to include with the appropriate DOS

Exemptions

- CMS/MACs may exempt a provider from the prior authorization process based on
  - Demonstrated compliance with Medicare coverage, coding, and payment rules as demonstrated by
    - ✓ Minimum of ten requests submitted
    - ✓ Affirmation threshold of at least 90% during semiannual assessment
  - When applicable, notice of exemption or withdrawal of exemption provided a minimum of 60 days prior to becoming effective

Scenarios to Consider

Provisional Affirmation

- MAC may deny claim
  - Technical requirements
  - Information not available with PA request
  - If there is any change on the submitted PAR that was submitted, adding HCPCS, changing of provider

PAR Submitted/Claim Denied

- PAR submitted with all required documentation
  - NGS issued non-affirmation
  - Any associated claim will be denied
  - Claim may be submitted to any available secondary insurance
  - When beneficiary is dually eligible for Medicare and Medicaid
    - ✓ Medicare non-affirmation decision may allow state to pursue other insurance before considering for Medicaid coverage
      - Provider may need to submit claim to Medicare first

No PAR Submitted/ABN

- No PAR submitted for services requiring PA: ABN not issued or not valid (OC 32/GA modifier billed)
  - Claim will suspend for review and documentation requested
  - NGS Medical Review determines validity of ABN
- Resources on ABNs
  - CMS Internet Only Manual 100-04, *Medicare Claims Processing Manual*, Chapter 30, Financial Liability Protections, Section 40
  - MLN Booklet® *Medicare Advance Written Notices Of Noncoverage*

Other Insurance Secondary or Dual Eligibility

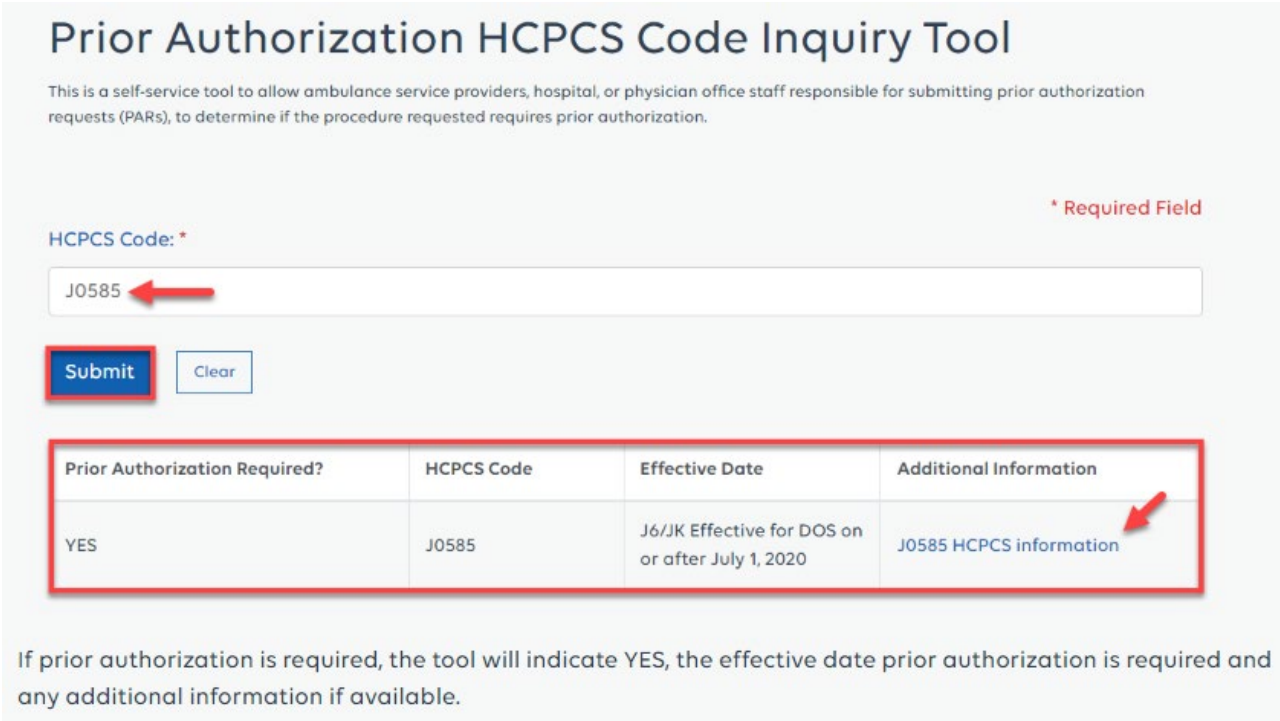
- PAR either not submitted or non-affirmed
  - Claim will be denied
  - Can be forwarded to the secondary insurer
- Beneficiary dually eligible for Medicare and Medicaid
  - May need to submit claim to Medicare to obtain a denial before submitting to Medicaid
    - ✓ Non-affirmed PA decision sufficient to meet states' obligation to pursue other coverage

Medicare Secondary Payer Situations

- MSP/other insurance primary
  - Provider submits PAR with all required documentation to NGS prior to providing services subject to PA
  - Provisional affirmation PA decision made
    - ✓ Claim submitted to primary insurance
    - ✓ If primary insurance denies claim then claim should be submitted to Medicare
      - Ensure UTN on claim

NGS Resources: Prior Authorization HCPCS Code Inquiry Tool

- Applies to hospital, physician office, and/or ambulance service provider
- To locate this tool: NGS Website> Resources > Tools & Calculators > Prior Authorization HCPCS Code Inquiry Tool



Part A PA Status Update Requests

- Use NGSConnex to initiate and check status of your prior authorization requests
- Additional information:
  - Part A Prior Authorization Status Update Requests
    - ✓ Includes link to “Check Status of Prior Authorization Requests” in the NGSConnex User Guide

Part A PA Exemption Status

- Use the Prior Authorization Exemption Status Inquiry Tool to check the exemption status of the HOPD
  - Prior Authorization Exemption Status Inquiry Tool
- Additional information:
  - Prior Authorization Exemption Status Inquiry Tool Alert

Resources

CMS Resources

- CMS web site: Prior Authorization for Certain Hospital Outpatient Department (OPD) Services
  - Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services Operational Guide (updated 4/11/2023)
  - OPD Questions and Answers document
- CMS Change Request 13016, Provider Education for Prior Authorization (PA) Process for Facet Joint Interventions in the Hospital Outpatient Department (OPD) Setting
- Fact Sheet: CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

NGS Resources

- NGS LCD L35936: Facet Joint Interventions for Pain Management
- NGS Associated LCD Article A57826: Billing and Coding: Facet Joint Interventions for Pain Management
- NGSConnex User Guide

NGS YouTube Videos

- How to Initiate and Check Status of Prior Authorization Requests for OPD Services in NGSConnex
- 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

Office of the Inspector General (OIG)

- OIG Report A-09-22-03006 (3/2023): Medicare Improperly Paid Physicians An Estimated $30 Million For Spinal Facet-Joint Interventions
- OIG Report A-09-21-03002 (12/2021): Medicare Improperly Paid Physicians for Spinal Facet-Joint Denervation Sessions
- OIG Report A-09-20-03003 (10/2020): Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period

Additional HOPD PA Resources

- NGS Local Coverage Determinations
  - A52837 Blepharoplasty – Medicare Policy Article
  - L33646 Botulinum Toxins
  - A52848 Botulinum Toxins - Billing and Coding Article
  - L33575 Varicose Veins of the Lower Extremity, Treatment of
  - A52870 Varicose Veins of the Lower Extremity, Treatment of – Billing and Coding Article
- NCD for Spinal Neurostimulators 160.7

Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course Code.

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