

Prior Authorization: Hospital Outpatient Department

The Prior Authorization Process

5/7/2024

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Today's Presenters

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AGENDA

Objectives

Medicare Prior Authorization Program
Overview

How to Successfully Submit Requests

Steps to a Streamlined Approach

Recognize Commonly Found Errors

Resources

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
- Learn 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 FFS enrolled Hospital Outpatient Departments (HOPDs) that provide certain HOPD services
- Condition of Medicare Payment: Providers must submit Prior Authorization (PA) requests to their Medicare Administrative Contractor (MAC) for any service on the list of OPD services that require PA. The program applies to all jurisdictions
- 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

HOPD Services that Require PA

- As a Condition of Payment for

Dates of service on/after 7/1/2020	Dates of service on/after 7/1/2021	Dates of service on/after 7/1/2023
<ul style="list-style-type: none">• Blepharoplasty	<ul style="list-style-type: none">• Cervical fusion with disc removal	<ul style="list-style-type: none">• Facet joint interventions
<ul style="list-style-type: none">• Botulinum toxin injections	<ul style="list-style-type: none">• Implanted spinal neurostimulators	
<ul style="list-style-type: none">• Panniculectomy		
<ul style="list-style-type: none">• Rhinoplasty		
<ul style="list-style-type: none">• Vein Ablation		

Medicare Prior Authorization Program Overview 1

- The HOPD is responsible for obtaining the Prior Authorization (PA)
- Requestor: person/entity submitting the Prior Authorization Request (PAR)
- A unique tracking number (UTN) will be assigned to each PAR that receives a clinical decision
- When the claim is submitted for billing, a Provisional Affirmation UTN must be placed on the claim to receive payment for the service(s)
- If billed with a Non-Affirmation UTN, the claim will deny, and appeal rights would then be available

[Prior Authorization - NGS MEDICARE](#)

Medicare Prior Authorization Program Overview 2

Claims Excluded from Prior Authorization 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

Medicare Prior Authorization Program Overview 3

Future Updates to Prior Authorization

- The list of HOPD services requiring PA 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

How to Successfully Submit Requests

How to Successfully Submit Requests 1

➤ To find important information, you will need: [Prior Authorization - NGSMEICARE](#)

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.

HCPCS Code: *

* Required Field

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

Prior Authorization HCPCS Code Inquiry Tool

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HCPCS Code: *

* Required Field

64646

Submit

Clear

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

[Prior Authorization HCPCS Code Inquiry Tool - NGSMEICARE](#)

How to Successfully Submit Requests

Ways to Submit Requests

- 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
 - J6: 877-702-0990

How to Successfully Submit Requests 3

- The standard timeframe to review and communicate a decision for all initial and resubmitted requests is 10-business days from the date of receipt
- The Provisional Affirmation UTN will have a validation period of 120 days
- The decision date will be counted as the first day of the 120 days

[Outpatient Department Guide \(cms.gov\)](https://www.cms.gov)

How to Successfully Submit Requests 4

Expedited Requests

- The requestor can 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

Documentation Requirements

- You can find all documentation requirements on the NGS Medicare site:

[Prior Authorization - NGS MEDICARE](#)

Steps to a Streamlined Approach

Steps to a Streamlined Approach 1

Resubmission

- PA Submission Types: Initial or Resubmission
 - Reminder: there is an unlimited number of resubmission attempts for PA
- 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
- When you resubmit a request, please include all documentation. Each case must stand alone, and documents contained in previous submissions will not be reviewed

Steps to a Streamlined Approach 2

Decision Letters

- The HOPD (provider), physician, and beneficiary will receive the decision letter from the MAC
- Each Provisional 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**

Mitigating Errors

Information that Must be Included with Submission

Hospital OPD Information

- Name of facility
- PTAN/CCN
- Facility Address
- Facility NPI

Common Reason for Rejection:

- Missing or invalid HOPD billing information
- Only HOPD services require PA as part of this program. Other 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

Physician/Practitioner Information

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

Other Information

- HCPCS Code(s)
- Type of Bill (TOB)
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why

Common Reason for Rejection

- Missing or invalid TOB
- Missing or invalid HCPCS code(s)

Mitigating Errors 1

Exempt Providers

- HOPDs who demonstrate compliance with Medicare coverage, coding, and payment rules related to PA may be eligible for exemption.
- This exemption would remain 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 requestor 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

Mitigating Errors 2

Prior Authorization Exemption Status Inquiry Tool - NGSMECARE

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.

PTAN *

Search Results	Exemption Start Date	Exemption End Date	Notes
No PAR is required	01/01/2023	12/31/2024	Providers who are currently NOT required to submit a PAR are exempt from all OPD services. Please check back on 12/10/2024 for updates on provider Exemption status.

Mitigating Errors 3

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
- A primary code must be present on all submissions. Requests with secondary codes only will be rejected

Mitigating Errors 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

Mitigating Errors 5

Facet Joint Interventions

- One of the most common errors are the pre-procedure and post-procedure pain assessments being omitted from the documentation for confirmatory diagnostic procedures and initial radiofrequency ablation (RFA) requests. In these instances, we must see both the percentage of relief and the pre/post pain scores to show a consistent positive response
- The documentation must support that diagnostic procedures have been completed, prior to the initial RFA, at the same spinal level(s) intended for treatment with subsequent RFA
- One to two levels, either unilateral or bilateral, are allowed per session per spine region

Mitigating Errors 6

Documentation requirements for each service type can be found at:

[Prior Authorization - NGS MEDICARE](#)

- [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](#)

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](#)
 - [Prior Authorization \(PA\) Program for Certain Hospital Outpatient Department \(OPD\) Services Operational Guide](#)
- 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 website: [Prior Authorization – NGS MEDICARE](#)

- [PA Rejections Alert – NGS MEDICARE](#)
- [Tools & Calculators – NGS MEDICARE](#)
- [NGSConnex – NGS MEDICARE](#)
 - [NGSConnex User Guide - NGS MEDICARE](#)

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](#)

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

[NCD for Spinal Neurostimulators 160.7](#)

Questions

Thank you for taking the time to join us today

We hope the information provided will be helpful in the HOPD Prior Authorization submission process

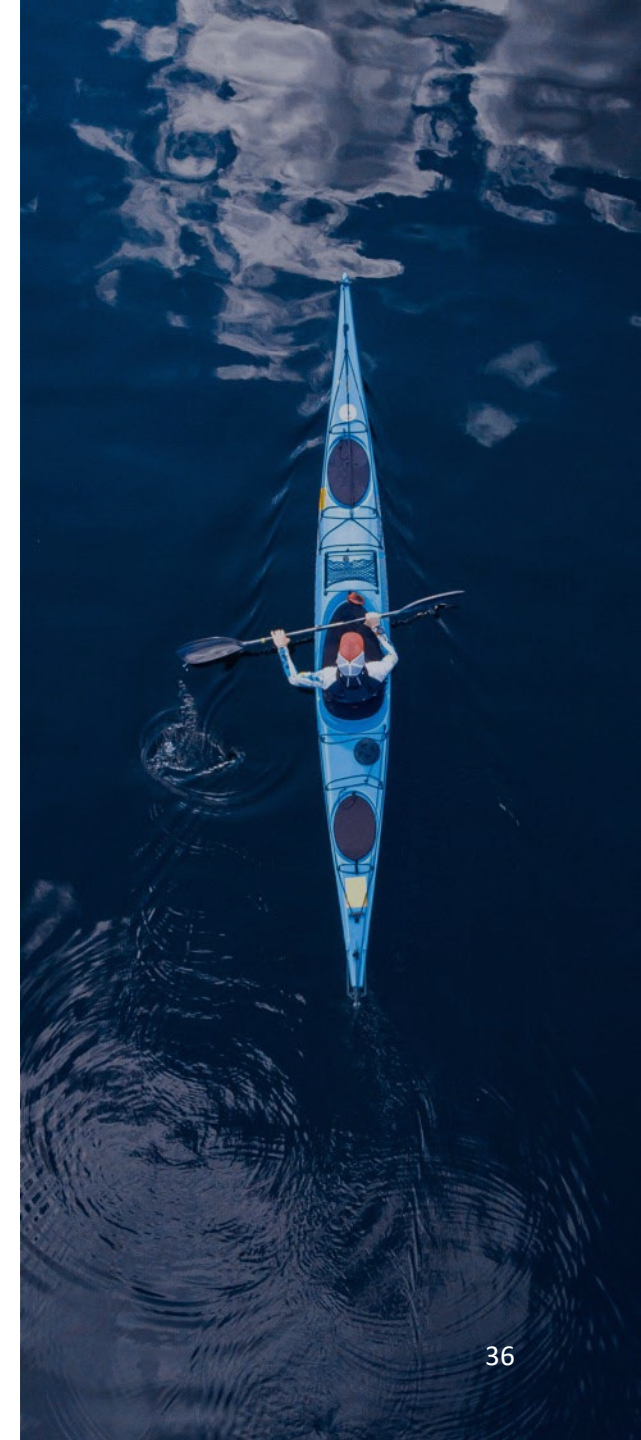
Join us for the:

Prior Authorization Exemption Webinar

- Tuesday, June 11, 2024
- 11:00 a.m.–12:00 p.m. EDT

Prior Authorization Hospital Outpatient Department: The Exemption Process

Exemption Process for HOPD Prior Authorization: Detailed review on how to become exempt and remain exempt



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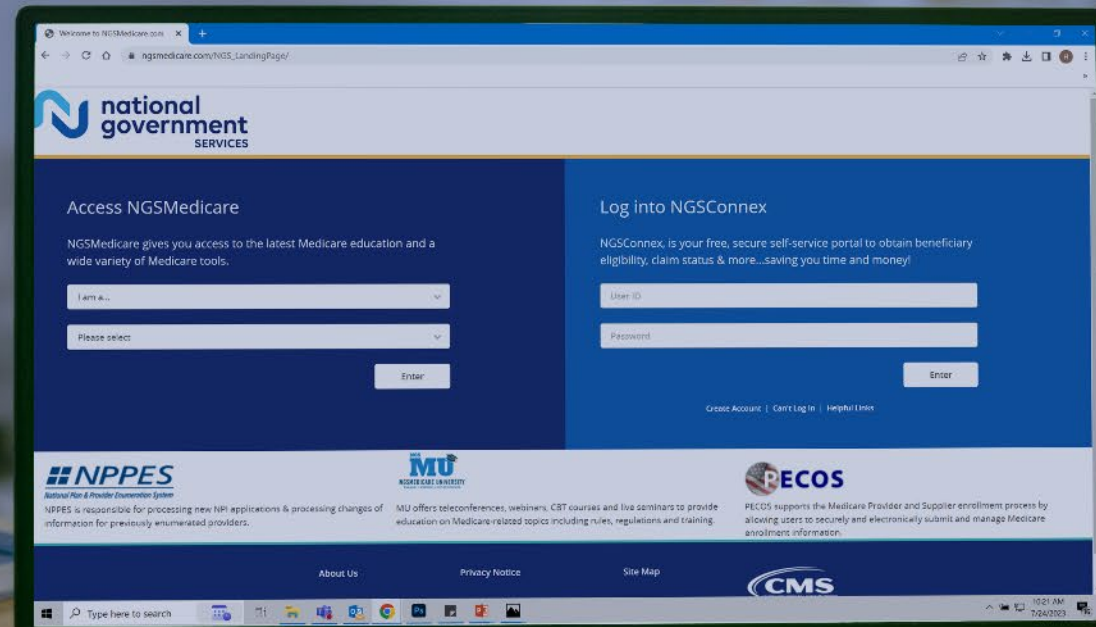
Text NEWS to 37702; Text GAMES to 37702



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