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Prior Authorization: Hospital Outpatient Department and Exemption Process

8/6/2025

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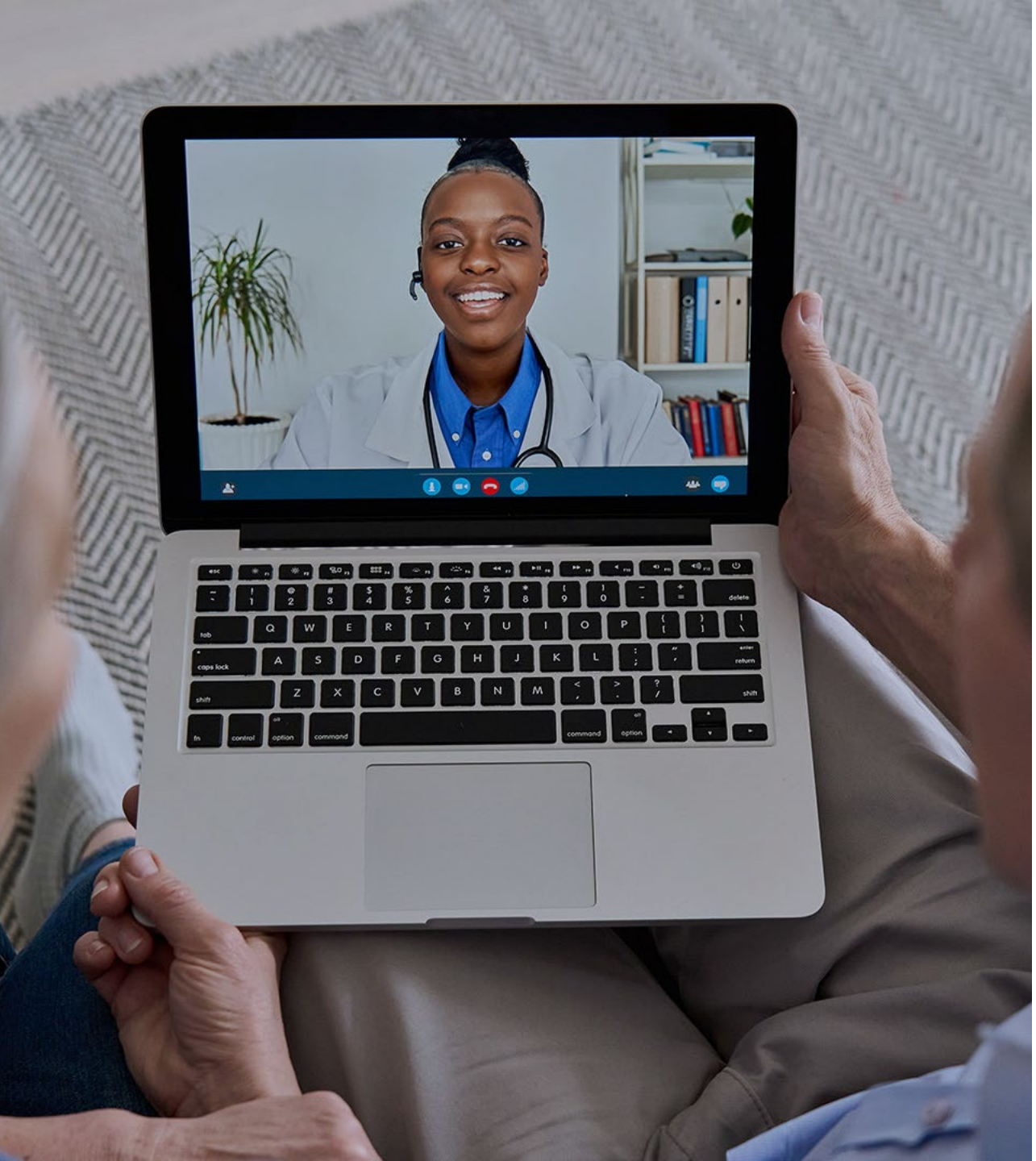

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Today's Presenters

- Hospital Outpatient Department (HOPD) Prior Authorization (PA) Clinical Review Nurse Leadership Team
  - Sydney Sabo, RN, BSN
  - Raeann Lawson, RN, BSN
- Provider Outreach and Education Consultant
  - Jean Roberts, RN, BSN, CPC

Agenda

Objectives
Presented by Sydney Sabo

Medicare PA Program Reminders
Presented by Sydney Sabo

How to Successfully Submit Requests
Presented by Sydney Sabo

Exemption
Presented by Raeann Lawson

NGS Resources
Presented by Raeann Lawson

Objectives

- Refresh key points and criteria for the Medicare PA Program
- Demonstrate the successful submission of all requests
- Exemption review and upcoming timeline
- Utilizing NGS Resources

Medicare PA Program Reminders

HOPD Services that Require PA

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

Medicare PA Authorization Reminders

- CMS OPD PA program does not change Medicare benefits or coverage requirements, nor does it create new documentation requirements
- Medicare Coverage
  - Eligible for a defined Medicare benefit category
  - Reasonable and necessary for 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 PA Reminders

- Condition of Payment: Providers must submit Prior Authorization Requests (PARs) to their 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 service is rendered to the beneficiary and claim is submitted for payment
- Beneficiary must have Medicare as primary or secondary insurance

Medicare PA Reminders

- Who can request/submit the PA request?
  - Part A (HOPD)
  - Part B on behalf of Part A
- Requester: Person/entity submitting PAR
- HOPD is ultimately responsible for obtaining PA
- A UTN will be assigned to each PAR that receives a clinical decision
  - Provisionally affirmed PAR: Claim submitted to Medicare for service(s) likely meeting Medicare's coverage, coding and payment requirements
  - Non-affirmed PAR: May resubmit, or bill for services, knowing services billed will deny, and appeal right becomes available

How to Successfully Submit Requests

How to Successfully Submit Requests

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

How to Successfully Submit Requests

Review Timeframe

- Standard review and decision timeframe for all initial and resubmitted requests
  - Seven (7) calendar days from the date of receipt
- Expedited Requests: Requester may seek expedited PAR review if a delay could seriously jeopardize beneficiary's life, health, or ability to regain maximum function
  - If PA OPD team confirms need for an expedited review, a decision will be communicated within two (2) business days of receiving request
  - Otherwise, request will follow the standard review timeframe
- Provisionally Affirmed UTNs have validation period of 120 days
  - Decision date is counted as first day of 120-day validation period
  - Validation periods cannot be extended

How to Successfully Submit Requests

Required Elements

- PAR coversheet
  - Any field marked REQUIRED on PAR coversheet is necessary for UTN creation
  - If a Part B provider is submitting on behalf of HOPD, they must have valid Part A information to successfully submit PA request
- Valid Procedures
  - Botox paired codes (example: 64612 and J0585)
  - Primary and secondary codes
  - Procedure codes included in the HOPD PA program
    - PA HCPCS Code Inquiry Tool

How to Successfully Submit Requests

- Resubmissions
  - Resubmission Policy
    - Standard procedure – resubmit after receiving non-affirmation
    - Unlimited attempts are allowed for PA submissions
  - Appeals and Peer Reviews
    - PA decisions cannot be appealed and do not include peer-to-peer reviews
  - Outreach
    - NGS may provide outreach calls to gather information supporting an affirmed decision
  - Review Timeframe
    - Standard review – complete within seven (7) calendar days
    - Resubmission of rejected cases should include the newly verified required elements
  - Resubmission Guidelines
    - For previously rejected cases, include newly verified required elements
    - For non-affirmed cases, submit both initial and additional documents addressing non-affirmation reasons

How to Successfully Submit Requests

Reminders

- Carefully review decision letter for non-affirmation reasons before resubmitting
- For inquiries, contact NGS
  - **Email**
    - NGSJKPriorAuthorization@elevancehealth.com
    - NGSJ6PriorAuthorization@elevancehealth.com
  - **Provider Contact Center**
    - J6: 877-702-0990
      - WI, MN, IL
    - JK: 888-855-4356
      - NH, VT, CT, RI, NY, MA, ME

Exemption Process

Standard Review Cycle

- Qualifications
  - Submit PARs to obtain a Provisional Affirmation
  - A minimum of ten PARs must be submitted between 1/1 and 9/30
  - Affirmation rates are based on initial submissions
  - Must achieve a 90% or greater compliance rate
- Exemption notices will be issued to qualifying providers by 11/2, including an option to opt-out

Standard Review Cycle Timeline

January – September

NGS calculates ongoing compliance rate for completed initial PA reviews.

October 1

NGS will begin processing exemption notices.

November 2

NGS will send written notice of exemption to eligible providers. Notices are displayed in NGSConnex provider portal and mailed to the medical review address listed in FISS.

January 1

PARs received by exempt providers will be rejected.

Exemption Cycle

- **Qualifications**
  - Submit at least ten qualifying claims with PA services by 6/30
  - 90% compliance with post-pay claim review
- **Potential Outcomes**
  - ADRs
    - Issued by 8/1
  - Notice of withdrawal
    - Issued by 11/2
  - Notice of continuation
    - Issued by 11/2 with option to opt-out

Exemption Cycle Timeline

January 1

- Exempt providers do not submit PARs.
- PARs submitted will be rejected.
- Non-exempt providers are still required to submit PARs.

August 1

- Exempt providers may receive an ADR for a random ten claim post-pay review.
- Claim samples are selected from dates of service during the exemption period.
- Providers have 45 days to submit documentation.

November 2

- NGS will issue notification letters regarding continued exemption or withdrawal.
- Providers must achieve a post-pay claim approval rate of at least 90% to continue their exemption.

December 18

- Providers notified of exemption withdrawal may begin submitting PARs.

January 1

- Withdrawn or opt-out providers return to standard PA process and must submit PARs for all PA services.

Exemption Process Updates

- New location to view and print ADRs from FISS/DDE
  - SB6006
  - Steps to view and print ADRs from FISS/DDE Provider Online System
    1. Access the claims through the Claims Inquiry screen/option
    2. Type 01 at the FISS/DDE Online System Main Menu and then type 12 on the Inquiry Menu for claims
    3. At the Claims Inquiry screen, type **SB6006** in the S/LOC field and press <Enter>. All claims in the **SB6006** status and location will be displayed, indicating an ADR has been generated
    4. At the desired claim, type S to the left of the claim under the SEL field and press <Enter>
    5. Locate the ADR letter on claim page 06

Responding to an ADR

- 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
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  National Government Services, Inc.
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Responding to an ADR

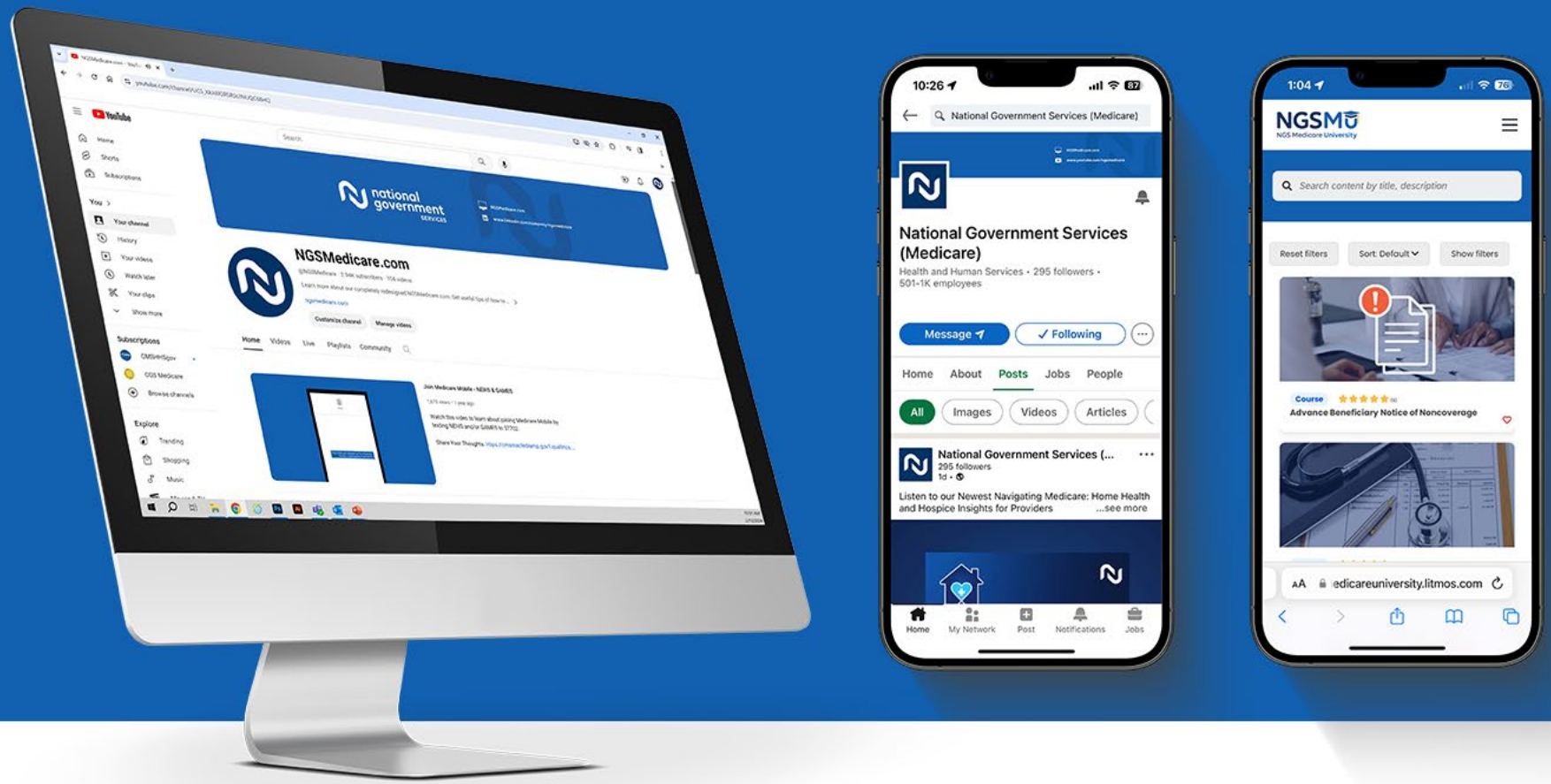
- To ensure compliance and minimize claim denials while maintaining exemption status, please adhere to the following guidelines
  - Provide comprehensive PA documentation and operative documentation
  - Medical necessity cannot be determined by the operative note alone
  - This approach will help minimize claim denials and maintain exemption status

Resources

- How to Find and Respond to Post Payment Review ADR
- *FISS/DDE Provider Online Guide*
- Part A: *NGSConnex User Guide*
- Part B: *NGSConnex User Guide*
- CMS: *Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services Operational Guide*
- NGSMedicare
- Prior Authorization Exemption Status Inquiry Tool
- Prior Authorization CPT/HCPCS Code Inquiry Tool

Questions?

Thank you!



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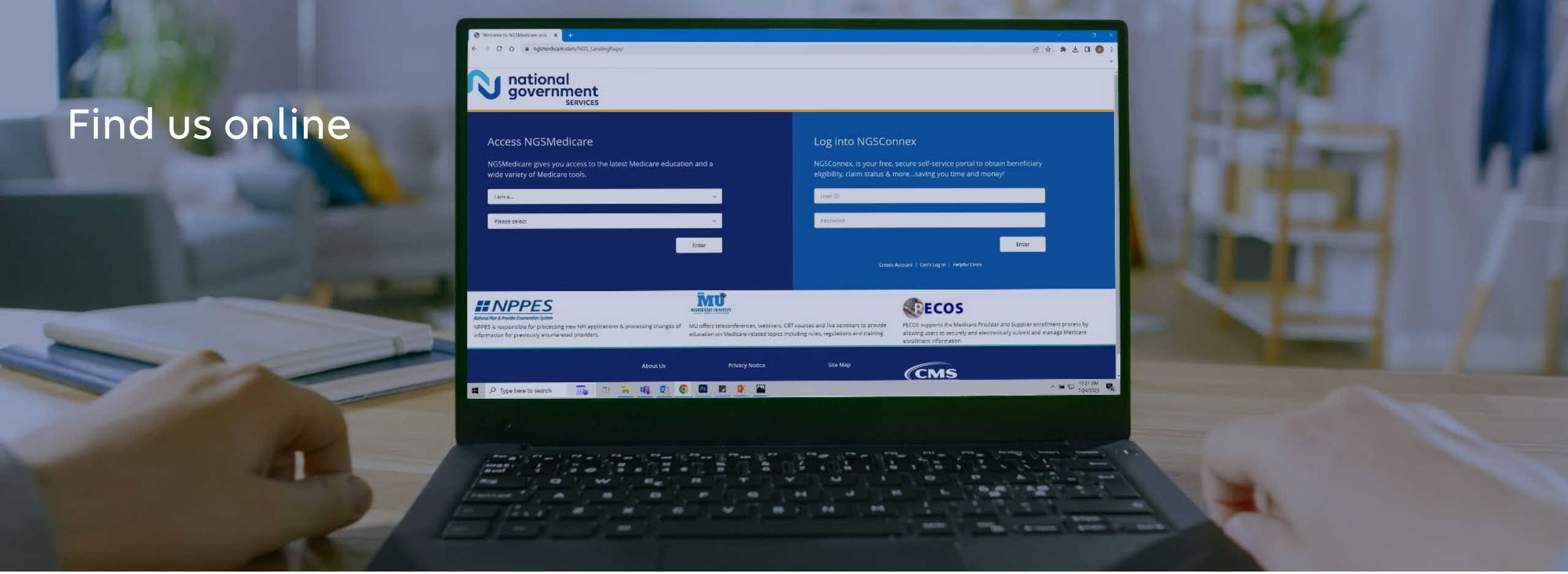

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

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