NGS Medicare Virtual Conference

Fall 2021

Understanding the Prior Authorization Program for Certain Hospital Outpatient Services

11/9/2021

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Today's Presenters

- Jean Roberts, RN, BSN, CPC
- Nathan L. Kennedy, Jr., CHC, CPC, CPPM, CPC-I, CPB, CPMA, AAPC I-10 Approved Trainer
  - Provider Outreach and Education, Consultants

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No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objectives

- Understand the prior authorization requirement including when prior authorization is required and how to request prior authorization
  - Effective DOS on/after 7/1/2020
    - Blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, vein ablation
  - Effective DOS on/after 7/1/2021
    - Cervical fusion with disc removal, implanted spinal neurostimulators

Agenda

- Overview of the Medicare Prior Authorization Program
- Prior Authorization Process
- Required Documentation to Submit with PAR
- Exemption from Prior Authorization
- Scenarios to Consider
- Appendix: 2021 Applicable CPT Codes
- Resources
- Questions

Overview of the Medicare Prior Authorization Program

Medicare Coverage

- For any item or service to be covered, it must be
  - Safe and effective; not experimental or investigational
  - 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

Prior Authorization Program Overview

- CY 2020 OPPS/ASC Final Rule (CMS -1717-FC)
- Authority as per SSA section 1833(t)(2)(F)
  - 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
    - Note: 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 outpatient department services (OPD or HOPD) covered under Part B of the Medicare FFS program
    - Hospital outpatient services are covered under Part B (of A) and are billed on the 1450 claim form

Prior Authorization Program Overview

- Nationwide program that includes Medicare FFS enrolled hospital outpatient departments (HOPDs) that provide certain HOPD services
  - Requestor – person/entity submitting prior authorization request (PAR), documentation, and/or claims
  - Requestor submits PAR to their Medicare FFS contractor, National Government Services will review the PAR and issue a decision

Prior Authorization Program Overview

- Effective for DOS on/after 7/1/2020 providers must request prior authorization for the following fie categories/groups of HOPD services and related services **before** the services are rendered
  - Blepharoplasty
  - Botulinum toxin injections
  - Panniculectomy
  - Rhinoplasty
  - Vein ablation

Prior Authorization Program Overview

- Effective for DOS on/after 7/1/2021 CMS added two additional services to the PA Program
- Providers must request prior authorization for the following two categories/groups of HOPD services and related services before the services are rendered
  - Cervical fusion with disc removal
  - Implanted spinal neurostimulators
    - NGS began accepting PARs for these services on 6/17/2021 for services rendered on/after 7/1/2021

Future Updates to Prior Authorization Program

- 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**
  - The 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 (ED; ER) services
    - Claim must be submitted with ET and/or includes 045x revenue code
    - FYI: Not excluded from regular medical review

New NGSMedicare.com Website

- Locate information on the Prior Authorization Program
  - Resources > Medicare Compliance > Prior Authorization

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NGSConnex Subscribe for Email Updates **Part A Provider** in **Illinois**

HOME EDUCATION RESOURCES EVENTS ENROLLMENT APPS

Resources > Medicare Compliance

PRIOR AUTHORIZATION

About Prior Authorization

Prior Authorization Program for Certain Hospital Outpatient Department Services

Ways to Submit Requests

Expedited Requests

Exemption Process

Prior Authorization Exemption Process FAQ

Documentation

About Prior Authorization

The CMS is implementing a prior authorization program for certain hospital OPD services for DOS on or after 7/1/2020. CMS believes prior authorization for certain hospital OPD services will ensure that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Fund from improper payments and keeping the medical necessity documentation requirements unchanged for providers. As a condition of payment for DOS on or after 7/1/2020, a PAR is required for the following hospital OPD services:

- Blepharoplasty, eyelid surgery, brow lift and related services
- Botulinum toxin injections
- Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy) and related services
- Rhinoplasty and related services
- Vein ablation and related services

CMS has added two new services to the hospital OPD Prior Authorization program. For dates of service beginning on or after 7/1/2021, the additional hospital OPD services will be required as a condition of payment. These services are:

Prior Authorization Process

Prior Authorization Request Types

- Three PAR submission types
  - Initial
    - Decision within ten business days
  - Expedited
    - Decision within two business days when applicable
      - Beneficiary's life/heath must be in jeopardy
  - Resubmission
    - Submit additional information to support initial PAR
    - Allowed an unlimited number of resubmissions
    - Decision within ten business days
  - Physician submitting request on behalf of hospital OPD
    - Same process & requirements as for initial, expedited, and resubmissions

Initial Prior Authorization Request

- Initial PAR request 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
  - Other information
    - Anticipated DOS, HCPCS/CPT code(s), diagnosis code(s), TOB, units of service
      - Include paired codes when applicable (e.g. Botulinum Toxin Injections)
    - Indicate initial request
    - Indicate if request is expedited and the reason why it is expedited

Expedited Resubmission of Prior Authorization Request

- Expedited PAR
  - 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 NGS agrees that expedited PA is necessary, decision is completed on accelerated timeframe

Resubmission of Prior Authorization Request

- Resubmission of PAR after reviewing detailed decision letter
  - Include all elements required for initial PAR submission
    - Must state this is a subsequent request
    - Must include UTN associated with previous submission
  - Ensure an exact match of the following that was submitted with the initial request
    - Beneficiary first name, last name, DOB
- Submitter may resubmit PAR request unlimited number of times

How to Submit PAR

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

NGS Part A – Submission of PA Request

J6	JK
▪ NGSConnex (preferred) ▪ Mailing Address National Government Services Att: Medical Review Prior Authorization Request PO BOX 1708 Indianapolis, IN 46207-7108 ▪ Fax: 317-841-4528 ▪ NGS Website ▪ esMD: indicate document/ content type 8.5	▪ NGSConnex (preferred) ▪ Mailing Address National Government Services Att: Medical Review Prior Authorization Request PO BOX 1708 Indianapolis, IN 46207-7108 ▪ Fax: 317-841-4530 ▪ NGS Website ▪ esMD: indicate document/ content type 8.5

NGS Part B – Submission of PA Request

J6

- ~~NGSConnex~~ – Cannot Use
- Mailing Address

  National Government Services

  Att: Medical Review Prior Authorization Request

  PO BOX 1708

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

JK

- ~~NGSConnex~~ – Cannot Use
- Mailing Address

  National Government Services

  Att: Medical Review Prior Authorization Request

  PO BOX 1708

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

Submission of PA Request

- Address for FedEx (J6 and JK Parts A and B)
  - National Government Services, Inc.
    8115 Knue Road
    Indianapolis, IN 46250
    Attn: Mail & Distribution
  - Add/insert the operational unit record to be scanned
- **For all submission methods:** Always check NGS Website for the most current information

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Questions About Prior Authorization

NGS Provider Contact Center	
J6	JK
Part A 877-702-0990	Part A 888-855-4356
Part B 877-702-0990	Part B 888-855-4356

NGS Review Decision

- NGS will review all information submitted and issue decision to PAR requestor
  - Send initial decision letter within ten business days
- Provisional affirmation: NGS will issue a Unique Tracking Number (UTN) for PA decisions
  - Provisional affirmation means: Future claim submitted to Medicare per the PAR likely meets applicable Medicare coverage, coding, and payment rules
    - Valid for 120 days from date of decision

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
- 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 with two days of NGS decision as to acceptance of expedited review or conversion 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**
  - A provider may resubmit a request for expedited review

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FAQ

- How long does PAR approval and associated UTN remain valid?
- PAR decisions and UTNs for these services are valid for 120 days
  - Example
    - 1/1/2021: PAR is affirmed
    - PAR is valid for DOS through 4/30/2021
      - Provider must submit new PAR to continue beyond 4/30/2021

Decision Letter

- Decision letter
  - Sent to both requestor (provider) and beneficiary
  - Includes the UTN
    - Unless letter is notification of non-accepted expedited request
  - NGS send 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

Reminder

- Decision letter includes the UTN
- Important: Do not claim(s) without a UTN
  - Otherwise the claim will deny

Claim Submission

- Provision affirmation decision granted: prior authorization unique tracking number is included on the decision notice
- UTN must be submitted on the claim in order to receive payment
  - Electronic Claim
    - 14 byte UTN must be in positions one through 18
    - Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim
      - FISS moves the UTN to positions 19 – 32; zeros will autofill the first field
  - All other claim submission types
    - TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN

Required Documentation to Submit with PAR

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PAR Documentation

- Patient's medical record must contain documentation that fully supports medical necessity for services rendered
- Ensure NGS Local Coverage Determinations and Local Coverage Articles when applicable, are adhered to

PAR Documentation

- Blepharoplasty, eyelid surgery, brow lift and related services
  - Documented excessive upper/ lower lid skin
  - Supporting preoperative photos
  - Signed clinical notes support a decrease in peripheral vision and/or upper field vision
  - Signed physician’s or nonphysician practitioner recommendations
  - Documented subjective patient complaints which justify functional surgery (vision, ptosis, etc.)
  - Visual field studies/exams (when applicable)

PAR Documentation

- Botulinum Toxin Injections (Paired coding required)
  - Support for medical necessity of botulinum toxin (type A or type B) injection
  - Covered diagnosis
  - Dosage and frequency of planned injections
  - Support for medical necessity of electromyography procedures performed in conjunction with botulinum toxin type A injections to determine the proper injection site(s) (when applicable)
  - Support of the clinical effectiveness of the injections (for continuous treatment)
  - Specific site(s) injected
  - Support of management of a chronic migraine diagnosis: medical record must include a history of migraine and experiencing frequent headaches on most days of the month
  - Description/statement about traditional methods of treatments such as medication, physical therapy, and other appropriate methods have been tried and proven unsuccessful

PAR Documentation

- Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services
  - Stable weight loss with BMI less than 35 obtained prior to authorization of coverage for panniculectomy surgery (when applicable)
  - Description of the pannis and the underlying skin
  - Description of conservative treatment undertaken and its results
  - The medical records document (s) that the panniculus causes chronic intertrigo or candidiasis or tissue necrosis that consistently recurs over three months and is unresponsive to oral or topical medication (when applicable)
  - Preoperative photograph (if requested)
  - Copies of consultations (when applicable)
  - Related operative report(s) (when applicable)
  - Any other pertinent information

PAR Documentation

- Rhinoplasty and related services
  - Medical documentation, with evaluation and management, supporting medical necessity of the service that is to be performed
  - Radiologic imaging if done
  - Photographs that document the nasal deformity (if applicable)
  - Documentation supporting unresponsiveness to conservative medical management (if applicable)

PAR Documentation

- Vein Ablation and related services
  - Doppler ultrasound results
  - Documentation stating presence or absence of DVT (deep vein thrombosis), aneurysm, and/or tortuosity (when applicable)
  - Documented incompetence of the valves of the saphenous, perforator or deep venous systems consistent with the patient's symptoms and findings (when applicable)
  - Photographs if the clinical documentation received is inconclusive
  - Patient's medical record must contain H and P examination supporting the diagnosis of symptomatic varicose veins (evaluation and complains), and the failure of an adequate (at least three months) trial of conservative management (before the initial procedure)

PAR Documentation

- Cervical Fusion with Disc Removal
  - Services rendered on/after 7/1/2021
  - Condition requiring procedure
  - Physical examination
  - Duration/character/location/radiation of pain
  - Activities of daily living limitations
  - Imaging reports pertinent to performed procedure
  - Operative report(s) (when applicable)
  - Conservative treatment modalities include but not limited to
    - Physical therapy, occupational therapy, injections, medications, assistive device use, activity modification

PAR Documentation

- Implanted Spinal Neurostimulators: services rendered on/after 7/1/2021
  - General documentation requirements for trial or permanent implanted spinal neurostimulators
    - PAR must specify whether for trial or permanent placement
    - Physician office notes including
      - Condition requiring procedure
      - Physical examination
      - Treatments tried and failed including but not limited to
        - Spine surgery, physical therapy, medications, injections, psychological therapy
    - Documentation of appropriate psychological evaluation
    - Permanent placement: Include all above as well as documentation of pain relief with the temporary implanted electrode
      - Successful trial: associated with at least 50% reduction of target pain or 50% reduction of analgesic medications

Exemption From Prior Authorization

Exemption

- CMS/MACs may exempt a HOPD 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
  - Exemption can be withdrawn by CMS at any time

Exemption

- February and August of each year
  - NGS calculates the affirmation rate of initial prior authorization requests reviewed during a six-month standard cycle
- Eligibility: HOPD must submit a minimum of ten PAR during the previous review period and achieve a provisional affirmation threshold of at least 90% during semiannual assessment
- HOPDs demonstrating compliance with Medicare coverage, coding, and payment rules related to PA are eligible for exemption
  - An exemption remains in effect for a six month period or until CMS elects to withdraw the exemption
- Notice of an exemption or withdraw of an exemption is provided at least 60 days prior to the effective date

Scenarios to Consider

Provisional Affirmation

- MAC may deny claim
  - Technical requirements
  - Information not available with PA request

PAR Submitted/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 Non-coverage, ICN MLN006266*

Other Insurance Secondary or Dual Eligibility

- PAR either not submitted or not 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

MSP Situations

- Medicare secondary/other insurance primary
  - Provider should submit PAR with all required documentation to NGS prior to providing services subject to Medicare 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

Appendix: 2021 Applicable CPT Codes

Codes: Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services

CODE	Description
15820	Removal of excessive skin of lower eyelid
15821	Removal of excessive skin of lower eyelid and fat around eye
15822	Removal of excessive skin of upper eyelid
15823	Removal of excessive skin and fat of upper eyelid
67900	Repair of brow paralysis
67901	Repair of upper eyelid muscle to correct drooping or paralysis
67902	Repair of upper eyelid muscle to correct drooping or paralysis
67903	Shortening or advancement of upper eyelid muscle to correct drooping or paralysis
67904	Repair of tendon of upper eyelid
67906	Suspension of upper eyelid muscle to correct drooping or paralysis
67908	Removal of tissue, muscle, and membrane to correct eyelid drooping or paralysis
67911	Correction of widely-opened upper eyelid

Codes: Botulinum Toxin Injection

*CODE	Description
64612	Injection of chemical for destruction of nerve muscles on one side of face
64615	Injection of chemical for destruction of facial and neck nerve muscles on both sides of face
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxina

* Also refer to list of required paired codes

Paired Codes Required: Botulinum Toxin Injection

- One UTN is assigned for services identified by paired codes on 13X TOB
  - Paired codes for botulinum toxin injection
    - 64612/J0585
    - 64612/J0586
    - 64612/J0587
    - 64612/J0588
    - 64615/J0585
    - 64615/J0586
    - 64615/J0587
    - 64615/J0588

Codes: Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy) and Related Services

CODE	Description
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure)
15877	Suction assisted removal of fat from trunk

Codes: Rhinoplasty and Related Services

CODE	Description
20912	Nasal cartilage graft
21210	Repair of nasal or cheek bone with bone graft
30400	Reshaping of tip of nose
30410	Reshaping of bone, cartilage, or tip of nose
30420	Reshaping of bony cartilage dividing nasal passages
30430	Revision to reshape nose or tip of nose after previous repair
30435	Revision to reshape nasal bones after previous repair
30450	Revision to reshape nasal bones and tip of nose after previous repair
30460	Repair of congenital nasal defect to lengthen tip of nose
30462	Repair of congenital nasal defect with lengthening of tip of nose
30465	Widening of nasal passage
30520	Reshaping of nasal cartilage

Codes: Vein Ablation and Related Services

CODE	Description
36473	Mechanochemical destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36474	Mechanochemical destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36475	Destruction of insufficient vein of arm or leg, accessed through the skin
36476	Radiofrequency destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36478	Laser destruction of incompetent vein of arm or leg using imaging guidance, accessed through the skin
36479	Laser destruction of insufficient vein of arm or leg, accessed through the skin using imaging guidance
36482	Chemical destruction of incompetent vein of arm or leg, accessed through the skin using imaging guidance
36483	Chemical destruction of incompetent vein of arm or leg, accessed through the skin using imaging guidance

Codes: Cervical Fusion with Disc Removal, Implanted Spinal Neurostimulators

Cervical Fusion with Disc Removal

CODE	Description
22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach, complex, initial
22552	Fusion of spine bones with removal of disc in upper spinal column below second vertebra of neck, anterior approach, each additional interspace

Implanted Spinal Neurostimulators

CODE	Description
63650	Implantation of spinal neurostimulator electrodes, accessed through the skin

Resources

Resources

- NGS website: Prior Authorization
  - About Prior Authorization
  - Prior Authorization Program for Certain Hospital Outpatient Department Services
  - Ways to Submit Requests
  - Expedited Requests
  - Exemption Process
  - Prior Authorization Exemption Process FAQs
  - Documentation
- Prior Authorization Request Cover Sheet
- Prior Authorization: Each UTN is Valid for One-time Use
- NGSConnex User Guide: Prior Authorization Requests

Resources

- Prior Authorization for Certain Hospital Outpatient Department (OPD) Services
  - Refer to the Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services Operational Guide for the full list of codes requiring prior authorization
  - Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs)
  - CMS Special ODF call: "Prior Authorization Process and Requirements for Certain Outpatient Hospital Department Services," 5/28/2020
- Prior Authorization Process and Requirements for Certain Hospital Outpatient Department Services
  - Federal Register 2020: Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment (NFRM) (CMS-1717-FC)
    - Policy: 84 CFR Sections 61446 - 61465
    - Process: 42 CFR Sections 419.80 - 419.89

Resources

- Federal Register Final Rule, Vol.84, No. 218, 11/12/2019
- CR 11288, *Annual Updates to the Prior Authorization/Pre-Claim Review Federal Holiday Schedule Tables for Generating Reports*, effective 1/1/2020
- CR 11516, *Implementation of Additional Requirement to add Healthcare Common Procedure Coding System (HCPC) and Current Procedural Terminology (CPT) - HCPC/CPT as Paired Items of Service for Prior Authorization and Medicare Claims Processing for Part A, Part B, DME, and Home Health and Hospice*, effective 7/1/2020
- CR 11633, *Updates to the Prior Authorization (PA) Guidance Within Publication (Pub.) 100-08*, effective 3/3/2020
- CR 11671, *Provider Education for Required Prior Authorization (PA) of Hospital Outpatient Department (OPD) Services*, effective 6/17/2020

Resources

- CR 11789 *Annual Updates to the Prior Authorization/Pre-Claim Review Federal Holiday Schedule Tables for Generating Reports*, effective 1/1/2021
- CR 12214 *Provider Education for Required Prior Authorization (PA) Process for the Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators in the Hospital Outpatient Department (OPD) Setting*, effective 6/17/2021
- CR 11743 *Implementation of the Hospital Outpatient Department (HOPD) Prior Authorization (PA) Paired Items of Service for the X12 278 PA Transactions*, effective 10/1/2021
- CR 12271 Annual Updates to the Prior Authorization/Pre-Claim Review Federal Holiday Schedule Tables for Generating Reports, effective 12/31/2021

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Resources

- NGS Local Coverage Determinations and Medical Policy (Billing and Coding) Articles
  - Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services
    - A52837 Blepharoplasty – Medicare Policy Article
  - Botulinum Toxin Injection
    - L33646 Botulinum Toxins
    - A52848 Botulinum Toxins - Billing and Coding Article
  - Vein Ablation and Related Services
    - L33575 Varicose Veins of the Lower Extremity, Treatment of
    - A52870 Varicose Veins of the Lower Extremity, Treatment of – Billing and Coding Article
    - A55704 Responses to Comments

Resources

- CMS National Coverage Determination
  - Implanted Spinal Neurostimulator
    - N160.7 Electrical Nerve Stimulators
    - CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 2, Section 160.7

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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