Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services

Amy Cinquegrani

Director, Division of Payment Methods & Strategies

Dr. Scott H. Lawrence

Deputy Director, Division of Payment Methods & Strategies

Purpose

- To provide an overview of the prior authorization process and requirements for certain hospital OPD services as outlined in the Calendar Year 2020 Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule 1717-F, codified at 42 CFR § 419.80 *et sec*.

- To provide specific operational guidance related to the prior authorization process for Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and Vein Ablation.

Prior Authorization

- Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is furnished to a Medicare patient and before a claim is submitted for payment.

- Prior authorization helps to ensure that all applicable Medicare coverage, payment, and coding rules are met before a service is furnished.

- A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for hospital OPD services likely meets Medicare's coverage, coding, and payment requirements.

Who, What, Where, and When

Who

- Hospital OPDs

What – Five Groups of Hospital OPD Services

- Blepharoplasty
- Botulinum Toxin Injections
- Panniculectomy
- Rhinoplasty
- Vein Ablation

Where and When

- The program will apply nationally to hospital OPD services rendered on or after July 1, 2020
- Medicare Administrative Contractors (MACs) will begin accepting prior authorization requests on June 17, 2020

Why

Prior Authorization

- Providers will know earlier in the process whether Medicare will likely pay for the hospital OPD service.
- Medicare patients will know, prior to receiving the service, whether Medicare will likely pay for the service.
- MACs can assess medical information, prior to making a claim determination, to provide provisional feedback on the services to be rendered.

Status Quo

- Medicare coverage policies and documentation requirements are unchanged.
- A/B MACs will continue to conduct the reviews.
- Advance Beneficiary Notice (ABN) policies and claim appeal rights are unchanged.

The prior authorization process developed for certain hospital OPD services does not create new documentation requirements.

Regularly required documentation must be submitted earlier in the process.

Prior Authorization Request Content

Request needs to identify:

- The beneficiary's name, Medicare Beneficiary Identifier (MBI), and date of birth
- Name of facility, PTAN/CCN, address, and National Provider Identifier (NPI)
- Physician/Practitioner's name, NPI, PTAN, and address
- The requester's name, telephone number, and address
- Anticipated date of service
- Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis code, type of bill, and units of service
- Indicate if the request is an initial or resubmission review
- Indicate if the request is expedited and the reason why

Prior Authorization Request Content (continued)

Requests also need to include (from the provider):

- Documentation from the medical record to support the medical necessity of the service
    - Please see the related Local Coverage Determinations/Articles (LCD/LCA) for detailed requirements per service, if applicable
- A request coversheet will be available on the MACs' websites

Prior Authorization Request Submission

- The provider must submit the prior authorization request
  - Physicians may complete the request on behalf of the provider (the Hospital OPD)
- The request can be:
  - Mailed
  - Faxed
  - Submitted through the Electronic Submission of Medical Documentation (esMD), content type 8.5* (available beginning July 6, 2020)
  - Submitted through the MAC's portal

* More info about Electronic Submission of Medical Documentation (esMD) can be found at www.cms.gov/esMD.

Review Timeframes

- **Initial Requests**
  - The MAC will ensure the determination is postmarked, faxed, or delivered electronically within **10 business days.**
- **Resubmitted Requests**
  - The MAC will ensure the determination is postmarked, faxed, or delivered electronically within **10 business days.**

Expedited Review Requests

- **Expedited Circumstances**
  - If it is determined that delays in receipt of a Prior Authorization decision could jeopardize the life, health, or ability to regain maximum function of the beneficiary, then the MAC will process the Prior Authorization request under an “expedited” timeframe, upon request.
  - The MAC will communicate a determination within **2 business days** of receipt of the expedited request**.**
  - Suppliers are encouraged to use fax, esMD, or the MAC Portal to avoid delays with mailing.

Review Decision Letters

- MACs will send the requester a letter providing their prior authorization decision (i.e., provisional affirmation, partial affirmation, or non-affirmation) via the same method it was requested (decision only, via esMD).

- MACs will have the option to send a copy of the decision to the requester via fax if a valid fax number is provided, even if the submission is sent via mail.

- MACs will send a copy of the decision letter to the beneficiary.

Unique Tracking Number

- Decision letters will contain a Unique Tracking Number (UTN).
- Claims submitted must include the UTN to receive payment.
- For resubmitted requests, the UTN associated with the previous submission must be included.

Review Decisions

- A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service (s) likely meets Medicare's coverage, coding, and payment requirements.
    - The provisional affirmation PA decision is valid for 120 days from the date decision was made.
- Claims for which there is an associated provisional affirmation decision will be paid in full, so long as all of the applicable Medicare coverage and clinical documentation requirements are met and the claim was billed and submitted correctly.
- Generally, claims that have an affirmation prior authorization decision will not be subject to additional review.
    - Claims may be chosen as part of the CERT sample (random) or by the UPIC (if there are concerns of fraud or gaming).

Review Decisions (continued)

- A non-affirmation decision is a preliminary finding that if a future claim is submitted to Medicare for the requested service does not likely meet Medicare's coverage, coding, and payment requirements.

- A provisional partial affirmation decision means that one or more service(s) on the PAR received a provisional affirmation decision and one or more service(s) received a non-affirmation decision.

- For any service(s) within the PAR that are given a provisional affirmation decision, the MAC will follow the process described on the previous slide. For any service(s) that are given a non-affirmation decision, the MAC will follow the process described on the next slide.

Review Decisions (continued)

- If the request is non-affirmed or partially affirmed, the letter will provide a detailed explanation for the decision.

- A requester can resolve the non-affirmation reasons described in the decision letter and resubmit the prior authorization request.

    - a non-affirmation prior authorization request decision is not appealable; however, unlimited resubmissions are allowed.

or

- A requester can forego the resubmission process, provide the hospital OPD service, and submit the claim for payment.

    - The claim will be denied.

    - All appeal rights are available.

Educational Outreach for Non-Affirmed Requests

- MACs have special tracking for requests that are not affirmed due to documentation or other technical errors, where the patient may otherwise meet Medicare's coverage criteria.

- Providers with these documentation errors receive individualized education and are encouraged to resubmit their request to ensure their patients receive the necessary services for which they are covered.

When a Prior Authorization Request is Not Submitted

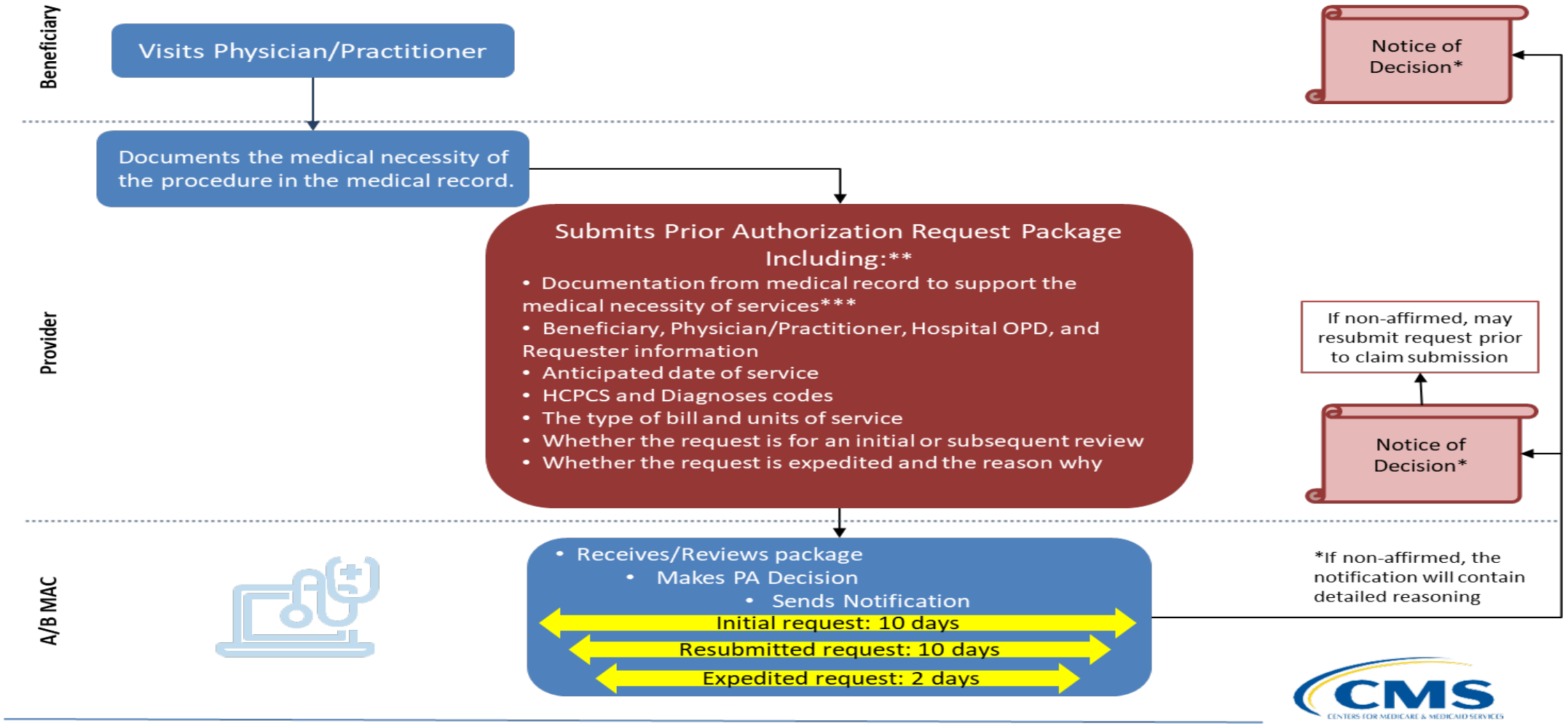
- As described in 42 CFR § 419.82, if an item is selected for required prior authorization under the program, then submitting a prior authorization request is a condition of payment.
- Claims for items subject to required prior authorization submitted without a prior authorization decision and a corresponding UTN will be automatically denied.

Denials for Related Claims

- Any claim associated with or related to a service that requires prior authorization for which a claim denial is issued would also be denied.

- Associated services include, but are not limited to, services such as anesthesiology services, physician services, and/or facility services.

Prior Authorization Process for Certain HOPD Services – Flow Chart



*A copy of the decision letter will be sent to the beneficiary as well.
**Must be submitted before providing the service or submitting a claim for processing.
***The MACs will review all prior authorization requests in accordance with the policy in place at the time of the anticipated date of service.

Scenarios

	Prior authorization request is:	The MAC decision is:	The requestor chooses to:	The MAC will:
1	Submitted	Affirmation	Submit a claim	Pay the claim (as long as all other requirements are met)
2	Submitted	Non- Affirmation	a. Submit a claim	a. Deny the claim
			b. Fix and resubmit the request	b. Review the resubmission and render a decision
3	Not submitted	N/A	Submit a claim	Deny the claim

Medicare Patient Impact

- The benefit is not changing.
- Medicare patients will know earlier in the payment process if a service will likely meet Medicare's coverage requirements.
- Medicare patients will receive a copy of their prior authorization decision.
- Dual eligible coverage is not changing. A non-affirmation prior authorization decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage.

CMS Oversight

- CMS will analyze the impacts of prior authorization, including impacts to patient care, access to service, and overall expenditures and savings.
- CMS will conduct regular reviews of MAC prior authorization decisions.
- CMS will discuss its findings with and seek feedback from the MACs during regularly scheduled meetings.

A/B MAC Information

- CGS (J15)
  - cgsmedicare.com
- NGS (JK, J6)
  - ngsmedicare.com
- Noridian (JE, JF)
  - JE - med.noridianmedicare.com/web/jea
  - JF - med.noridianmedicare.com/web/jfa
- WPS (J5, J8)
  - wpsgha.com
- First Coast (JN)
  - fcso.com/
- Novitas (JL, JH)
  - novitas-solutions.com/
- Palmetto GBA (JJ, JM)
  - JJ - palmettogba.com/JJA
  - JM - palmettogba.com/JMA

Summary

Where:	National	**PAR Submissions Begin:**	June 17, 2020
Submitted By:	Hospital OPD	**For Services On or After:**	July 1, 2020

OPD Services Requiring PA	HCPCS Codes
Blepharoplasty, Eyelid Surgery, Brow Lift, and related services	15820, 15821, 15822, 15823, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67911
Botulinum Toxin Injection	64612, 64615, J0585, J0586, J0587, J0588
Panniculectomy , Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services	15830, 15847, 15877, 21235
Rhinoplasty and related services	20912, 21210, 21235, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30520
Vein Ablation and related services	36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483

CMS Resources

- Prior Authorization Web Site: http://go.cms.gov/OPD_PA
- Feedback: OPDPA@cms.hhs.gov

Questions?