Operational Guidance -Medicare claims

Prior authorization helps to ensure that all applicable Medicare coverage, payment, and coding rules are met before a service is furnished.
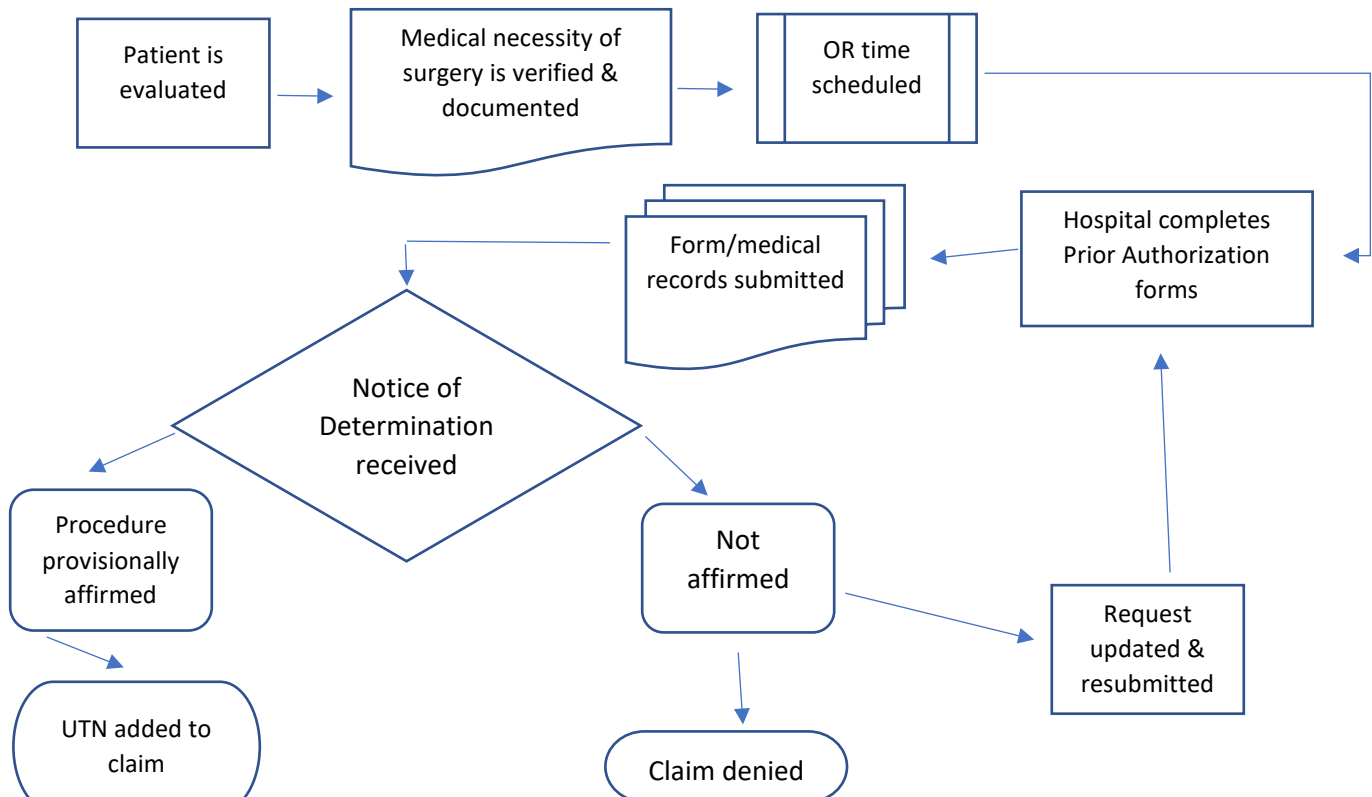
As of July 1, 2020, the use of prior authorization has applied nationally to hospital outpatient department (OPD) services for five groups of hospital outpatient department (OPD) services:

OPD Service 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

* Beginning for dates of service on or after January 7, 2022, CMS is removing CPT 67911 (correction of lid retraction) from the list of codes that require prior authorization as a condition of payment. This service is not likely to be cosmetic in nature and commonly occurs secondary to another condition.

The prior authorization process does not create new documentation requirements or change coverage policies – rather, it ensures the medical necessity of the service. Both providers and patients will know earlier in the process if Medicare will likely cover the hospital OPD service.

PRIOR AUTHORIZATION WORK FLOW

Any Prior Authorization form must include:

• 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

• An indication if the request is an initial or resubmission review

• An indication if the request is expedited and the reason why

The hospital OPD will be required to submit this data; however, **surgeons must work with them to ensure the process is completed timely.** Requests will need to include documentation from the medical record to support the medical necessity of the service. This may include a review any related Local Coverage Determinations/Articles (LCD/LCA) for detailed requirements per service, if applicable.

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.

o 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. o Claims may be chosen as part of the CERT sample (random) or by the UPIC (if there are concerns of fraud or gaming).

MEDICARE BENEFITS ARE NOT CHANGING!

Medicare patients will know earlier in the payment process if a service will likely meet Medicare's coverage requirements.

Frequently Asked Questions

Q. What process is used to submit a prior authorization (PA)?

A: The PA requests can be:

> o Mailed

> o Faxed

> o Submitted through the Electronic Submission of Medical Documentation (esMD), content type 8.5* (available beginning July 6, 2020)

> o Submitted through the MAC's portal

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

Q. Who is my Medicare Administrative Contractor (MAC)?

A. A list of MACs is available on the CMS Website. Please click here to view the list.

Q. How long will it take to hear back from the MAC?

A. The MAC will ensure the determination is postmarked, faxed, or delivered electronically to the hospital OPD within 10 business days.

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

Q. If a PA is initially denied, can it be updated and resubmitted?

A. Yes. The MAC will ensure the determination for any resubmitted requests is postmarked, faxed, or delivered electronically within 10 (additional) business days.

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

Q. Can a PA request be expedited?

A. 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.

> o The MAC will communicate a determination within 2 business days of receipt of the expedited request.

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

> o Hospital OPDs are encouraged to use fax, esMD, or the MAC Portal to avoid delays with mailing these types of requests.

Q. What if the hospital forgets to obtain a prior authorization?

A. Hospital claims for items subject to required prior authorization submitted without a prior authorization decision and a corresponding UTN will be automatically denied.

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.*

Q. What is a UTN?

A. UTN stands for unique tracking number. This information must be included on <u>hospital</u> claims to receive payment.

- For resubmitted requests, the UTN associated with the previous submission must be included.