CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Prior Authorization of Non-Emergent Hyperbaric Oxygen (HBO) Therapy

Open Door Form: November 4, 2014

Purpose

- To establish a three year prior authorization process for non-emergent hyperbaric oxygen (HBO) therapy

- To ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments to protect the Medicare Trust Fund by granting provisional affirmation for a service prior to submission of the claim

Prior Authorization

- Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before a service is rendered to a beneficiary and before a claim is submitted for payment

- Prior authorization helps ensure that applicable coverage, payment and coding rules are met before services are rendered

- Some insurance companies, such as TRICARE, certain Medicaid programs, and the private sector, already use prior authorization to ensure proper payment before the service is rendered

Definition of HBO

- HBO therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure
- The National Coverage Determination (NCD) can be found in the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.29
- Of the 15 covered clinical conditions listed in the NCD, 6 will be available for prior authorization

The Six Covered Conditions

- The six conditions available for prior authorization are:
  - Preparation and preservation of compromised skin grafts (not for primary management of wounds)
  - Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management
  - Osteoradionecrosis as an adjunct to conventional treatment
  - soft tissue radionecrosis as an adjunct to conventional treatment
  - Actinomycrosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment
  - Diabetic wounds of the lower extremities in patients who meet the following three criteria:
    - Patient has Type I or Type II diabetes and who has a lower extremity wound that is due to diabetes
    - Patient has a wound classified as Wagner grade III or higher
    - Patent has failed an adequate course of wound therapy as defined in the NCD

When

- The model will begin in early 2015 and continue for three years

Where

- Illinois
- Michigan
- New Jersey

HCPCS Codes

- The following HBO HCPCS code is subject to prior authorization:
  - **C1300** - Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
- Prior authorization is only needed for the facility payment part of the HBO therapy service
- However, if a facility does not have prior authorization or has a non-affirmed prior authorization, the associated physician claims with the following code will be subject to medical review:
  - **99183** - Physician attendance and supervision of hyperbaric oxygen, per session

Coverage and Documentation Requirements

- Medicare coverage policies are unchanged
- Documentation requirements are unchanged
- Time frames for HBO therapy are unchanged

The model does NOT create any new documentation requirements.

It simply requires the information be submitted earlier in the claims process.

Current requirements can be found on the A/B MAC websites.

Existing Coverage Requirements

- The NCD can be found in the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.29
- HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care
- Failure to respond to standard wound care occurs when there are no measurable signs of healing for at least 30 consecutive days
- Wounds must be evaluated at least every 30 days during administration of HBO therapy
- Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment

Also Unchanged

- The A/B MACs conduct these reviews
- All Advanced Beneficiary Notice (ABN) policies
- Claim appeal rights

What Has Changed?

- The facility will know BEFORE THE SERVICE IS RENDERED whether Medicare will pay for the service
- Upon request, the beneficiary will be notified BEFORE THE SERVICE IS RENDERED whether Medicare will pay for the service
- CMS will reduce reliance on the “pay and chase” method of post-payment review to reduce improper payments

Prior Authorization Request Content
(as of 10/31/2014)

- Request needs to identify:
  - The beneficiary's name, Medicare Number, date of birth and gender
  - The physician's name, National Provider Identifier (NPI), and address
  - The facilities name, NPI, and address
  - The requestor's name and telephone number
  - Procedure code
  - Submission date
  - Start of the 12-month period
  - Number of treatments requested
  - Indicate if the request is an initial or resubmission review
  - Indicate if the request is expedited and the reason why

Prior Authorization Request Content Cont.
(as of 10/31/2014)

- Request needs to include:
  - Documentation from the medical record to support the medical necessity
  - Any other relevant document as deemed necessary by the Contractor to process the prior authorization

Number of Treatment Courses

- A provisional affirmative prior authorization decision may affirm up to 36 courses of treatment in a 12 month period
- If additional sessions are needed in excess of the 36 treatments, a new prior authorization request may be submitted

Prior Authorization Request Submission

- The facility or the beneficiary may submit the request
- The request can be:
  - Mailed (check A/B MAC website for address)
  - Faxed (check A/B MAC website for fax number)
  - Submitted through the Electronic Submission of Medical Documentation (esMD) system*

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

Review Timeframes

- **Initial Requests**
  - The A/B MAC makes every effort to review request and postmark decision letters within **10 business days**
- **Resubmitted Requests**
  - The request submitted with additional documentation after the initial prior authorization request was non-affirmed
  - The A/B MAC makes every effort to review request and postmark decision letters within **20 business days**
- **Expedited Circumstances**
  - The request submitted when the standard timeframe could jeopardize the life or health of the beneficiary; however, under this model this should be extremely rare
  - The A/B MAC will make reasonable efforts to communicate a decision within **2 business days**

Detailed Decision Letter

- Decision letters are sent to:
  - Facility
  - Beneficiary – Upon Request
- Decision letters that do not affirm the prior authorization request will:
  - Provide a detailed written explanation outlining which specific policy requirement(s) was/were not met

When a Prior Authorization Request is Submitted but Non-Affirmed

- A submitter can:
  - Resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request

    or

  - Provide service and submit a claim
    - The claim will be denied
    - All appeal rights are available

Resubmission and Appeals

- For non-affirmed prior authorization requests, unlimited resubmissions are allowed
    - These requests are not considered appeals
- For denied claims, all normal appeal rights apply

Unique Tracking Number

- Medicare Administrative Contractors will list the prior authorization unique tracking number on the decision letter
- This tracking number **must** be submitted on the claim
- When submitting an electronic 837 institutional claim, the unique tracking number (UTN) should be submitted at the 2300 – Claim Information level in the Prior Authorization reference (REF) segment where REF01 = “G1” qualifier and REF02 = UTN.
- When submitting a paper CMS 1450 Claim form, the unique tracking number (UTN) should be submitted in Form Locator 63. The UTN should be submitted on the same line (A, B, C) that Medicare is shown in Form Locator 50 (Payer Line A, B, C). The UTN should begin in position 1 of Form Locator 63.

What Happens if I Don't Use the Prior Authorization Process?

- Pre-Payment Review….
  - If a facility has not requested prior authorization
    1. The subsequent claims will be stopped for prepayment review
       - A/B MAC sends Additional Request letter and waits **45** days for a response
       - A/B MAC reviews submitted documentation within **60** days
    2. Without a prior authorization decision, the facility or the beneficiary will not know whether Medicare will pay for the service (and the facility or beneficiary may be financially liable)

CMS strongly encourages providers/suppliers to use the Medicare prior authorization process.

Scenarios

	Prior authorization request is:	The A/B MAC decision is:	The facility chooses to:	The A/B MAC will:
1	Submitted	Affirmative	Submit a claim	Pay the claim (as long as all other requirements are met)
2	Submitted	Non- Affirmative	a. Submit a claim b. Fix and resubmit a PA request	a. Deny the claim
3	Not submitted	N/A	Submit a claim	• Develop the claim • Pre-Pay Review the claim

- If a facility has no prior authorization or a non-affirmed prior authorization, the associated physician claim will be subject to medical review.

Beneficiary Impact

- The service benefit is not changing
- Beneficiaries, upon request, will receive a notification of the decision about their prior authorization request
- Dual eligible coverage is not changing
- Private insurance coverage is not changing

References on Service from the A/B MACs

- Illinois
  - Jurisdiction J6: NGS
    - http://www.ngsmedicare.com/
- Michigan
  - Jurisdiction J8: WPS
    - http://www.wpsmedicare.com
    - Accepts esMD transactions
- New Jersey
  - Jurisdiction JL: Novitas
    - http://www.novitas-solutions.com
    - Accepts esMD transactions

CMS Resources

- Model Web Site: http://go.cms.gov/PAHBO
  - Fact Sheet
  - Frequently Asked Questions
  - Background
  - Information on Open Door Forums

Summary

Where:	Il, MI, NJ
The model begins:	Early 2015
Submitted by:	Facility or beneficiary
Ends:	3 year model

For More Information

Email the Prior Authorization Team:	HBOPA@cms.hhs.gov
CMS Demonstration Website:	http://go.cms.gov/PAHBO
FAQs:	See website above
Open Door Forums:	November 4, 2014

Questions?