Prior Authorization Review

Kimberly Hanson, Director of Reimbursement

Mission Statement

We help people maintain or regain their freedom of movement.

Prior Authorization

1. What is Prior Authorization with Medicare?
2. How to navigate the process?
3. Documents required
4. Forms required
5. Resources

Background
Prior Authorization

Medicare Prior Authorization Program

Prior authorization is be required for certain Lower Limb Prosthetics with dates of service on or after September 1, 2020 in California, Michigan, Pennsylvania, and Texas.

- L5856
- L5857
- L5858
- L5973
- L5980
- L5987

On December 1, 2020 Prior authorization for these codes will be required in all of the remaining states and territories.

Background
Prior Authorization

All claims will require a prior authorization if they contain one or more of the codes. Prior Authorization is a condition of payment for claims.

Claims must be associated with an affirmative prior authorization decision to be eligible for payment.

The DME MACs have been conducting prior authorizations on complex rehab and support surfaces for years.

Suppliers reported in 2017 a high level of satisfaction with the process

- Turnaround times < 2 weeks
- Majority of PA requests are getting affirmed the first time in (60-65%)
- Even when their initial requests are non-affirmed, providers are typically able to get them affirmed with subsequent requests.

Prior Authorization

Benefits

- Allows you to know early in the process & before purchasing the componentry whether Medicare will likely pay for the item(s).

- Allows your patients to know, prior to receipt of the item(s), whether Medicare will likely pay for the item(s).

- Allows the DME MACs to assess the medical information provided, prior to making a claim determination and provide provisional feedback on item(s) to be furnished to the beneficiary.

- Allows you to obtain more documentation from providers to ensure medical necessity is met before you deliver the componentry.

Prior Authorization

Timelines

Initial Requests

- Processed within 10 business days

Subsequent Requests

- Processed within 10 business days
- Unlimited number of submissions in order to achieve affirmative decision

Expedited Requests

- Within 2 days
- Must provide explanation for the need of quick decision

Prior Authorization

Documentation to Include in Submission

- Medicare issued coversheet (CGS is different than Noridian)
- Standard Written Order (signed by the ordering physician)
- Documentation from the medical record to support medical necessity
  - Physician notes
  - Prosthetist notes

Prior Authorization

DME MAC issued Coversheet

CGS:

Supplier information

Physician Information (name, address, NPI)

Beneficiary Name, MBI, Address, DOB

HCPCS Codes: only HCPCS that require PA, not all billing codes

CGS Jur C PA Coversheet CGS Jur B PA Coversheet

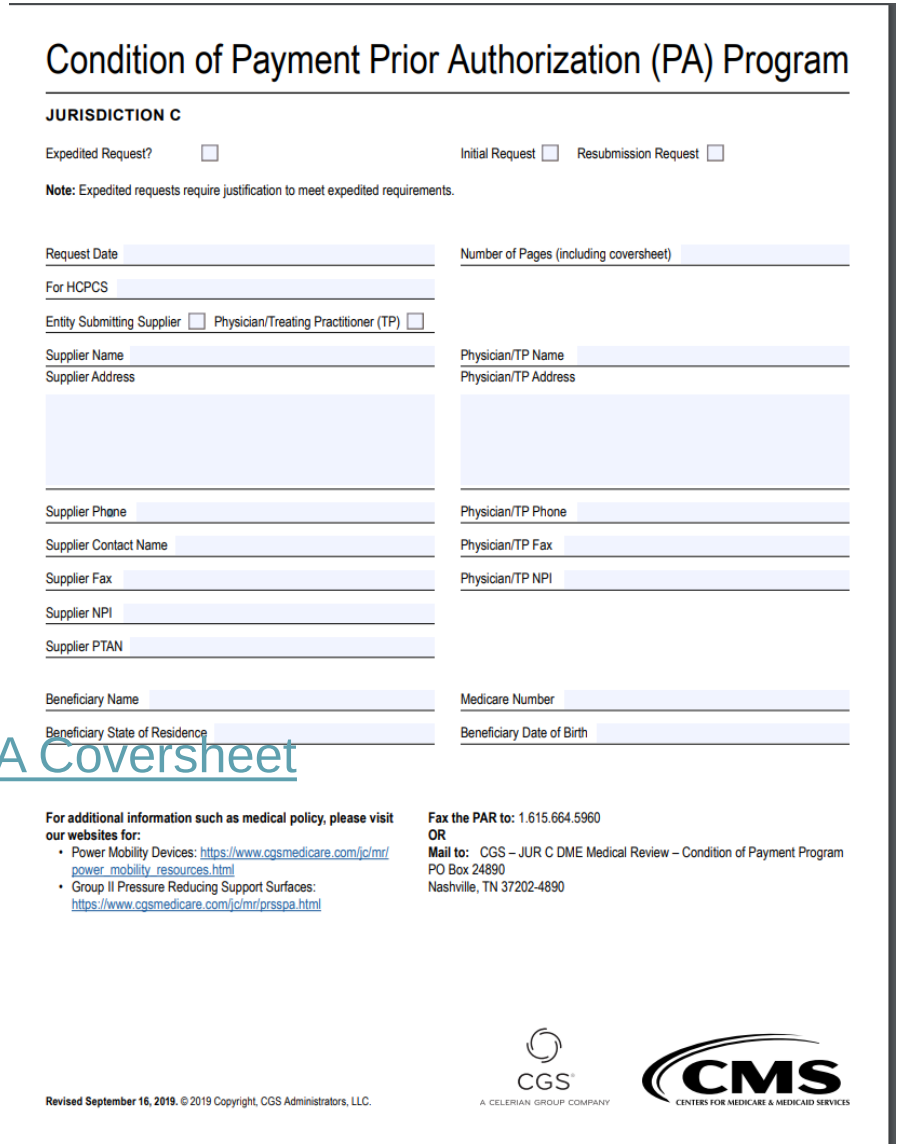
Noridian:

Supplier information

Beneficiary Name, MBI, Address, DOB

HCPCS Codes

Noridian PA Coversheet



Condition of Payment Prior Authorization (PA) Program

JURISDICTION C

Expedited Request? ☐ Initial Request ☐ Resubmission Request ☐

Note: Expedited requests require justification to meet expedited requirements.

Request Date | Number of Pages (including coversheet)

For HCPCS

Entity Submitting Supplier ☐ Physician/Treating Practitioner (TP) ☐

Supplier Name | Physician/TP Name

Supplier Address | Physician/TP Address

Supplier Phone | Physician/TP Phone

Supplier Contact Name | Physician/TP Fax

Supplier Fax | Physician/TP NPI

Supplier NPI

Supplier PTAN

Beneficiary Name | Medicare Number

Beneficiary State of Residence | Beneficiary Date of Birth

For additional information such as medical policy, please visit our websites for:

- Power Mobility Devices: https://www.cgsmedicare.com/jc/mr/power_mobility_resources.html
- Group II Pressure Reducing Support Surfaces: https://www.cgsmedicare.com/jc/mr/prsspa.html

Fax the PAR to: 1.615.664.5960
OR
Mail to: CGS – JUR C DME Medical Review – Condition of Payment Program
PO Box 24890
Nashville, TN 37202-4890

Revised September 16, 2019. © 2019 Copyright, CGS Administrators, LLC.

CGS A CELERIAN GROUP COMPANY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Prior Authorization

Documentation to Include in Submission

Standard Written Order Effective 01/01/2020 – replaces DWO

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- General description of the item, HCPCS code, HCPCS code narrative, or Brand Name/Model Number.
- Quantity & RT/LT
- Date of Order
- Treating Physician Name & NPI
- Treating Physician's hand written signature & date

Tip: Check to make sure this list meet your state requirements for orders. State law might require physician address, phone number, diagnosis codes & state licensing number.

CGS SWO Checklist

Noridian SWO Checklist

Prior Authorization

Documentation from the medical records to support medical necessity

The DME MAC requires a face-to-face evaluation with the patient addressing the medical need for a prosthesis including a full patient's review of systems **within 6 months** of the intended billing of the prosthesis.

Due to the Public Health Emergency (PHE), the Face-to-Face are waived, but the physician must provide a standard written order (SWO) for all items, documentation in their record for medical necessity for all services, the medical record must be sufficient to support payment for the services billed. (CR modifier on each HCPCS is required if use the waiver)

Tip: Have the physician conduct the face-to-face evaluation via audio video to ensure the requirement is met even if you have to bring the patient to your office to assist with this. (CR modifier on each HCPCS is required)

Prior Authorization

Documentation from the medical records to support medical necessity

Note: Suppliers are reminded that for purposes of determining the reasonableness and medical necessity of prosthetics, documentation created by prosthetist shall be **considered** part of the individual's medical record to **support** documentation created by eligible professionals.

Documentation from a face-to-face encounter conducted by a treating practitioner, as well as the prosthetist documentation becomes part of the medical records and if the prosthetist notes support the documentation created by eligible professionals they can be used together to support medical necessity of an ordered DMEPOS item.

In the event the prosthetist documentation does not support the documentation created by the eligible professional, the DME MAC may deny payment.

Tip: Read the physician notes to ensure they match in patient activities, description and motivation.

Source: Section 1834(h)(5) of the Act; **Section 1848(k)(3)(B),

Prior Authorization

Lower Limb Prosthesis is covered when the beneficiary:

… Will reach and maintain a defined functional state within a reasonable period of time; and

… Is motivated to ambulate.

 Functional level documentation for certain components and additions is based on beneficiary's potential functional abilities, as determined based on the reasonable expectations of the prosthetist and treating physician, considering factors including, but not limited to:

 Past history (including prior prosthetic use if applicable); and

… Current condition including the status of the residual limb and nature of other medical problems; and

… Desire to ambulate

… Clinical assessments of beneficiary rehabilitation potential based on the following functional classification levels: Level 0,1,2,3,4

* Coverage criteria does not equal medical necessity

Prior Authorization

What should be in the Physician's note?

Treating practitioner's records assessing the beneficiary's physical and cognitive capabilities

- History of the present condition(s) and past medical history that is relevant to functional deficits
- Cognitive ability to use & care for new prosthesis
- Symptoms limiting ambulation or dexterity
- Diagnoses causing these symptoms
- Other co-morbidities relating to ambulatory problems or impacting the use of a new prosthesis
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used (either in addition to the prosthesis or prior to amputation)
- Situational/temporary? Why do they use it, safety, balance, fear of falling?
- Plan to be free of assistive devices (if applicable).

Prior Authorization

What should be in the Physician's note?

- Description of activities of daily living and how impacted by deficit(s)
- Physical examination that is relevant to functional deficits
  - Date and Cause of amputation(s) or congenital
  - Affected side(s) & Condition of residual limb
  - Clinical course, interventions & results, prognosis
- Weight and height, including any recent weight loss/gain
- Cardiopulmonary examination, including if the patient has any limitation to prevent mobility or if not, stated clearly
- Musculoskeletal examination
  - Arm and leg strength and range of motion
- Neurological examination
  - Gait
  - Balance and coordination

Prior Authorization

What should be in the Physician's note?

- Description of activities of daily living and how impacted by deficit(s)
- Functional Level
- Patient's activities prior to amputation
- Patient's current activities & impact of the limitations.
- Desired & potential activities using new prosthesis

Prosthetic Use

- Past: components tried & result
- Current: History and condition of each component
- Reason for replacement

Prior Authorization

What should be in the Prosthetist note?

Functional Level – should match physician's determination

- Testing – what tests were performed, what were the results & what do they mean
- Activities prior to amputation
- Current Activities
- Are there any activities the patient would actually like to do but is unable due to current componentry?
- Are there activities the patient avoids for fear of falling or safety concerns?
- Future activities – what will the patient achieve or maintain with the new prosthesis?
- For potential K-Level: explanation on how the patient will achieve the goal, therapy, or other intervention

History of Prosthetic Use Over Time

- Brand, how long used, result

Prior Authorization

What should be in the Prosthetist note?

History of Current Components

- History of components being replaced (age, condition, result)
- Description of Labor (casting, modification, time, tools, materials & where applied
- Reason for Replacement

Recommendation for Type and Brand of Prosthesis

- Based on physician's recommendation
- Medical Necessity and Justification for each component
- What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently used (either in addition to the prosthesis or prior to amputation)
- Situational/temporary? Why do they use it, safety, balance, fear of falling?
- Plan to be free of assistive devices (if applicable).

Desire and Motivation

- To ambulate and use new prosthesis

Prior Authorization

What should be in the Physician or Prosthetist's note?

It is recommended to be in both sets of records, but not required as long as the Prosthetist notes match up with the Physicians.

- The beneficiary's current functional capabilities
- His/her expected functional potential, including an explanation for the difference, if that is the case.
- The beneficiary will reach or maintain a defined functional state within a reasonable period of time.
- The beneficiary is motivated to ambulate.

Prior Authorization
Replacements

… Replacement of a prosthesis or major component is covered if the treating physician orders a replacement device or part because of any of the following:

Both treating physician and prosthetist should document the reason

…Change in the physiological condition of the patient resulting in the need for a replacement.

Ex. changes in beneficiary weight, changes in the residual limb, beneficiary functional need changes;

 Irreparable change in the condition of the device, or in a part of the device resulting in the need for a replacement; or

… Condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost (Medicare allowed amount) of a replacement device, or, as the case may be, of the part being replaced.

Prior Authorization
Submission

Complete all boxes on the Prior Authorization Coversheet

Complete properly the SWO

Obtain and read all the Physician & Prosthetist paperwork

Paperwork can be uploaded into DME MAC portal, faxed or mailed

The response will be posted on the portal and postmarked 10 business days of the submission.

After the PA submission goes through the medical review process, the supplier will receive a decision letter. Affirmative or Non-affirmative

- You do not need to wait for the mail, if you check the portal and confirm the affirmative decision. Proceed with the fitting.

Prior Authorization

Affirmative Decisions

Affirmative: Based on the review, it was determined the beneficiary meets the medical necessity requirements established for the LLP HCPCS code requested. The DME MAC will issue a specific Unique Tracking Number (UTN) for each code that required Prior Authorization.

Process:

Deliver LLP and obtain Proof of Delivery

Bill with correct Unique Tracking Number (UTN)

If billing on CMS-1500 Claim Form, include UTN in Item 23

If billing electronically, include UTN in loop 2300 REF02 (REF01 = G1) or loop 2400 REF02 (REF01 = G1)

- If 2 codes are required for PA, you will get 2 UTNs, 2 Letters, but both codes can be billed on the same claim

Prior Authorization

Non-Affirmative Decisions

Based on the review, a supplier is required to follow-up prior to submitting a resubmission.

Options:

1. Review decision and resubmit a PA request

- Gather missing and/or clarifying documentation
- Mark resubmission on the coversheet

2. Deliver LLP and submit claim for denial

- Execute Advance Beneficiary Notice of Non-coverage (ABN) prior to delivery, if appropriate
- File an appeal

3. Do not deliver or bill the LLP

Prior Authorization

Advance Beneficiary Notice

If you choose the option to deliver LLP and submit claim for denial

- Execute Advance Beneficiary Notice of Non-coverage (ABN) prior to delivery, if applicable
- If you feel that the claim will be denied as not medically necessary,
  - Is it based on the Prosthetist notes?
  - If the errors are related to not meeting the coverage criteria then you are at the mercy of the reviewer when you present your case for coverage.
  - It's a challenge to predict the outcome without understanding each beneficiary's scenario.
- File an appeal
- Success is contingent on the reason for denial. If the errors identified are curable errors, chances are the claim could reverse the denial to allow for payment.
- Source: ABN form & instructions

Prior Authorization
Proof of Delivery

…Proof of Delivery

Beneficiary's name

- Delivery address
- A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature
    - Date the beneficiary received the Prosthesis must be the DOS on the claim.
- Source: CGS Proof of Delivery checklist

Prior Authorization

Proof of Delivery

…Beneficiary's name

…Delivery address

…A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.

…Quantity delivered

…Beneficiary (or designee) signature

…Date delivered

- Date the beneficiary received the Prosthesis must be the DOS on the claim.

- Source: CGS Proof of Delivery checklist Noridian Proof of Delivery info

Prior Authorization

Billing Tips

- Make sure you put the UTN with the corresponding HCPCS code, When the claim is submitted electronically, each UTN must be entered on the 2400 -Service Line for the applicable HCPCs code.
- Claims for knees, feet, ankles, and hips must be submitted with modifiers K0 – K4, indicating the expected functional level.
- The right (RT) and left (LT) modifiers must be used with prosthesis codes.
- When the same code for prostheses, sockets, or components for bilateral amputees are billed on the same date of service bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line.
- Do not use the RTLT modifier on the same claim line
- RTLT on the same claim line and 2 UOS, will be rejected as incorrect coding.

Prior Authorization

Resources

CGS website **CGS Prior Auth Resources for LLP**

Noridian website Noridian Prior Auth for Lower Limb Prosthetics

Ottobock Reimbursement Website Ottobock Tools & Checklists

PDAC Verification

What is it?

Palmetto GBA is contracted by CMS to verify proper coding for a product billed to Medicare.

Effective 1/1/2021 PDAC Verification is required for the following codes:

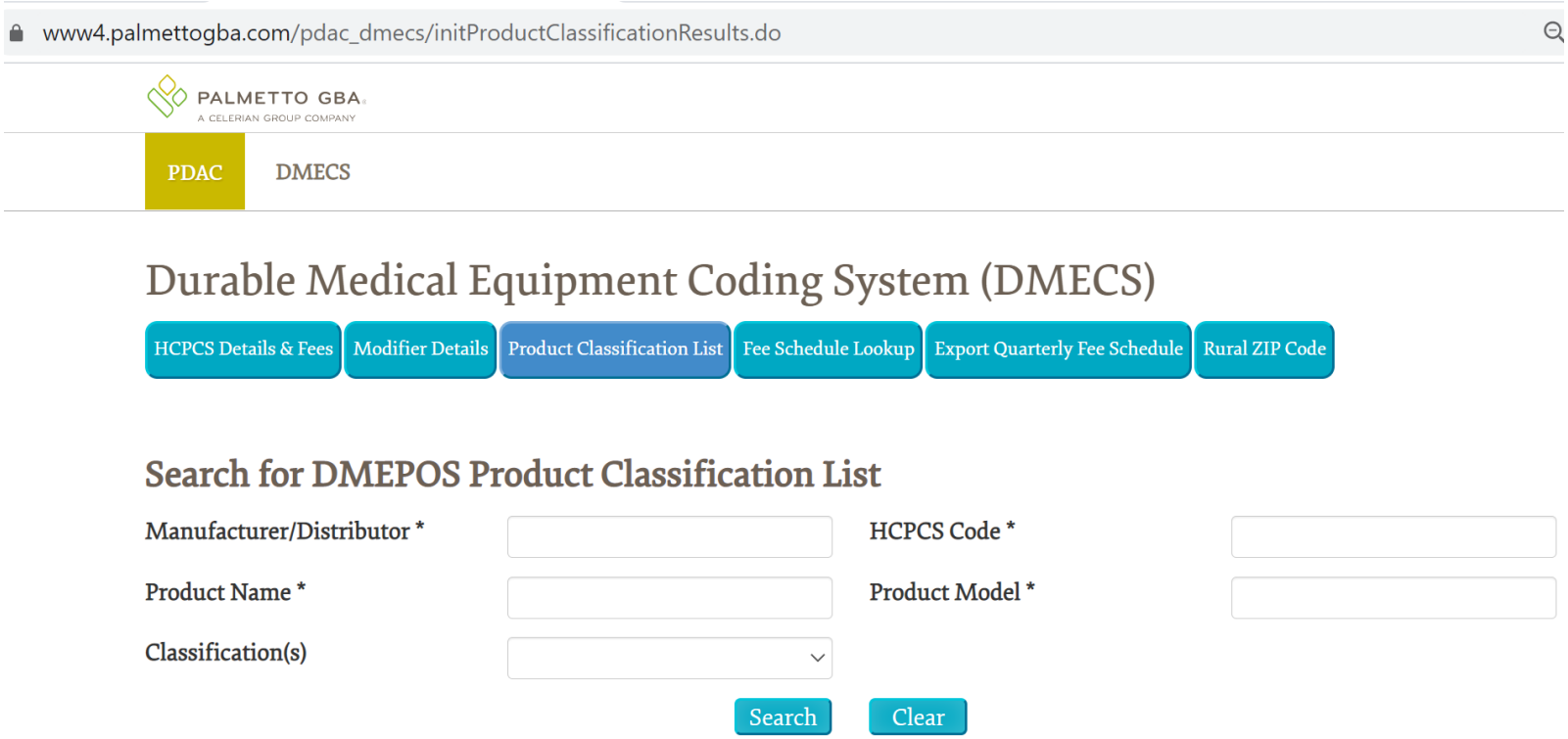
L5856, L5857, L5858, L5973, L5980, L5987

Every manufacturer is submitting their products in order to be compliant with the requirement.

To check to see if a product is listed and it's coding assignment visit the product classification list (PCL) on the DMEPDAC.com website

PDAC Verification

DMEPDAC.com



Prior Authorization
Resources

CGS website **CGS Prior Auth Resources for LLP**

Noridian website Noridian Prior Auth for Lower Limb Prosthetics

Ottobock Reimbursement Website Ottobock Tools & Checklists

Product Classification Listing on PDAC Product Classifcation Search

ottobock.

Thank you very much for your attention!

Kimberly Hanson

Contact: kimberly.hanson@Ottobock.com

Reimbursement requests: Reimbursement911@Ottobock.com

Quality for life