# CMS IMPLEMENTED PRIOR AUTHORIZATION PROCESS

## Billing Medicare just became more complex, and this is only the beginning.

**Effective: July 1, 2020**

The Centers for Medicare and Medicaid Services (CMS) began requiring prior authorization for traditional Medicare for certain outpatient procedures including:

1. **Blepharoplasty**
2. **Botulinum toxin injections**
3. **Panniculectomy**
4. **Rhinoplasty**
5. **Vein ablation**

The full list of HCPCS codes requiring prior authorization is available by clicking **here**.

**Key Points to Consider:**

- The standard review timeframe is up to ten business days from the date of request, excluding federal holidays. Expedited reviews may be completed within two business days if the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary.
- Authorizations may be requested up to 120 days in advance, and retroactive authorizations will not be provided.
- Scheduled appointments for these services covered by Medicare should allow for time to complete the authorization request and receive a final decision.
- Prior authorization requests can be submitted to your respective MAC by all of the following methods: fax, mail, Electronic Submission of Medical Documentation (esMD), and MAC electronic portals.
- Note that while this prior authorization process is only applicable to claims submitted to Medicare Fee-for-Service, Medicare Advantage plans may have their own authorization requirements.
- Medicare requires prior authorization, even as a secondary payer for an applicable hospital OPD service.

# How Has Ensemble Helped Their Client Partners?

Ensemble partnered with clients to prepare for the change:

1. Created educational reference guides for associates
2. Provided education through virtual training sessions focused on the new rules
    a) Explained how rules would impact associate workflows
    b) Instructed associates and leaders how to use tip sheets provided
3. Audited accounts for accuracy.

# What's Next For CMS Requirements Around Prior Authorizations?

**Effective: June 30, 2020**

The Interoperability and Patient Access final rule (CMS-9115-F) identified Health Level 7® (HL7) Fast Healthcare Interoperability Resources® (FHIR) Release 4.0.1 as the foundational standard to support data exchange via secure application programming interfaces (APIs). Please see below for more details on each.

**Interoperability and Patient Access final rule API timeframes:**

- Patient Access API beginning **January 1, 2021**
- Provider Directory API by **January 1, 2021**
- Payer-to-payer data exchange beginning **January 1, 2022**
- States to exchange certain enrollee data for individuals dually eligible for Medicare and Medicaid, from monthly to daily exchange starting **April 1, 2022**

**Proposed Rule: December 10, 2020**

Building on the CMS Interoperability and Patient Access final rule (CMS-9115-F), this proposed rule would require increased patient electronic access to their health care information and would improve the electronic exchange of health information among payers, providers and patients.

# Proposals

**Patient Access Application Programming Interface (API)**

- Starting **January 1, 2023**, impacted payers will be required to include information about the patient's pending and active prior authorization decisions:
    - Require impacted payers to report metrics quarterly about patient use of the Patient Access API to CMS to assess the impact the API is having on patients.

**Provider Access APIs**

- Require impacted payers to build and maintain a Provider Access API for payer-to-provider data sharing of claims and encounter data (not including cost data), a sub-set of clinical data as defined in the U.S. Core Data for Interoperability (USCDI) version 1, and **pending and active prior authorization decisions** for both individual patient requests and groups of patients starting **January 1, 2023**.

**Documentation and Prior Authorization Burden Reduction through APIs**

- Document Requirement Lookup Service (DRLS) API: require impacted payers build and maintain a FHIR-enabled DRLS API -- that could be integrated with a provider's electronic health record (EHR) -- to **allow providers to electronically locate prior authorization requirements for each specific payer** from within the provider's workflow.
- Prior Authorization Support (PAS) API: require impacted payers build and maintain a FHIR-enabled electronic Prior Authorization Support API that has the capability to **send prior authorization requests and receive responses electronically within their existing workflow** (while maintaining the integrity of the HIPAA transaction standards).
- Denial Reason: require impacted payers include a **specific reason for a denial** when denying a prior authorization request, regardless of the method used to send the prior authorization decision.
- Shorter Prior Authorization Timeframes: require impacted payers (not including QHP issuers on the FFEs) to **send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for standard requests.**
- Prior Authorization Metrics: require impacted payers to **publicly report data about their prior authorization process**, such as the percent of prior authorization requests approved, denied, and ultimately approved after appeal, and average time between submission and determination.
    - These prior authorization policies are proposed to take effect **January 1, 2023**, with the initial set of metrics proposed to be reported by **March 31, 2023**.

**Payer-to-Payer Data Exchange on FHIR**

- Payer-to-Payer API: proposing to enhance the previously finalized payer-to-payer data exchange requirements for impacted payers by requiring that such exchange be via a FHIR-based Payer-to-Payer API, and that in addition to a sub-set of clinical data as defined in the USCDI version 1, impacted payers would also be **required to exchange claims and encounter data (not including cost data), and information about pending and active prior authorization decisions, at a patient's request.**
- Payer-to-Payer Data Exchange at Enrollment: proposing to require impacted payers share claims and encounter data (not including cost data), a sub-set of clinical data as defined in the USCDI version 1, and **information about pending and active prior authorization decisions at enrollment,** for payers that have a specific annual open enrollment period, or during the first calendar quarter of each year. Payers could efficiently exchange information for one or more patients at one time using the HL7 FHIR Bulk specification, allowing patients to take their health information with them as they move from one payer to another.
- Leveraging Information about Pending and Active Prior Authorization Decisions during Patient Transitions: As part of this proposal we would encourage patients' new impacted payers to consider such information from previous payers when making new prior authorization determinations, potentially **eliminating the need for patients and providers to repeat the prior authorization process with the new payer.**
- These policies are proposed to take effect **January 1, 2023**.

The proposed rule is available to review **here**.

# The Interoperability and Patient Access Final Rule (CMS-9115-F) API Information

**Patient Access API**

CMS-regulated payers, specifically MA organizations, Medicaid Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP FFS programs, CHIP managed care entities, and QHP issuers on the FFEs, excluding issuers offering only Stand-alone dental plans (SADPs) and QHP issuers offering coverage in the Federally-facilitated Small Business Health Options Program (FF-SHOP), are required to implement and maintain a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice. These payers are required to implement the Patient Access API beginning J**anuary 1, 2021** (for QHP issuers on the FFEs, plan years beginning on or after January 1, 2021).

**Provider Directory API**

CMS-regulated payers noted above (except QHP issuers on the FFEs) are required by this rule to make provider directory information publicly available via a standards-based API. MA organizations, Medicaid and CHIP FFS programs, Medicaid managed care plans, and CHIP managed care entities are required to implement the Provider Directory API by **January 1, 2021**.

**Payer-to-Payer Data Exchange**

CMS-regulated payers are required to exchange certain patient clinical data (specifically the U.S. Core Data for Interoperability (USCDI) version 1 data set) at the patient's request, allowing the patient to take their information with them as they move from payer to payer over time. These payers are required to implement a process for this data exchange beginning **January 1, 2022** (for QHP issuers on the FFEs, plan years beginning on or after January 1, 2022).

**Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges**

This final rule will update requirements for states to exchange certain enrollee data for individuals dually eligible for Medicare and Medicaid, including state buy-in files and "MMA files" (called the "MMA file" after the acronym for the Medicare Prescription Drug, Improvement and Modernization Act of 2003) from monthly to daily exchange to improve the dual eligible beneficiary experience, ensuring beneficiaries are getting access to appropriate services and that these services are billed appropriately the first time, eliminating waste and burden. States are required to implement this daily exchange starting **April 1, 2022**.

# FINAL RULE: CMS-1717-FC: PRIOR AUTHORIZATION PROCESS and REQUIREMENTS for CERTAIN HOSPITAL OUTPATIENT DEPARTMENT (OPD) SERVICES

## TABLE 65: FINAL LIST of OUTPATIENT SERVICES THAT REQUIRE PRIOR AUTHORIZATION

***Federal Register*** */ Vol. 84, No. 218 / Tuesday, November 12, 2019*

| Code | (i) Blepharoplasty, Eyelid Surgery, Brow Lift, and related services |
|---|---|
| | |
| 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 |
| | |
| Code | (ii) Botulinum Toxin Injection (*Procedure codes must be paired with the botulinum product code)*[1] |
| | |
| 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 |

[1] *Prior authorization is only required when one of the required Botulinum Toxin codes (**J0585, J0586, J0587, or J0588**) is used in conjunction with the one of the required CPT injection codes (**64612**, injection of chemical for destruction of nerve muscles on one side of face, or **64615**, injection of chemical for destruction of facial and neck nerve muscles on both sides of face). Use of these Botulinum Toxin codes in conjunction/paired with procedure codes other than 64612 or 64615 will not require prior authorization under this program.*

| | |
|---|---|
| J0586 | Injection, abobotulinumtoxina |
| J0587 | Injection, rimabotulinumtoxinb, 100 units |
| J0588 | Injection, incobotulinumtoxin a |
| | |
| Code | (iii) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services |
| | |
| 15830 | Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy |
| 15847 | Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure) |
| 15877 | Suction assisted removal of fat from trunk |
| | |
| Code | (iv) Rhinoplasty, and related services [2] |
| | |
| 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 |
| | |
| Code | (v) Vein Ablation, and related services |
| | |
| 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 |

## Sources


- CMS Interoperability and Patient Access final rule
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index.
- Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients' Electronic Access to Health Information CMS-9123-P: Fact Sheet
  - https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients
- Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs)
  - https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf