

**Non-Emergent Hyperbaric Oxygen Therapy Model Operational Guide**  
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## **Purpose**

The purpose of this Operational Guide is to interpret and clarify the prior authorization process for Medicare participating facilities when providing non-emergent hyperbaric oxygen therapy services for Medicare beneficiaries. Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps make sure that applicable coverage, payment and coding rules are met before services are rendered.

These guidelines are merely to assist and do not alter the documentation requirements that are set forth in the Medicare National Coverage Determinations Manual (NCD), Chapter 1, Part 1, Section 20.29 and in applicable Local Coverage Determinations (LCDs) found at <http://www.cms.gov/Medicare/Coverage/DeterminationProcess/LCDs.html>.

## Chapter 1: Hyperbaric Oxygen Therapy Benefit

For any service to be covered by Medicare it must:

1. Be eligible for a defined Medicare benefit category,
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
3. Meet all other applicable Medicare statutory and regulatory requirements.

Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The medical necessity requirements for Medicare coverage of HBO therapy are set forth in the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.29. In addition to the medical necessity requirements, the service must meet all other Medicare coverage and payment requirements.

Further details for the circumstance under which the HBO therapy will be covered by Medicare in each jurisdiction can be found through the following links:

- [Jurisdiction 6 Medical Policy Article for Illinois facilities](#)
- [Jurisdiction L LCD for New Jersey facilities](#)
- [Jurisdiction 8 for Michigan facilities should follow the NCD](#)

## Chapter 2: Model Overview

This model establishes a prior authorization process for non-emergent HBO therapy for certain covered conditions to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care.

### Who

- Facilities who submit HBO claims with bill type 13 - Hospital Outpatient for beneficiaries under traditional Medicare.
- Facilities under review for HBO therapy services by a Zone Program Integrity Contractor (ZPIC) are **not** eligible to submit prior authorization requests.

The facility or the beneficiary may submit the prior authorization (PA) request.

### What

- HBO therapy treatments billed on claims with bill type 13 - Hospital Outpatient and
  - One of the following five included conditions:
    - 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, and
    - 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
      - Patient has failed an adequate course of wound therapy as defined in the NCD.
- The Medicare Administrative Contractors (MACs) are using the following definitions for Wagner Grade classifications:
- Grade 0- no open lesion,
  - Grade 1- superficial ulcer without penetration to deeper layers,
  - Grade 2- ulcer penetrates to the tendon or capsule,
  - Grade 3- lesion has penetrated deeper than grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths,
  - Grade 4- wet or dry gangrene in the toes or forefront, and
  - Grade 5- gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated.

- As of December 28, 2015 the condition preparation and preservation of compromised skin grafts (not for primary management of wounds), will no longer require prior authorization.
- Note: The remaining conditions listed in the NCD are still covered by Medicare, but do not require prior authorization.

## Where

- The HBO prior authorization model will impact the states of:
  - Illinois facilities serviced by MAC J6 NGS,
  - Michigan facilities serviced by MAC J8 WPS, and
  - New Jersey facilities serviced by MAC JL Novitas.

## When

- Facilities and beneficiaries in **Michigan** are encouraged to utilize the prior authorization process for HBO therapy with one of the included conditions as stated above beginning on:
  - **March 1, 2015** for HBO therapy treatments which occur on or after **April 13, 2015**.
  - All HBO therapy treatments included in the prior authorization program with a date of service on or after **April 13, 2015** must have completed the prior authorization process or the claims will be stopped for pre-payment review.
- Facilities and beneficiaries in **Illinois** and **New Jersey** are encouraged to utilize the prior authorization process for HBO therapy with one of the included conditions as stated above beginning on:
  - **July 15, 2015** for HBO therapy treatments which occur on or after **August 1, 2015**.
  - All HBO therapy treatments included in the prior authorization program with a date of service on or after **August 1, 2015** must have completed the prior authorization process or the claims will be stopped for pre-payment review.
- The model will continue for three years.

## Additional Information

- Submitting a prior authorization request is voluntary.
- If a facility in a model state does not obtain prior authorization for a claim with one of the conditions under the prior authorization model, the HBO therapy claim will be subject to pre-payment review.
- Facilities that have received a prior authorization decision for either an affirmed or non-affirmed decision should place the unique tracking number on claims submitted for these treatments.
- Physician claims do not need to include a unique tracking number.

### **Chapter 3: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to the Prior Authorization Model**

#### **HBO HCPCS Code**

The following HBO HCPCS code is subject to prior authorization:

- **G0277** - Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
  - HCPCS G0277 replaced HCPCS C1300 on January 1, 2015.

Physicians do not need to request prior authorization. However, if a facility does not have prior authorization nor has a non-affirmed prior authorization, the associated physician Part B claims with the following code will be subject to medical review:

- **99183** - Physician attendance and supervision of hyperbaric oxygen, per session

#### **Prior Authorization Request Received for a Code of Condition Not Listed**

No prior authorization decisions will be made on any code or condition NOT listed. If an MAC receives a prior authorization request for a code or condition not listed, the MAC will not review the request and will not issue a decision letter.

## **Chapter 4: Number of Treatments**

A provisional affirmative prior authorization decision affirms a specified number of treatments.

- The provisional prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 courses of treatment per prior authorization request in a 12-month time period.
- A provisional affirmative prior authorization decision may affirm less than 40 courses of treatments.

Beneficiaries exceeding 40 courses of treatments in a 12-month period require an additional prior authorization request.

## Chapter 5: Submitting a Request

Prior authorization should be requested as soon as the HBO therapy treatment is scheduled. Treatment should not be delayed due to a pending prior authorization decision. An affirmed decision will retroactively apply to services based on the earliest date noted on documentation that supports medical necessity or the start date requested on the prior authorization request – whichever is later. Claims, however, should not be submitted until the prior authorization decision has been received as it will contain the tracking number that must be placed on the claim.

Submitters are encouraged to use their respective MAC's form specifically designed for prior authorization requests. The form assists submitters with making sure requests are completing.

### **Submitters should include the following data elements in a PA request package:**

#### Beneficiary Information

- Beneficiary Name,
- Beneficiary Medicare Number (also known as HICN),
- Beneficiary Date of Birth, and
- Beneficiary Gender

#### Ordering Physician/Practitioner Information

- Physician/Practitioner Name,
- Physician/Practitioner National Provider Identifier (NPI), and
- Physician/Practitioner Address

#### Facility Information

- Facility Name,
- Facility National Provider Identifier (NPI), and
- Facility Address

#### Requestor Information

- Contact Name, and
- Telephone Number

#### Other Information

- Number of treatments requested,
- Number of units per treatment requested,
- HCPCS Code,
- Submission Date,
- Start Date of the 12 month period,
- Indicate if the request is an initial or resubmission review,
- Indicate if the request is expedited and the reason why,
- State, and
- Diagnosis Codes

### Additional Required Documentation

- Documentation from the medical record to support the medical necessity of HBO treatment, and
- Any other relevant document as deemed necessary by the MAC to process the prior authorization. Please see your MAC's website for additional information.

### **Methods for sending a PA request package:**

Submitters have four options for submitting prior authorization requests to the MACs:

- Mail,
- Fax,
- Electronic submission of medical documentation (esMD) if available, or
- MAC Provider Portal, if available.

For more information about esMD, see [www.cms.gov/esMD](http://www.cms.gov/esMD) or contact your MAC.

### **Addresses and fax numbers of the MACs:**

- For facilities in New Jersey, send requests to MAC JL at:
  - Fax Number: 1-877-439-5479
  - Mailing Address: Novitas Solutions  
Part A Prior Authorization Request  
PO Box 3702  
Mechanicsburg, PA 17055or
  - Novitas Solutions  
Attention: Part A Prior Authorization Request  
2020 Technology Parkway, Suite 100  
Mechanicsburg, PA 17050
- esMD: (indicate content type "82" or "8.2")
- For facilities in Illinois, send requests to MAC J6 at:
  - Fax Number: 1-717-565-3840
  - Mailing Address: National Government Services  
PO Box 6474  
Indianapolis, IN 46206-6474
- esMD: (indicate content type "82" or "8.2")
- For facilities in Michigan, send requests to MAC J8 at:
  - Fax Number: 608-224-3508
  - Mailing Address: WPS Medicare Medical Review  
PO Box 1268  
Madison, WI 53701-1268
- esMD: (indicate content type "82" or "8.2")

### **Possible Outcomes of Prior Authorization Request Review:**

- Provisional affirmation (Chapter 6) or
- Non-affirmation
  - Incomplete request (Chapter 7)
  - Not medically necessary

### **Cases where Medicare is primary and another insurance company is secondary:**

- Facilities may submit the claim without a prior authorization decision if the claim is non-covered (GY modifier). A prior authorization is not needed and the claim will not be developed due to the prior authorization model.
- Services billed as not medically necessary (GA modifier) will be developed and reviewed under the prior authorization model.

If a facility chooses to use the prior authorization for a denial then the following process is to be followed:

- The submitter may submit the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the treatment, then a non-affirmative prior authorization decision will be sent to the facility and to the beneficiary advising them that Medicare will not pay for the service.
- A claim with a non-affirmed decision submitted to the MAC for payment will be denied.
- The submitter may forward the denied claim to the secondary insurance payee as appropriate to determine payment for the treatment.

### **Cases where another insurance company is primary and Medicare is secondary:**

If a facility plans to bill another insurance first and bill Medicare second, the submitter has two options:

1. Seek Prior Authorization:
  - The submitter submits the prior authorization request with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the treatment, then a provisional affirmative prior authorization decision will be sent to the facility and to the beneficiary advising them that Medicare **will** pay for the treatment as long as all other requirements are met.
  - The facility renders the service and submits a claim to the other insurance company.
  - If the other insurance company denies the claim, the facility can submit a claim to the MAC (listing the prior authorization tracking number on the claim). The MAC will pay the claim.
2. Skip Prior Authorization:
  - The facility renders the service and submits a claim to the primary payer for a determination as appropriate.
  - If the other insurance company denies the claim, the facility can submit a claim to the MAC. The MAC will stop the claim for pre-payment review and will send an

Additional Documentation Request (ADR) letter. The supplier should respond to the ADR.

**Timeframe for Decisions:**

- The MAC will postmark notification of the decision to the facility and to the beneficiary within 10 business days for an initial request.
- A resubmitted request is a request submitted with additional documentation after the initial prior authorization request was non-affirmed. The MAC will postmark notification of the decision of these requests to the facility and to the beneficiary within 20 business days.
- A facility or beneficiary may request an expedited review when the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. The MAC will make reasonable efforts to communicate a decision within 2 business days of receipt of all applicable Medicare required documentation.
  - As this model is for non-emergent services and approvals are retroactive based on the earliest date noted on documentation that supports medical necessity or the start date requested on the prior authorization request – whichever is later, CMS expects requests for expedited reviews to be extremely **rare**.

**Provider Telephone Inquiries:**

Providers who have questions about the prior authorization process should call the appropriate MAC. The numbers for Customer Service Representatives at the MACs are as follows:

- For providers in New Jersey, call 855-340-5975.
- For providers in Michigan, call 866-234-7331.
- For providers in Illinois, call 1-877-702-0990 or TTY: 888-897-7523.

**See Appendices A and B for visual representations of the prior authorization request process.**

## Chapter 6: A Provisional Affirmative Decision

### Provisional Affirmative Decision

A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

### Decision Letter(s):

The MAC will send decision letters with the provisional affirmative prior authorization tracking number to the submitter via fax, mail, or the MAC provider portal (when available) postmarked within 10 business days for initial requests and 20 business days for resubmitted requests. Decision letters sent via esMD are not available at this time. A copy of the decision letter will also be mailed to the beneficiary.

### Non-Transferability of a provisional affirmative PA Decision:

A provisional affirmative prior authorization decision does not follow the beneficiary. Only one facility is allowed to request prior authorization per beneficiary per time period. If the initial facility cannot complete the total number of prior authorized treatments and the beneficiary will continue treatment at another facility, the initial facility should contact their MAC to cancel their prior authorization. The subsequent facility may submit a prior authorization request to provide treatment for the same beneficiary and must include the required documentation in the submission.

### Facility's Actions:

- Render the service to the beneficiary.
- Have all documentation available upon request.
- Submit the claim with the unique tracking number (UTN) on the claim.
  - When submitting an electronic 837 institutional claim, the 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 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.
- If all requirements are met the claim will be paid.
- The prior authorization model has specific parameters for pre-payment review; however other contractors (CERT, ZPICs, etc.) may have parameters outside of the prior authorization model that can suspend the same claim for another type of review. If your claim is selected for review, guidance and directions will be provided on the Additional Documentation Request Letter from the requesting contractor.
- Physician Part B claims do **not** need a tracking number.

**See Appendix A for a visual representation of the prior authorization request process.**

## **Chapter 7: A Non-Affirmative Decision for Incomplete Requests**

**An incomplete request is considered non-affirmed. When an incomplete request is submitted:**

- The MAC will provide notification of what is missing with the prior authorization request to the submitter via fax, mail, or the MAC provider portal (when available) through a detailed decision letter postmarked within 10 business days for initial requests and 20 business days for resubmitted requests. Decision letters sent via esMD are not available at this time. A copy of the decision letter will be mailed to the beneficiary.
- The submitter may resubmit another complete package with all documentation required as noted in the detailed decision letter. See Chapter 8 for instructions on resubmitting a prior authorization request.
- If the claim is submitted to the MAC for payment with a non-affirmative prior authorization decision, it will be denied.
  - All appeal rights are then engaged.
  - The claim could then be submitted to secondary insurance.

### **Facility's Action:**

- Use the detailed decision letter to ensure that the request package complies with all requirements.
  - Resubmit a prior authorization request, if appropriate.

## **Chapter 8: Resubmitting a Prior Authorization Request**

- The submitter should review the detailed decision letter that was provided.
- The submitter should make whatever modifications are needed to the prior authorization package and follow the submission procedures.
- The entire prior authorization request should be resubmitted with the new modifications.
- The MAC will provide notification of the decision through a detailed decision letter postmarked within 20 business days of the review to the facility and to the beneficiary.

## **Chapter 9: Claim Submission Where Prior Authorization was Sought**

### **Cases Where a Prior Authorization Request was Submitted and Affirmed:**

- The submission of the prior authorized HBO therapy claim is to have the 14 byte unique tracking number (UTN) that is located on the decision letter. When submitting an electronic 837 institutional claim, the unique tracking number 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 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.
- Series of claims:
  - Should be submitted with the prior authorization tracking number on the claim.
  - Should be submitted to the applicable MAC for adjudication.
  - If the facility changes during the scheduled treatment period, the claim will undergo a complex medical review. The new facility is required to submit all medical documentation to support a provisional affirmative prior authorization decision.

### **Cases Where a Prior Authorization Request was Submitted and Non-Affirmed:**

- When submitting an electronic 837 institutional claim, the 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 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.
- Series of claims:
  - Should be submitted with the prior authorization tracking number on the claim.
  - Should be submitted to the applicable MAC for adjudication.
- If the claim is submitted to the MAC for payment with a non-affirmative prior authorization decision, it will be denied.
  - All appeal rights are then engaged.
  - This claim could then be submitted to secondary insurance.

**See Appendix C for a visual representation of the claim line process when prior authorization was sought.**

## **Chapter 10: Claim Submission Where PA was NOT Sought: The Pre-payment Review Process**

If an applicable claim is submitted in which a prior authorization decision was not sought, it will be stopped for pre-payment review. Claims with treatments rendered before April 13, 2015 are not applicable for the prior authorization model.

At this time, facilities do not need to do anything differently when submitting a claim without a unique tracking number. They do not need to put any information in the remarks field. They do not need to submit any unsolicited documentation.

### **Stopping a Claim for Pre-Payment Review:**

- The MAC will stop the claim and send an Additional Documentation Request (ADR) through the US Postal Service.
- The facility will have 45 days to respond to the ADR with all requested documentation.
- The facility can send the documentation via:
  - Fax
  - Mail
  - esMD (for more information see: [www.cms.gov/esMD](http://www.cms.gov/esMD))
- The MAC will have 30 days to review the documentation.

**See Appendix D for a visual representation of the claim line process when prior authorization was not sought.**

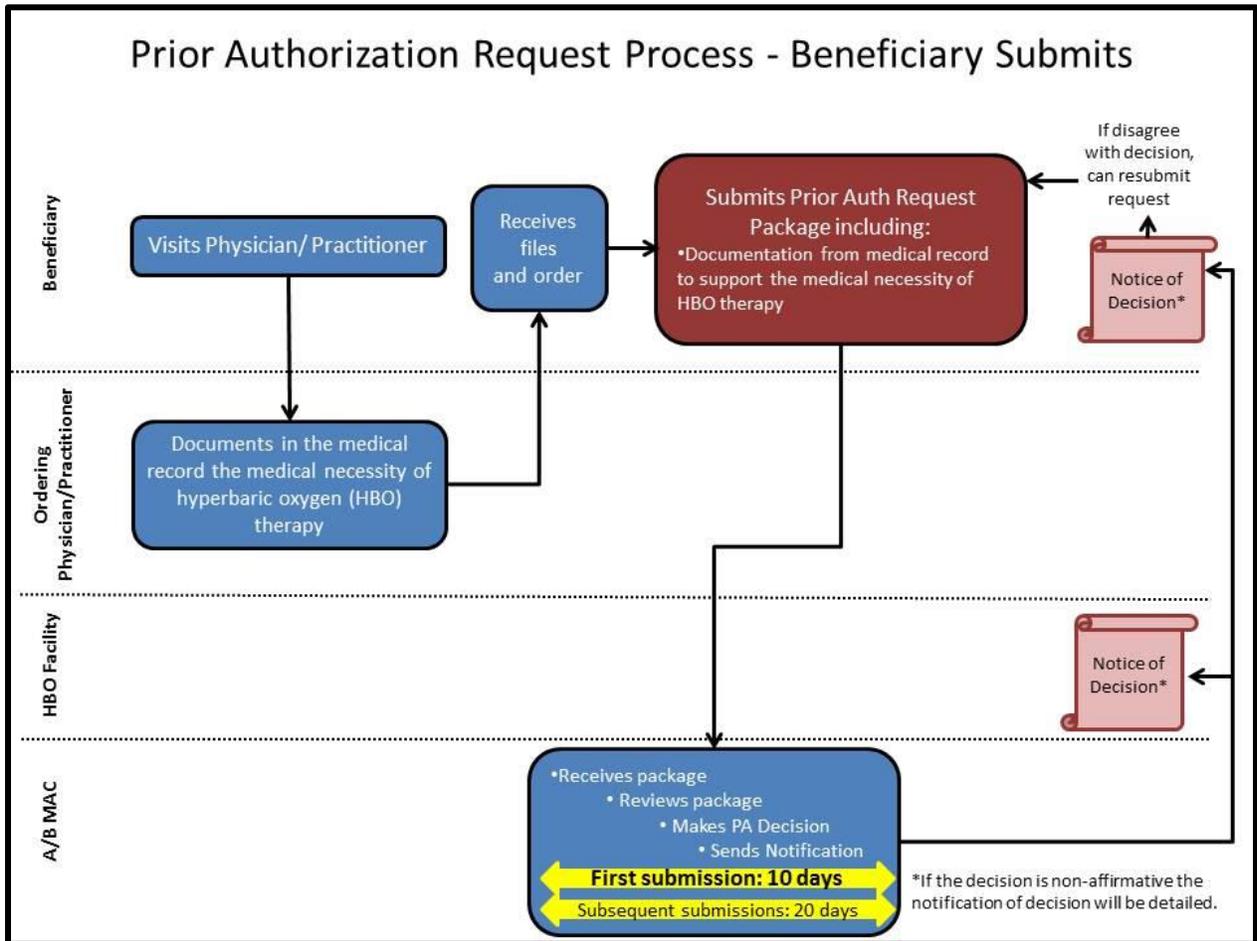
## **Chapter 11: Claim Appeals**

Appeals follow all current procedures. For further information consult the Medicare Claims Processing Manual publication 100-04, chapter 29 Appeals of Claims Decision. This prior authorization model does not include a separate appeal process for a non-affirmative prior authorization request decision.

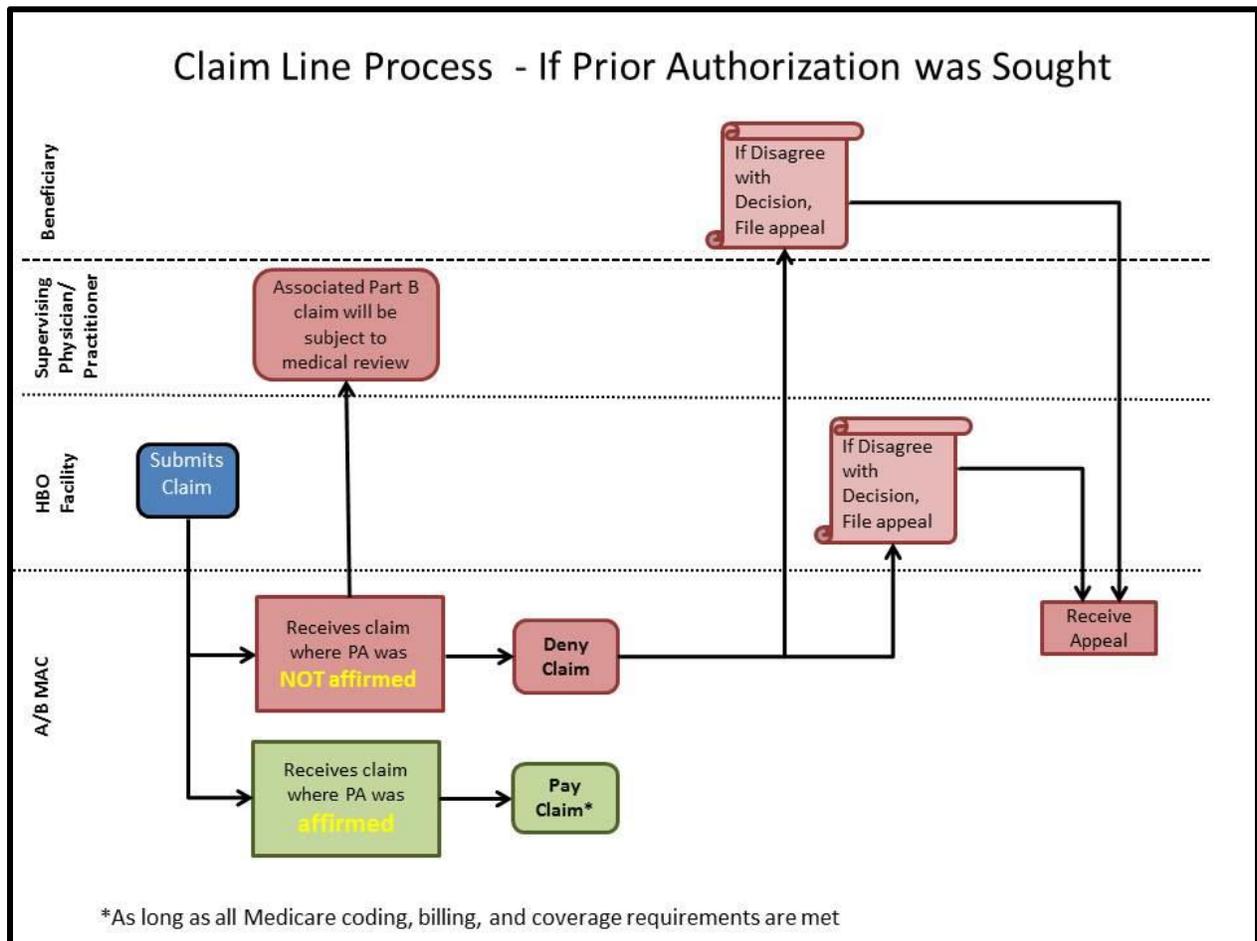
However, a non-affirmative prior authorization request decision does not prevent the facility from submitting a claim. Such a submission of a claim and resulting denial by the MAC would constitute an initial determination that would make the appeals process available for disputes by beneficiaries and facilities.



## Appendix B: Prior Authorization Request Process - Beneficiary Submits



## Appendix C: Claim Line Process - If Prior Authorization was Sought



**Appendix D: Claim Line Process - If Prior Authorization was Not Sought**

