New Prior Authorization Demonstration Projects Non-Emergent Hyperbaric Oxygen Therapy

Frequently Asked Questions

1. **What is prior authorization?**

   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 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 help ensure proper payment before the service is rendered.

2. **Does prior authorization create new documentation requirements?**

   Prior authorization does not create new documentation requirements. Prior authorization would simply require currently mandated documentation earlier in the claims payment process.

3. **Under prior authorization, how long will Medicare have to affirm or non-affirm a prior authorization request?**

   Medicare will make every effort to postmark a decision on a prior authorization request within 10 business days for an initial request and 20 business days for a resubmitted request.

4. **Is the 10-day review period under prior authorization calendar days or business days?**

   The 10-day review period is business days. Medicare Administrative Contractors will make every attempt to review initial prior authorization requests in 10 business days and resubmitted prior authorization requests in 20 business days.

5. **In what cases could a provider, supplier, or beneficiary request an expedited review?**

   A provider, supplier, 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. Medicare Administrative Contractors will make reasonable efforts to communicate a decision within 2 business days of receipt of all applicable Medicare required documentation. As these models are for non-emergent services, CMS expects requests for expedited reviews to be extremely rare.

6. **Will there be a tracking number for each prior authorization decision?**

   Yes, Medicare Administrative Contractors will list the prior authorization tracking number on the decision notice. This tracking number must be submitted on the claim.

7. **Is there a way to expedite the payment of a claim under prior authorization?**

In most circumstances, a claim that has been prior authorized will not be stopped for prepayment review and therefore not subject to any delay. However, normal claims processing timelines still apply, which require that Medicare Administrative Contractors wait a minimum numbers of days before issuing payment.

8. Will these claims still be subject to additional post pay review?

Generally, the claims that have a prior authorization decision will not be subject to additional review. However, CMS contractors, including Zone Program Integrity Contractors and Medicare Administrative Contractors, may conduct targeted pre- and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process, such as documentation showing proof of delivery and/or accessories. In addition, the Comprehensive Error Rate Testing contractor must review a random sample of claims for post payment review.

9. For prior authorization, who will make the decision on the prior authorization request?

Medicare Administrative Contractors will make these decisions.

10. How will CMS administer prior authorization? Is there specialized staff devoted to the program?

The prior authorization is administered by the Medicare Administrative Contractors, the same contractors that currently process claims and conduct medical review on part B services. Clinical staff are assigned to medical review and trained to ensure consistency. In addition, we will employ private sector standards in our prior authorization program such as responding to prior authorization requesters within 10 days of receipt of an initial prior authorization package, providing responses that are specific about missing information and giving providers an opportunity to resubmit the prior authorization package for re-review. During re-submission the contractor has 20 business days for review.

11. Will prior authorization allow for electronic submission of prior authorization requests?

Yes. Submitters who choose to utilize the prior authorization process may send prior authorization requests to the Medicare Administrative Contractors via mail, fax, or through the Electronic Submission of Medical Documentation (esMD) system. More information can be found at http://www.cms.gov/esMD.

12. When will CMS provide operational details related to prior authorization?

Prior authorization operational details are forthcoming and will be discussed on upcoming Open Door Forum Calls. Our website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Overview.html will provide additional operational details.

13. Where can I send additional questions?

Additional questions on the prior authorization model can be sent to CMS at HBOPA@cms.hhs.gov.

14. What does the prior authorization model do?

The model establishes a prior authorization process for hyperbaric oxygen therapy for certain covered conditions to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care.

15. What states would this model impact?

This prior authorization model will impact the states of Illinois, Michigan, and New Jersey based on where the service is rendered.

16. Why did CMS choose these three states?

Illinois, Michigan, and New Jersey were selected for initial implementation of this process because of their high utilization and improper payment rates. Beneficiaries in these states had the highest average sessions by total expenditures.

17. Why did CMS choose to test prior authorization on hyperbaric oxygen therapy for certain covered conditions?

Previous experience indicates that hyperbaric oxygen therapy has a high potential for improper payments and raises concerns about beneficiaries receiving medically unnecessary care. In calendar year 2000, an Office of Inspector General Report on hyperbaric oxygen therapy found that:

i. $14.2 million (of the $49.9 million allowed charges for outpatient hospitals and physicians) was paid in error – beneficiaries received treatments for either non-covered conditions or documentation did not adequately support hyperbaric oxygen therapy;
ii. An additional $4.9 million was paid for treatments deemed to be excessive; and
iii. Lack of testing and treatment monitoring raise quality of care concerns.

18. What part of the payment is under prior authorization?

The prior authorization decision will address the facility payment for the hyperbaric oxygen therapy service. If a facility has no prior authorization or a non-affirmed prior authorization, the associated physician claim will be subject to medical review.

19. What conditions are covered under this model?

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; and,
- diabetic wounds of the lower extremities in patients who meet the following three criteria:
    - patient has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;
    - patient has a wound classified as Wagner grade III or higher; and
    - patient has failed an adequate course of wound therapy as defined in the National Coverage Determinations..

20. How many treatments will be allowed under prior authorization?

A provisional affirmative prior authorization decision may affirm up to 36 courses of treatment in a year.

21. Is prior authorization required for hyperbaric oxygen therapy for certain covered conditions?

Prior authorization for hyperbaric oxygen therapy for certain covered conditions is voluntary; however, if the facility elects not to submit a prior authorization request before the service is rendered, the claim related to the hyperbaric oxygen therapy will be subject to a pre-payment medical review.