May 13, 2021

Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services

Operational Guide

Table of Contents

Purpose

The CY 2020 OPPS/ASC Final Rule (CMS -1717-FC) established a nationwide PA process and requirements for certain hospital OPD services. CMS added additional services to the process through the CY 2021 OPPS/ASC Final Rule (CMS-1736-FC). The PA program for certain hospital OPD services ensures that Medicare beneficiaries continue to receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in the volume of covered services and improper payments. The prior authorization process does not alter existing medical necessity documentation requirements. The purpose of this Operational Guide is to interpret and clarify the review process for the hospital OPD when rendering certain OPD services for Medicare beneficiaries. This guide will advise hospital OPD providers on the process of submitting documents in support of the final claim.

1- Hospital Outpatient Department (OPD) Services Benefits

For any service or item to be covered by Medicare, it must:

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

1.1 -Medicare statutory and regulatory requirements

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of Social Security Act, Section 1862(a)(10). No payment may be made under part A or part B for any expenses incurred for items or services where such expenses are for cosmetic surgery or are incurred in connection therewith; except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Federal Register References:

- 42 CFR 419.8 *et sec* provides the regulatory guidance for this program, which is further explained in this operational guide.
- 42 CFR 411.15(h) Particular services excluded from coverage. Cosmetic surgery and related services.

In order to be covered under Medicare, a service shall be reasonable and necessary. A service to be considered reasonable and necessary when the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  - Furnished in a setting appropriate to the patient's medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - One that meets, but does not exceed, the patient's medical needs.
  - At least as beneficial as an existing and available medically appropriate alternative.

2- Program Overview

This nationwide program will include the hospital OPDs that provide certain OPD services and are enrolled in the Medicare FFS program. The term requester will be used throughout this document to describe the person or entity that submits the prior authorization request (PAR), documentation, and /or claims. The providers will be required to obtain PA before the services are provided to Medicare beneficiaries and before the provider submit claims for payment under Medicare for these services.

The hospital OPD provider will submit the PARs to their local Medicare Administrative Contractor (MAC) jurisdiction. The MAC will review the information submitted and issue the decision (affirmative or non-affirmative) to the provider.

The provider may submit a request for an expedited review of a PAR if delays in receipt of a PA decision could jeopardize the life or health of the beneficiary.

The MAC will deny a claim for a service that requires PA if the provider has not received a provisional affirmation of coverage, unless the provider is exempt. The Centers for Medicare and Medicaid Services (CMS) may elect to exempt a provider from PA upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules and that this exemption would remain in effect until CMS elects to withdraw the exemption.

The provider may resubmit a PAR with additional supporting information, upon receipt of a non-affirmation, as many times as necessary to achieve an affirmation decision.

Inquiries Regarding the Program:
Hospital OPD providers who have questions about the program review process should contact their local MAC jurisdiction.

Appendix A includes the specific Healthcare Common Procedure Coding System (HCPCS) codes that are included in the OPD PA program.
Note: Codes in Appendix A may be subject to change.

2.1- Additional Hospital OPD Services That Require Prior Authorization

The CMS has added two new services to the hospital OPD Prior Authorization program. For dates of service beginning on or after July 1, 2021, the additional hospital OPD services will be required as a condition of payment. These services are Cervical Fusion with Disc Removal and Implanted Spinal Neurostimulators.

The addition of new services to the Prior Authorization program does not change Medicare benefit or coverage requirements, nor does it create new documentation requirements. The documentation required to be included with a prior authorization request is information that hospital OPDs are regularly required to maintain for Medicare payments.

3 – Prior Authorization Request (PAR)

The PAR must be submitted before the service is provided to the beneficiary and before the claim is submitted for processing. The PAR must include all documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules.

3.1-General PAR Documentation

Requesters must include the following data elements in all PARs to avoid potential delays in processing. Your MAC may request additional, optional elements for submission of the PAR.

Initial Submission Documentation:

Beneficiary Information (as written on their Medicare card)
- Beneficiary Name
- Beneficiary Medicare Number (also known as the MBI)
- Beneficiary Date of Birth

Hospital OPD Information
- Name of facility
- PTAN/CCN
- Facility Address
- Facility National Provider Identifier (NPI)

Physician/Practitioner Information
- Physician/Practitioner's Name
- Physician/Practitioner's National Provider Identifier (NPI)
- Physician/Practitioner PTAN
- Physician/Practitioner's Address

Requestor Information
- Requestor Name
- Requestor Phone Number
- Requestor Email Address

Other Information
- HCPCS Code(s)
- Diagnosis Code(s) (providers who submit using esMD ***must*** include a diagnosis code(s))
- Type of Bill
- Units of Service (providers who submit using esMD ***must*** include units of service)
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why

Resubmission (s) documentation:

In addition to the required PAR documentation in the Initial Submission section, the resubmission of the PAR should contain an exact match of the beneficiary's first name, last name, date of birth to the previous submission, and the UTN associated with the previous submission.

3.1.1–Sending a PAR

Requesters have the following options for submitting PARs to the A/B MACs:

1) mail,
2) fax,
3) electronic submission of medical documentation (esMD), content type 8.5*, or
4) CMS- approved electronic portal (A/B MAC specific).

*Submissions through esMD will be available beginning July 6, 2020. For more information about esMD, see www.cms.gov/esMD or contact your A/B MAC.

MACs Contact Information:

J5
WPS GHA
Mailing Address:
WPS GHA
PO Box 7953
Madison, WI 53707-7953
Fax #: 608.223.7553
Website: wpsgha.com
esMD: indicate document/ content type 8.5

J8
WPS GHA
Mailing Address:
WPS GHA
PO Box 7954
Madison, WI 53707-7954
Fax #: 608.224.3508
Website: wpsgha.com
esMD: indicate document/ content type 8.5

J15
CGS
Mailing Address:
CGS Administrators, LLC
J15 Part A Prior Authorization Requests
PO Box 20203
Nashville, TN 37202

FedEx/UPS/Certified Mail (Physical Address):
CGS Administrators, LLC
J15 Part A Prior Authorization Requests
26 Century Blvd., Suite ST610
Nashville, TN 37214-3685
Fax#: 615.782.4486
Customer Service #: 1.866.590.6703
Website: cgsmedicare.com
esMD: indicate document/content type "8.5"

JK
National Government Services (NGS)
Mailing Address:
National Government Services
PO BOX 1708
Indianapolis, IN 46207-7108
Fax#: 317.841.4530
Website: ngsmedicare.com
esMD: indicate document/ content type 8.5

J6
National Government Services (NGS)
Mailing Address:
National Government Services
PO BOX 1708
Indianapolis, IN 46207-7108
Fax#: 317.841.4528
Website: ngsmedicare.com
esMD: indicate document/ content type 8.5

JE
Noridian Healthcare Solutions LLC
Mailing Address:
PO Box 6782
Fargo, ND 58103
Customer Service: 855-609-9960
Fax: 701-277-2903
Website: med.noridianmedicare.com/web/jea
esMD: indicate document/content type "8.5"

JF
Noridian Healthcare Solutions LLC
Mailing Address:

PO Box 6722
Fargo, ND 58103
Customer Service: 877-908-8431
Fax: 701-277-2903
Website: med.noridianmedicare.com/web/jfa
esMD: indicate document/content type “8.5”

JJ
Palmetto GBA
Mailing Address:
Palmetto GBA
Part A – Prior Authorization
PO BOX 100212
Columbia, SC 29202-3212
Fax #: 803.462.7313
Phone Number: 877.567.7271
Website: palmettogba.com/JJA
esMD: indicate document/content type “8.5”

JM
Palmetto GBA
Mailing Address:
Palmetto GBA
Part A – Prior Authorization
PO BOX 100212
Columbia, SC 29202-3212
Fax #: 803.462.7313
Phone Number: 877.567.7271
Website: palmettogba.com/JMA
esMD: indicate document/content type “8.5”

JL
Novitas Solutions
Mailing Address (including the P.O. Box):
Novitas Solutions
JL Prior Authorization Requests
PO BOX 3702
Mechanicsburg, PA 17055
Fax#: 1.877.439.5479
Phone #: 855.340.5975 (Prior Auth Customer Service)
Website: novitas-solutions.com/
esMD: indicate document/content type “8.5”

JH
Novitas Solutions
Mailing Address (including the P.O. Box):
Novitas Solutions
JH Prior Authorization Requests
PO BOX 3702
Mechanicsburg, PA 17055
Fax#: 1.877.439.5479
Phone #: 855.340.5975 (Prior Auth Customer Service)
Website: novitas-solutions.com/
esMD: indicate document/content type "8.5"

JN
First Coast
Mailing Address (including the P.O. Box):
First Coast Services Options, Inc.
JN Prior Authorization
PO Box 3033
Mechanicsburg, PA 17055-1804
Fax#: 1.855.815.3065
Phone # 1.855.340.5975
Website: fcso.com/
esMD: indicate document/content type "8.5"

4- Review of the PAR

The information submitted will be reviewed by the MAC, and the decision (affirmative or non-affirmative) will be issued to the provider. A provisional affirmation will be issued to the provider if it is decided that applicable Medicare coverage, coding, and payment rules are met. A non-affirmation will be issued to the provider if it is decided that applicable Medicare coverage, coding, and payment rules are not met. A unique tracking number (UTN) will be assigned with each PAR. The MAC will, when the PAR results in a non-affirmative decision, provide detailed information about all missing and/or non-compliant information that resulted in the non-affirmative decision.

4.1- Review Decisions and Timeframes

The timeframes for conducting PA of certain hospital OPD services will be dependent upon the service (s) selected and documentation submitted for PAR. There are 3 types of review timeframes:

- **Initial Submission**—the first PAR sent to the contractor for review and decision. The MAC will complete its review of medical records and send an initial decision letter that is either postmarked or faxed within **10 business days** following the receipt of the initial request.
- **Resubmission**—any subsequent resubmissions to correct an error or omission identified during a PA decision. A resubmitted PAR is a request submitted with additional/updated documentation after the initial PAR was non-affirmed. The MAC will postmark or fax notification of the decision of these resubmitted requests to the provider or beneficiary (if specifically requested by the beneficiary) within **10 business days** of receipt of the resubmission request.
- **Expedited**—a PA decision that is performed on an accelerated timeframe based on the MAC determination that delays in review and response could jeopardize the life or health of the beneficiary. If the MAC substantiates the need for an expedited decision, the MAC will make reasonable efforts to communicate a decision within **2 business days** of receipt of the expedited request.

4.1.1- Validation Period for Prior Authorization Decisions

PAR decisions and UTNs for these services are valid for 120 days. The decision date shall be counted as the first day of the 120 days. For example: if the PAR is affirmed on January 1, 2021, the PAR will be valid for dates of service through April 30, 2021. Otherwise, the provider will need to submit a new PAR.

4.1.2 –Resubmission of PAR

The provider should review the detailed decision letter that was provided. A provider may resubmit a PAR an unlimited number of times, upon receipt of a non-affirmative decision. The UTN will be assigned with each PA resubmission request.

4.2- Expedited Review of a PAR

The requester can submit an expedited review of the PAR if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function. The requester will be notified regarding the acceptance of the PAR for expedited review or if it will convert the request to the standard PA review process. The affirmative or non-affirmative decision will be rendered within the CMS-prescribed expedited review timeframe of 2 business days for requests that are deemed valid for expedited review, and provide the decision to the provider via telephone, fax, electronic portal, or other "real-time" communication, within the requisite timeframe.

To prevent the claim from denying upon submission, the provider should ***hold their claim and not submit it*** until such time as the UTN is provided. The MAC will follow the normal process to obtain a UTN from CMS shared systems.

A provider may resubmit a request for expedited review.

4.3- Decision Letter (s)

The MAC will send decision letters with the UTN to the requester using the method the PAR was received postmarked within the timeframes described in Section 4.1 of this guide. The MAC will have the option to send a copy of the decision to the requester via fax if a valid fax number was provided, even if the submission was sent via mail. The requester (s) will be notified to hold their claim and not submit it until the UTN is received (in order to avoid a claims payment denial) if the MAC exercises the option to send the PA decision without the UTN.

While the PA process is applicable to hospital OPDs, as specified in CMS-1717-FC, CMS allows the PAR to be sent by the physician/practitioner on behalf of the hospital OPD. Physicians/practitioners who submit the PAR on behalf of the OPD should include their contact information on the PAR cover sheet, in addition to the hospital OPD's contact information. If the physician/ practitioner is not the requester and would like to obtain a copy of the decision letter, they should contact the hospital OPD.

Decision letters sent via electronic submission of medical documentation (esMD) are not available at this time.

A copy of the decision letter will be sent to the beneficiary as well.

5- Exemption(s)

The CMS may elect to exempt a hospital OPD provider from PA upon a provider's demonstration of compliance with Medicare coverage, coding, and payment rules. This exemption would remain in effect until CMS elects to withdraw the exemption. CMS or its contractors would exempt providers that submitted at least 10 requests and achieve a PA provisional affirmation threshold of at least 90 percent during a semiannual assessment. By achieving this percentage of provisional affirmations, the provider would be demonstrating an understanding of the requirements for submitting accurate claims. Notice of an exemption or withdraw of an exemption will be provided at least 60 days prior to the effective date.

5.1- Exemption Timeline Example

Hospital outpatient departments can expect the following process:

February 1, 2021- February 28, 2021:

- MACs calculate the affirmation rate of initial PARs for all five service categories combined, reviewed September 1, 2020 and after, and notify those providers with an affirmation rate of 90% or greater. Providers will receive a written Notice of Exemption through the US mail or MAC provider portal no later than the first business day on or after March 1, 2021.

March 1, 2021- April 30, 2021:

- Exempt providers receive 60 days' notice prior to the beginning of the exemption cycle.

May 1, 2021:

- The exemption cycle begins for providers who met the compliance rate threshold. Exempt providers should not submit PARs (including PARs for the two new additional hospital OPD services - cervical fusion with disc removal and implanted spinal neurostimulators - with dates of service on or after July 1, 2021).
- PARs received during an exemption period will be rejected.
- Providers who did not meet the compliance rate threshold should continue submitting PARs as usual.

September 30, 2021:

- Exempt providers will receive a postpayment Additional Document Request (ADR) for a 10-claim sample from the period such providers were exempt to determine continued compliance. The sample may include claims for two new OPD services (cervical fusion with disc removal and implanted spinal neurostimulators).
- Providers have 45 days to submit documentation, and MACs will complete their review within 30 days of receipt of the requested documentation.
- Providers who submit additional documentation after the initial 45-day response timeframe will not have their compliance rate changed if the MAC has already finalized their compliance rate and sent notification to the provider. The MAC will still review late documentation, issue a review determination, and make a claim

adjustment, if necessary. Claim denials are subject to the normal appeals process; however, overturned appeals will not change the provider's exemption status.

December 17, 2021:

- No later than December 17, 2021, providers will receive a Notice of Withdrawal of Exemption if they receive less than a 90% claim approval rate during their exemption cycle.

February 16, 2022:

- Providers who did not meet the 90% claim approval rate will no longer be exempt and may start submitting PARs in advance of the March 1 review cycle.

March 1, 2022:

- Providers who are not exempt must have an associated PAR for any claim submitted on or after this date.
- Providers who *continue* to demonstrate a 90% or greater claim approval rate based upon the 10-claim review will receive a Notice of Exemption and do not need to submit PARs.

For providers who are not exempt, CMS will continue assessing a provider's compliance through their PAR affirmation rates in March and September of each year. For exempt providers, CMS will continue to evaluate their claim approval rate through ADRs on the subsequent September 30 or April 2.

6- Program Specifics

6.1 – Implementation of Prior Authorization

The MACs began accepting PARs for services requiring PA on June 17, 2020, and rendered on or after July 1, 2020.

6.2 – Required Documentation

For detailed documentation requirements, the hospital OPD providers should refer to their MAC jurisdiction's Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs), where applicable. To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services[1].

The following hospital OPD services require PA:

(i) Blepharoplasty

(ii) Botulinum toxin injections

(iii) Panniculectomy

(iv) Rhinoplasty

(v) Vein ablation

6.2.1- Blepharoplasty, Eyelid Surgery, Brow Lift, and related services

General Documentation Requirements for Blepharoplasty, Eyelid Surgery, Brow Lift, and related Services:

- Documented excessive upper/ lower lid skin;
- Supporting pre-op photos;
- Signed clinical notes support a decrease in peripheral vision and/or upper field vision;
- Signed physician's or non-physician practitioner recommendations;
- Documented subjective patient complaints which justify functional surgery (vision, ptosis, etc.);
- Visual field studies/exams (when applicable).

[1] The MACs will review all PARs in accordance with the policy in place at the time of the anticipated date of service, including any waivers, flexibilities, and/or revised guidance issued as a result of the COVID-19 Public Health Emergency.

6.2.2 - Botulinum Toxin Injections

PA 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 PA under this program.

General Documentation Requirements for Botulinum Toxin Injections:

- Support for the medical necessity of the botulinum toxin (type A or type B) injection;
- A covered diagnosis;
- Dosage and frequency of planned injections;
- Support for the medical necessity of electromyography procedures performed in conjunction with botulinum toxin type A injections to determine the proper injection site(s) (when applicable);
- Support of the clinical effectiveness of the injections (for continuous treatment);
- Specific site(s) injected;
- For support of management of a chronic migraine diagnosis, the Medical Record must include a history of migraine and experiencing frequent headaches on most days of the month;
- A statement that traditional methods of treatments such as medication, physical therapy, and other appropriate methods have been tried and proven unsuccessful (when applicable);

6.2.3- Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services

General Documentation Requirements for Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services:

- Stable weight loss with BMI less than 35 be obtained prior to authorization of coverage for panniculectomy surgery (when applicable);
- Description of the pannis and the underlying skin;
- Description of conservative treatment undertaken and its results;
- The medical records document (s) that the panniculus causes chronic intertrigo or candidiasis or tissue necrosis that consistently recurs over three months and is unresponsive to oral or topical medication (when applicable);
- Pre-op photograph (if requested);
- Copies of consultations (when applicable);
- Related Operative report(s) (when applicable);
- Any other pertinent information.

6.2.4 - Rhinoplasty, and related services

General Documentation Requirements for Rhinoplasty and related services:

- Medical documentation, with evaluation and management, supporting medical necessity of the service that is to be performed;
- Radiologic imaging if done;
- Photographs that document the nasal deformity (if applicable);
- Documentation supporting unresponsiveness to conservative medical management (if applicable).

6.2.5 - Vein Ablation, and related services

General Documentation Requirements for Vein Ablation and related services:

- Doppler ultrasound;
- Documentation stating the presence or absence of DVT (deep vein thrombosis), aneurysm, and/or tortuosity (when applicable);
- Documented Incompetence of the Valves of the Saphenous, Perforator or Deep venous systems consistent with the patient's symptoms and findings (when applicable);
- Photographs if the clinical documentation received is inconclusive;
- The patient's medical record must contain a history and physical examination supporting the diagnosis of symptomatic varicose veins (evaluation and complains), and the failure of an adequate (at least 3 months) trial of conservative management (before the initial procedure).

6.3 – Program Specifics for Additional Hospital OPD Services

6.3.1- Implementation of Prior Authorization

The MACs will begin accepting PARs for two new services on June 17, 2021, for services rendered on or after July 1, 2021.

6.3.2- Required Documentation

For detailed documentation requirements, the hospital OPD providers should refer to National Coverage Determinations (NCDs) and their MAC jurisdiction's LCDs/LCAs, where applicable. To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services.

The following additional hospital OPD services will require PA:

i. Cervical Fusion with Disc Removal
ii. Implanted Spinal Neurostimulators

6.3.2.1- Cervical Fusion with Disc Removal

General Documentation Requirements for Cervical Fusion with Disc Removal:

- Condition requiring procedure
- Physical examination
- Duration/character/location/radiation of pain
- Activity of daily living (ADL) limitations
- Imaging reports pertinent to performed procedure
- Operative report(s) (when applicable)
- Conservative treatment modalities include but are not limited to:
    - Physical Therapy
    - Occupational Therapy
    - Injections
    - Medications
    - Assistive device use
    - Activity modification

6.3.2.2 - Implanted Spinal Neurostimulators[2]

Providers who plan to perform **both** the trial and permanent implantation procedures using CPT 63650 in the hospital OPD will **only** be required to submit a PAR for the trial procedure. To avoid a claim denial, providers must place the Unique Tracking Number (UTN) received for the trial procedure on the claim submitted for the permanent implantation procedure. When the trial is rendered in a setting other than hospital OPD, providers will need to request PA for CPT 63650 as part of the permanent implantation procedure in the hospital OPD.

General Documentation Requirements for trial **or** permanent Implanted Spinal Neurostimulators:

- Indicate if this request is for a trial or permanent placement
- Physician office notes including:
    - Condition requiring procedure
    - Physical examination
    - Treatments tried and failed including but are not limited to:
        - Spine surgery
        - Physical therapy
        - Medications
        - Injections
        - Psychological therapy
- Documentation of **appropriate** psychological evaluation[3]
- For permanent placement, include all the above documentation, as well as documentation of

[2] CPT codes 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) were temporarily removed from the list of OPD services that require prior authorization, as finalized in CMS-1736-FC.
[3] See Medicare Learning Network (MLN1986542) booklet and Publication# 100-2, Chapter 15 for more information on psychological evaluations.

pain relief with the temporary implanted electrode(s).

- A successful trial should be associated with at least 50% reduction of target pain or 50% reduction of analgesic medications.

Services associated with devices approved under an Investigational Device Exemption (IDE) study must undergo prior authorization and meet the coverage requirements in NCD 160.7.

7 – Decisions

7.1 - Provisional Affirmation PA Decision

A provisional affirmation PA decision is a preliminary finding that a future claim submitted to Medicare for the service (s) likely meets Medicare's coverage, coding, and payment requirements. The provisional affirmation PA decision is valid for 120 days from the date decision was made.

7.2 - Non-Affirmation PA Decision

A non-affirmation PA decision is a preliminary finding that if a future claim is submitted to Medicare for the requested service does not likely meet Medicare's coverage, coding, and payment requirements.

The MAC will provide the PAR requester notification of what required documentation is missing or noncompliant with Medicare requirements via fax, mail, or the MAC provider portal (when available). The decision letter for an incomplete PAR will be detailed and postmarked within the applicable timeframes described in Section 4.1 as it pertains to each hospital's OPD service.

7.3 - Provisional Partial Affirmation PA Decision

A provisional partial affirmation PA decision means that one or more service(s) on the PAR received a provisional affirmation decision and one or more service(s) received a non-affirmation decision.

The MAC will follow the same process for any service(s) within the PA request that are given a provisional affirmation decision as is described in § 7.1 and for any service(s) that are given a non-affirmation decision as is described in § 7.2.

7.4 - Resubmitting a PAR

The requestor may resubmit another complete PAR with all documentation required and whatever modifications are needed, as noted in the detailed decision letter. Unlimited resubmissions are permitted. The requestor is encouraged to include the original non-affirmed UTN on the resubmitted PAR.

8 - Claim Submission

8.1 – Affirmed PA Decision on File

Cases where a PAR was submitted and a provisional affirmation PA decision was granted, including any service(s) that was part of a partially affirmed decision.

- The submission of the prior authorized claim is to have the 14 bytes UTN that is located on the decision letter. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the Fiscal Intermediary Shared System (FISS), the UTN will move to positions 19 through 32 and zeros will autofill the first field. For providers submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.

- For all other submissions, the provider must TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1 through 18), it will come into FISS as zeros. If the Treatment Authorization Code is entered into the first field, FISS changes the Treatment Authorization code to zeros and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN, but will edit for the OPD UTN.

- Should be submitted to the applicable MAC for adjudication.

Note: If all Medicare coverage, coding, and payment requirements are met, the claim will likely be paid.

- Claims receiving a provisional affirmation may be denied based on either of the following:

- Technical requirements that can only be evaluated after the claim has been submitted for formal processing; or

- Information was not available at the time of a PAR.

- We note claims for which there is a provisional affirmation PA decision will be afforded some protection from future audits, both pre- and postpayment; however, review contractors may audit claims if potential fraud, inappropriate utilization, or changes in billing patterns are identified.

8.2 – Non-Affirmed PA Decision on File

Cases where a PAR was submitted and a non-affirmed PA decision was granted, including any non-affirmed service(s) that was part of a partially affirmed decision.

- The submission of the prior authorized claim is to have the 14 byte UTN that is located on the decision letter. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the Fiscal Intermediary Shared System (FISS), the UTN will move to positions 19 through 32 and zeros will autofill the first field. For providers submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.

- For all other submissions, the provider must TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1 through 18), it will come into FISS as zeros. If the Treatment Authorization Code is entered into the first field, FISS changes the Treatment Authorization code to zeros and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN, but will edit for the OPD UTN.

- Should be submitted to the applicable MAC for adjudication.

    - If the claim is submitted to the MAC for payment with a non-affirmative PA decision, it will be denied.

    - All appeal rights are then available.

    - This claim could then be submitted to secondary insurance, if applicable.

8.3- Claims Submitted without a PA Decision on File

- As described in 42 CFR §419.82, if a service requires PA under this program, then submitting a PAR is a **condition of payment**.

- Claims for HCPCS code subject to required PA submitted without a PA determination and a corresponding UTN will be automatically denied.

8.4 – Denials for Related Services

Claims related to or associated with services that require PA as a condition of payment will not be paid, if the service requiring PA is not also paid. These related services include, but are not limited to, services such as anesthesiology services, physician services, and/or facility services. Only associated services performed in the OPD setting will be affected.

Depending on the timing of claim submission for any related services, claims may be automatically denied or denied on a postpayment basis.

8.4.1 –Associated Services Codes

CMS intends to deny services that are associated with the OPD services (blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation) that require PA as a condition of payment and have received non-affirmation decisions and/or have denied claims. The codes for these associated services are listed in the table located in Appendix B (OPD PA Part B Associated Codes List). This list is subject to change in the future.

9 – Special Claim Considerations

9.1 – Advanced Beneficiary Notice (ABN)

If the hospital OPD receives a non-affirmed PA decision because the service was determined to be not medically reasonable and necessary, the provider should issue an ABN in advance of performing the service if it is expected that payment will be denied. The provider should submit the claim with the GA modifier appended to it. The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30)

If an applicable claim is submitted without a PA decision and is flagged as having an ABN, it will be stopped for additional documentation to be requested, and a review of the ABN will be performed (to determine the validity of the ABN) following standard claim review guidelines and timelines.

The provider should issue ABN and submit the claim with a GX modifier if it is expected that Medicare would deny payment for a service under the statutory exclusion for purely cosmetic services. Under those circumstances, ABN is voluntary and is not required to bill the patient for the service that is denied under the cosmetic services exclusion. However, CMS encourages providers to issue an ABN in this situation to inform the beneficiary of the likelihood of financial liability.

9.2 – Claims Exclusions

The following claim types are excluded from the PA program described in this operational guide unless otherwise specified:

- Veterans Affairs
- Indian Health Services
- Medicare Advantage
- Part A and Part B Demonstration
- Medicare Advantage sub-category IME only claims
- Part A/B rebilling
- Claims for Emergency Department services when the claim is submitted with an ET modifier or 045x revenue code. (This does not exclude these claims from regular medical review.)

10 – Secondary Insurance

This section pertains to the instances where the beneficiary has more than one insurance. In these instances, Medicare must be either the first or the secondary insurance company.

10.1 – Medicare is Primary Insurance

In cases where Medicare is primary and another insurance company is secondary:

The contractors will suspend claims to request documentation and conduct a review of the Advanced Beneficiary Notice (ABN) when there is no PAR, and the claim is submitted with the GA modifier appended.

The Contractor will determine the validity of the ABN in accordance with standard ABN policies. (See IOM 100-04, Chapter 30, Section 40).

Providers who choose to use the PA process to obtain a claim denial should follow the below process:

- The requester may submit the **PAR** with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the service, then a non-affirmative PA decision will be sent to the provider and beneficiary, advising that Medicare will not pay for the item.

- After receiving a non-affirmative decision for the PAR, if the associated **claim** is submitted by the provider to the MAC for payment, it will be denied.

- The provider or beneficiary may forward the denied claim to his/her secondary insurance payer as appropriate to determine payment for the service.

In cases where a beneficiary is dually eligible for Medicaid and Medicare, a non-affirmed PA decision is sufficient for meeting states' obligation to pursue other coverage before considering Medicaid coverage. The provider may need to submit the claim to Medicare first and obtain a denial before submitting the claim to Medicaid for payment[4].

10.2 – Another Insurance Company is Primary

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

- The requester submits the PAR with complete documentation as appropriate. If all relevant Medicare coverage requirements **are** met for the item(s), then a provisional affirmative PA decision will be sent to the provider and to the beneficiary, if specifically requested by the beneficiary, advising them that Medicare **will** pay for the service.
- The provider submits a claim to the other insurance company.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib011317.pdf

- If the other insurance company denies the claim, the provider or beneficiary can submit a claim to the MAC for payment (listing the unique tracking number on the claim).

11- Claim Appeals

Claims subject to PA requirements under the hospital OPD program follow all current appeals procedures. A PAR that is non-affirmed is not an initial determination on a claim for payment for services provided and, therefore, would not be appealable; however, the provider has an unlimited number of opportunities to resubmit a PAR, provided the claim has not yet been submitted and denied.

A non-affirmation PA decision does not prevent the provider from submitting a claim. Submission of such a claim and resulting denial by the MAC would constitute an initial payment determination, which makes the appeal rights available.

For further information, please consult the Medicare Claims Processing Manual publication, Chapter 29, Appeals of Claims Decision.

12- Suspension of PA process

CMS may suspend the OPD services PA process requirements generally or for a particular service(s) at any time by issuing a notification on the CMS website.

Appendix A

2021 Final List of Outpatient Department Services That Require Prior Authorization

The following is the list of codes associated with the list of hospital outpatient department services contained in 42 CFR 419.83(a)(1) and (2).	
The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after *July 1, 2020*: (i) Blepharoplasty. (ii) Botulinum toxin injections. (iii) Panniculectomy. (iv) Rhinoplasty. (v) Vein ablation.	
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 lid retraction
Code	(ii) Botulinum Toxin Injection
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
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 (e.g., 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
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
The following service categories comprise the list of hospital outpatient department services requiring prior authorization beginning for service dates on or after July 1, 2021: (i) Cervical Fusion with Disc Removal. (ii) Implanted Spinal Neurostimulators.	
Code	(i) Cervical Fusion with Disc Removal

22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach, complex, initial
22552	Fusion of spine bones with removal of disc in upper spinal column below second vertebra of neck, anterior approach, each additional interspace
Code	(ii) Implanted Spinal Neurostimulators[1]
63650	Implantation of spinal neurostimulator electrodes, accessed through the skin

[1]CPT codes 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) were temporarily removed from the list of OPD services that require prior authorization, as finalized in CMS-1736-FC.

Appendix B

OPD PA Part B Associated Codes List

Blepharoplasty

HCPCS Codes	HCPCS Description
00103	Anesthesia for procedure on eyelid
00300	Anesthesia for procedure on esophagus and neck
11604	Removal of malignant growth (3.1 to 4 centimeters) of the trunk, arms, or legs
12032	Repair of wound (2.6 to 7.5 centimeters) of the scalp, underarms, trunk, arms, and/or legs
13132	Repair of wound (2.6 to 7.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
13133	Repair of wound of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
14040	Tissue transfer repair of wound (10 sq centimeters or less) of the forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
14041	Tissue transfer repair of wound (10.1 to 30.0 sq centimeters) of the forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
14060	Tissue transfer repair of wound (10 sq centimeters or less) of eyelids, nose, ears, and/or lips
15004	Preparation of graft site of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 100 sq cm or 1% body area of infants and children)
15260	Relocation of patient skin to nose, ears, eyelids, and/or lips (20 sq centimeters or less)
15275	Application of skin substitute (wound surface up to 100 sq cm) to face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 25 sq cm or less)
15730	Creation of flap graft to midface
15733	Creation of flap graft to head and/or neck
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
21016	Removal of (2 centimeters or greater) soft tissue growth of face or scalp
21235	Obtaining ear cartilage for grafting (when related to/associated with a code from the required prior authorization list)
21282	Reattachment of nasal and eye socket ligament
21365	Open treatment of broken cheek bones with insertion of internal hardware
30120	Removal or scraping of skin on nose
31205	Removal of nasal sinus
65400	Removal of growth of cornea
66821	Removal of recurring cataract in lens capsule using laser
67399	Eye muscle procedure
67400	Exploration of cavity behind eye, frontal or transconjunctival approach

67412	Removal of growth in cavity behind eye
67414	Removal of bone from cavity behind eye
67830	Incisional removal of eyelashes
67840	Removal of eyelid growth
67875	Temporary closure of eyelids by suture
67880	Creation of permanent eyelid margin scarring
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
67912	Restoration of eyelid blinking function
67917	Extensive repair of turning-outward eyelid defect
67921	Suture repair of turning-inward eyelid defect
67924	Repair of turning-inward eyelid defect
67950	Enlargement of eyelid margin
67966	Removal of over one-fourth of the eyelid involving lid margin
67973	Reconstruction of lower eyelid by transfer of eyelid tissue from opposite eyelid
67999	Eyelid procedure
68100	Biopsy of sclera
68320	Repair of conjunctiva
68700	Plastic repair of tear ducts
68810	Insertion of probe into the tear duct
68815	Probing of nasal-tear duct with insertion of tube or stent
88300	Pathology examination of tissue using a microscope, limited examination
88302	Pathology examination of tissue using a microscope
88304	Pathology examination of tissue using a microscope, moderately low complexity
88305	Pathology examination of tissue using a microscope, intermediate complexity
88331	Pathology examination of tissue during surgery
95954	Measurement and recording of electrical activity (EEG) of the brain including stimulation by medication or physical activity
99100	Anesthesia for patient younger than 1 year and older than 70 years of age

Botulinum Toxin Injections

HCPCS Codes	HCPCS Description
17999	Skin, mucus membrane and beneath the skin procedure
20553	Injections of trigger points in 3 or more muscles
31573	Injection of drug into one side of voice box using a flexible endoscope
31575	Diagnostic examination of voice box using flexible endoscope
64400	Injection of anesthetic agent and/or steroid into trigeminal nerve of face
64405	Injection of anesthetic agent and/or steroid into greater occipital nerve of upper neck and back of head
64450	Injection of anesthetic agent and/or steroid into other peripheral nerve or branch
64611	Injection of chemical for destruction of salivary glands on both sides of the mouth
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
64616	Injection of chemical for destruction of nerve muscles on one side of neck excluding voice box accessed through the skin
64617	Injection of chemical for destruction of nerve muscles on one side of voice box accessed through the skin
64635	Destruction of lower or sacral spinal facet joint nerves using imaging guidance
64636	Destruction of lower or sacral spinal facet joint nerves with imaging guidance
70551	MRI scan brain
76942	Ultrasonic guidance imaging supervision and interpretation for insertion of needle
90837	Psychotherapy, 60 minutes
92012	Eye and medical examination for diagnosis and treatment, established patient
92014	Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits
92226	Examination of eye by ophthalmoscope with retinal drawing
92285	Photography of content of eyes
95874	Needle measurement and recording of electrical activity of muscles for guidance with injection of chemical for destruction of muscles
95886	Needle measurement and recording of electrical activity of muscles of arm or leg complete study
95913	Nerve transmission studies, 13 or more studies
95970	Electronic analysis of implanted brain, spinal cord or peripheral stimulation device
95983	Electronic analysis of implanted brain, spinal cord or peripheral stimulation device with brain stimulator programming, first 15 minutes face-to-face time with qualified health care professional
95984	Electronic analysis of implanted brain, spinal cord or peripheral stimulation device with brain stimulator programming, additional 15 minutes face-to-face time with qualified health care professional
96372	Injection beneath the skin or into muscle for therapy, diagnosis, or prevention
98927	Osteopathic manipulative treatment to 5-6 body regions
94010	Measurement and graphic recording of total and timed exhaled air capacity
J0585	Injection, onabotulinumtoxina

J0586	Injection, abobotulinumtoxina
J0587	Injection, rimabotulinumtoxinb
J0588	Injection, incobotulinumtoxin a
J1885	Injection, ketorolac tromethamine

Panniculectomy

HCPCS Codes	HCPCS Description
00400	Anesthesia for procedure on skin of arms, legs, or trunk
00402	Anesthesia for breast reconstruction
00802	Anesthesia for removal of excess tissue on lower abdominal wall
11406	Removal of growth (4.0 centimeters) of the trunk, arms, or legs
13101	Repair of wound (2.6 to 7.5 centimeters) of trunk
13102	Repair of wound of trunk
14301	Tissue transfer repair of wound (30.1 to 60.0 sq centimeters)
14302	Tissue transfer repair of wound (30.0 sq centimeters)
15777	Implantation of biologic implant to soft tissue
15830	Removal of excessive skin and tissue beneath the skin of abdomen
15847	Removal of additional excessive skin and tissue beneath the skin of abdomen
15877	Suction assisted removal of fat from trunk
19300	Removal of extra breast tissue
19318	Repositioning of breast on chest
19342	Insertion of breast prosthesis following breast repositioning, removal or reconstruction
19357	Insertion of tissue expander in breast
19364	Plastic surgery to reconstruct breast with muscle flap
19371	Removal of capsule surrounding breast
19380	Revision of reconstructed breast
20926	Tissue graft
31571	Injection of vocal cords using an endoscope with operating microscope or telescope
33286	Removal of heart rhythm monitor from under skin
49561	Repair of trapped incisional or abdominal hernia
49566	Repair of incisional or abdominal hernia
49568	Placement of mesh to repair incisional or abdominal hernia, open procedure
49585	Repair of hernia at navel patient age 5 years or older
64488	Injections of local anesthetic for pain control and abdominal wall analgesia on both sides
88300	Pathology examination of tissue using a microscope, limited examination
88302	Pathology examination of tissue using a microscope
88304	Pathology examination of tissue using a microscope, moderately low complexity
88305	Pathology examination of tissue using a microscope, intermediate complexity
88311	Preparation of tissue for examination by removing any calcium present
88312	Special stained specimen slides to identify organisms including interpretation and report

Rhinoplasty

HCPCS Codes	HCPCS Description
00160	Anesthesia for procedure on nose and sinus
13132	Repair of wound (2.6 to 7.5 centimeters) of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
13133	Repair of wound of forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
14040	Tissue transfer repair of wound (10 sq centimeters or less) of the forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
14041	Tissue transfer repair of wound (10.1 to 30.0 sq centimeters) of the forehead, cheeks, chin, mouth, neck, underarms, genitals, hands, and/or feet
14060	Tissue transfer repair of wound (10 sq centimeters or less) of eyelids, nose, ears, and/or lips
15004	Preparation of graft site of face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 100 sq cm or 1% body area of infants and children)
15260	Relocation of patient skin to nose, ears, eyelids, and/or lips (20 sq centimeters or less)
15275	Application of skin substitute (wound surface up to 100 sq cm) to face, scalp, eyelids, mouth, neck, ears, eye region, genitals, hands, feet, and/or multiple fingers or toes (first 25 sq cm or less)
15730	Creation of flap graft to midface
15733	Creation of flap graft to head and/or neck
15821	Removal of excessive skin of lower eyelid and fat around eye
15822	Removal of excessive skin of upper eyelid
20912	Nasal cartilage graft
21016	Removal of (2 centimeters or greater) soft tissue growth of face or scalp
21210	Repair of nasal or cheek bone with bone graft
21235	Obtaining ear cartilage for grafting (when related to/associated with a code from the required prior authorization list)
21282	Reattachment of nasal and eye socket ligament
21365	Open treatment of broken cheek bones with insertion of internal hardware
30120	Removal or scraping of skin on nose
30140	Removal of nasal air passage
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
31253	Under endoscopy procedures on the accessory sinuses

31259	Under endoscopy procedures on the accessory sinuses
31267	Removal of nasal sinus tissue using an endoscope
31276	Exploration of nasal sinus using an endoscope
61782	Computer-assisted procedure outside the brain
65400	Removal of growth of cornea
66821	Removal of recurring cataract in lens capsule using laser
67399	Eye muscle procedure
67400	Exploration of cavity behind eye, frontal or transconjunctival approach
67412	Removal of growth in cavity behind eye
67414	Removal of bone from cavity behind eye
67830	Incisional removal of eyelashes
67840	Removal of eyelid growth
67875	Temporary closure of eyelids by suture
67880	Creation of permanent eyelid margin scarring
67900	Repair of brow paralysis
67903	Shortening or advancement of upper eyelid muscle to correct drooping or paralysis
67904	Repair of tendon of upper eyelid
67908	Removal of tissue, muscle, and membrane to correct eyelid drooping or paralysis
67911	Correction of widely-opened upper eyelid
67912	Restoration of eyelid blinking function
67917	Extensive repair of turning-outward eyelid defect
67921	Suture repair of turning-inward eyelid defect
67924	Repair of turning-inward eyelid defect
67950	Enlargement of eyelid margin
67966	Removal of over one-fourth of the eyelid involving lid margin
67973	Reconstruction of lower eyelid by transfer of eyelid tissue from opposite eyelid
67999	Eyelid procedure
68100	Biopsy of sclera
68320	Repair of conjunctiva
68700	Plastic repair of tear ducts
68810	Insertion of probe into the tear duct
68815	Probing of nasal-tear duct with insertion of tube or stent
88300	Pathology examination of tissue using a microscope, limited examination
88302	Pathology examination of tissue using a microscope
88304	Pathology examination of tissue using a microscope, moderately low complexity
88305	Pathology examination of tissue using a microscope, intermediate complexity
88331	Pathology examination of tissue during surgery
95954	Measurement and recording of electrical activity (EEG) of the brain including stimulation by medication or physical activity
99100	Anesthesia for patient younger than 1 year and older than 70 years of age

Vein Ablation

HCPCS Codes	HCPCS Description
01930	Anesthesia for X-ray procedure on vein or lymph system
36470	Injection of chemical agent into single incompetent vein
36471	Injection of chemical agent into multiple incompetent veins of one leg
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
37761	Tying of varicose veins in one leg, open procedure
37765	Multiple incisions for removal of varicose veins of arm or leg
37766	Multiple incisions for removal of varicose veins of arm or leg
37799	Blood vessel procedure
88304	Pathology examination of tissue using a microscope, moderately low complexity
88305	Pathology examination of tissue using a microscope, intermediate complexity
93922	Ultrasound study of arteries of both arms and legs
93970	Ultrasound scan of veins of both arms or legs including assessment of compression and functional maneuvers
93971	Ultrasound scan of veins of one arm or leg or limited including assessment of compression and functional maneuvers
99152	Moderate sedation services by physician also performing a procedure, patient 5 years of age or older, first 15 minutes
99153	Moderate sedation services by physician also performing a procedure, additional 15 minutes
99183	Management and supervision of oxygen chamber therapy per session