

Medicare Prior Authorization

What you need to know

December 2020

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General Information

Which prosthetic codes are currently subject to Prior Authorization?

L5856, L5857, L5858, L5973, L5980, and L5987 (functional level is 3 and above)

When will Prior Authorization Start?

California, Pennsylvania, Michigan and Texas

- Begins with September 1, 2020 date of service
- Requests may be submitted starting August 18, 2020

All remaining States and Territories

- Begins with December 1, 2020 date of service
- Requests may be submitted starting November 17, 2020

Prior Authorization Request (PAR) Form

Where can I find the PAR Submission form?

Jurisdiction A, Noridian

<https://med.noridianmedicare.com/documents/2230703/6501021/Lower%20Limb%20Prosthetic%20Prior%20Authorization%20Coversheet>

Jurisdiction B, CGS

https://cgsmedicare.com/jb/mr/pdf/condition_of_payment_prior_auth.pdf

Jurisdiction C, CGS

https://cgsmedicare.com/jc/mr/pdf/condition_of_payment_prior_auth.pdf

Jurisdiction D, Noridian

<https://med.noridianmedicare.com/documents/2230703/6501021/Lower%20Limb%20Prosthetic%20Prior%20Authorization%20Coversheet>

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What information should I include on a Prior Authorization Submission Form?

Patient’s Information (as written on their Medicare card): First and Last Name, Medicare Number (MBI), Date of Birth, State of Residence, Diagnosis Code

Supplier Information: Company Name, PTAN, National Provider (NPI) Identification, Address (where patient receives Social Security check), Phone Number

Requestor Information: Name, Phone Number, NPI (if applicable), Address

Other Information:

HCPCS Code: only include the HCPCS code that requires prior auth on the request form
Submission Date

Indicate if the request is an initial or subsequent review

Indicate if the request is expedited and the reason why

Indicate if the request includes an upgrade

What documentation should I attach to the Submission Form?

- Standard Written Order (SWO) signed by ordering physician
- Face-to-Face Evaluation by treating physician (conducted within 6 months)
- Physician and Prosthetist medical records to support functional level and medical necessity

How long will it take to get a response to my Prior Authorization submission?

Initial Request: 10 business days

Subsequent Requests: 10 business days

Expedited Requests (if delay will jeopardize patient’s life or health): 2 business days

What will the response be?

Decision letters are sent with a Unique Tracking Number (UTN) number to include on your claim.

Where do I put the UTN on my claim?

Always put the UTN number in the first position, before any other information pertaining to your claim. Add the 14 byte UTN to your claim in one of the following locations:

Electronic Claim	Loop 2300 – REF 01= G1 Prior Authorization Number field (this field pertains to the entire claim)
	Or
	Loop 2400 - Service Line loop in the reference (REF) segment (this field pertains to the code that you received the Prior Authorization for)
Paper Claim	Line 23: Prior Authorization Number

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What methods can I use to submit a Prior Authorization Request (PAR)?

CGS Jurisdiction B	CGS Jurisdiction C
<p>Ways to Submit the PAR:</p> <p>myCGS Web portal:</p> <p>https://cgsmedicare.com/jb/mycgs/index.html</p> <p>Note: Allow 3 business days for submissions to appear in myCGS.</p> <p>esMD:</p> <p>https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information for Providers</p> <p>Fax: (615) 660-5992</p> <p>Mail:</p> <p>CGS – JUR B DME Medical Review - Condition of Payment Program PO Box 23110 Nashville, TN 37202-4890</p>	<p>Ways to Submit the PAR:</p> <p>myCGS Web portal:</p> <p>https://cgsmedicare.com/jb/mycgs/index.html</p> <p>Note: Allow 3 business days for submissions to appear in myCGS.</p> <p>esMD:</p> <p>https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information for Providers</p> <p>Fax: (615) 664-5960</p> <p>Mail:</p> <p>CGS – JUR C DME Medical Review – Condition of Payment Program PO Box 24890 Nashville, TN 37202-4890</p>
Noridian Jurisdiction A	Noridian Jurisdiction D
<p>Noridian Medicare Portal:</p> <p>www.noridianmedicareportal.com</p> <p>esMD</p> <p>https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information for Providers</p> <p>Fax: (701) 277-7891</p> <p>Mail:</p> <p>Noridian Healthcare Solutions PO Box 6742 Fargo, ND 58108-6742</p>	<p>Noridian Medicare Portal:</p> <p>www.noridianmedicareportal.com</p> <p>esMD</p> <p>https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Information for Providers</p> <p>Fax: (701) 277-7891</p> <p>Mail:</p> <p>Noridian Healthcare Solutions PO Box 6742 Fargo, ND 58108-6742</p>

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Where can I get help prior to submission?

Noridian: Hotline (701) 433 3041

Information you will need: Supplier name, phone, hours of availability & time zone, beneficiary name, MBI, brief description of issue.

CGS: Call customer service

How long is the Prior Authorization valid for?

- The Prior Authorization is valid for 120 days

If I miss the deadline, can the Prior Authorization be extended?

- The Prior Authorization cannot be extended past 120 days. You must start over if it expires.

What if I bill for the prosthetic component without getting Prior Authorization?

- Your claim will be denied, because Prior Authorization is a condition of payment. The denial will have appeal rights.

What are my appeal rights?

There are no appeal rights if you receive a non-affirmative decision. Your only option is to resubmit.

Standard appeals process applies when a claim is submitted without a PAR. Types of denials:

- No GA modifier appended on claim (CO denial)
- GA modifier is appended and ABN deemed missing or invalid (CO denial)
- GA modifier is appended and ABN deemed valid (PR denial)

Again, Prior Authorization is a condition of coverage. If you bypass the prior auth process, your claim will be denied! Appeal process:

- If billed for payment, during the appeal process you must explain why you were not able to submit a PAR (natural disaster, life threatening emergency, etc.).
- If billed for denial, your medical records will be reviewed to confirm that the ABN is valid. Generally an ABN is used when patient does not meet Medicare's criteria for medical necessity. Medical records must support the reason stated on the ABN.

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Coronavirus (COVID 19) Waivers

What are the rules during the Public Health Emergency for Coronavirus (COVID 19)?

Treating practitioners and suppliers must:

- Provide a standard written order (SWO) for all items
- Ensure that the items or services are reasonable and necessary
- Document the medical necessity for all services.
- Medical record must be sufficient to support payment for all services billed (that is, the services were actually provided, were provided at the level billed, and were medically necessary);
- Make documentation available, upon request.

At the conclusion of the COVID-19 PHE, the DME MACs will return to enforcement of the clinical indications for coverage.

Physician Face-to-Face Evaluation

- Telehealth visit is allowed in lieu of in-person visit due to COVID-19 concerns
- Telehealth visit must include both audio and visual
- Physical examination is waived in this situation

Proof of Delivery

- Signature is not required if patient is unable to sign due to COVID-19 concerns
- Item delivered direct to patient: suppliers should document (on the delivery ticket) the date of delivery and that a signature was not able to be obtained because of COVID-19.
- Does not apply to delivery via shipping or delivery service, being that does not require a signature from the beneficiary or designee; only evidence of delivery.

Billing Instructions for Telehealth Face-to-Face visit and Proof of Delivery (without beneficiary signature)

- Suppliers should continue to use the appropriate modifiers, where applicable, for all HCPCS codes.
- Additional, add the CR modifier (CATASTROPHE/DISASTER RELATED) to all of the HCPCS code(s) billed.
- **Electronic Claim:** Enter "COVID-19" in the NTE 2400 (line note) or NTE 2300 (claim note) segments of the American National Standard Institute (ANSI X12) format.
- **Paper Claim:** Enter "COVID-19" in Item 19 of the CMS-1500 claim form.

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Are there limitations on electronically submitted files?

Types of files allowed:

Word Documents with extensions: .doc .docx

Electronic Images with extension: .pdf

Graphic Images with extensions: .gif .jpg .jpeg .tif .tiff

Character limits of electronic files:

There is a 40 character limit (including spaces) in the length of the file name. Examples

Using MBI#: XXXX-XX-XXXX_MD_Ini_Eval.pdf (28 characters)

Using Patient's name & date of birth: Mary_Patient_09-02-1950_MD_Ini_Eval.jpeg (40 characters)

Total file size limit: 50MB for myCGS / 15 attachments

What if there is more than one payer?

Medicare is Primary:

If your patient does not meet Medicare's medical necessity criteria, but the secondary insurance/patient has agreed to pay:

- Submit a PAR with complete documentation and valid ABN. You will receive a non-affirmative decision with a 14 byte UTN number. Submit the claim with the UTN number to receive an appropriate denial that can be forwarded to the second insurance/patient for payment.
- If you bypass PAR and simply bill Medicare for denial with a GA modifier, Medicare will request documentation and review it to confirm that your ABN is valid, before issuing the denial.
- Submitting the PAR is the fastest way to get an appropriate denial.

Another Insurance is Primary and Medicare is Secondary

- Since prior authorization is a condition of payment, you will need to submit a PAR to get reimbursed for the co-insurance.
- If you are not sure the Primary Insurance will cover the device, you can submit a PAR to Medicare and if the primary insurance denies coverage, you can submit the claim to Medicare for payment.

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Duly Eligible Medicare & Medicaid:

- Duly Eligible (Medicare & Medicaid): If you receive a non-affirmative decision, the claim can be billed straight to Medicaid (bypassing Medicare).

Retroactive Medicare Coverage

- Beneficiary has disability/Medicaid and receives Medicare coverage retroactively and you have to rebill the claim to Medicare: Submit PAR; 1) indicate on the PAR that item has already been delivered, and 2) indicate on the PAR that Medicare coverage is retroactive. Submit all appropriate documentation with the PAR.
- If you treat a patient on disability/Medicaid that might possibly qualify for/transition to Medicare/Social Security within the next 12 months, we highly recommend that you have Medicare compliant documentation, as those awards are often retroactive.

Ottobock reimbursement is here to help with Prior Authorization questions.

Phone: 800 328 4058 (ask for reimbursement)

Email: reimbursement911@ottobock.com

Reimbursement, Ottobock North America
P 800 328 4058
professionals.ottobockus.com

MEDICARE DME



October , 2020

COMPANY NAME
ADDRESS
STE
CITY, STATE, ZIP

UTN/Case Number: XXXXXXXXXXXXXXXX
Beneficiary Name:
Medicare ID: XXXXXXXXXXXXX

Subject: Prior Authorization (PA) Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items

Dear Sir/Madam:

We received your Prior Authorization (PA) Program for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items request for the above named beneficiary. Based on the information submitted, we have determined that the beneficiary does meet the medical necessity requirements Medicare has established for the lower limb prosthesis listed below:

L5856-Endoskeletal knee-shin system, microprocessor control feature, swing and stance phase.

This decision does not provide assurance that the beneficiary meets Medicare eligibility requirements nor does it assure that any other Medicare requirements (Medicare Secondary Payer, etc.) have been met. Only upon submission of a complete claim can the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) make a full and complete determination.

Before submitting a claim for any item, determine if the HCPCS code in the approval letter is valid for the date of service the item is provided.

The DME MAC reserves the right to review claims on a pre- or post-payment basis and, notwithstanding the requirements for performing prior authorization, may deny claims and take appropriate action if we determine that an affirmative prior authorization decision was made based on incorrect information.

Please visit our Web site at www.cgsmedicare.com to review current local policies which were also utilized for this prior authorization decision:

CGS
Jurisdiction C
P.O. BOX 20010
Nashville, TN 37202

MEDICARE DME



L33787 - LCD for Lower Limb Prostheses

A52496 – Policy Article - Lower Limb Prostheses

A55426 – Policy Article - Standard Documentation Requirements for All Claims Submitted to DME MACs

If you would like additional information regarding Medicare law, regulations or guidelines that apply, submit a written request to the address listed at the top of this letter. If you need more information or have any questions, suppliers and practitioners should contact our office at 1-866-270-4909; beneficiaries should call 1-800-Medicare (1-800-633-4227) and ask for "Medical Supplies."

Sincerely,

CGS, DME MAC Jurisdiction C
Medical Review Department