CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10155	**Date: May 21, 2020**
	Change Request 11671

Transmittal 10061, dated April 24, 2020, is being rescinded and replaced by Transmittal 10155, dated, May 21, 2020 to change the effective and implementation dates from May 26, 2020 to June 17, 2020. All other information remains the same.

SUBJECT: Provider Education for Required Prior Authorization (PA) of Hospital Outpatient Department (OPD) Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide instructions to the Medicare Administrative Contractors (MACs) regarding provider education regarding the PA process for certain hospital OPD services.

EFFECTIVE DATE: June 17, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 17, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	**Transmittal: 10155**	**Date: May 21, 2020**	**Change Request: 11671**

Transmittal 10061, dated April 24, 2020, is being rescinded and replaced by Transmittal 10155, dated, May 21, 2020 to change the effective and implementation dates from May 26, 2020 to June 17, 2020. All other information remains the same.

SUBJECT: Provider Education for Required Prior Authorization (PA) of Hospital Outpatient Department (OPD) Services

EFFECTIVE DATE: June 17, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 17, 2020

I. GENERAL INFORMATION

A. Background: Under the CY 2020 OPPS/ASC Final Rule (CMS -1717-FC), a provider must submit a PA request as a condition of Medicare payment.

Operational instructions for the Prior Authorization (PA) of Outpatient Department (OPD) Services rendered on or after July 1, 2020 is provided under separate instruction. This CR provides instructions to the contractor for education regarding the hospital OPD services PA program.

In this program, medical necessity documentation requirements remain unchanged. Effective July 1, 2020, as the date of service, providers must request prior authorization for the following outpatient hospital department services:

• Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services

• Botulinum toxin injections

• Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and Related Services

• Rhinoplasty and Related Services

• Vein ablation and Related Services

The CMS would like to educate physicians and providers about this program by sending the Introductory Letters attached to this CR, related requirements, and resources to access additional information, if needed. CMS will implement prior authorization as a condition of payment nationwide for the services identified beginning on July 1, 2020.

As instructed in previously issued CRs, the Common Working File (CWF) recognizes the application of such CRs to the current program but has not identified an associated workload.

B. Policy: 42 CFR 410 and 419.8 *et sec* (CMS-1717 FC).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11671.1	The MAC shall generate lists of all active providers and physicians/practitioners, to receive the appropriate Introductory Letter attached to this CR (Attachments A and B), who have billed, since January 1, 2019, the Healthcare Common Procedure Coding System (HCPCS) codes that are included in the OPD PA (Attachment C).	X	X							
11671.1.1	The MAC shall determine which active providers and physicians/practitioners from the list are applicable to its jurisdiction and performed these services in the Hospital OPD setting for receipt of the letters.	X	X							
11671.2	The MAC shall use the Introductory Provider Letter template provided by CMS (Attachment A).	X								
11671.2.1	The MAC shall prepare and mail the Introductory Letters to all applicable providers no later than 10 days from the effective date.	X								
11671.3	The MAC shall use the Introductory Physician Letter template provided by CMS (Attachment B).		X							
11671.3.1	The MAC shall prepare and mail the Introductory Letters to all applicable physicians/practitioners (those who performed these specific services in the Hospital Outpatient Department setting). • Place of Service Code 19 – Off Campus - Outpatient Hospital • Place of Service Code 22 – On Campus - Outpatient Hospital		X							
11671.4	The MAC shall create web postings describing the program parameters.	X	X							
11671.5	The MAC shall hold group or individualized training sessions, as appropriate, to notify stakeholders of the	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	PA program and to ensure understanding of the specific requirements.									
11671.6	The MAC shall use the information publically available in the Final Rule (CMS -1717-FC) and the Medicare Learning Network (MLNconnects 2020-01-09) message to begin education. At such time that additional MAC instructions are finalized, MACs shall include that information in their education.	X	X							
11671.6.1	MACs shall, at a minimum, provide public access to the agency-developed information, including, but not limited to, any developed prior authorization operational guides, special Medicare Learning Network materials, and/or other support materials, by posting the link(s) on their website.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Yuliya Cook, 410-786-0157 or Yuliya.Cook@cms.hhs.gov , Justin Carlisle, 410-786-4265 or Justin.Carlisle@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 3

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

MAC Header Here

PROVIDER NAME
PROVIDER ADDRESS
CITY ST ZIP

Mail Date (ex. June 1, 2020)
Provider NPI Number: Provider NPI

Dear Provider:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has implemented **a Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services** furnished on or after July 1, 2020, **nationwide**.

As a condition of payment, Prior Authorization is required for the following certain hospital OPD services:

i. Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services
ii. Botulinum toxin injections
iii. Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and Related Services
iv. Rhinoplasty and Related Services
v. Vein ablation and Related Services

The list of the specific Healthcare Common Procedure Coding System (HCPCS) codes that are included in the OPD Prior Authorization program located in Attachment B.

What You Need to Know

The PA 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 (PAR) is information that hospital OPDs are regularly required to maintain for Medicare payments. The request must be submitted by the hospital OPD (or by the OPD physician on behalf of the OPD), referred to as a "requester." Under the Prior Authorization process, the requester must submit the request with the required documentation before the service is rendered and before the claim is submitted for payment, so that Medicare can make sure all Medicare requirements are met.

The hospital OPD, or the physician on behalf of the hospital OPD, is responsible for submission of the Prior Authorization Request and all documentation to Medicare on behalf of the Medicare patient.

After receipt of all required documentation from the requester, [Insert MAC name here] will review the Prior Authorization Request and will issue a provisional affirmation or non-affirmation within 10 business days of

receipt of the prior authorization request. A provider may submit a request for expedited review of a Prior Authorization Request showing that the processing of the prior authorization request must be expedited due to the beneficiary's life, health, or ability to regain maximum function being in jeopardy. Upon receipt of a request for expedited review, [Insert MAC name here] will complete an expedited review of the prior authorization request if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function, and issue a provisional affirmation or non-affirmation decision in accordance with 42 CFR 419.82(d)(2) within 2 business days of the expedited review request. [Insert MAC name here] will send the decision letter regarding the Prior Authorization to the requester and, upon request, to the Medicare patient.

If the Prior Authorization Request is non-affirmed by [Insert MAC name here], the requester may revise and resubmit the PAR an unlimited number of times. [Insert MAC name here] will make every effort to conduct a review and communicate a decision within 10 business days on each resubmitted PAR. [Insert MAC name here] will send the provider detailed reasons for the non-affirmation decisions and offer education, to help the provider understand the reason for the non-affirmation decision and how the issue can be fixed.
For detailed information about this program please refer to the following resources:

[Insert MAC website here]

Additional Resources

Providers are vital partners in the Medicare program, and CMS is preparing additional resources to give you the information you need. To facilitate open and ongoing dialogue with both patients and providers, and to support program transparency, CMS has established a dedicated website for the hospital OPD services PA with comprehensive information for patients, suppliers, and physicians.

You may request an individual education session if you have concerns about the program. More information is available online. CMS and [insert MAC name] will post details of any upcoming educational sessions on its website (link noted above).

CMS Welcomes Feedback

CMS is committed to launching the hospital OPD PA program in an open and transparent manner that serves and protects patients and the health care providers that care for them. Your feedback will be a critical part of the process. Providers, Physicians and Practitioners with questions or other feedback can contact CMS at: OPD_PA@cms.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

MAC Header Here

PHYSICIAN/PRACTITIONER NAME
PHYSICIAN/PRACTITIONER ADDRESS
CITY ST ZIP

Mail Date (ex. June 1, 2020)
Physician/practitioner NPI Number: Physician/practitioner NPI

Dear Physician/Practitioner:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has implemented a **Prior Authorization Program for Certain Hospital Outpatient Department (OPD) Services** rendered on or after July 1, 2020, **nationwide**.

As a condition of payment, prior authorization is required for the following hospital OPD services:

i. Blepharoplasty, Eyelid Surgery, Brow Lift, and Related Services
ii. Botulinum toxin injections
iii. Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and Related Services
iv. Rhinoplasty and Related Services
v. Vein ablation and Related Services

The list of the specific Healthcare Common Procedure Coding System (HCPCS) codes that are included in the OPD prior authorization program can be found attached to this letter.

What You Need to Know

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. The request must be submitted by the hospital OPD (or by the OPD physician on behalf of the OPD), referred to as a “requester.” Under the prior authorization process, the requester must submit the request with the required documentation before the service is rendered and before the claim is submitted for payment, so that Medicare can confirm that all Medicare requirements are met.

The hospital OPD is responsible for submission of the prior authorization request and all documentation to Medicare on behalf of the Medicare patient. Physicians/providers will need to ensure the hospital OPD has all necessary medical record documentation to support the prior authorization request. In some relationships the physician may submit the request on behalf of the hospital OPD.

After receipt of all required documentation from the requester, [Insert MAC name here] will review the Prior Authorization Request and will issue a provisional affirmation or non-affirmation within 10 business days of receipt of the prior authorization request. A provider may submit a request for expedited review of a Prior Authorization Request showing that the processing of the prior authorization request must be expedited due to the beneficiary's life, health, or ability to regain maximum function being in jeopardy. Upon receipt of a request for expedited review, [Insert MAC name here] will complete an expedited review of the prior authorization request if it is determined that a delay could seriously jeopardize the beneficiary's life, health, or ability to regain maximum function, and issue a provisional affirmation or non-affirmation decision in accordance with 42 CFR 419.82(d)(2) within 2 business days of the expedited review request. [Insert MAC name here] will send the decision letter regarding the Prior Authorization to the requester and, upon request, to the Medicare patient.

If the Prior Authorization Request is non-affirmed by [Insert MAC name here], the requester may revise and resubmit the PAR an unlimited number of times. [Insert MAC name here] will make every effort to conduct a review and communicate a decision within 10 business days on each resubmitted PAR. [Insert MAC name here] will send the provider detailed reasons for the non-affirmation decisions and offer education, to help the provider understand the reason for the non-affirmation decision and how the issue can be fixed.
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[Insert MAC website here]

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Additional Resources

Physician/practitioners are vital partners in the Medicare program, and CMS is preparing additional resources to give you the information you need. To facilitate open and ongoing dialogue with both patients and physician/practitioners, and to support program transparency, CMS has established a dedicated website for prior authorization program for Certain Hospital Outpatient Department (OPD) Services with comprehensive information for patients, suppliers, and physician/practitioners at:https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services.

You may request an individual education session, if you have questions about the program. More information is available online. CMS and [insert MAC name] will post details of any upcoming educational sessions on its website (link noted above).

CMS Welcomes Feedback

The CMS is committed to launching the hospital OPD prior authorization program in an open and transparent manner that serves and protects patients and the health care physician/practitioners that care for them. Your feedback is appreciated and considered. Providers, Physicians, and Practitioners with questions or other feedback can contact CMS at: OPD_PA@cms.hhs.gov.

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

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

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

Code	(i) Blepharoplasty, Eyelid Surgery, Brow Lift, and related services
15820	Removal of excessive skin of lower eyelid
15821	Removal of excessive skin of lower eyelid and fat around eye
15822	Removal of excessive skin of upper eyelid
15823	Removal of excessive skin and fat of upper eyelid
67900	Repair of brow paralysis
67901	Repair of upper eyelid muscle to correct drooping or paralysis
67902	Repair of upper eyelid muscle to correct drooping or paralysis
67903	Shortening or advancement of upper eyelid muscle to correct drooping or paralysis
67904	Repair of tendon of upper eyelid
67906	Suspension of upper eyelid muscle to correct drooping or paralysis
67908	Removal of tissue, muscle, and membrane to correct eyelid drooping or paralysis
67911	Correction of widely-opened upper eyelid
Code	(ii) Botulinum Toxin Injection
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 (eg, abdominoplasty) (includes umbilical transposition and fascial plication) (list separately in addition to code for primary procedure)

15877	Suction assisted removal of fat from trunk
Code	(iv) Rhinoplasty, and related services
20912	Nasal cartilage graft
21210	Repair of nasal or cheek bone with bone graft
21235	Obtaining ear cartilage for grafting
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