New Prior Authorization Requirements for Blepharoplasty and Botox in HOPDs

Effective July 1, 2020, there are new rules for hospital outpatient departments (HOPDs): Before clinicians perform eyelid surgery or inject Botox (botulinum toxin), the HOPD must 1) request a prior authorization and 2) receive a provisional affirmation decision.

Using an ASC? The new rules don't impact ambulatory surgery centers.

Why the new requirement? The Centers for Medicare & Medicaid Services (CMS) has seen an increase in HOPD surgeries that, depending on the circumstances, can qualify as either functional or cosmetic. By making prior authorization compulsory, the agency hopes to avert incorrect payments when the purpose of the surgery is cosmetic and assure that patients are covered when the purpose is functional.

Prior Authorization in Action

The HOPD and your practice collaborate in filling out the paperwork and supplying the documentation, and then the HOPD sends the request to its Medicare Administrative Contractor (MAC).

What should the request include? Include what's listed on the prior authorization checklist (see "More Online"), plus supporting documentation that meets the MAC's requirements.

A turnaround of up to 10 days. MACs should make a decision and send their response within 10 business days. How the HOPD submits the request (e.g., by mail, fax, or online) is likely to determine how the MAC sends its response. The MAC also notifies the patient about its decision.

What about emergencies? If an HOPD asks for a request to be expedited, the MAC will respond within two business days. However, the request must document how a delay could severely impact life, health, or limb.

No UTN, no payment! The UTN is the unique tracking number that a MAC assigns to a request for prior authorization; look for it in the MAC's response. Next, when you submit your claim, make sure you include the UTN in the correct places (e.g., in positions 1-18 for electronic claims).

What about ABNs? Advance Beneficiary Notice (ABN) policies are unchanged and should still be followed.

What about audits? While audits of records may still happen, if you received a provisional affirmation for a service, the claim for that service is unlikely to be included in a review.

Eventually, some HOPDs may be exempt from prior authorization. CMS is authorized to allow exemptions from the process for providers who can demonstrate consistent compliance with Medicare's requirements. What is consistent compliance? CMS materials state that an HOPD must submit at least 10 requests and at least 90% of those must get a provisional affirmation. The agency doesn't expect to start approving any exemptions until 2021.

Eyelid Surgery

HOPDs must obtain prior authorization for the following CPT codes.

Blepharoplasty:

- 15820 *lower eyelid*
- 15821 *lower eyelid; with extensive herniated fat pad*
- 15822 *upper eyelid*
- 15823 *upper eyelid; with excessive skin weighting down lid*

Repair of brow ptosis:

- 67900 *supraciliary, mid-forehead or coronal approach*

Repair of blepharoptosis:

- 67901 *frontalis muscle technique with suture or other material (e.g., banked fascia)*
- 67902 *frontalis muscle technique with autologous fascial sling (includes obtaining fascia)*
- 67903 *(tarso) levator resection or advancement, internal approach*
- 67904 *(tarso) levator resection or advancement, external approach*
- 67906 *superior rectus technique with fascial sling (includes obtaining fascia)*
- 67908 *conjunctivo-tarso-Muller's muscle-levator resection (e.g., Fasanella-Servat type or MMCR)*

Correction:

- 67911 *Correction of lid retraction*

MORE ONLINE. For a list of Botox codes and prior authorization checklists, see this article at aao.org/eyenet.

BY **EMON ALAVI,** ACADEMY HEALTH POLICY SPECIALIST, **JENNY EDGAR, CPC, CPCO, OCS, OCSR,** ACADEMY MANAGER, CODING AND REIMBURSEMENT, AND **SUE VICCHRILLI, COT, OCS, OCSR,** ACADEMY DIRECTOR, CODING AND REIMBURSEMENT.

Botox Injection

HOPDs require prior authorization for the following CPT and HCPCS codes.

Chemodenervation of muscle(s):

- 64612 *muscle(s) innervated by facial nerve (e.g., for blepharospasm, hemifacial spasm)*
- 64615 *muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine)*

HCPCS codes for the injected medication:

- J0585 *onabotulinumtoxina, 1 unit*
- J0586 *abobotulinumtoxina*
- J0587 *rimabotulinumtoxinb, 100 units*
- J0588 *incobotulinumtoxina, 1 unit*

Prior Authorization Checklist for Eyelid Surgery

The HOPD and practice must collaborate in completing a cover-sheet provided by the MAC. It may include requests for some or all of the following information.

- ☐ Beneficiary's name
- ☐ Medicare Beneficiary Identifier (MBI)
- ☐ Date of birth
- ☐ Facility information, including
  - ◯ Name
  - ◯ Address
  - ◯ National Provider Identifier (NPI)
  - ◯ Provider Transaction Access Number/CMS Certification Number (PTAN/CCN)
- ☐ Physician information, including
  - ◯ Name
  - ◯ Address
  - ◯ NPI
  - ◯ PTAN
- ☐ Requester's information, including
  - ◯ Name
  - ◯ Telephone number
  - ◯ Address
- ☐ Anticipated date of service
- ☐ CPT surgical codes
- ☐ ICD-10 diagnosis codes appropriate for procedure, including laterality when appropriate
- ☐ Type of bill (use a four-character alphanumeric code to indicate the type of facility, type of care, and sequence of this bill in this episode of care)
- ☐ Units of service
- ☐ Type of request
  - ◯ Indication whether this is an initial or resubmission review
  - ◯ Indication if review is to be expedited and reason

Note: In addition to the information above, the MAC will also want documentation that supports the request. What documentation is required for eyelid surgery? This varies among Medicare payers. Visit aao.org/lcds for your MAC's preoperative documentation requirements.