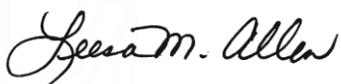




ISSUE DATE August 31, 2015	EFFECTIVE DATE September 1, 2015	NUMBER 01-15-30, 14-15-25, 31-15-30
SUBJECT Prior Authorization Requirements and Fee Schedule Updates for Hyperbaric Oxygen Therapy		BY  Leesa M. Allen, Deputy Secretary Office of Medical Assistance Programs

IMPORTANT REMINDER: On **October 1, 2015**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. Additional information is available on the Department of Human Services website at:
http://www.dhs.state.pa.us/provider/icd10information/P_012571

IMPORTANT REMINDER: All providers (including all associated service locations - 13 digits) who enrolled on or before **March 25, 2011** must revalidate their enrollment information no later than **March 24, 2016**. New enrollment application including all revalidation requirements may be found at http://www.dhs.state.pa.us/provider/promise/enrollmentinformation/S_001994. Please send in your application(s) as soon as possible.

PURPOSE:

The purpose of this bulletin is to inform providers of prior authorization (PA) requirements, Medical Assistance (MA) Program Fee Schedule changes and limits, billing requirements, and issue updated provider handbook pages regarding hyperbaric oxygen therapy (HBOT) services provided in a full body chamber, effective with dates of service on and after September 1, 2015.

SCOPE:

This bulletin applies to acute care general hospitals, physicians, and podiatrists enrolled in the MA Program who provide services to MA beneficiaries in the Fee-for-Service (FFS) delivery system. Providers who render services to MA beneficiaries in the managed care delivery system should direct prior authorization, procedure coding, billing and payment questions relating to the respective managed care organization.

BACKGROUND

HBOT is used to treat decompression sickness and neutralize the effects of nitrogen for scuba and deep sea divers. Pressurization of pure oxygen allows the lungs

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll free number for your provider type

Visit the Office of Medical Assistance Programs Web site at
<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/index.htm>

and skin to absorb more oxygen in a shorter period of time and substantially increases oxygen flow within bodily tissues. Utilization of HBOT has now expanded to treat conditions such as air or gas embolisms, unhealed or infected wounds, carbon monoxide poisoning, crush injuries and skin grafts with excellent results. However, patients with several existing comorbidities may be subject to increased risks and possible complications as a result of HBOT. Additionally, HBOT may be contraindicated for some patients.

DISCUSSION:

The Department of Human Services (Department) implemented the 2015 Health Care Procedure Coding System updates, effective September 1, 2015. As a result, the MA Program end-dated procedure codes C1300 and X2061 and added procedure code G0277, defined as “Hyperbaric Oxygen Under Pressure, Full Body Chamber, Per 30 Minute Interval” (limited to 4 30-minute units of service per day), effective with dates of service on and after September 1, 2015. Also, effective with dates of service on and after September 1, 2015, the MA Program will no longer pay for HBOT services when performed in POS 99, as the HBOT full body chamber is contained in the outpatient area of the hospital, i.e., POS 22 and not POS 99.

As noted in the Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2005 Payment Rates final rule at 69 FR 65758, the Centers for Medicare and Medicaid Services indicates that HBOT is typically ordered for a patient to be placed under pure oxygen for 90 minutes with the actual treatment taking 120 minutes, to account for compression time, treatment and decompression time.

PROCEDURE:

The MA Program is end-dating procedure codes X0621 and C1300 from the MA Program Fee Schedule, effective with dates of service on and after September 1, 2015.

The MA Program added procedure code G0277 to the MA Program Fee Schedule, effective with dates of service on and after September 1, 2015, as indicated below:

Procedure Code	Provider Type	Provider Specialty	Place of Service	Description	MA Fee	Limits	PA Required
G0277	01	183	22	Hyperbaric Oxygen Under Pressure, Full Body Chamber, Per 30 Minute Interval	\$43.89 per unit	Four (4) units per day	Yes

Effective with dates of service on and after September 1, 2015, providers must secure PA approval for HBOT services provided in the hospital outpatient setting, POS 22, using procedure code G0277. Providers must follow the instructions in their MA Program Provider Handbook (Attachment A) for PA of HBOT services in a full body chamber.

Because the brief provider notification time frame, the Department will retrospectively review authorization requests for HBOT services in a full body chamber (procedure code G0277) for dates of service on and after September 1, 2015, through October 31, 2015. The MA Program will deny claims for HBOT services performed in the hospital outpatient setting, POS 22, on or after November 1, 2015, when the provider fails to secure PA for HBOT services.

When the MA beneficiary has a medical need requiring more than 4 units of service per day of HBOT in a full body chamber in the hospital outpatient setting, POS 22, the prescriber may request an 1150 Administrative Waiver, i.e., Program Exception (PE), by following the directions in their MA Program Provider Handbook.

Under certain circumstances, the MA Program allows providers to request retrospective prior authorization after a procedure was performed on a patient, who subsequently receives retroactive MA eligibility coverage. These cases are called "Late Pick-Ups (LPU)". Information and the procedure for processing LPU cases are set forth in the MA Program Provider Handbook, which may be viewed by accessing the following website link:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p_010915.pdf.

Providers are not required to secure PA for HBOT services provided in a full body chamber when an MA beneficiary is admitted to the hospital inpatient setting, POS 21, since inpatient admissions are prospectively authorized through the MA Program's Place of Service (PSR) or retrospectively authorized through the Automated Utilization Review AUR processes.

Effective with dates of services on or after September 1, 2015, the MA Program will pay claims for the podiatrist's attendance and supervision of the HBOT session, under procedure code 99183. The MA Program added podiatrists to existing procedure code 99183 on the MA Program Fee Schedule, effective September 1, 2015, as follows:

Procedure Code	Provider Type	Provider Specialty	Place of Service	Description	MA Fee	Limits	PA Required
99183	14	140	21	Physicians or other qualified health care professional attendance and supervision of HBOT, per session	106.80	One (1) unit per day	No

ATTACHMENT:

MA Program Provider Handbook pages - Prior Authorization and Program Exception
Review of Hyperbaric Oxygen Therapy Services in a Full Body Chamber

**PRIOR AUTHORIZATION AND PROGRAM EXCEPTION REVIEW OF
HYPERBARIC OXYGEN THERAPY IN FULL BODY CHAMBER**

CONTENTS

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I. **GENERAL REQUIREMENTS FOR PRIOR AUTHORIZATION AND PROGRAM EXCEPTION REQUESTS FOR HYPERBARIC OXYGEN THERAPY SERVICES IN A FULL BODY CHAMBER.**

A. Hyperbaric Oxygen Therapy Services In A Full Body Chamber That Require Prior Authorization

1. Hyperbaric oxygen therapy services provided in a full body chamber in the hospital outpatient setting.
2. Hyperbaric oxygen therapy services provided in a full body chamber on an outpatient basis to a Medical Assistance (MA) beneficiary who is admitted to an inpatient facility.

B. Hyperbaric Oxygen Therapy Services in a Full Body Chamber That Require a Program Exception (1150 Waiver)

1. A request for hyperbaric oxygen therapy services in a full body chamber that exceeds the MA Program Fee Schedule limit of 4 units per day.

C. Emergency Services

Retrospective authorization or program exception is required for hyperbaric oxygen therapy services in a full body chamber that is provided in the hospital outpatient setting on an emergency basis. The request must be submitted within thirty (30) days of the date of service, following the procedure in Section II. If it is determined that the service was not provided to treat an emergency medical condition or was not found to be medically necessary, as set forth in Department regulations and program bulletins, the prior authorization or program exception request will be denied.

D. Retrospective Reviews

Retroactive MA Eligibility

A prescriber may request authorization for outpatient hospital claims for hyperbaric oxygen therapy services in a full body chamber provided to individuals who are determined to be eligible for MA retroactively ("late pickups"). The request must be submitted within thirty (30) days of the date the provider receives notice of the eligibility determination, following the procedure in Section II. If it is determined that the service was not medically necessary, the authorization request will be denied.

Individuals with Third Party Resources

For those individuals with Third Party Resources, including Medicare and private insurance, the Department will not require PA or PE approval of hyperbaric oxygen therapy services prior to the service being performed. In

these instances, the rendering provider will submit its claim for cost sharing to the MA Program in the usual manner as set forth in the CMS 1500 Billing Guide for PROMISe™. If the Third Party Resource denies payment for the hyperbaric oxygen therapy service or pays less than the MA Program fee, the prescriber may request retrospective approval from the Department within 30 days of the date of the Third Party Resource Explanation of Benefits (EOB).

II. PROCEDURE FOR REQUESTING PRIOR AUTHORIZATION OR A PROGRAM EXCEPTION FOR HYPERBARIC OXYGEN THERAPY SERVICES IN A FULL BODY CHAMBER

A. Initiating the Prior Authorization or Program Exception Request

1. Who May Initiate the Request

The prescribing practitioner must request prior authorization or a program exception.

2. How to Initiate the Request

The Department accepts prior authorization requests for prior authorization by telephone at 1-800-537-8862, choose Option 1, then choose Option 3, and then choose Option 2, between 7:30 a.m. - 12 p.m. and 1:00 p.m. - 4:00 p.m. Monday through Friday.

To request a Program Exception to exceed the limit of 4 units of service per day, follow the telephonic PA Process.

B. Information and Supporting Documentation that Must Be Available for the Prior Authorization Review

The information required at the time prior authorization is requested includes the following:

1. Prescribing practitioner's name, address, and office telephone number, or prescribing practitioner's Medical Assistance Identification (MAID) number and National Provider Identifier (NPI) number/taxonomy/zip code
2. Rendering provider's or facility's MAID number and NPI number/taxonomy/zip code
3. Beneficiary's name and Medical Assistance Identification number
4. Procedure code of the requested service
5. Diagnosis and ICD-9 or ICD-10, as applicable, diagnosis code
6. Clinical information to support the medical necessity for the requested service, including:
 - a. Symptoms and their duration
 - b. Physical examination findings
 - c. Corresponding laboratory and/or imaging reports
 - d. Treatments the beneficiary has received

- e. Reason the service is being requested
- f. Specialist reports or evaluations
- g. Clinical notes

C. Documentation Supporting the Need for a Service That Requires Prior Authorization or a Program Exception

The clinical information provided during the course of the prior authorization or program exception review must be verifiable within the patient's medical record. Upon retrospective review, the Department may seek restitution for the payment of the service and any applicable restitution penalties from the prescriber if the medical record does not support the medical necessity for the service. See 55 Pa.Code § 1101.83(b).

D. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of hyperbaric oxygen therapy services in a full body chamber (HBOT), the determination of whether the requested service is medically necessary will take into account whether the beneficiary:

1. Has a diagnosis of Type I or Type II Diabetes.

AND

2. Chronic, severe, or gangrenous diabetic lower extremity wound(s) that is (are) a Wagner grade 3 or higher.

AND

3. The wound(s) have no documented measurable improvement in the last 30 days of standard wound therapy.

OR

4. Has compromised skin grafts or flaps (not for the primary management of wounds) and the graft or flap has no documented measurable improvement of the wound(s) in the last 30 days of standard wound therapy.

OR

5. Has a diagnosis of active radionecrosis (osteoradionecrosis, myoradionecrosis, brain radionecrosis, and other soft tissue radiation necrosis).

OR

6. Has a diagnosis of radiation proctitis.

OR

7. Is undergoing dental surgery of a radiated jaw and requires prophylactic pre- and post-treatment.

OR

8. Has a diagnosis of idiopathic sudden deafness, acoustic trauma or noise-induced hearing loss within the past 3 months.

OR

9. Chronic refractory osteomyelitis that has been unresponsive to conventional medical and surgical management.

E. Clinical Review Process

Prior authorization nurse reviewers will review the request for prior authorization and apply the clinical guidelines in Section D. above, to assess the medical necessity of the requested service. If the nurse reviewer determines that the requested service meets the medical necessity guidelines, then the nurse reviewer will approve the request. If the nurse reviewer determines that the guidelines are not met, then the request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization or a program exception may be approved when, in the professional judgment of the physician reviewer, the service is medically necessary to meet the medical needs of the beneficiary.

F. Timeframe of Review

The Department will make a decision on the prior authorization request within two (2) business days of receiving all information reasonably needed to make a decision regarding the medical necessity of the services. A decision may be made during the call if sufficient information is provided at that time. If additional information is requested and not received by the 15th day of the date of initial request, the request will be denied for lack of sufficient information.

The Department will make a decision on a program exception request based on the regulations set forth at 55 Pa.Code § 1150.63 within 21 days of receiving the request for a beneficiary less than 21 years of age.

G. Notification of Decision

The Department will issue a written notice of the decision to the beneficiary, the prescribing provider and the rendering provider (if applicable).

NOTE: An approved prior authorization or program exception request means only that the service has been determined to be medically necessary. It does not address the beneficiary's eligibility for the service on the date of service. It is the responsibility of the rendering provider to verify the beneficiary's eligibility through the Eligibility Verification System (EVS) on the date the service is provided.

H. Denials

If a prior authorization or program exception request is denied or approved other than as requested, the beneficiary has the right to appeal the Department's decision. The beneficiary has thirty (30) days from the date on the prior authorization notice to submit an appeal in writing to the address listed on the notice.

I. Prior Authorization or Program Exception Number

If the prior authorization or program exception request is approved, the Department will issue a prior authorization or program exception number, which is valid for the time period not to exceed a maximum of thirty (30) calendar days.

J. Duration of Approvals

A prior authorization or program exception approval is valid for a maximum of thirty (30) calendar days.

K. Subsequent Approvals

If the treatment period exceeds thirty (30) calendar days, the provider must contact the Department by telephone at 1-800-537-8862 to request reevaluation and update the prior authorization or program exception every thirty (30) days.

III. PROCEDURES TO SUBMIT CLAIMS

A. Submission of Claims

Follow the instructions for submitting a claim for approved hyperbaric oxygen therapy under pressure found in the General Hospitals (including Outpatient Hospital Clinic, Emergency Room, Hospital Short Procedure Unit (SPU), and Outpatient Rehabilitation Hospital providers) billing guide on the Department's website at the following address:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001877.pdf

Follow the instructions for submitting a claim for approved hyperbaric oxygen therapy under pressure as a program exception found in the Claims Submission Instructions for Services Approved via the 1150 Administrative Waiver on the Department's website at the following address:

http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/s_001859.pdf

Providers who are unable to access the billing guide online may obtain a hard copy by calling 1-800-537-8862, prompt 4.

Follow the instructions for submitting an internet claim for approved hyperbaric oxygen therapy under pressure found in the PROMISe™ Provider Internet User Manual on the Department's website at the following address:

<http://promise.dpw.state.pa.us/promisehelp/manuals/promiseproviderinternetusermanual.pdf>

B. Claims for Emergency Room Services

When hyperbaric oxygen therapy under pressure is provided as part of an emergency room treatment where the beneficiary is admitted directly to the inpatient setting from the emergency room, the service must be included on the inpatient invoice rather than being billed as an outpatient claim.