Dear NANS Members:

The Advocacy and Policy Committee would like to bring to your attention some very recent updates put forth by CMS concerning prior authorization.

This past March, Medicare (CMS) adopted a new rule requiring prior authorization (PA) for selected Implanted Spinal Neurostimulator (SCS) procedures performed in an Outpatient Hospital Department (OPD) for dates of services on or after July 1, 2021.

The potential impact to SCS patients and providers due to these new requirements are highlighted below. Please note that the information below is for informational purposes only. They are not legal guidelines and are subject to change by Medicare.

NANS, along with our partners in the field, is providing this update to keep you informed and to raise awareness of these coming changes in order to minimize the impact of the requirements on patient access to care. Please share this information, as appropriate, with your billing department staff and preapproval teams.

WHAT DO THE CHANGES APPLY TO?

- These PA requirements apply to SCS procedures performed in an Outpatient Hospital Department. They do not apply to SCS procedures performed in an Ambulatory Surgery Center (ASC), Critical Access Hospital, nor physician office setting. Additionally, these requirements do not impact/change Medicare Advantage patients.

WHAT CPT CODES REQUIRE PRIOR AUTHORIZATION?

- 63650 – percutaneous implantation of neurostimulator electrode array, epidural (trial and/or implant)
- 63685 – insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
- 63688 – revision or removal of implanted spinal neurostimulator pulse generator or receiver

WHO IS RESPONSIBLE FOR PA SUBMISSION?

- The hospital must submit the PA request or delegate the PA submission request to the physician.
- Hospitals must place the approved PA number on the submitted hospital claim.

WHAT HAPPENS IF THE REQUIRED PA ISN'T SUBMITTED OR APPROVED?

- For Medicare (similar to commercial payers) lack of required PA approval will result in denial of related facility and physician(s) claims.

WHERE CAN YOU LEARN MORE?

- Please reach out to your local Medicare Administrative Contractor (MAC) for information - CMS has published general PA guidance.

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems. Final Rule. 85 Fed Reg 86017. https://www.govinfo.gov/content/pkg/FR-2020-12-29/pdf/2020-26819.pdf. Published December 29, 2020

2. https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior- authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd- services