Pre-Authorization Reference Guide - Neuromodulation

Important Resources:

- Pre-authorization Support Hours of Operation: 6:00 a.m. to 5:00 p.m., Pacific Time.
- Pre-authorization Support Toll Free Number: 1-866-287-0778.
- Pre-authorization Support Toll Free Fax Number: 1-877-835-2520 (Pre-authorization requests must be submitted to this number) or emailed to BSN.IntakeUnit@bsci.com.
- Website: **www.ControlYourPain.com/preauthorization**

Support Provided:

At the request of the Health Care Professional (HCP), Boston Scientific facilitates the preparation and submission of requests for coverage determination, pre-authorization and pre-certification including the following:

- Provides information on payer policies and procedures for obtaining prior authorization.
- Provides sample letters and information on medical necessity and appeals of denied claims.
- Provides coordination and follow up support with payers, relating to the pre-authorization process.
- Provides education on the pre-authorization process.

Pre-Authorization Overview:

- This process involves obtaining advance notification from the health plan that medical necessity and other coverage criteria have been met, as set forth by the health plan. Boston Scientific assists patients/HCPs with the pre-authorization process upon receipt of the information below (Note: all forms referenced can be found on our website):

http://www.bostonscientific.com/en-US/reimbursement/neuromodulation/pre-authorization.html

- **Pre-Authorization Form:** Provides easy format to clearly identify Primary and Secondary diagnosis(es) along with procedure codes to support neuromodulation therapy. This form, along with supporting clinical documentation, will assist in expediting the pre-surgical authorization process. This form is required to facilitate the pre-authorization process.
- **Provider Intake Form:** Provides relevant demographic information for the physician, ambulatory surgery center (ASC) or hospital. This form is **mandatory** to assist with the pre-authorization process.
- **HIPAA Business Associate Agreement:** This agreement describes our privacy practice and our obligations to safe-guard patient information. This agreement goes into effect when you provide us protected health information (PHI) for pre-surgical authorization assistance (please review the HIPAA Business Associate Agreement at http://www.controlyourpain.com/files/reimbursement/Business%20Associate%20Agreement_3%20200974.pdf).
- **Clinical Documentation:** Provides the insurer with a clinical history of treatment received prior to Boston Scientific Spinal Cord Stimulator (SCS) System recommendation. Psychological evaluation report, letter of medical necessity and other applicable documentation needs to be included for consideration.
- **Other:** Additional information may be requested, based on specific payer coverage criteria. For example; workers' compensation may require a claim number and date of injury, and HMO cases may require a referral from the Primary Care Physician.

Please see page 2 for important information about the uses and limitations of this document.

GUIDEPOINT Reimbursement Resources

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Frequently Asked Questions

Q. How does Pre-authorization differ from Predetermination?

A. **Pre-authorization** of benefits is the process that allows physicians and other healthcare providers to determine if the patient is eligible for coverage for a proposed treatment or service. It is also the process of securing authorization from a payer for a specialist and/or referral for non-emergency healthcare service. Pre-authorization of benefits does not guarantee reimbursement.

Predetermination of benefits is similar to pre-authorization in that it allows services and treatment to be reviewed for medical necessity. Benefit coverage is predetermined before services are rendered and any limitation under a plan can be addressed before services are rendered. A predetermination is a courtesy, where a pre-authorization is a requirement under a plan. Most predetermination requests can take 30 to 45 days, and complete medical history and physical exam documentation should be included.

Q. Which payers require a pre-authorization for SCS procedures and therapies?

A. A summary of typical pre-authorization requirements for different types of payers follows:

- Medicare does not pre-authorize or guarantee benefits. The patient must meet the Medicare criteria for SCS coverage.
- Medicaid requires pre-authorization for SCS procedures in many states. The pre-authorization process varies from state-to-state, so check with your local Medicaid office to determine the pre-authorization process for your state.
- Commercial Payers typically recommend predetermination for SCS procedures. Check with each payer to verify benefits, coverage policies, plan limitations, and/or exclusions.
- Worker's Compensation requires pre-authorization for SCS treatment.
- Managed Care Payers:
  - 1. *Health Maintenance Organizations* (HMOs). HMO members often must receive their medical treatment from physicians and facilities within the HMO network. HMOs may require a referral authorization from the primary care physician to the specialist. In addition to a referral authorization, the plan may require a separate authorization for the services to be rendered.
  - *2. Preferred provider organizations* (PPOs). These plans may not have pre-authorization requirements for outpatient surgery. Members may also receive treatment from physicians and facilities outside the network, but different benefits apply. The plan may allow benefits to be predetermined prior to a procedure or service. The center should schedule surgeries to allow for appropriate approval processing times. Predeterminations can take 30 to 45 days for an outcome.

Q. How long does the pre-authorization process take?

A. This is dependent on the health plan and its pre-authorization requirements. Usually, the process can take anywhere from five to 30 business days, depending on how timely the health plan facilitates these requests.

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