

Steps in the Prior Authorization/Pre-Determination Process

The protocol for Percutaneous Tibial Nerve Stimulation (PTNS) recommends an initial series of 12 weekly treatments to optimize patient response. It is important to request prior authorization/pre-determination for 12 treatments at the outset to avoid confusion and potential denials of coverage.

Step 1 – Contact Payer

- » Collect all patient, physician, and payer information.
- » Identify all appropriate diagnoses, corresponding ICD-9 and CPT® codes.

Note: Ensure the ICD-9 codes are within the FDA-cleared indications for Urgent® PC: urinary urgency, urinary frequency and urge incontinence. Unapproved uses may not be covered.

- » Verify patient's eligibility.
- » Verify coverage for PTNS for 12 treatments.
- » Confirm payer's preferred CPT® code
 - If payer suggests CPT® Code 64999, guidelines are available at www.urgentpcreimbursement.com.
- » Follow payer requirements for prior authorization/pre-determination.

Verbal authorization may be given. Written authorization is preferred. The provider should obtain an authorization number or written confirmation.

Step 2 – Send Requested Information

- » Gather all requested materials and mail or fax them to the individual or department responsible for the payer's prior authorization/pre-determination decisions. If additional PTNS materials are needed, download them from www.urgentpcreimbursement.com.

Step 3 – Follow-up

- » Continue to follow up routinely until a prior authorization/pre-determination decision has been made.
- » When prior authorization/pre-determination has been granted, verify the patient's eligibility to ensure that the patient is still covered by his/her payer.

Step 4 – Authorization or Appeal

- » If authorization is approved, obtain an authorization number or written confirmation.
- » If authorization is denied, the physician and patient must decide if the decision will be appealed. For an appeal:
 - Request information from the payer regarding their appeal process.
 - Send an appeal letter and required materials as directed.

Prior Authorization/Pre-Determination Payer Requirements

Medicare

Medicare does not routinely require prior authorization.

Private Payers

Prior authorization/pre-determination is considered essential and strongly recommended.

Medical Assistance (Medicaid)

Prior authorization may be required. Contact your state authority for instructions.

The information contained in this document is provided to help you understand the reimbursement process. It is not intended to increase or maximize reimbursement by any payer. We strongly recommend that providers consult their payer organization with regard to local reimbursement policies. The information contained in this document is provided for information and training purposes only and represents no statement, promise or guarantee by Uroplasty, Inc. concerning levels of reimbursement, payment, or charge. Providers are encouraged to contact their local payers with questions regarding coverage, coding, or payment.



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