Special Open Door Forum:
Prior Authorization Process and Requirements for
Certain Outpatient Hospital Department Services
Moderator: Jill Darling
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1:30 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants will be in listen-only until the question-and-answer session of today's conference. At that time, you may press star 1 to ask a question. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to your host, Jill Darling. You may begin.

Jill Darling: Great thank you (Amber) and welcome everyone. good morning and good afternoon. Welcome to today's Special Open Door Forum. Before we get into today's call I would like to - I just have one brief announcement. This Special Open-Door Forum is open to everyone, but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have inquiries, please contact CMS at press@cms.hhs.gov. And I would like to hand the call over to Amy Cinquegrani.

Amy Cinquegrani: Hi everyone and thanks for joining. My name is Amy Cinquegrani. I am the Director of the Division of Payment Methods and Strategies within the provider compliance group in the center for program integrity at CMS.

We are happy to have you join our educational call today about the upcoming prior authorization process and requirements for certain hospital department outpatient services.

We do have slides that we are going to be running through. The links for those

slides was found on the special open-door forum announcement. But if you still need to find them, I am just going to quickly mention our Web site, the short link is go.cms.gov/opd as in Out Patient Department, pa as in prior authorization (go.cms.gov/OPD_PA)

So go.cms.gov/opd_pa and that will take you to our program Web site and we have recently put up these slides for today's presentation at the bottom of the page in the download section, as well as some frequently asked questions and an operational guide.

Now the frequently asked questions and operational guides are living documents so we will make sure to incorporate additional feedback and additional items that might be discussed during the Q&A portion on this call. Those will be incorporated in those documents and we expect to have some updates to those as we continue along.

So hopefully everyone has found the slides. And I am going to go ahead and get started. About halfway through the presentation I will turn the call over to my Deputy Director, Dr. Scott Lawrence and then we will take questions after.

So the purpose of today's call is to provide an overview of the prior authorization process for certain hospital outpatient department services. And this program was finalized in the calendar year 2020 outpatient prospective payment system and ambulatory surgical center final rule 1717. And we have the - where the federal regulations are located as well.

And so we are going to providing specific operational guidance related to this process for the five services that we have finalized in the rule. Botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation.

Moving onto the next slide. Just some information about the prior authorization process. It is a process through which a request for provisional affirmation of coverage is submitted for review before the service is furnished and before the claim is submitted to Medicare for payments. This helps ensure that all Medicare coverage and payment and coding rules are met before the service is furnished.

And receiving an affirmation decision is a preliminary finding that a future claim submitted to Medicare for this service meets the Medicare requirements and we will talk a little bit more about the decision that you can get on the prior authorization request later in the presentation.

On Slide 4 we have some information on the who, what, where and when of this process. So the who. This is really important. This process affects hospital outpatient departments. It is not applicable to ambulatory surgical centers or other types of settings. Only hospital outpatient departments. They are the ones submitting the OPPS claim for payment. And so they are the ones that are responsible for obtaining this prior authorization.

The what is the five groups of hospital outpatient department services I mentioned before. These five groups of services constitute a total of 43 codes. And we have a list of the codes at the back of the slide presentation. We have a summary slide that lists all the codes in the individual groups. That was just also on our Web site that I mentioned earlier and it is in the final rules.

And so this program will apply nationally to all states and territories for these services that rendered one or after July 1, 2020. And our Medicare administrative contractors will begin accepting prior authorization requests for these services on June 17th.

The next slide has some information about why we are doing this. Again we will know earlier in the process whether Medicare will likely pay for the service. Patients will know whether Medicare will pay for the service and are able to make, you know, financial or decisions related to financial liability as necessary.

And our MACs can assess medical information prior to making a determination on the claim to provide feedback on the services that are to be rendered.

On Slide 6, some things that are not changing are Medicare coverage policies and documentation requirements are not changing. There is no additional, you know, coverage requirements associated with the prior authorization process. So the documentation that you are regularly required to have for submitting claims to Medicare for payments, that is just required to be submitted earlier in the process.

The same MACs that oversees the jurisdictions and our processing and reviewing claims now, they will review prior authorization requests and make decisions. And our ABN policies and appeal rates are not changing as well.

Slide 7 has some information on the prior authorization requests content. We have gotten some questions about, you know, is there a form? Where can I find a form to fill out? There is not one required form for Medicare. There is content elements that need to be included on the prior authorizations requests and we will go through these in just a moment.

Your individual MAC will likely have a cover sheet and have some additional information that they suggest you use to be able to quickly review that

request. But there is no specific form that needs to be used. As long as the request has these elements it will be processed.

So the request needs to identify obviously beneficiary information, name, date of birth, MBI, facility information, the physician or practitioner's information, the requester's information if it is different, you know, from the facility, from the hospital outpatient department.

The anticipated date of service of the procedure. We need to know what codes. What actual procedure are you requesting prior authorization on? Diagnosis, type of bill, and you know units as necessary. Also, you are requested to indicate if it is an initial submission or a resubmission. And your request should indicate if it is expedited or not and the reason why and we will go over these things on subsequent slides.

Slide 8, the medical documentation. Your request should also include information from the medical record to support why this service is medically necessary. Your individual MACs may have some LCDs for one or more of these procedures. And so you will want to make sure that you know your MAC requirements as well for submitting documentation.

If there is no LCD associated with a particular service, then the general medical documentation to support medical necessity should be included.

In the operational guide we do have some basic information that should be applicable to the services in the absence of any specific LCD requirements. And also your MACs will likely have checklists and other educational resources for the individual procedures that you can review.

So the submission process. Moving onto Slide 9. The hospital outpatient

department is the provider in this scenario. So they are the ones responsible for the prior authorization request process since they are the ones receiving payment for this.

A physician may complete the request on behalf of the provider. But again the outpatient hospital department provider is the one that will put the prior authorization request indicator that we call a UTN on the claim.

The request can be mailed. It can be faxed. It can be submitted through our ESMD process which is the Electronic Submission of Medical Documentation. Or it can be submitted through your MAC Portal. I will mention that even though the MAC will begin accepting requests on June 17th, requests through ESMD will not be available until July 6th. So just a few weeks difference there.

But all of our A/B MACs have CMS approved portals where you are able to submit the request and all the documentation through that portal.

The review timeframes on Slide 10. So for initial requests and resubmitted requests, the timeframe for the MACs to review the request and render a decision is 10 business days. Some of you that may be familiar with prior authorizations for some of other programs, sometimes we do have different timeframes for initial or resubmitted requests. But these timeframes are the same for outpatient department services.

Slide 11 goes into information about an expedited review. If you believe that the normal 10-day process for the review and decisions could jeopardize the life or health of your beneficiaries, then you can request an expedited review. And that timeframe is 2 days. So the MACs will review the request, will review why you believe this should be processed as an expedited request, and

we will communicate a decision within 2 business days.

If the MAC does not believe that the documentation supports an expedited review, they will again let you know within 2 business days and that request just turns over into the normal request process and you will get a prior authorization decision within the 10-day timeframe.

We are not thinking that a lot of hospital outpatient departments are using mail to request prior authorization these days. But if you are and you make an expedited request, we really encourage you to use a more timely mechanism such as the MAC portal or fax or ESMD.

The next slide is about our decision and decision letters. So the MAC will send back a letter providing the prior authorization decision which is either a provisional affirmation decision, a partial affirmation, or a non-affirmation via the same method that it was requested. However, if you request prior authorization through ESMD, the ESMD only sends back the decision not the full letter. However, there will be a full letter mailed with additional information.

If you request to receive a fax letter even if you did not submit your prior authorization request by fax, the MAC can do that as well. And all MACs will send a copy of the decision letter to the beneficiary. So they will know whether Medicare will likely cover their particular procedure.

And Slide 13 has some information on the unique tracking number. And this is Medicare's way of matching to the claims that are submitted for payment, whether or not prior authorization was requested. Every decision letter will contain unique tracking number that we call UTN. Claims submitted for payment must include the UTN. And so that is the outpatient, the hospital

outpatient department claim.

And if you are resubmitting a prior authorization request because the first one was not affirmed and you provided some additional documentation in a resubmitted request. that resubmitted request should have the UTN that is associated with the previous submission.

And now I am going to turn the presentation over to my Deputy Director, Dr. Scott Lawrence.

Scott Lawrence: Thanks very much, Amy. I am going to pick up at Slide 14, where we are discussing reviewed decisions. So once the MAC gets the request, they will render a decision. A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service or services likely meets the coverage requirements.

An original affirmation decision is valid for 120 days from the date the decision was made. Claims for which there is an associated provisional affirmation decision will be paid in full so long as all the applicable Medicare coverage and clinical documentation requirements are met and the claim was billed and submitted correctly.

Generally, claims that have an affirmation prior authorization decision will not be subject to additional review; however, certain programs within CMS that are outside of this like the CERT (or Error Rate Testing) program, which is a random program, or the UPIC program, the Unified Program Integrity Contractor (if there are concerns for gaming or fraud) will still happen, independent of this program.

Moving to Slide 15. We are continuing with review decisions. You also may

receive a non-affirmation decision which is also preliminary finding that the future claim is submitted to Medicare for the requested services does not likely meet Medicare's coverage, coding, and payment requirements.

A provisional partial affirmation is another type of decision. That means that one or more of the services on the request received the provisional affirmation decision and one or more of the services received a non-affirmation decision.

For any services within the prior authorization request that are given a provisional affirmation decision, the MAC will follow the process described on the previous slide for affirmation decisions. And for any services that are given a non-affirmation decision, the MAC will follow the process that I will describe on the next slide.

Moving to Slide 16. We are going to talk about the non-affirmed or partially affirmed decisions. A letter will be provided with details explaining the decision. The requester can resolve the non-affirmation reasons described in the decision letter and resubmit the prior authorization request.

A non-affirmation prior authorization request decision is not appealable; however, you have an unlimited number of resubmissions available to you.
Or -
Requesters can forgo to resubmission process, provide the service in the hospital outpatient department, and submit the claim for the payment, but the claims will be denied (although appeal rights are available at that time).

Moving to Slide 17. We are going to talk about outreach for non-affirmed requests. So MACs have special tracking for requests that are not affirmed due to documentation or other technical errors where the patient may otherwise meet Medicare's coverage criteria.

Providers with these documentation errors will be offered individualized education and are encouraged to resubmit their request to ensure their patients receive the necessary services for which they are covered.

Moving to Slide 18. As described in the code of federal regulation, Section 419.82, if an item is selected for required prior authorization under this program, then submitting a prior authorization request is a condition of payment, which is an important point.

Claims for items subject to required prior authorization submitted without a prior authorization decision and, therefore, a corresponding UTN, will automatically be denied.

Moving to Slide 19. Any claim associated with or related to a service that requires prior authorization for which a claim denial was issued would also be denied. Also, associated services include but are not limited to services such as anesthesiology services, physician services, and/or facility services.

On Slide 20, we have a flow chart of the general process for this prior authorization program. As you can see in what we call “swim lanes,” you have actions by the beneficiary, you have actions by the provider, and actions by your A/B MAC. Basically, the beneficiary will visit the practitioner and documentation will be created as a result of this.

We have the list of potential documentation that is required for the prior authorization. When that is gathered and put together correctly, they send in the request to the MAC. The MAC will make their decision in the set period of time, typically 10 days for initial and resubmitted is the time frame limit, or two days, for expedited (as Amy had described earlier).

Then they go back with a decision to the provider, whether it is affirmed or not affirmed. If it is non-affirmed, providers can resubmit. Providers will receive education with a detailed letter and make the corrections accordingly.

Moving to Slide 21. We offer a couple of different scenarios, just to make sure that it is clear. So under Scenario 1, the request is submitted. The MAC decides that it is affirmed. The requester then submits the claim, and then the MAC will pay the claim, as long as all the other requirements are met and the claim is clean.

In Scenario Number 2, we have a couple of options. The request is submitted, but they get a non-affirmation decision from the MAC. If they submit the claim, the claim will be denied.

If, however, they fix and resubmit the request, then the review of the submission will render a new decision, depending on what was fixed. If all the requirements are met, they will get an affirmation decision, and it will follow along Scenario 1. If not, it will stay in Scenario 2 until they can fix the records appropriately to obtain an affirmation decision.

In Scenario Number 3, they do not submit the prior authorization request. Of course, there is no decision, because nothing was submitted. Then, they submit the claim. The claim will be denied.

Moving on to Slide 22. We are looking at the patient impact. So, the benefit is not changing at all. Medicare patients will know earlier in the payment process if the service would likely need Medicare coverage requirements. Medicare patients will receive a copy of their prior authorization decision.

And, dual eligible coverage is not changing. So, a non-affirmation prior authorization decision is sufficient for meeting state's obligations to pursue other coverage before considering Medicaid coverage.

Slide 23 discusses our oversight of the program. So, we will analyze the impacts of prior authorization including impacts to patient care, access to service, and other expenditures and savings. CMS will also conduct regular reviews of MAC prior authorization decisions, and CMS will discuss its findings with and receive feedback from the MAC during regularly scheduled meetings.

Slide 24 contains contact information for all the MACs involved in the program.

On Slide 25 we have the summary of the program with some details. So, it describes that this is a national program for hospital outpatient departments to submit prior authorization requests. They can begin submitting requests as early as June 17, 2020 for services that will occur on or after July 1, 2020.

We have here the five categories:
Blepharoplasty - for which there are 12 codes
Botulinum toxin injections - for which there are 6 codes, 2 of which are CPT, 4 of which are J codes.
We have panniculectomy - for which there are 4 codes.
We have rhinoplasty - which has 13 codes.
Vein ablation - which has 8 codes.
Totaling the 43 codes that Amy had talked about before.

And then on Slide 26, we have our Web sites. So, Amy had described this. To go to that cms.gov/opd (and there is an underscore there) pa

(http://www.go.cms.gov/opd_PA). Or, you can send to our mailbox which is opdpa (or outpatient department prior authorization) at cms.hhs.gov (opdpa@cms.hhs.gov). Any questions?

And, I wanted to say before we start questions, I would like to thank everybody again for making the call and hope everybody has been safe through this very unique and trying time for all of us. We will take questions now. Thank you.

Coordinator: Thank you. We will now begin the question-and-answer session. If you would like to ask a question, please press star 1. You will be prompted to record your name so please be sure to unmute your phone.

Once again if you would like to ask a question please press star 1. Our first question comes from (Ronald Hirsh). Your line is open.

Ronald Hirsh: Hi thank you. So a couple of things. One is that when a physician schedules a procedure, they will give a CPT code. But it is not uncommon for the procedure to change in the OR when the patient is actually cut open or the procedure happens.

According to First Coast this morning, if a CPT that is submitted does match the CPT that was performed, the claim will reject and deny and the hospital will have to go through the formal review process.

They are also stating that they have no information at all that physician associated claims are also going to be denied. So if you can address those two things and then I have another question.

Scott Lawrence: Sure. So, this is Dr. Lawrence. I will take them one at a time. So, the first

question is with respect to having to make some decisions on the fly in the operating room. We were very careful when we created this particular program to target services where that would really be a minimal concern.

We know that in surgeries sometimes this is a fairly common thing in certain types of surgeries. So we were anticipating that these would be more narrowly focused.

That being said, it is true that if the procedure that they want to change over toward for some reason is different than the one they understood to be going into the process, and it is one of the codes that we have in our prior authorization program, they would need to have that prior authorization, because it is a condition of payment.

So, they would have to deal with submitting the claim, getting the denial, and dealing with that, or the appeal, or having some sort of mechanism in place to be able to handle another prior authorization and sending it in quickly and waiting to submit the claim.

And your second question - could you please repeat that one more time?

(Ronald Hirsh): About physician claims being automatically denied when the hospital claim is denied.

Scott Lawrence: Yes, thank you. So as we stated in the presentation, any claims associated with or related to a service that requires prior authorization for which a claims have been denied would also be denied.

And, these associated services include, but aren't limited to, anesthesiology, physician services, and facility services. This is consistent with our current

medical review and claims process and guidance that has been established for years now and is codified in regulation.

(Ronald Hirsh): Right but the MACs don't know that. Like I said they were asked that. They said they received no guidance from CMS that we should deny physician charges. So once again we don't want to cry wolf until the doctor - their money is at stake when they are still going to get paid.

Scott Lawrence: (Unintelligible) I am sorry. Go ahead. You weren't finished.

(Ronald Hirsh): You may just need to clarify it with the MAC so they understand what they are supposed to do.

Scott Lawrence: Absolutely. Well, we apologize if there is any confusion on the part of the MACs. We will certainly reach back to the MACs and clarify the guidance, and make sure everyone is signing from the same sheet of music, so to speak.

(Ronald Hirsh): Great thank you.

Scott Lawrence: And, again, this is specific to the outpatient department setting.

(Ronald Hirsh): Yes.

Scott Lawrence: So, this is common medical review procedure, you know, we again apologize. I am not sure why there would be confusion there, but we will be sure to clear that up, and thanks for bringing that up.

(Ronald Hirsh): Thank you.

Scott Lawrence: Appreciate that.

(Ronald Hirsh): And then my other question is you mentioned that it is a condition of payment. But is it not true if a procedure is performed in the hospital outpatient department with no prior authorization it will be denied? But then the hospital can go through the formal appeal process and still get paid if it meets medical necessity on the review.

Scott Lawrence: Are you asking a question?

(Ronald Hirsh): Yes. I mean if they just don't do any prior authorization at all, and they just do it, it's the claim will go to MAC, the MAC will deny it, they then have the ability to do a redetermination. The MAC will request records, review for medical necessity and if the surgery was appropriate, the hospital will get paid. Is that not correct?

Scott Lawrence: No, no this is correct; however, it certainly is our hope and intention that providers will avoid that fairly lengthy and expensive process if they have the documentation that's not any different than the documentation they would send on their appeal, and it's all there, they just send it at a different time, if none of these are emergent procedures, they send it in, they get the approval...

(Ronald Hirsh): Yes.

Scott Lawrence: …they get paid, it's easier and simpler for everyone. So, we're not trying to restrict necessary care at any point with this process. And, we're not changing any of the requirements. We're just trying to make it more efficient for those who need the services and can properly document that the services are required.

(Ronald Hirsh): Of course. But so the issue is sometimes dealing with physicians is a little

difficult. And their cooperation is not always optimal. But thank you for taking my question.

Scott Lawrence: Thank you.

Coordinator: Our next question comes from, excuse me, question comes from (Valerie Wrinkle). Your line is open.

(Valerie Wrinkle): Thank you. My first question concerns Slide 7. And you mentioned the address of the hospital provider for which the procedures being performed, or intended to be performed. My question is, do you want the main address or do you want the literal service address of the hospital since hospitals can have numerous provider-based departments?

(Amy): Hi this is (Amy). I'll take that question. Thank you. That's a good one and that we might need to clarify. We did ask one of our MAC partners, (Palmetto GBA), to be on the speaker line to assist with some of these questions. I believe that it means the billing address. But (Charles) from (Palmetto GBA), can you confirm or clarify if I'm incorrect?

(Charles): Yes. The billing address would be the address you would -- that's correct.

(Amy): Okay.

(Valerie Wrinkle): All right. Perfect. And then I have one more if you would bear with me. On Slide 12, you talk about of course sending the requester the letter as to your provisional decision. And copying the beneficiary. But you don't mention sending a letter to the physician.

And since this is directly between the physician and the patient, and the

hospital cannot literally do anything without the orders of the physician or the intent of the physician, before the documentation from the physician with regards to the request, the prior authorization request, I'm curious as to why a letter is also not to be sent to the physician.

(Amy): This is (Amy) again. Another good question and something that we have struggled with a little bit over the years with our prior authorization processes. We continue to bring this up with our general council to try to find a good solution. Sort of the short answer is that, or for our purposes, for Medicare payer service purposes, prior authorization is between Medicare and the entity that's billing for the service.

And so since that's the, you know, hospital outpatient department, in this case, there shouldn't be any communication, you know, that's not, you know, automated sort of communication with -- for this respect between Medicare and the physician, who is not billing for the particular service.

And some other programs we do have optional processes where the physician or the ordering practitioner can request a letter. And, you know, we've considered some processes where the physician or the ordering practitioner can sort of provide a letter to the hospital outpatient department to include in their prior authorization request packet that says, you know, "Please send me a letter. I'm letting you know right now." And we can - and we are allowed to in those circumstances.

So that's definitely a process that we can consider for this process. But ultimately there won't be, you know, per our council's guidance, there won't be an automated communication from the MAC to, you know, an entity that's not billing for the service.

(Valerie Wrinkle): Okay. So given that, then if the physician that's initially ordering one of these services for the patient, does -- is not necessarily forthcoming with all of the documentation required to improve your options of getting an acclimation on the request, then is it appropriate for hospitals to schedule those patients pre-procedure for a complete pre-operative assessment at the hospital to determine and gather the documentation at the hospital for purposes of submitting the prior authorization request?

((Crosstalk))

(Amy): That's another great question and -- oh, go ahead. Sorry.

(Scott Lawrence): Sorry about that. Yes. One of the issues with the setting, I think you articulate really well, is that many of these hospital departments have different relationships for physicians. Where the physicians are more or less integrated into the working of the outpatient department.

We are, as (Amy) said, we're sticking to the outpatient department itself, so each of these relationships will have to figure out the mechanism internally to get the process to us correctly, and will send it back to the hospital outpatient department. And, they can set-up their own communication systems.

As we started to calculate this, there just seemed to be too many different variations of settings for us to capture them all. And again, we talked about it and we still will keep working toward trying to find the perfect balance to get everyone the communication they need as quickly as possible so they can be efficient to deliver the necessary services.

(Valerie Wrinkle): So in your update use or guidance, do you think you could suggest what some of those various options are so, you know, so, you know, could there be

disciplinary actions through the independent medical staff with regard to privileges and things like that? Because I appreciate the fact that you've got various types of relationships of the clinicians or physicians with the outpatient hospital departments.

So it's challenging to come up with our one size fits all program, from your end. But I think where hospitals are challenged is politically sometimes internally, they have ideas about what's allowed. But leadership struggles with it. So if there were some examples from CMS and FAQ's or something, that could at least help start the processes rolling if you will.

(Scott Lawrence): So, I just wanted to make sure I'm understanding your question. You're saying that the outpatient department leadership is having trouble communicating with their physicians, and you're looking for guidance from us in how to make that happen?

(Valerie Wrinkle): How -- right, how to add to the requirement if you will that the physician, of where they could (unintelligible) doing a procedure on the patient is obligated to submit the required documentation to the hospital.

(Scott Lawrence): So I'm just going to ask a question back. Do you think the physician, knowing they won't get paid to do the procedure if they don't get it because it's a condition of payment, wouldn't be motivation enough for them to decide to cooperate?

(Valerie Wrinkle): It -- I can attest to you with your (NCD)'s on much more expensive procedures, like (ICD) implants or pacemakers, that that's not always a motivational factor.

(Scott Lawrence): So it's interesting. I have to say this - a part of me is curious about who these

providers are that don't want to cooperate. And, you can send us a list of their names or something. But, you know, we - the kind of oversight that we can do for these programs, it's difficult to give lots of scenarios (and there are many) and it's hard, as you said, to come up with a one-size-fits-all set of scenarios or concise set of scenarios to do that.

We'll work on that. I don't want to make a promise that I can't keep. I do think that the hospital, you know, could make an announcement to their staff that for these services. They're going to need to do this process, and they'll need to submit the documentation in a timely way.

That should be enough as a general term, but we'll talk about it. And maybe that you want to send us some thoughts in the email with regard to this, so that we can consider them. We're always looking to improve.

(Valerie Wrinkle): Thank you.

(Scott Lawrence): Thank you (Virginia) -- (Valerie), I'm sorry. Any other questions?

Coordinator: Our next question comes from (Sandy Conway). Your line is open.

(Sandy Conway): Hi, you know, I work for a physician that we also do some outpatient services here at our facility. And my question is, is that we do a lot of Botox injections for certain patients. Do I have to obtain prior authorization for those patients since it's not really an outpatient hospital? Or do you consider that as an outpatient hospital?

(Scott Lawrence): All right (Sandy), so are you confirming that you are not an outpatient department? You're not working out of an outpatient department?

(Sandy Conway): I am not. No. I am working in a physician's office. (Montana Facial Surgery) is actually a facility. And like I said, we do some procedures here in our office, outpatient procedures I guess, here in our office for certain things. Other things we do of course at outpatient surgery -- or, outpatient services in a hospital setting.

But like for Botox injections for like a patient who has a tic or has migraine headaches, my question is do I need to obtain a prior authorization prior to us doing those from this point forward on July 1st?

(Scott Lawrence): If you're not in an outpatient department setting, then this program doesn't -- isn't directed toward you.

(Sandy Conway): Oh it isn't? All right. Great. Thank you so much.

(Scott Lawrence): Okay. Thanks for calling.

Coordinator: And next, we'll go to (Lisa Hoight). Your line is open.

(Lisa Hoight): Thank you. I believe you already answered this question in the very beginning (Amy), but I just want to make sure I'm hearing this correctly. This is not applicable to an ambulatory surgery setting, correct?

(Amy): Yes, that's correct.

(Lisa Hoight): Okay. All right, because that's how it was effective January 1st but somebody had thought that was changing. Okay. Very good. Thank you.

(Amy): Sure.

Coordinator: Our next question comes from (Elizabeth Coddle). Your line is open.

(Elizabeth Coddle): Hi, thank you very much. I wanted to just clarify if we think that the procedure is solely cosmetic, we don't have to go through the process of looking for a denial for an authorization that we never intended to receive?

(Scott Lawrence): That is correct. If you're doing a purely cosmetic procedure it would not be covered under Medicare. And, if you're seeking to get your own payment, independent of Medicare, then you're not part of the program.

(Elizabeth Coddle): All right. Thank you.

(Scott Lawrence): Thank you.

Coordinator: And next, we'll go to (Caroline McGlinsky). Your line is open.

(Caroline McGlinsky): I just want to verify, I work for a specialty office, (Lyguster) Ear, Nose, and Throat, and I just want to verify that we do no procedures here, we do them in the hospital setting, and in outpatient surgery centers, so none of this would apply to me either except for just making sure that the office has everything documented in the patient chart.

Dr. (Lawrence): So again, this is Dr. (Lawrence), CMS, when you say outpatient surgical center, if it's not an outpatient department, then you're correct. It's not part of our program. Our program is...

((Crosstalk))

Dr. (Lawrence): ...specifically saying the hospital outpatient departments. Mm-hm. I'm sorry?

(Caroline McGlinsky): Working in the doctor's office, so that's the only thing that applies to us is just to make sure everything's documented in the patient's chart with the physician?

Dr. (Lawrence): Always good to document your stuff.

(Caroline McGlinsky): Yes.

Dr. (Lawrence): Absolutely.

(Caroline McGlinsky): Yup. Okay.

Dr. (Lawrence): Yup.

(Caroline McGlinsky): Thank you very much.

Dr. (Lawrence): Thank you very much.

Coordinator: Our next question comes from (Gweneth Hoffman). Your line is open.

(Gweneth Hoffman): Hi, I'm sorry. I think I may have answered my own question but it's related to the Botox injections. I know that Botox is given for many different diagnoses. And I know that we were questioning if it applies to all diagnoses. But would we actually be reviewing our local -- our (MAC LCD) to determine which diagnoses are payable and then submitting the (auth) for those diagnoses. Is that right?

Dr. (Lawrence): Yes, for the botulinum toxin injections, we're just narrowly focused on the specific codes that we have in our program. So, it's not all botulinum toxin injections. And, I would look to your (LCD)'s and with your (MAC) for

guidance on those particular codes or other CMS guidance.

(Gwyneth Hoffman): Oh okay. So for the diagnosis, because I know there's no diagnosis information listed here, but I guess yes, we -- I guess I did, you know, kind of answer the question knowing that we would have to review the (LCD) to look for a payable diagnosis and then submit authorization for the (CPT) codes, or the (HCPCS codes) that are included, right?

Dr. (Lawrence): Right. You always have to have a diagnosis that matches the code, all the standard coding requirements exist, and then again, we're really looking at the two procedure codes, the 64612 and 64615. So, if you're doing botulinum toxin injections elsewhere, they wouldn't be part of this program.

(Gweneth Hoffman): Okay. Thank you.

Coordinator: Next question comes from (Charlotte Ward). your line is open.

(Charlotte Ward): Hi, thank you. I just have two questions. Mine's related more to the vein ablations. It says that we need to use a tracking number on our claim. Do you suggest putting that like in a treatment authorization line?

(Amy): Hi, this is (Amy). That's a great question. In our operational guide, that you can get the link to on our website, we have that section on where to put the (UTM), unique tracking number on your electronic claim. And it's in Section 8.1. And it -- I believe it's consistent with 1 through 18. And that will come into our (FISS system) for processing. (Charles) from (Palmetto GBA), is there anything else you want to add to that or did I answer that accurately?

(Carl): Yes. 1 through 18 is where it should go. You are correct.

(Charlotte Ward): Okay. And I'm sorry (Amy), I didn't -- I missed the first part of that. Where am I going to get that information?

(Amy): Oh that's -- we have a section on that in our operational guide.

(Charlotte Ward): Okay.

(Amy): It is -- we have a link to that on our website. It has all the details that we've discussed today, as well as some more, you know, detailed information such as where to put the (UTN) on the claims...

(Charlotte Ward): Okay.

(Amy): ...so you can get your payment.

(Charlotte Ward): Okay. And my other question, right now I have a lot of Medicare replacements that do not require an authorization. Do -- should we anticipate going forward, since most of them follow Medicare guidelines, that they will now require an authorization since Medicare is doing the same?

(Amy): So just to clarify, are you referring to other insurers or other payors?

(Charlotte Ward): Right. Like the commercial Medicare replacement. You know? They always had the disclaimer that they follow the Medicare guidelines, so now if Medicare is going to start requiring for these codes that I work with, I'm just wondering if we can anticipate all of the replacements falling in line.

(Amy): It's definitely possible but I...

(Charlotte Ward): Okay.

(Amy): ...don't think we can speak specifically to what their requirements are going to be.

(Charlotte Ward): Okay. We'll just find that out going forward. Okay, thank you for your help.

(Amy): Thank you. Do we have any other questions in the queue?

Coordinator: Hello?

(Amy): Hi (Amber), are there additional questions?

Coordinator: Yes. (Gretchen Case), I'm sorry about that, your line is open for your question.

(Gretchen Case): Hi, yes thank you. Good morning. Thank you for taking my question. Obviously, there is a fair amount of internal work that goes on in the hospitals in order to put into place these requirements and take action on them. Various points of registration, different service areas, and so forth. Is there any consideration being given to a delay in implementation? Specifically, not only as it relates to the workflow that has to be changed, but additionally to the system though.

So I had -- I do have a question with regard to the (837 segment) where the data would be required. And I understand that there is an answer. But as I'm sure you can appreciate, we're in an entirely electronic system now. And I have to make sure that the system is built to take those codes. I can't manually add the (UPN) Number into a (segment loop) of an (837) manually, even if I have done the process to get that actual number.

And so given the last six to eight to ten weeks of our lives in hospital work,

which has been completely redirected, I'm just asking if there's any consideration being given to a delay by chance.

(Amy): Sure. This is (Amy). Thanks for that question. And we definitely have, you know, considered if a delay was appropriate. But ultimately, we have decided that this is the right time to focus on these services since they are elective and can be prone to abuse since they're considered cosmetic. And while we agree that obviously hospitals and facilities have had a tremendous amount of additional work to deal with the public health emergency, as states are beginning to relax their rules and allow elective surgeries to begin, we believe it's an appropriate time to begin the program.

So while we did consider it, at this time we don't believe that there will be any delay.

(Gretchen Case): Okay. Thank you for taking my question.

(Amy): Sure.

Coordinator: Our next question comes from (Tammy Walsh). Your line is open.

(Tammy Walsh): Hi, I just wanted to ask you, I didn't have the actual slide, I've got it now, so I wanted to ask you, I know you said the request could be mailed, faxed, the electronic system, the (ESMD), and then submitted through (MAC) portal. Do you happen to know like the fax number? How do we get access to the MAC portal, etcetera?

(Amy): Sure, this is (Amy). In our operational guide, we have, which can be found again on the same link where you found the slides for the presentation, we have contact...

(Tammy Walsh): I...

(Amy): ...information for all...

(Tammy Walsh): ...I didn't have that link. I actually was emailed this slide. And I don't know if it's because the invite was forwarded to me.

(Amy): Okay. I'll -- sure not a problem. So, if you have the slides, on the last slide, actually second to the last slide, Slide 26, there's...

(Tammy Walsh): 26.

(Amy): ...a slide that says, "CMS Resources." And there's a link there. It's http://go.CMS.gov/OPD_PA. And so that's our program website where we have some additional resources on this program. One of which is an operational guide with lots of good information.

And that operational guide has contact information for all of our MAC's. Because obviously, you know, we're dealing with across the country, each MAC is going to have a little bit of a different process. So, you know, it should have the fax number to fax prior authorizations. t should have the mailing address. And it should have a web link.

You should check out your specific MAC's, you know, internet site for information on your portal. All of the MAC's are also doing, you know, individualized or additional provider education and outreach to the providers in their jurisdictions where they can get more into the details about how specifically their portal will work.

And, you know, what specific things they're going to be looking for. So really, we suggest, you know, contacting your MAC and getting on their website to find out that information.

But if you have trouble, you know, getting in touch with your MAC or you're not sure who that should be or where to go, you know, please let us know. And we can help direct you.

(Tammy Walsh): Okay. And who would I contact if I needed additional help?

(Amy): Sure. On that same resource slide with our...

((Crosstalk))

(Amy): ...address, we also have an email box which is OPDPA@CMS.HHS.Gov. And if you send us, you know, your name, your state, and the MAC that you submit your claims to, we can definitely get you in touch.

(Tammy Walsh): Okay. Thank you.

(Amy): Sure.

Coordinator: And next, we'll go to (Muriel Michelle). Your line is open.

(Muriel Michelle): Hi, thank you. I wanted to clarify, we are a physician practice that is hospital-owned. And we are considered an outpatient clinic of the hospital. Would that -- would we meet the criteria to have to submit a PA, or would this exclude us because we are a physician practice?

(Amy): This is (Amy). If it sounds like since you're saying physician practice you're

excluded. But, you know, without knowing specifics, it's hard to say. If you submit, you know, an OPPS claim on a 13 X type of bill, then you will be included.

(Muriel Michelle): Okay. So I have to find out what type of bill we submit on?

(Amy): Sure. Or your place of service, you know, the place of service where you're - where you're billing your claims.

(Muriel Michelle): Yes, our place of service is actually off-site from the hospital. And I know a couple of places asked (unintelligible) practices, but we're hospital-owned and we're considered an outpatient clinic. I wasn't sure if that means we would meet the criteria. Because we do Botox for migraines and (spasticity). So I want to make sure we're not -- that we're doing it if we need to.

(Amy): No I definitely understand. I would suggest contacting your MAC and, you know, they can look, you know, at your NPI and, you know, the information that's in your -- their provider enrollment system. And they can tell you for sure.

(Muriel Michelle): Okay. And how do I know which MAC is mine? Because I don't do the billing because we're hospital-based. They do it for us. So how do I...

(Amy): Sure. What state are you in?

(Muriel Michelle): Maine.

(Amy): Okay. So it's like your MAC is (NGS), National Government Services. But, you know, the MAC is the one that processes provider enrollment claims and provider enrollment applications and billing. So whoever does those

processes, should be able to guide you.

(Muriel Michelle): Okay. And...

(Amy): And it not, please contact the resource mailbox that was on the slides and we can find out that information for you.

(Muriel Michelle): Great, thank you so much.

Jill Darling: Okay. Our next question comes from (Cindy Higgins). Your line is open.

(Cindy Higgins): Thank you. Can you clarify who should be getting the authorization? Is it -- should it be the hospital or should it be provider? On Page 9 it says the provider must submit the prior authorization. The provider being the hospital, outpatient department. However, the physicians making the request on behalf of the provider. And on Page 19, it seems to indicate that the provider is responsible for getting the authorization. So can you speak to that? And then I have another question.

(Amy): Sure, this is (Amy). In this presentation and for this process, the provider is the hospital outpatient department. We are not talking about the physician or the practice here. So, the hospital outpatient department is the one that submits the claim for payment. So they are ultimately the ones that need to have the unique tracking number put on that claim in order to receive payment for the service.

(Cindy Higgins): Okay. So, just to verify, the whole service (unintelligible) getting the authorization and that authorization will cover both the hospital and the provider of services?

(Amy): Yes. The prior authorization is really for, you know, it's for billing. So it matches up to claims that are submitted for payment for that service. So, you know, if the hospital outpatient department is not approved on prior authorization to, you know, bill Medicare for that service, then, you know, associated services are affected as well, such as physicians and other services. But ultimately it is the hospital outpatient department that's responsible for prior authorization.

(Cindy Higgins): Okay. And so here's a scenario, if the hospital does get the authorization and say specifically for a Botox case, and the hospital will only be billing the (J code). And the provider of service would be billing the 64165. So am I to understand that the provider will be paid for their services as well, as long as the hospital has an authorization?

Man: This is...

((Crosstalk))

(Scott Lawrence): ...I -- yes, so all the codes that are involved in the program will require prior authorization. So, if the hospital is trying to prior authorize one of the J codes and the - your physician is obviously providing the service, which is the CPT code, they would have to both be together on the prior authorization request.

(Cindy Higgins): Okay. So the hospital is responsible for getting both of those authorized?

(Scott Lawrence): Correct.

(Cindy Higgins): Okay. And one last question, does the authorization number also have to be on the provider's claim, as well as the hospital claim?

(Scott Lawrence): It would just go onto the hospital claim.

Woman: Okay thank you very much.

Dr. (Scott Lawrence): Thank you.

Coordinator: Our next question comes from (Jill Decoy). Your line is open.

(Jill Decoy): Hi. I work for a private practice here in Pittsburgh and I do all four visuals - I mean for persons in (unintelligible). No I'm reading regarding blepharoplasty eyelid surgery and it's saying visual field study exams when applicable. Normally they are required with the other insurance companies. Are they going to be required for the Medicare when I submit a prior authorization?

Dr. (Lawrence): This is Dr. (Lawrence). The guidance for each specific procedure would be followed on the LCDs in the MAC or also in any other guidance that we have. So…

(Jill Decoy): Okay.

Dr. (Lawrence): …each procedure has its different things, as you probably already know, and whatever the requirements are will still be required for us. We're not changing the requirements at all.

(Jill Decoy): Okay. Okay now we have one physician that does see patients in West Virginia. He does these surgeries in West Virginia as well. Now entering the prior authorization, the billing is going to come here to the Pittsburgh, the Pennsylvania office. Is that going to be a problem when I enter the prior authorization if he is going to the surgery in West Virginia?

Dr. (Scott Lawrence): It depends on the relationship that you have.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): So, if his Virginia office is an outpatient department setting and the bill is 13 X, then yes.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): However, if you're just doing it through some sort of different arrangement, and he's not an outpatient department, then no.

(Jill Decoy): Okay. And my understanding the UTN number once the decision is made that will become the authorization number?

Dr. (Scott Lawrence): Correct. That's the number that gets applied to the claim and will track with - that decision will track through the UTN with the claim to allow it to either be paid or denied once it's submitted.

(Jill Decoy): Okay. Now regarding blepharoplasty, the 15823-procedure code when it is entered is there going to be a primary diagnosis for it because there will be two? There will be three separate codes, one for the right eye, one for the left and then the bilateral visual field testing. Do you know if there's going to be a primary? Will it get denied if it doesn't have a primary diagnosis?

Dr. (Scott Lawrence): It would still have the same requirement that it has now.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): You just send them in earlier.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): So, if your procedure has a requirement, which I'm guessing it does for a primary diagnosis, then it would still – that would not change.

(Jill Decoy): Okay. Okay, all right. It's - and I have one more question. If it does get denied I can do the next - so I can resubmit another request with the previous UPN number that was denied?

Dr. (Scott Lawrence): So, I want to be sure we're clear on our language. So, if it's denied, that means that a claim was submitted. So, a determination was made. If it's not affirmed, then you sent in the prior authorization request…

(Jill Decoy): Right.

Dr. (Scott Lawrence): …they said that it didn't comply with the rules or there was something missing or whatever. They will try and get back to give you a detailed reason as why it was not affirmed and then, depending on what it is you can correct – or make a decision based on that. If you correct it, then you can re-submit it as many times as you need to until it gets correct. The (MAC) will provide education to help you through that process if needed.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): So, if it's not affirmed then you can resubmit. If you submit the claim and it gets denied, then it would be a new submission if you submit it again. It wouldn't be related. You've already been denied, and then you could appeal or you could try again, but the simpler and easier process across the board is to try and resubmit the prior authorization request before you submit the

claim.

(Jill Decoy): Okay. And then I will be able to attach all the clinical information for review on the Mac portal then when getting the prior authorization?

Dr. (Scott Lawrence): Yes, the MAC will - the MAC is able to help determine exactly the best way to submit all of the information.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): Yes, if all the information would go through.

(Jill Decoy): Okay.

Dr. (Scott Lawrence): And, when you do resubmit, you'll have to include your UTN…

(Jill Decoy): Okay.

Dr. (Scott Lawrence): …from the prior submission so they can track it…

(Jill Decoy): Yes okay.

Dr. (Scott Lawrence): …together if it's related.

(Jill Decoy): Okay. Okay thank you.

Dr. (Scott Lawrence): Thank you.

Coordinator: Our next question comes from (Dale Gibson). Your line is open.

(Dale Gibson): Yes, I just wanted make sure this is only PPS hospitals, it does not impact critical access hospitals?

Dr. (Scott Lawrence): That's correct. This is outpatient department only.

Coordinator: And are you ready for your next question?

Dr. (Scott Lawrence): Yes, please.

Coordinator: The next one comes from (Ema Bender). Your line is open.

(Ema Bender): Yes, hi. Thank you for taking my call. I have a couple questions. Just to confirm the issues do not apply to any managed care plans unless they develop their own requirements. Is that correct?

Dr. (Scott Lawrence): This plan is – thank you (Ema). This plan is specific to the Medicare Fee-for-Service Program.

(Ema Bender): Okay. And then for the dual eligible patients so if we get a denial, you know, from Medicare saying it's not covered or, you know, one of those noncovered decisions does that claim is eligible then to be submitted to secondary payer. So let's if they should have Medicaid or commercial payer if Medicare denies we can go to the next payer that the patient might have?

Dr. (Scott Lawrence): Yes. The non-affirmation decision is sufficient to meet those obligations.

(Ema Bender): And the last question I have for the cases where if we don't - the election that there's no authorization submitted are we allowed to do a retro authorization or basically we would have to go through the denial process to resolve the case?

Dr. (Scott Lawrence): So, if I understand your question correctly...

((Crosstalk))

Dr. (Scott Lawrence): ...you're saying that, if a claim was submitted without a request and was then denied, what do you do at that point? Is that the question?

(Ema Bender): Yes, yes.

Dr. (Scott Lawrence): Right. So you can start over with a new request. I guess something slipped through the cracks accidentally, but you'll get denied for that. So we would hope you would submit another request. You could appeal the denial and fight it that way, but, as we describe before in an earlier question, that's a much longer more expensive process for all parties involved.

(Ema Bender): So if we for some reason had a claim where it slipped through the cracks or maybe it's one of those scenarios where we authorized one code and the, you know, that the patient ended up with another code we can still go and try to do a prior authorization process first even though the case was already done instead of doing the actual process of getting the denial and then getting the appeal process going?

Dr. (Scott Lawrence): Yes, the ideal scenario, of course, is to try and get it done before the procedure is performed.

(Ema Bender): Right.

Dr. (Scott Lawrence): But, you can still submit the request and wait to get the affirmation UTN to then attach to your claim to get it through to get it paid.

(Ema Bender): And the last question I have you mentioned that it affects other providers. So if you're doing the surgery usually there's going to be an anesthesiologist and there's going to be a facility fee. So if the hospital submits authorization request and just your UTN number does anesthesiologist for example if they're submitting their claim do they need to get their own number or they can basically just attach as long as we got our authorization all their claims will get paid as well?

Dr. (Scott Lawrence): Yes, only the hospital outpatient department claim will require the UTN number to be submitted with – attached to the claim or submitted within the claim. All the associated services will be able to bill and they will be tied together. They will be related.

(Ema Bender): So the system will know yes this was authorized to anybody else attaching their portion of the charges or claims so that visit will get paid as long as that (auth) is on the claim?

Dr. (Scott Lawrence): The system is supposed to know, yes.

(Ema Bender): Okay all right. Thank you.

Dr. (Scott Lawrence): Thank you.

Coordinator: Our next question comes from (Barbara Zimmer). Your line is open.

(Barbara Zimmer): Hi. Thanks for taking my call. I have a couple of quick billing questions. I'm looking at the Operational Guide and it says that the UTN needs to be in positions one through 18. Do you have the loop and segment for that for the electronic claim? And then the second question is it says here that the UTN is

14 bytes. Is that all numeric or is it alphanumeric?

Dr. (Scott Lawrence): I'm going to ask one of our friends at Palmetto to help with this technical question, please.

Man 1: Okay to answer to the second piece it should be alphanumeric. And can you repeat your first question again for me?

(Barbara Zimmer): Sure. The operational guide just says that the UTN just needs to be in positions one through 18 but it doesn't give the loop in segment for the 8307I. So for the electronic claim do you have the loop and segment where this - the number needs to be reported?

Man 1: Okay off the top of my head I cannot think of it. We can get that information to make sure we publish it somewhere so everybody will know but I can't think of it off the top of my head.

(Barbara Zimmer): Okay. Yes that would be great if you could maybe put it in the Frequently Asked Questions document.

Dr. (Scott Lawrence): Additionally (this is Dr. (Lawrence) again from CMS) Additionally you can probably reach out to your MAC and they'll be able to help you with some of those details.

(Barbara Zimmer): Thank you.

Dr. (Scott Lawrence): Thank you. Next question.

Coordinator: Our next question comes from (Catherine French). Your line is open.

(Catherine French): Hi. Thanks for taking my call. This was a great presentation. We learned a lot today. I just wanted to clarify that on Slide 7 I believe you are asking for provider information as part of the prior authorization request. And if no information is going to be sent back to the provider the physician the practitioner about this authorization process is that necessarily going to be something that's required or is that just a nice to know?

(Amy): Hi. This is (Amy). Do you mean on Slide 7 where we say the physician practitioners name?

(Catherine French): Yes.

(Amy): Okay all right just to clarifying because I think a lot of us use the, you know, facility provider hospital practitioner some of those terms interchangeably. And they have really specific names, you know, when we're talking about what is – what's billed and what's not. That information is still needed.

(Catherine French): Okay thank you.

Coordinator: Our next question comes from (Anthony Ledino). Your line is open.

(Anthony Ledino): Thank you, appreciate you taking the questions. I have a little bit of concern we're – I'm one of the supervisors for the pre-cert department for one of the largest neurology services in the United States. And we do a lot of these Botox injections for neurological function.

And we do use those J codes quite a bit. My question is, is when my team gets a pre-cert typically for these Botox injections a lot of our patients are repeat patients and we see a volume of anywhere from 300 to 400 a month for just Botox from peds to adults.

And so what were concerned about is when we get these pre-certs for these J codes based off diagnosis codes, say we meet all the guidelines and it's approved are we going to meet the FDA guidelines? Are you going to allow the approval to be good for a year for 100 - like for migraines FDA guidelines is 155 units every 12 weeks or are we going to have to pre-CERT every time this patient comes in? Because a lot of our patients are on a schedule. A lot are cerebral palsy patients. We have a lot of Syria injections, dystonia, migraines -- things of that nature.

And so there's a little bit of concern just for us for pure volume process if that makes sense. Is this something that for every visit or is that UTN going to take the place of that authorization number and be good for the let's say the 12 visits, the 155 units for the 12 visits or every 12 weeks I'm sorry for the year?

Dr. (Scott Lawrence): Thanks (Anthony). That's an excellent question. The prior authorization, once you receive that decision, is valid for 120 days. So, we recognize for the chronic migraine with the botulinum injection procedures that there are the 12-week dosage windows.

But, we don't - to the best of our knowledge, it doesn't go on forever, so you would have to recertify, you know, reapprove that they would still be needed over time. So, each one is valid for 120 days. You would need to redo them. And, again, this is just for those services that are performed in the hospital outpatient department setting.

(Anthony Ledino): Correct. And I assume when they are performed in the inpatient setting there will be no need for the patient that we have the common through the ED or through the ICU. I – that's at least that's my assumption correct?

Dr. (Scott Lawrence): Yes, it's just the hospital outpatient department setting.

(Anthony Ledino): Okay. And then another question is, is the UTN is essentially taking the place of the authorization number, is that correct?

Dr. (Scott Lawrence): It would act as the decision code. So, I am going to say "yes." So, this is like language of different programs and things like that?

(Anthony Ledino): Correct.

Dr. (Scott Lawrence): But, when you send in your prior authorization request, the decision is tied to this UTN, if affirmative or non-affirmative. And then, when you send it in, our system is designed to recognize that decision through this code so your claim could be paid or stopped.

(Anthony Ledino): Okay. And then another quick question on the J codes looking at the J codes one of them is one that we used for mild block which is the botulism. I think it's the B if I'm not correct if it's not right in front of me. But we also do the mild block for the Syria and one of those J codes matches.

In the past we've had a little bit of issues with getting those approved. What and I assume my best route would be to go through the MAC to see what the guidelines are because we'd like to be prepped. I mean we have over 100 and 100 to 150 providers that do these injections. So it's definitely something that I want to be prepped for and get the information to my physician so they meet those guidelines.

Dr. (Scott Lawrence): Certainly, and another excellent question. So, to be clear, in the botulinum toxin injection category, those J codes would have to tie specifically to one of those two CPT codes. So, if you're using one of those J codes for botulinum

toxin injections somewhere else in the body for another purpose, they are not part of this program. So…

((Crosstalk))

(Anthony Ledino): Okay that clarifies a lot.

Dr. (Scott Lawrence): Yes.

(Anthony Ledino): So they just - those J codes have to be tied to the CPT codes correct?

Dr. (Scott Lawrence): Exactly. So it will be some combination of one of those J codes with one of those CPT codes, and that is what the program is designed for.

(Anthony Ledino): Okay.

Dr. (Scott Lawrence): So, we're not trying to capture every incident of botulinum toxin injections or of those codes necessarily, just when they work in combination.

(Anthony Ledino): Okay so that answers a lot and that takes a lot off my plate. I appreciate the clarification for that dock.

Dr. (Scott Lawrence): No, thank you. It was a good question, and I'm glad to have had the opportunity to clear it up.

Coordinator: Next we'll go to (Linda Hogle). Your line is open. (Linda) you want to check your mute button please? Okay we can move on to the next person. (Steven Rawlings). Your line is open.

(Steven Rawlings): Thank you. I have two questions. My first question has to do with the

place of service. I see on Slide 4 this clearly for outpatient department but trying to confirm the code. Would that be limited to site and service 19 and 22 or are there any other service calls that would be included in that?

Dr. (Scott Lawrence): And, I'm sorry I am going to ask you to repeat that question again. I got distracted slightly in the middle of your question, and I apologize for that.

(Steven Rawlings): No worries, no worries. So Slide 4 specifies that this is for outpatient departments only. I just wanted to clarify that the codes are not provided is that for services 19 and 22? Are there any other codes that would be included in OPD?

Dr. (Scott Lawrence): The type of bill would be 13 X. So as long as it were in that 13 X outpatient department setting that's what we're working on for this program.

(Amy): This is (Amy). I…

(Steven Rawlings): Okay.

(Amy): …just was able - while (Scott) was talking I was able to pull up the place of service list and…

(Steven Rawlings): Okay.

(Amy): …you're correct. It's 19 - place of service 19 which is off-campus outpatient hospital department and 22 which is on-campus hospital outpatient department.

(Steven Rawlings): Okay perfect. And so anything outside of those two would not require this. And then my second question pertains to Slide 9. It makes clear that the

request could to be mailed, faxed or electronically. And for requests that were submitted through mail or through fax to questions I guess are tied to that.

(Steven Rawlings): One, can we call the MACs directly for a decision or is the response only going to be provided through mail or fax? And then also related to that question then would be would is a third-party calling at the request of the provider were to call and check on the status would you reveal the results to a third party?

(Amy): This is (Amy). That's a good question and we might want to clarify with our (MACs) some of the processes. You know, if it's a third-party as in, you know, a biller that would normally be allowed to, you know, discuss those types of, you know, billing and claim type situations then that's probably okay. I think it's hard to, you know, give a firm answer for every scenario here.

I think that was the second part of your question. The first part of your question if you are, you know, mailing or faxing the prior authorization request we - I think we would really appreciate just waiting for the MAC to provide the written response, you know, within that timeframe instead of calling and requesting that. Because it's likely if, you know, you haven't received some sort of decision that it's probably likely that it hasn't been rendered yet.

So if timing is a little bit of a concern then we would encourage you to use, you know, something other than the mail in order to get those decisions more quickly.

(Steven Rawlings): Okay thank you. And another (unintelligible) tied to that too then would be in terms of whether or not a call to the MAC can be made and whether or

not the MAC would provide information to a third party will that vary from MAC to MAC or is there a standard there?

(Amy): Calls to the MAC, you know, are definitely encouraged and welcome. They have, you know, customer service departments they can answer those questions. So, you know, just the act of calling and, you know, getting answers should not vary from MAC to MAC.

I just didn't want to say, you know, without knowing who the particular third-party is you're referring to and if they are, you know, on – if they already have a relationship with the MAC or the MAC knows that, you know, for your particular facility this third-party is allowed to receive information, you know, I think it's hard to know those details just from this question. So…

(Steven Rawlings): Right.

(Amy): …You know, it could potentially vary from MAC to MAC and obviously depending on what the relationship with the third-party is.

(Steven Rawlings): Right okay. Yes, and ultimately, I can say that for a third party that provides reimbursement services at the request of provider's offices and with patient consent those I guess the three pieces that…

(Amy): Right.

(Steven Rawlings): …are most relative.

(Amy): Yes, typically those situations are okay but definitely, you know, discuss with your MAC. And if there is, you know, some authorization or a form or something that, you know, might need to be signed but typically those things

are okay.

(Steven Rawlings): Okay wonderful. Thank you.

(Amy): Sure.

Woman: (Amber) we'll take one more question please.

Coordinator: Okay. This question comes from (Patricia Henry). Your line is open.

(Patricia Henry): Hi. Thank you for taking my call. Actually most of my questions have been answered. It's been great. But I do there is something wrong with my computer and they have been trying to work on it so I don't have access to the slides right now.

So I wanted to make sure that I someone could give me the fax number for the preauthorization so I could submit the request. And I'm assuming - I work for a plastic surgery and we also do a lot of breast reduction. And since that's not on the list that's not something will have to get authorization for is that correct?

Dr. (Scott Lawrence): That is correct.

(Patricia Henry): Okay. All right I'm really, really, really glad that we're doing the blepharoplasty and the redundant skin, the abdominal plasty for (cholecyestectomy), because there are - I have so many patients that come in the know how to kind of work the system and once they sign the waiver, you know, we have to oblige and let them proceed knowing that it's not going to be covered. So this is great. I'm so happy for this process this is great.

Dr. (Scott Lawrence): And, we appreciate that.

(Patricia Henry): Thank you.

Dr. (Scott Lawrence): Write us a letter so we can share the good news.

(Patricia Henry): I absolutely will. It's fantastic. But is there anyone there that would be able to give me the fax number for the preauthorization line?

Dr. (Scott Lawrence): Do you know how to contact your MAC?

(Patricia Henry): I do not because we're in the Kentucky clinic so we're in a clinic. But we're hospital-based so the hospital is across the street. And our billing department is not even located anywhere near us it's on the other part of town. So I'm guessing is through our Kentucky medical services maybe? I don't know.

Dr. (Scott Lawrence): In Kentucky?

(Patricia Henry): Yes.

Dr. (Scott Lawrence): Does someone have the – I don't have the map in front of me of which MAC is Kentucky.

Man: That would be CGS.

Dr. (Scott Lawrence): CGS. so I think the CGS Web site is CGS - might be cgs.gov or cgsmedicare.gov or.com, rather, CGS.com or cgsmedicare.com and they will be able to give you all the information you need to send the stuff in.

(Patricia Henry): Okay great. All right thank you so much.

Dr. (Scott Lawrence): Thank you. So, I believe we are out of…

(Jill): Okay.

Dr. (Scott Lawrence): … time for more questions. Is that correct?

(Jill): Yes, we are at the 3 o'clock timeframe. So (Scott) you may give your closing remarks.

Dr. (Scott Lawrence): Thank you (Jill). So, I'd like to thank everybody for participating. It was an excellent series of questions. I'm sorry for any of those questions we were not able to get to, but hopefully your question was answered by someone else's question.

If you have more questions, please email us at our question box op - opdpa, (outpatient department prior authorization) at cms.hhs.gov (opdpa@cms.hhs.gov) or send a note to your local MAC.

And, again, we hope that everyone is safe out there, and thank you so much for your time. We look forward to this being a very successful program as we do with all our programs. Thanks for the feedback and the questions, and enjoy the rest of your afternoon. Thank you.

Coordinator: Thank you for that concludes today's conference. Thank you for participating. You may now disconnect.

End