Questions and Answers from Special Open Door Forum: Prior Authorization Process and Requirements for Certain Outpatient Hospital Department Services, May 28, 2020

1. 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.
    a. 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.
        i. Physician claims being automatically denied when the hospital claim is denied.
            1. 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.
2. 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.
    a. 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 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.
3. 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?
    a. Yes. The billing address would be the address.

4. 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.
    a. 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. Hospital outpatient department, in this case, there shouldn't be any communication, you know, that's not, 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. 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." 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.
        i. 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?
            1. 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'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.
                i. So in your update use or guidance, do you think you could suggest what some of those various options are? 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.

   a. 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? 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, 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 could make an announcement to their staff for these services. They're going to need to do this process, and they'll need to submit the documentation in a timely way.

5. I work for a physician that we also do some outpatient services here at our facility. 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?
   a. If you're not in an outpatient department setting, then this program is not directed toward you.
6. This is not applicable to an ambulatory surgery setting, correct?
   a. Yes, that's correct.
7. 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?
   a. 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.
8. 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.
   a. 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 specifically saying the hospital outpatient departments. Always good to document your stuff.
9. 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?
   a. 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.

10. My question is related more to the vein ablations. It says that we need to use a tracking number on our claim. Do you suggest putting that in a treatment authorization line?
    a. 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. I believe it's consistent with 1 through 18. And that will come into our (FISS system) for processing.
        i. Right now I have a lot of Medicare replacements that do not require an authorization. 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?
            1. I don't think we can speak specifically to what their requirements are going to be.
11. 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.
    a. We definitely have 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.
12. 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 the fax number? How do we get access to the MAC portal, etcetera?
    a. There is 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. It should have the mailing address and 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. We also have an email box which is OPDPA@CMS.HHS.Gov. And if you send us your name, your state, and the MAC that you submit your claims to, we can definitely get you in touch.
13. We are a physician practice that is hospital-owned. And we are considered an outpatient clinic of the hospital. Would we meet the criteria to have to submit a PA, or would this exclude us because we are a physician practice?
    a. If you submit, you know, an OPPS claim on a 13 X type of bill, then you will be included. 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.
14. Can you clarify who should be getting the authorization? 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.

a. 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.
    i. The whole service getting the authorization and that authorization will cover both the hospital and the provider of services?
        1. Yes. The prior authorization is really for billing. So it matches up to claims that are submitted for payment for that service. 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.
            a. Does the authorization number also have to be on the provider's claim, as well as the hospital claim?
                i. It would just go onto the hospital claim.

15. 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?
    a. The guidance for each specific procedure would be followed on the LCDs in the MAC or also in any other guidance that we have. 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.
        i. 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?
            1. If his Virginia office is an outpatient department setting and the bill is 13 X, then yes. However, if you're just doing it through some sort of different arrangement, and he's not an outpatient department, then no.
                a. The UTN number once the decision is made that will become the authorization number?
                    i. 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.
                        1. 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?

a. It would still have the same requirement that it has now.

16. I just wanted make sure this is only PPS hospitals, it does not impact critical access hospitals?
    a. That's correct. This is outpatient department only.
17. Just to confirm the issues do not apply to any managed care plans unless they develop their own requirements. Is that correct?
    a. This plan is specific to the Medicare Fee-for-Service Program.
        i. 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?
            1. Yes. The non-affirmation decision is sufficient to meet those obligations.
                a. 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?
                    i. 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.
18. 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?
    a. 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.
19. 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?
    a. Just to clarify, because I think a lot of us use the facility provider hospital practitioner, some of those terms interchangeably. And they have really specific names, when we're talking about what is – what's billed and what's not. That information is still needed.
20. 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.

a. 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. we don't - to the best of our knowledge, it doesn't go on forever, so you would have to recertify, 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.
    i. Is the UTN is essentially taking the place of the authorization number, is that correct?
        1. It would act as the decision code. 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.
            a. 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. 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 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.
                i. 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.

21. For the outpatient department, been 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?
    a. 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.
        i. 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?
            1. We might want to clarify with our (MACs) with some of the processes. If it's a third-party, a biller that would normally be allowed to discuss those types of billing and claim type situations then that's probably okay. I think it's hard to give a firm answer for every scenario here. Mailing or faxing the prior authorization request we I think we would really appreciate just waiting for the MAC to provide the written response, within that timeframe instead of calling and requesting that. Because it's likely if you haven't received some sort of decision that it's probably likely that it hasn't been rendered yet.
22. 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?
    a. That is correct.