

# Mastering Utilization Review and Patient Status

a NAHRI virtual event 

## Breaking Down Prior Authorization Requirements for OPPS Departments

**Kimberly A. Hoy, JD, CPC**

*Director of Medicare and Compliance*

HCPPro, a division of Simplify Compliance

Livingston, MT



1



## Presented By



- **Kimberly A. Hoy, JD, CPC**

Kimberly is the Director of Medicare and Compliance for HCPPro, Inc. She oversees HCPPro's Medicare Boot Camps® and is the lead instructor for HCPPro's Medicare Boot Camp® – Hospital Version and Utilization Review Version and an instructor for the Medicare Boot Camp® - Critical Access Hospital Version, Rural Health Clinic Version and Provider-Based Department Version. Kimberly serves as a Regulatory Specialist for HCPPro's Medicare Watchdog services, specializing in regulatory guidance on coverage, billing and reimbursement. She is a former hospital compliance officer and in-house legal counsel and has over 25 years of healthcare experience, including 15 years of experience teaching, speaking and writing about Medicare coverage, payment, and coding regulations. She is a frequent expert on HCPPro's webinars and has been a speaker at national conferences on patient status and observation.

2

2

## Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Indicate three services that require prior authorization as a condition of payment
  - Differentiate between when an Advance Beneficiary Notice of Noncoverage (ABN) is required and not required for services that receive a non-affirmation
  - Describe the exemption process and what it means for hospitals that qualify

3

3

## Agenda

- Medicare Fee-for-Service Prior Authorization Details
  - Where and when are they required
  - What services
- The Process
  - Submission of prior authorization requests (PAR)
  - What to do about 'non-affirmations', including providing ABNs
- Exemption Process
  - What it means for providers and patients
  - New timeline starting 2022

4

4

# Mastering Utilization Review and Patient Status

a NAHRI virtual event



## Medicare Fee-For-Service Prior Authorization Details

---



5



## Prior Authorization Program Overview

- Regulation first adopted in the calendar year (CY) 2020 Outpatient Prospective Payment System (OPPS) final rule
  - Made prior authorization a condition of payment for certain services
  - Prior authorizations required as of 7/1/20 – CMS declined to extend due to COVID
- New services were added in the CY2021 OPPS final rule
- No new services for CY2022
- Caution: much of the guidance is sub-regulatory

6

6

## Prior Authorization Program Overview

- Sources of Guidance
  - Regulations at 42 CFR 419.80-83: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-419/subpart-I>
  - Operational Guide: <https://www.cms.gov/files/document/opd-operational-guide.pdf>
    - Most recently updated December 27, 2021
  - FAQs: <https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf>
    - Most recently updated December 27, 2021

7

7

## Prior Authorization: Where And When It Applies

- Applies only to services provided in hospital outpatient departments and related professional services (although CMS has not issued denials for physician services)
  - Does not apply to critical access hospitals (CAH), Veterans Affairs (VA) hospitals, or Indian Health Services (IHS) hospitals
  - Does not include procedures performed at ambulatory surgical centers (ASC) or freestanding physician offices
- Certain claims are exempt
  - Medicare Advantage claims (including IME only claims) – they are responsible for their own utilization plan for these procedures
  - Part A/B rebilling claims (presumably 12X claims with condition code W2)
  - Emergency department claims with modifier ET or revenue code 45X
  - Part A or Part B demonstration claims

8

8

## Prior Authorization: What Services

Procedures requiring prior authorization as of July 1, 2020:

- Blepharoplasty, blepharoptosis repair, and brow ptosis repair
  - Effective 1/7/22 removed 67911 (correction of lid retraction) from blepharoplasty list
- Rhinoplasty and related services
- Panniculectomy, excision of excess skin and subcutaneous tissue (including lipectomy), and related services
- Vein ablation, and related services
- Botulinum toxin injections
  - Limited to botulinum toxin in conjunction with two codes related to injections in the face and neck only

9

9

## Prior Authorization: What Services

Procedures requiring prior authorization as of July 1, 2021:

- Cervical fusion with disc removal
- Implantable spinal neurostimulators
  - Codes 63685 and 63688 were originally included and then excluded from the requirement
  - The same PAR may be used for both the trial and permanent implantation

10

10

# Mastering Utilization Review and Patient Status

a NAHRI virtual event



## The Process



11



## Submitting The Prior Authorization Request (PAR)

- Payment impact only applies to hospital claims at this point... SO
  - Effectively the hospital must submit the PAR
  - CMS does allow for physician to submit the PAR – but no incentive to do so
- PARs are submitted through portal on the MAC website
  - Must be submitted prior to providing the service
  - Must submit all documentation demonstrating coverage is met – more on documentation below
- Normal response time should be 10 days
  - Can request decision in two business days if delay may jeopardize the beneficiary's life, health, or ability to regain maximum function

12

12

## Submitting the Prior Authorization Request (PAR)

- CMS published general documentation guidelines in the Operational Guide
  - Each procedure has a separate section outlining general documentation requirements
- Local Coverage Determinations (KCD) and Local Coverage Articles
  - Most services have LCDs and/or “Billing and Coding” articles
  - Requirements vary widely – KNOW YOUR LOCAL POLICY

13

13

## Submitting the Prior Authorization Request (PAR)

Two results:

- Provisional affirmation
  - Decision letter with Unique Tracking Number (UTN) used for claims submission
    - Patient also receives a decision letter
  - Good for 120 days
  - Does not guarantee coverage – CMS reserves the right for MACs to later deny claims for failure to meet technical requirements
- Provisional non-affirmation
  - MAC issues detailed decision letter, including any missing or noncompliant documentation in the original request
  - Provider can resubmit the PAR an unlimited number of times to correct errors or omissions
    - 10-day response time for each additional request
  - Not considered “determination” so decision is not appealable

14

14

## What To Do About a “Non-affirmation”

- Option 1
  - Service is medically necessary – resubmit request with additional documentation as noted on the decision letter
- Option 2
  - Service is not medically necessary – issue an ABN to transfer liability to the patient
    - Submit claim with –GA modifier
    - NOTE: Claims submitted with the –GA modifier that do not have a non-affirmation on file are suspended, documentation is requested, and review of the validity of the ABN is performed
- Option 3
  - Service is cosmetic/excluded from coverage – PAR and ABN is optional, ABN “encouraged”
    - Submit claim with –GZ modifier
    - Unclear if these services will be suspended for review – some places note just claims flagged as having an ABN

15

15

## Claims Denials

- Claims submitted without UTN (or UTN for non-affirmation) for HCPCS codes on the prior authorization list are automatically denied
  - Any claims associated/related services will (should) also be denied
    - Includes physician’s services (e.g., anesthesiologist, surgeon)
      - Currently no system edits, unclear how they would identify without manual review
    - CMS has published a list of related services in the Operational Guide
      - But unclear how the list was developed – some service clearly more extensive/unrelated
- Denials for claims submitted without UTN are appealable denials
  - CMS has instructed contractors to only determine if a prior authorization was obtained, and if not deny the claim, even if the services would otherwise be covered and payable

16

16



## What About Other Insurance

- Medicare Primary
  - Medically necessary (under Medicare policies) – obtain PA and bill to Medicare for payment
  - Not medically necessary (under Medicare policies), covered by other insurance
    - Obtain non-affirmation
    - Provide ABN to the patient
    - Bill to Medicare with the non-affirmation UTN and GA modifier
    - Obtain denial from Medicare for submission to other insurance
      - Remember if no ABN is issued and Medicare denies, liability will be assigned to the provider and not to the patient – can't bill other insurer, even if they would otherwise pay
      - Also remember that if ABN is provided and claim submitted with the –GA modifier, the claim will likely be stopped for review
  - Service is excluded from Medicare benefits because it is purely cosmetic
    - No requirement to bill Medicare first before billing the patient/other payer – use caution

17

17

## What About Other Insurance

- Medicare Secondary
  - Medically necessary (under Medicare policies)
    - Obtain provisional affirmation
    - Bill to other insurance as primary payer
    - If denied, bill to Medicare for payment
  - Not medically necessary (under Medicare policies)
    - Obtain non-affirmation
    - Provide ABN to the patient
    - Bill to other insurance as primary payer
    - If denied, bill to Medicare for denial with –GA modifier
      - Remember this will likely cause manual review of claim
    - Bill to the patient
  - Service is excluded from Medicare benefits because it is purely cosmetic
    - Billing to Medicare is optional, check other insurance requirements

18

18

# Mastering Utilization Review and Patient Status

a NAHRI virtual event



## Exemption Process



19



## Prior Authorization Exemption

### Exemption from the prior authorization process

- Typical prior authorization programs focus on each individual patient and whether they require the procedure – i.e., utilization controls
- This program focuses on the compliance of the provider with documentation requirements (which show the patient requires the procedure) – i.e., a compliance initiative
  - If the provider shows compliance with documentation requirements they do not have to continue to submit PARs
    - Odd because the regulation makes the PA a condition of payment, but then CMS is waiving the condition of payment for providers that demonstrate compliance
  - Exemption applies across all seven categories – whether or not a service from a particular category was reviewed for compliance

20

20

## Prior Authorization Exemption

### Exemption from the prior authorization process

- In 2021, the exemption process was on an approximate 6-month cycle
- Starting in 2022, CMS announced the exemption process would transition to an annual process corresponding with the calendar year
  - Providers with an exemption in 2021 will have 10 claims from the period they were exempt reviewed to determine their continued exemption in 2022
- Requirements starting in 2022 (for exemption in 2023)
  - Provider must have 10 claims submitted by June 30th to be considered for exemption
  - Providers must maintain a 90% affirmation rate
  - The affirmation rate is calculated across all seven categories of services combined
  - Reviews to start approximately August 1 (?)
    - Provider have 45 days to submit documentation, MACs have 45 days to do their review

21

21

## Prior Authorization Exemption

### Exemption from the prior authorization process

- October the MAC calculates the compliance rate and notifies the providers with affirmation rates of at least 90%
  - Notice of exemption or withdrawal of exemption must be provided at least 60 days prior to the effective date of the change (i.e., by November 2, 2022)
  - Providers who lost their exemption can begin submitting PARs by December 18 for services starting January 1, 2023
  - Providers with an exemption should not submit PARs starting January 1, 2023 and PARs from exempt providers will be rejected
- Providers may opt out no later than November 30
  - If the provider opts out they are required to continue to submit PARs

22

22

# Mastering Utilization Review and Patient Status

a NAHRI virtual event



**Thank you!**

[khoy@hcpro.com](mailto:khoy@hcpro.com)

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.

