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As Prior Auth Gets Underway, Hospitals Will Have Several Chances for Claims Approval

By Nina Youngstrom

Starting July 1, hospitals are required to ask Medicare for prior authorization for five outpatient procedures, but there's no such thing as flat-out rejection. If the answer is "no," hospitals can keep asking Medicare to approve payment, assuming there's documentation of medical necessity somewhere. When they hit a dead end, hospitals still have appeal rights. But prior authorization is not always a guarantee they will hold onto their payment forever. If hospitals are suspected of gaming the system, they may be audited on the back end by CMS's program integrity contractors.

"While the procedures that will require prior authorization represent only 0.188% of CMS outpatient spending on procedures, CMS feels that the amount spent on them has increased over the past 10 years out of proportion to the average increase across all procedures," said Ronald Hirsch, M.D., vice president of R1 RCM, at a June 4 webinar sponsored by RACmonitor.com. "They all also precariously straddle the line between medical necessity and cosmetic indications."

The prior authorization process,[1] which was announced in the 2020 Outpatient Prospective Payment System/Ambulatory Surgical Center final rule,[2] is in the hands of Medicare administrative contractors (MACs). It's starting with five procedures—blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation—but hospitals should brace for an expansion of prior authorization to other procedures, Hirsch said. Hospitals are required to get MAC approval for the surgeries before submitting claims. The process only applies to fee-for-service Medicare for procedures performed at hospital outpatient departments (type of bill 13x), although CMS may eventually add ambulatory surgery centers, he said.

Without prior authorization, Medicare will deny claims for the procedure and "any claims associated with or related to a service that requires prior authorization," the Outpatient Prospective Payment System rule stated. That includes the professional fees for the surgeon, radiologist, pathologist and anesthesiologist. On educational calls, the MACs seem indifferent to this idea, but during a May 28 open-door forum, a CMS official said physicians would lose payment for procedures that didn't get a green light, Hirsch noted.

There's a lot to digest about the prior authorization process, and Hirsch expects changes over time. "Many of the MACs have limited information, so you can expect more from them," he said. The fundamentals are the same because it's a national program, but there are variations among the MACs, partly because the local coverage determinations (LCDs) for some of the procedures aren't identical.

Affirmation: The New Word to Know

Before surgery, hospitals submit a prior authorization request to the MACs, which spit out a unique tracking number (UTN) that's valid for 120 days. One of three (or more) things happen next:

- The MAC gives hospitals an affirmation, which means the claim will probably be covered. "A provisional

affirmation decision is a preliminary finding that a future claim submitted to Medicare for the item or service likely meets Medicare's coverage, coding, and payment requirements," CMS said in answers to frequently asked questions[3] about prior authorization.

- The MAC turns hospitals down with a non-affirmation decision, because the claim doesn't meet coverage, coding or payment requirements. However, hospitals keep requesting prior authorization for the same procedure until hopefully it's approved. "They are giving you a mulligan," Hirsch said. "Get more information from the doctor or pictures and send it in." Non-affirmations are not denials with appeal rights. If hospitals are unable to satisfy the MAC, that's the end of it, sort of. Hospitals can still perform the procedure, submit the claim, get a denial and appeal the usual way.
- MACs may give hospitals a provisional partial affirmation decision, which "means that one or more service(s) on the request received a provisional affirmation decision and one or more service(s) received a non-affirmation decision," the FAQs state.

MACs will start taking prior authorization requests June 17. They have 10 business days from the date they received the request to affirm or not. Hospitals also have the option to seek expedited reviews of two days "if the standard timeframe for making a decision could seriously jeopardize the life or health of the beneficiary," according to the FAQs.

A bunch of information about the hospital, beneficiary, physician and procedure must be provided on prior authorization requests, Hirsch said. That includes details about the anticipated date of service, HCPCS code, paired codes for botulinum toxin injections, diagnosis code(s), the start date of the authorization, state (location) of authorization and units of service, although this varies a bit by MAC. There's no CMS request form, although some MACs have developed their own. Not all auto-populate, so hospitals may have to start fresh every time, he said. The requests can be submitted by mail, fax, the electronic submission of medical documentation (if the MAC allows this) and the Secure Provider Online Tool.

Although hospitals bear the burden, "you obviously need physicians to cooperate" and produce documentation for medical necessity,[4] Hirsch said. "Medicare has nothing in place to force them to do that," although the Outpatient Prospective Payment System regulation makes it sound like they have skin in the game. It's unclear how this will play out, however, because physicians don't put the UTN on their claims, at least for now.

There are specific parameters around the procedures themselves. For example, prior authorization is only required for botulinum toxin injections of the face (CPT codes 64612 – one side of face and 64615 – both sides of face) if they're associated with J codes (J0585-J0588). As CMS said in response to a question from Hirsch, "A J-code will not require prior authorization on its own. It would need to be associated with one of the service codes."

And panniculectomy, which is excision of excess skin and subcutaneous tissue (including lipectomy), will require documentation of something more than skin hanging down after a patient's weight loss, Hirsch said. Surgery will be considered reconstructive when there's complicating factors, such as inability to walk normally or chronic pain, according to one LCD.

If hospitals are affirmed 90% of the time over six months, CMS will free them from prior authorization. But one physician in your hospital who is responsible for all the non-affirmations could keep the hospital on prior authorization indefinitely, Hirsch noted.

CMS said prior authorization is a condition of payment, "but in my mind it's not really a condition of payment because you could choose not to do prior authorization," Hirsch said. "You could get denied and appeal. It's a lot more work, but if the procedure is medically necessary, you could still get paid."

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1 CMS, "Prior Authorization for Certain Hospital Outpatient Department (OPD) Services," last modified June 2, 2020, http://go.cms.gov/OPD_PA.
2 Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, 84 Fed. Reg. 61,142 (November 12, 2019) .
3 CMS, "Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services: Frequently Asked Questions," accessed June 5, 2020, https://go.cms.gov/30nvB5N.
4 Nina Youngstrom, "CMS Prior Authorization Program: What Hospitals Need From the Physician's Office," *Report on Medicare Compliance* 29, no. 21 (June 8, 2020).