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How to Successfully Navigate the New Prior Authorization Process for Hospital Outpatient Departments

June 10, 2020
Webinar FAQ Document

1. **Question** – Is the provider or the facility responsible for initiating the prior authorization process?

   Answer – The provider is responsible for submitting the prior authorization request before the service is provided to the beneficiary and before the claim is submitted for processing. The Centers for Medicare & Medicaid Services (CMS) did note that physicians may complete the request on behalf of the provider.[1]

2. **Question** – What method will be used to alert the provider and the facility of the authorization number?

   Answer – Medicare Administrative Contractors (MACs) will send the requestor (the hospital outpatient department) and the patient a letter outlining their prior authorization decision, which will include the Unique Tracking Number (UTN), via the same method it was requested. MACs will have the option to send a copy of the decision to the requestor via fax if a valid fax number is provided, even if the submission is sent via mail.[2] Note that the physician will not automatically receive a copy of the decision but a copy may be requested by the physician.

3. **Question** – How can we get to the appropriate location on the MAC's portal and how do we find the correct fax numbers for the MACs?

   Answer – Please reference the PowerPoint presentation for this webinar. Contact information, including fax number and website URLs, are provided for each of the MACs.

4. **Question** – Does this apply only to the hospital outpatient departments or will this also apply to ambulatory surgery centers and procedures performed in a physician's office?

   Answer – At the current time, this new process applies only to certain services provided in a hospital outpatient department that are submitted on type of bill 13x. Other facilities such as physician's offices, critical access hospitals, ambulatory surgery centers, and providers who submit claims other than type of bill 13x are not required to submit preauthorization requests.[3] It should be noted that associated services,

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[1] OPD Prior Authorization Slides 05 28 2020, page 9, https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services (05/28/20)

[2] OPD Prior Authorization Slides 05 28 2020, page 12, https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services (05/28/20)

[3] Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs), pages 2-3, https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf

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including anesthesiology services, physician services, and related facility services, will also be denied if prior authorization is either not obtained or if the requestor receives a non-affirmation decision.

5. **Question** – Does the prior authorization process apply to critical access hospitals?

   Answer – At the current time, this new process applies only to certain services provided in a hospital outpatient department and submitted on type of bill 13x. Other facilities such as physician's offices, critical access hospitals, ambulatory surgery centers, and other providers who submit claims other than type of bill 13x are not required to submit preauthorization requests.[4]

6. **Question** – Does the prior authorization process apply to procedures performed at a provider-based clinic that submits claims using place of service code 22?

   Answer – At the current time, this new process applies only to certain services provided in a hospital outpatient department and submitted on type of bill 13x. Other facilities such as physician's offices, critical access hospitals, ambulatory surgery centers, and other providers who submit claims other than type of bill 13x are not required to submit preauthorization requests.[5]

7. **Question** – If the physician submits the request for prior authorization and receives the determination decision and the UTN, how will the facility be informed of the decision?

   Answer – Although a physician may complete a request on behalf of the provider, only the hospital outpatient department and the patient will automatically receive a copy of the decision letter.[6] The physician may request that a copy of the letter be provided to them, if desired.

8. **Question** – If we receive prior authorization for 50 units of Botox, and the physician actually uses 100 units of Botox, do we need to obtain a separate authorization for the additional 50 units?

   Answer – During the Open Door Forum call on May 28, 2020, CMS stated that they understand that physicians may provide different services due to unforeseen circumstances that arise during the performance of the procedure. The MACs will have some discretion as to how to handle differences between the preauthorization request that was affirmed and the claim submitted for payment. However, a separate preauthorization will not be required since these must be submitted prior to the service(s) being provided.

9. **Question** – During the Open Door Forum call on May 28, CMS advised that prior authorization is not required for all Botox injections, but that it would be required when one of the listed drugs is reported in conjunction with CPT codes 64612 or 64615. However, WPS advised us that prior authorization would be required when Botox was given for chronic anal fissure. Can you clarify which response is correct?

[4] Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs), pages 2-3, https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf
[5] Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs), pages 2-3, https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf
[6] Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services Frequently Asked Questions (FAQs), page 5, https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf

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Answer – The response from CMS is the correct one. Prior authorization for Botulinum Toxin codes J0585, J0586, J0587, or J0588 is required only when used in conjunction with one of the required injection codes: Current Procedural Terminology[7] (CPT®) code 64612, *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)*, or code 64615, *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)*. CMS has requested that misinformation being provided by any of the MACs be brought to their attention so that they can correct this as soon as possible.

10. **Question** – Will any other services eventually require prior authorization?

    Answer – CMS has not publicly stated that they will be expanding this program in the future. However, based upon past actions, it appears likely that expansion of this program will depend upon the perceived success of the initial results. CMS has stated that that they will likely expand the program to include other providers, such as ambulatory surgery centers, if they notice that the site of service for these procedures is shifting away from hospital outpatient departments to other providers.

11. **Question** – Can claim denials still be appealed with documentation to prove medical necessity if the hospital does not obtain prior authorization before the procedure is performed?

    Answer – The appeal process is not changing at this time. If the provider receives a non-affirmation decision or if the provider chooses not to seek preauthorization prior to performance of the service, the claim and claims for associated services will be denied, at which point all appeal rights are available.[8] More information regarding appeals can be found in the Medicare Claims Processing Manual, Chapter 29.

12. **Question** – Does Botox require prior authorization if used in bladder surgeries for a non-cosmetic reason?

    Answer – Prior authorization for Botulinum Toxin codes J0585, J0586, J0587, or J0588 is required only when used in conjunction with one of the required injection codes: CPT® code 64612, *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)*, or 64615, *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)*. Use of Botox in conjunction with procedure codes other than 64612 or 64615 will not require prior authorization under this program.[9]

13. **Question** – Will the authorization numbers be viewable on each MAC's website? If not, how can the facility access this information is they lose it?

    Answer – Each MAC will likely develop their own process for storing and retrieving the Unique Tracking Numbers for each preauthorization request. It will be necessary to contact your MAC to determine how best to recover this information in the event that it is misplaced. Contact information for each MAC can be found in the PowerPoint slides for this presentation.

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[7] CPT® is a registered trademark of the American Medical Association.

[9] OPD Prior Authorization Slides 05 28 2020, page 16, https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services (05/28/20)

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