Successfully Defending Outpatient Authorization Denials

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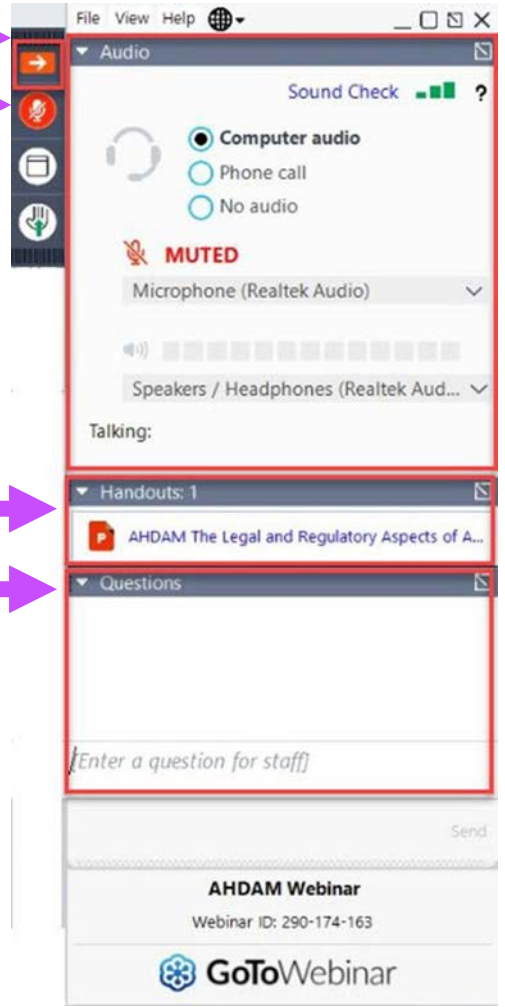

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- Our vision is to create an even playing field where patients and healthcare providers are successful in persuading medical insurers to make proper payment decisions.

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There are no conflicts of interest to declare for any individual in a position to control the content of this presentation.

Denise Wilson MS, RN, RRT

Senior Vice President, PayerWatch/AppealMasters; President, AHDAM

Denise has over thirty years of experience in healthcare, including clinical management, education, compliance, and appeal writing.

Denise has extensive experience as a Medical Appeals Expert and has personally managed hundreds of Medicare, Managed Medicare, and Commercial appeal cases and presented hundreds of cases at the Administrative Law Judge level. Denise is a nationally known speaker and dynamic educator on Medicare and Commercial appeals processes, payer behaviors, standards of care, appeal template development, and building a road map to drive the payer to a decision in the provider's favor. She has educated thousands of healthcare professionals around the country in successfully overturning healthcare denials.

Reggie Allen, MBA RN ACM

Chief of Clinical/Business Operations/PayerWatch

Reggie has more than 35 years of experience in a variety of healthcare positions, including staff nurse, nurse manager, Chief Nursing Officer, Chief Operating Officer, and Vice President, Clinical/Business Operations Transformation. He has been recognized nationally as an expert in care management and clinical operations. He is a results-driven leader who emphasizes operational transformation by integrating clinical and financial care aspects. He obtained a bachelor's degree in nursing from Vanderbilt University and an MBA from the University of Phoenix. He is a member of the American Case Management Association (ACMA) and the American College of Healthcare Executives.

Reggie possesses comprehensive knowledge and experience in all facets of care management, including case management, utilization management, disease management, quality management, and resource management. He has designed and implemented an enterprise-wide Clinical Appeals Unit and a clinical documentation program with success. Using six sigma and Lean principles, he is an expert in clinical and operational efficiencies that enhance clinical outcomes and financial performance through a variety of methodologies.

Preauthorization Meaning and Purpose

- Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.
- Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.
- Preauthorization isn’t a promise your health insurance or plan will cover the cost.

https://www.healthcare.gov/glossary/

Preauthorization Meaning and Purpose

- The preauthorization process is utilized by health plans to ensure:
  - Necessity of services – evidence-based care
  - Effectiveness and safety of services
  - Cost efficiency
- Cons:
  - Burdensome on providers
  - Delay in or non-coverage of services for patients

Preauthorization Meaning and Purpose

NEW!

- Managed Medicare: CFR 422.138(c) Prior Authorization
- "If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity…"

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#422.138

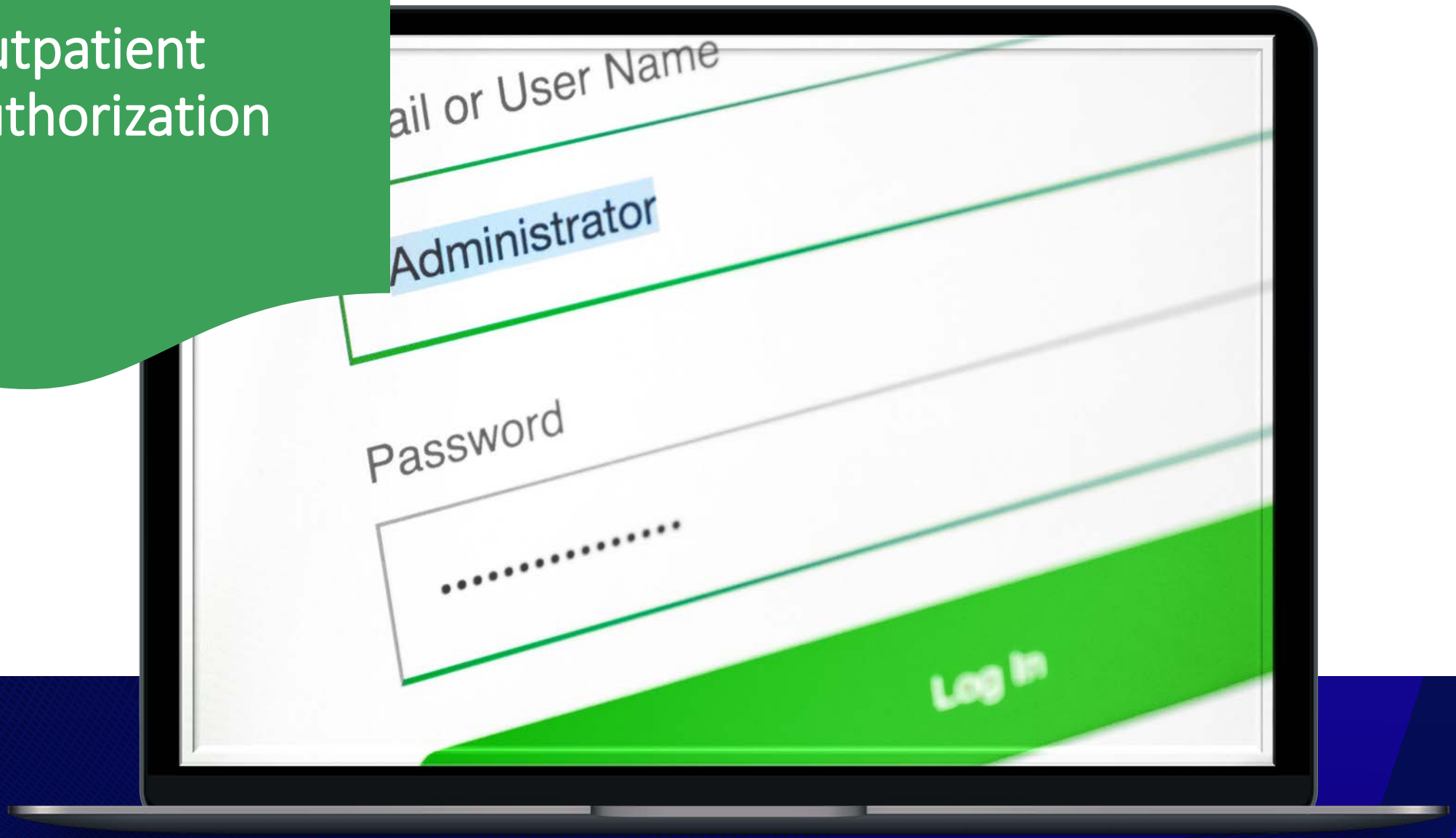
As compared to Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 10.16 – Medical Necessity:

"Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity (Program Integrity Manual, *chapter* 6, Section 6.1.3(A))"

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf

CURRENT

Outpatient Authorization



Outpatient Authorization Process Flow

- Work with the physician's office to get referrals and authorization a week in advance
- Develop a process for obtaining documentation from the physician's office where conservative treatment or other measures are required before the procedure can be performed (implants, cardiac, orthopedics)

Track Authorization Denial Causes

Reasons why denials are issued post-service for authorized care

- Medical documentation does not support medical necessity of the procedure/service
- Missing physician office notes
- Surgical note without good H&P
- Lack of authorization for ALL procedures that need to be completed

Need for teaming up OP CDI, coding, medical necessity specialists

Track Authorization Denial Causes

Reasons why denials are issued post-service for authorized care

- IP procedures should have been done as OP and vice versa
- Care provided not the same as care authorized – incidental procedure/service
- Outdated charge master – incorrect codes
- Authorization number not included on claim submission

CMS and Prior Authorization

CMS and Prior Authorization

Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services

- Only OPD services (does not include ED) require prior authorization as part of this program
- Review your Medicare Administrative Contractor policies
- Hospital OPD responsible for obtaining; MAC must respond in 10 days
- Prior authorization exemption available after demonstration of compliance with Medicare coverage, coding, and payment rules

https://www.cms.gov/files/document/opd-operational-guide.pdf

https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf

https://med.noridianmedicare.com/web/jfa/cert-reviews/pre-claim

CMS and Prior Authorization

July 1, 2020	July 1, 2021	July 1, 2023
Blepharoplasty	Implanted Spinal Neurostimulators	Facet Joint Interventions
Botulinum Toxin Injections	Cervical Fusion with Disc Removal	
Panniculectomy		
Rhinoplasty		
Vein ablation		

Full list of HCPCS codes requiring prior authorization: https://www.cms.gov/files/document/opd-services-require-prior-authorization.pdf

Prior Authorization Requirements

- For detailed prior authorization documentation requirements, the hospital OPD providers should refer to their MAC jurisdiction’s Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs), where applicable.
- To meet coverage criteria, the patient's medical record must contain documentation that fully supports the medical necessity for services

CMS Proposed Rule on Prior Authorization

Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule CMS-0057-P

New proposed requirements for:

- Medicare Advantage (MA)
- State Medicaid and CHIP Fee-for-Service (FFS) programs
- Medicaid managed care plans
- Children's Health Insurance Program (CHIP) managed care entities,
- Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs)

CMS Proposed Rule on Prior Authorization

New proposed requirements (to start January 1, 2026):

- adopt the electronic prior authorization processes
- include a specific reason when they deny a prior authorization request
- to send prior authorization decisions within 72 hours for expedited (i.e., urgent) requests and seven calendar days for standard (i.e., non-urgent) requests.
- publicly report certain prior authorization metrics

https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact

NCDs, LCDs, and CPBs

National Coverage Determinations - NCDs

- Policies published by CMS and the Medicare Administrative Contractors (MACs) to manage the cost and utilization of healthcare.
- National Coverage Determinations - NCDs - written and published by the Centers for Medicare and Medicaid Services (CMS).
- NCDs apply to traditional (Fee for Services, or FFS) Medicare and managed Medicare claims.
- NCDs apply to all Medicare and managed Medicare claims in the Unites States and its territories regardless of where in the US the services were provided, or which Medicare Administrative Contractor (MAC) has jurisdiction over the area.

Local Coverage Determinations - LCDs

- LCDs are like NCDs except they are written and published by the MACs.
- LCDs apply to traditional (Fee for Services, or FFS) Medicare and managed Medicare claims.
- LCDs apply to Medicare and managed Medicare claims in the MAC jurisdiction where the LCD was published.

NCDs and LCDs – What services are involved?

- NCDs and LCDs typically address coverage of diagnostic or therapeutic procedures or services (such as home health visits).
- NCDs and LCDs are especially focused on procedures and services that are high-cost, of questionable diagnostic or therapeutic value, or could be prone to fraudulent billing.
  - High cost: Implantable Cardiac Defibrillator
  - Questionable value: Acupuncture
  - Prone to fraudulent billing: Motorized wheelchairs

Local Coverage Determinations - LCDs

- LCDs typically cover procedures and services for which no NCD already exists.
- LCDs are not allowed to conflict with a respective NCD or other Medicare policy*.

*Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations13.5.1 - General Requirements *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf*

NCDs and LCDs – Where are they posted?

- CMS MCD = Medicare Coverage Database
- Where all NCDs and LCDs are stored
- Search by keyword, code, state, MAC

https://www.cms.gov/medicare-coverage-database/search.aspx

Clinical Policy Bulletins – Commercial Payers

- Primarily relate to outpatient services or procedures
- Payer-specific policies – may change every 6 months
- Consider creating a checklist of required documentation/diagnosis codes
  - Use as education for providers
  - Incorporate into appeal letter templates
  - Explain the ‘outliers’ in the appeal
    - “As a long-distance truck drive, Mr. Jones was unable to complete a course of physical therapy prior to his total knee replacement surgery. He did practice strength-training exercises while on the road as prescribed by his physician.”

Outpatient Denials and Appeals

UnitedHealthcare® Commercial
Coverage Determination Guideline

Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair

Guideline Number: CDG.002.19
Effective Date: April 1, 2021

Instructions for Use

Table of Contents Page

Related Commercial Policy
• Cosmetic and Reconstructive Procedures
Community Plan Policy
• Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair
Medicare Advantage Coverage Summary
• Blepharoplasty and Related Procedures

Outpatient Denials and Appeals

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair	
15820, 15821, 15822, 15823, 21280, 21282, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67912, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67950, 67961, 67966	Medical notes documenting the following, when applicable: • Planned procedure • Results of automated or manual, taped and un-taped, Reliable Visual Field testing • Marginal reflex distance (MRD-1) • Visual complaints, functional impairments and ruling out other causes • High-quality photograph(s); all photos must be full face, labeled with the date taken and the applicable case number obtained at time of notification, or member's name and ID number on the photograph(s) Note: Submission of color photos can be submitted via the external portal at www.uhcprovider.com/paan; faxes of color photos will not be accepted

For code descriptions, see the Applicable Codes section.

Outpatient Denials and Appeals

Upper eyelid blepharoptosis repair (CPT 67901–67909) is considered reconstructive and medically necessary when the following criteria are present:

- The member must have a Functional or Physical Impairment complaint directly related to the position of the eyelid(s); and
- Other treatable causes of ptosis are ruled out (e.g., recent Botox® injections, myasthenia gravis when applicable); and
- Eyelid droop (upper eyelid ptosis) and a Marginal Reflex Distance -1 (MRD-1) of 2.0 mm or less; and
- The MRD is documented in clear, high-quality, clinical photographs with the member looking straight ahead and light reflex centered on the pupil; and
- Automated peripheral or superior Reliable Visual Field testing, with the eyelids taped and un-taped, showing improvement of 30% (or 12 degrees) or more improvement in the number of points seen
  - In situations where computerized Reliable Visual Field testing is not available, we will accept manual Reliable Visual Field testing
  - In situations where Reliable Visual Field testing is not possible, see section below titled When the Member is Not Capable of Reliable Visual Field Testing

Note: For children under age 10 years, ptosis repair is covered to prevent amblyopia. Reliable Visual Field testing is not required, but high-quality, clinical photographs are required.

Case Studies

#1 Requesting Authorization Post Procedure

(Provider did not request authorization pre-procedure)

Summary of Facts

UnitedHealthcare denied this claim due to no authorization for CPT 43249 (esophagogastroduodenoscopy dilatation). Memorial Hospital is requesting retrospective authorization as the medical necessity is clearly established in the clinical record attached.

#1 Requesting Authorization Post Procedure

Justification for Appeal

J Doe was a 33-year-old woman who had undergone Roux-en-Y gastric bypass surgery for morbid obesity 5 weeks prior. She had done well for over 2 weeks, but then she began to vomit everything she ate. An upper GI showed high-grade stenosis of the anastomosis site (Consultation, p. 34). She had undergone one previous dilation of the site.

On 02/23/23, she underwent an esophagogastroduodenoscopy with balloon dilation of stenotic gastrojejunostomy anastomosis. The surgeon noted that the anastomosis was still friable and somewhat stenotic (Operative Report, p. 44).

#1 Requesting Authorization Post Procedure

J Doe’s treatment was clearly ordered by the physician as being required medical treatment. In the case now under appeal, a qualified physician clearly certified that J Doe required the medical treatment delivered by Memorial Hospital. The services rendered were deemed by the physician to be reasonable and necessary for the active treatment of the patient’s condition, and her condition would not have improved without the services rendered.

#2 Retro Auth for Additional Procedure

Summary of Facts

The provider attempted to obtain pre-authorization for coronary angiography (CPT 93458). On 1/6/2023, a payer representative informed the provider that authorization was NOT required for CPT 93458. A left heart catheterization was performed on 1/8/2023. Based upon blockage discovered during the procedure, a coronary artery stent was placed in the left descending coronary artery. The provider submitted an OP UB04 claim to the payer that included CPT 92928LD.

#2 Retro Auth for Additional Procedure

Justification for Appeal

J Doe was 61-year-old gentleman with recent development of chest pain and abnormal stress test results with significant ischemia noted suggesting potential LAD disease. J Doe underwent a left heart catheterization on 1/8/2023. A high-grade proximal left anterior descending stenosis was treated with a Xience drug-eluting stent (Cath Lab Report, p. 22).

The medical record documentation provided demonstrates the medical necessity for the coronary angiography performed and the subsequent stent placement. Rightfully, Memorial Hospital should be fully reimbursed for the CPT 92928LD.

#3 No Auth Emergency Procedure

Summary of Facts

Payer denied the following procedure codes for lack of prior authorization:

- Arthrodesis procedures on the spine (vertebral column), posterior, posterolateral or lateral transverse process technique arthrodesis (CPT 22614)
- Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (CPT 22842)

#3 No Auth Emergency Procedure

Justification for Appeal

J Doe, 58, had a medical history of metastatic renal cell carcinoma (RCC) on chemotherapy. He suffered acute onset and progressive bilateral lower extremity weakness with reduced sensation from below the umbilicus with urinary retention requiring Foley catheter placement. The weakness progressed to the point he could no longer ambulate, and his legs became numb.

Found to have destructive mass involving the left posterior elements, costovertebral junctions, paraspinal muscles, and epidural space from T8 to T10 causing severe spinal canal stenosis with cord compression/deformation at T9.

#3 No Auth Emergency Procedure

Justification for Appeal

Mr. Doe underwent the following emergency decompressive surgery (Operative Report, pp. 61 & 130):

- T7-T11 posterior spinal arthrodesis with allograft
- T9-10 laminectomies for spinal cord decompression and tumor resection
- T7-T11 posterior spinal instrumentation

The surgeon documented, “There was obvious spinal cord compression from epidural tumor and the tumor was removed with curettes and pituitary rongeurs. The spinal cord decompression was confirmed with intraoperative ultrasound.”

#3 No Auth Emergency Procedure

Justification for Appeal

Post operatively the oncologist noted: “Currently, Mr. Doe remains in NICU. His BLE weakness is already improving. There is concern for significant remaining tumor needing expedited radiation.

He has regained almost all his strength and sensation in the legs. He still feels slightly weak or wobbly when standing, but denies paresthesias, and just occasional altered sensation in the left foot. His prior severe flank/back pain, and pain with looking down, have all resolved after surgery. He is feeling optimistic now that his pain is much improved.”

Take-Aways

- Work with the physician's office to get referrals and authorization a week in advance – develop checklists of requirements
- Develop a process for obtaining documentation from the physician's office where conservative treatment or other measures are required before the procedure can be performed (implants, cardiac, orthopedics)
- It takes a team: To avoid denials you need OP CDI, coding, and medical necessity specialists
- Track denial trends = Root Cause
- Include medical necessity of procedure/service in your appeal

References

- *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422#422.138*
- *https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf*
- *https://www.cms.gov/files/document/opd-operational-guide.pdf*
- *https://www.cms.gov/files/document/opd-frequently-asked-questions.pdf*
- *https://med.noridianmedicare.com/web/jfa/cert-reviews/pre-claim*
- *https://www.cms.gov/files/document/opd-services-require-prior-authorization.pdf*

References

- *https://www.cms.gov/newsroom/fact-sheets/advancing-interoperability-and-improving-prior-authorization-processes-proposed-rule-cms-0057-p-fact*
- *Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations13.5.1 - General Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf*
- *https://www.cms.gov/medicare-coverage-database/search.aspx*

Questions and Answers

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Thank you for attending today's event!

For more information, please contact:

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For slides or a recording of the webinar, please check the AHDAM website at AHDAM.org in a few days or contact info@ahdam.org

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