
Although Medicare fee schedules are commonly lower than commercial rates for most procedures (including vein ablations), this has been balanced by the relative ease of use. The current process is such that CMS and MACs publish coverage determinations with appropriateness criteria, and physicians are expected to know and follow the rules. As such, when you have a fee for service Medicare patient who you know meets criteria for an endovenous vein ablation, you can simply schedule the patient, do the surgery, and submit a charge with an expectation that you will be paid. Of course, being consistent with Ronald Reagan’s adage of “trust but verify,” CMS conducts both random and for cause audits and reserves the right to claw back payments in cases of error or to impose penalties in cases of fraud.

However, things are about to change. CMS announced this in November 2019 (61142 Federal Register / Vol. 84, No. 218 / Tuesday, November 12, 2019 / Rules and Regulations 42 CFR Parts 405, 410, 412, 414, 416, 419, and 486). No longer satisfied with the look back option, CMS is implementing a new preauthorization procedure for a limited number of procedures performed in hospital outpatient departments. These changes are scheduled to go into effect on July 1, 2020. Full details of the policy change can be viewed at http://go.cms.gov/OPD_PA. CMS conducted an informational session on May 28, 2020 and answered questions relating to the program.

Here are some details that you should know:

1. What case types are included?
   a. Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and **Vein Ablation**. (43 total CPT codes)

2. What programs are affected?
   a. Medicare Fee for service only!

3. When does this start?
   a. Medicare MACs begin accepting prior authorization requests on June 17, 2020
   b. Prior authorization required for cases performed after July 1, 2020

4. What sites of service are required to file prior auth requests?
   a. Hospital Outpatient Departments (OPDs)
   b. Not ASCs, not office based
5. Are there specific forms to be submitted?
   a. No there are not specific forms, the provider must submit documentation that “supports medical necessity.” The MACs may provide a face sheet.

6. Whose responsibility is it to submit the prior auth request?
   a. The OPD is responsible for filing the prior authorization request
   b. However, the physicians’ office may submit on behalf of the OPD

7. What happens if prior authorization is not submitted/approved?
   a. Payment to the OPD and all associated charges for this procedure (i.e. physician payment) will be denied

8. How long will the process take?
   a. Response from the MAC is promised within 10 days.
   b. There is an expedited option available to request 2 day turn around.

9. What will the response be?
   a. If approved, a “Provisional Affirmation” will be provided
   b. Decision letters will contain a Unique Tracking Number (UTN)
   c. Claims submitted must contain this UTN which acts at the approval number
   d. It is assumed that having provisional approval results in payment of the claim, claims will be further review only if subject to random audits or for cause

10. What if the request is “Not Affirmed?”
    a. A letter will provide a detailed explanation for the decision
    b. Requester can resolve the non-affirmation reasons described in the decision letter and resubmit the prior authorization request
    c. or A requester can forego the resubmission process, provide the hospital OPD service, and submit the claim for payment. The claim will be denied. All appeal rights are available.

11. Can I appeal payment denial if the case is done without Prior Authorization?
    a. Yes, but this appeal process may result in significant payment delays, will increase your practice expense relating to refiling, and may be rejected